Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

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

1.15 pm to 4.30 pm, Wednesday 19 November 2025
(Private pre-meet for members 1.00 pm; meeting in public 1.15 pm)
HEART: Headingley Enterprise and Arts Centre, Bennett Road, Headingley, Leeds, LS6 3HN

AGENDA

No.	Item	Lead	Page	BAF Link(s)	Time
1	**Welcome, Introductions**	**Rebecca Charlwood** Independent Chair	-	N/A	1.15
2	**Apologies and Declarations of Interest** - To note and record any apologies. - A register of interests of members can be found at mydeclarations.co.uk. Once redirected to the portal, please select 'filter', and in the 'All decision-making groups' field, select 'Leeds Committee of the WYICB' from the drop-down box.	**Rebecca Charlwood** Independent Chair	-	N/A	-
3	**Minutes of the Previous Meeting** - To approve the minutes of the meeting held 3 September 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	015	N/A	-
6	**People's Voice** - To receive a lived experience of health care services in Leeds: People's experiences of digital health and care – Keeping every door open: Ensuring access beyond digital in health and care. Members are also requested to watch the video Diane and Gemma May 2025 update part 1 prior to the meeting.	**Healthwatch Leeds Co-Chair**	017	N/A	1.20
7	**Questions from Members of the Public** - To receive questions from members of the public in relation to items on the agenda.	**Rebecca Charlwood** Independent Chair	-	N/A	1.35

No.	Item	Lead	Page	BAF Link(s)	Time
8	**Place Lead Update** - To receive the attached update from the Place Lead.	**Tim Ryley** Place Lead	Verbal	N/A	1.45
ROUTINE REPORTS					
9	**Quality and People's Experience Sub-Committee Update** - To receive an assurance report from the Chair of the sub-committee.	**Rebecca Charlwood** Independent Chair and Chair of the Quality and People's Experience Sub-Committee	050	N/A	2.15
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	054	N/A	2.20
FINANCE					
11	**Financial Position Update** - To receive an update on the financial position.	**Alex Crickmar** Director of Operational Finance	057	3.2	2.25
BREAK 2.40 – 2.50					
ITEMS FOR DECISION / ASSURANCE / STRATEGIC UPDATES					
12	**NHS Planning Framework** - To receive assurance on the process followed in developing the local plans.	**Sabrina Armstrong** Director of Partnership and Operations	074	3.1 3.2 3.3	2.50
13	**Chapel Allerton Hospital New Elective Care Centre** - To approve the business case.	**Rob Hakin** Director of Healthcare Planning, Leeds Teaching Hospitals NHS Trust	091	2.4	3.15
14	**Proposed Merger of Ashton View and Conway Practices** - To consider the proposals.	**Kirsty Turner** Associate Director of Primary Care	103	3.1	3.35
GOVERNANCE / RISK MANAGEMENT					
15	**Risk Register (Cycle 3 2025/26)** - To receive and consider the risk management information provided.	**Tim Ryley** Place Lead supported by **Asma Sacha** Risk Manager	147	All	3.50
FORWARD PLANNING					
16	**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	4.00
17	**Forward Workplan 2025/26** - To consider the workplan and any further items to be added.	**Rebecca Charlwood** Independent Chair	197	N/A	4.05
18	**Any Other Business** - To discuss any other business.	**Rebecca Charlwood** Independent Chair	-	N/A	4.10

No.	Item	Lead	Page	BAF Link(s)	Time
19	**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 11 February 2026 (private pre-meet for members 1.00 pm; meeting in public 1.15 pm) at HEART: Headingley Enterprise and Arts Centre, Bennett Road, Headingley, Leeds, LS6 3HN	**Rebecca Charlwood** Independent Chair	-	N/A	-

Draft Minutes

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

2.00 pm, Wednesday 3 September 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
Dan Barton (deputising for JL)	DB	Deputy Director for Learning, Leeds City Council
Alex Crickmar	AC	Director of Operational Finance, ICB in Leeds
Tim Fielding (deputising for VE)	VE	Public Health, Leeds City Council, Leeds Teaching Hospitals NHS Trust
Dr Sarah Forbes	SF	Medical Director, ICB in Leeds
Pip Goff	PG	Volition Director, Forum Central
Jo Harding	JH	Director of Nursing and Quality, ICB in Leeds
Mike Harvey (deputising for PW)	MH	Director of Transformation, Leeds Teaching Hospitals NHS Trust
Cheryl Hobson	CH	Independent Member – Finance and Governance
Yasmin Khan	YK	Independent Member – Health Inequalities
Jane Mischenko	JM	Co-Chair, Healthwatch Leeds
Andrea Osborne (deputising for SM)	AO	Executive Director of Finance and Resources, Leeds Community Healthcare NHS Trust
Tim Ryley	TR	Place Lead, ICB in Leeds
Dr George Winder	GW	Chair, Leeds GP Confederation
In attendance		
Dawn Bailey (minute 34)	DBa	Chief Officer/Consultant in Public Health (Health Protection and Sexual Health), Leeds City Council
Sue Baxter	SB	Head of Partnership Governance, WY ICB
Nick Earl (minutes 35 and 36)	NE	Associate Director of Population Health, ICB in Leeds
Nick Lamper	NL	Governance Manager, WY ICB
Asma Sacha (minute 37)	AS	Risk Manager, WYICB
Apologies		
Caroline Baria	CB	Director of Adults and Health, Leeds City Council
Victoria Eaton	VE	Director of Public Health, Leeds City Council
Julie Longworth	JL	Director of Children and Families, Leeds City Council

Dr Sara Munro	SM	Chief Executive, Leeds and York Partnership Foundation Trust and Chief Executive Designate, Leeds Community Healthcare NHS Trust
Prof. Phil Wood	PW	Chief Executive, Leeds Teaching Hospitals NHS Trust

Members of public and/or staff observing – 0

22 WELCOME AND INTRODUCTIONS

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

23 APOLOGIES AND DECLARATIONS OF INTEREST

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

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

In respect of the item on Procurement of Short-Term Community Beds (minute 33 below), a number of partners were potential providers of the service. In addition to seeking the approval of the procurement process, the report recommended reinvestment of the current spend on beds into an integrated model. As prospective providers, AO and GW declared direct financial interests and would withdraw to the public gallery during the consideration of the item.

It was acknowledged that a number of partners were potentially involved in other items on the agenda but 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.

24 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 21 May 2025 were approved as an accurate record, subject to the amendment of “the ICB footprint” to “revised ICB responsibilities” at the end of the eleventh paragraph of the preamble to minute 8.

The Leeds Committee of the WY ICB:

- **APPROVED** the minutes of the previous meeting held on 21 May 2025, subject to the above amendment.

25 MATTERS ARISING

No matters were raised.

26 ACTION TRACKER

There were no current open actions.

27 PEOPLE'S VOICE

JM presented the Healthwatch report: "What trans and non-binary people told us about GP care". The report had been published in July 2025, prior to the issue of any guidance following the Supreme Court judgment on the meaning of "sex" in the Equality Act 2010.

The committee's discussions were very much focussed upon the importance of the provision of compassionate care to all.

The Chair believed this to be an interesting national report and GW welcomed it, noting that the local response was already in place. He congratulated the ICB on commissioning an incentive scheme to provide training towards the "Pride in Practice" award, which many Leeds practices had taken up.

The Chair observed that a possible digital solution to some of the issues around sex and gender could be both sex and gender markers.

DB commented that all children attending school who may be on a trans pathway would one day become adults; it may therefore be helpful to see how this applied to schools.

PG welcomed the report and TR noted that the recent changes had affected people in what could be a hostile environment for them.

AO asked whether the training offered to GPs could be expanded beyond Primary Care and MH concurred that there may be opportunities, for example, at LTHT. YK added that, irrespective of the court ruling and subsequent ongoing appeal process, it was important to educate people to have compassion, and thereby provide assurance.

TF agreed with the need for consistent, integrated training, with compassion and understanding at its forefront, to underpin the report's first recommendation, and noted the need for sex-specific healthcare issues to be taken into account in matters such as invitations for screening, in line with its second. JF added that there was a need to await national guidance in relation to a number of issues, such as the treatment of markers for under-18s.

Referring to intersectionality and the many minority groups, DB noted the importance of looking to aggregate the learning, not only across staff but also society.

JM would check whether Healthwatch England had received a response from the government, and acknowledged the suggestion of a need for cultural competency training across healthcare leaders. She added that the focus of the report had been on Primary Care because it was seen as a gateway to healthcare, and noted that most negative experiences had been encountered by those who were also neurodivergent.

The Leeds Committee of the WY ICB:

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

28 QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been submitted.

29 PLACE LEAD UPDATE

TR presented a report providing an overview of the NHS ten-year plan and a summary of some of the work being undertaken in response to this, in terms of neighbourhoods and provider partnerships. These changes had also been reflected in the revised NHS planning guidance and new performance assurance framework.

The report also set out leadership changes across the NHS in Leeds and the implications for the committee's work and the city's health and care agenda, as well as providing an update on winter planning, neurodiversity and weight management.

TF referred to the new NHS performance framework and noted its comparability to the Local Government Outcome Framework. There was a need for a conversation about the relationship between the two and to talk about the One City Ambitions and draw connections as a partnership. The Chair suggested this could be brought together at a future development session.

DB saw an opportunity for Leeds to shape national policy and suggested that, when determining what was meant by neighbourhoods, consideration should be given to co-terminosity.

The Leeds Committee of the WY ICB:

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

30 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.

The Leeds Committee of the WY ICB:

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

31 FINANCE, VALUE AND PERFORMANCE SUB-COMMITTEE ASSURANCE REPORT

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

JM referred to the Adult Neurodivergence Services: Deep Dive, and asked whether a similar exercise had been undertaken in respect of children and young people. CH responded that another report may be coming in respect of this.

The Leeds Committee of the WY ICB:

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

32 FINANCIAL POSITION UPDATE

AC presented a report providing an update on the month 4 financial position of the ICB in Leeds, the wider Leeds Place, and West Yorkshire Integrated Care System (ICS).

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

The ICB in Leeds was 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; and £2.7m stretch across LTHT, LYPFT and LCH). However, there were 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 was reporting a month 4 position of £18.3m deficit, which was circa £7m adverse to plan. This was driven by the positions 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 had deteriorated from the adverse variance at month 3 of £4.0m. The deterioration in-month had been driven predominantly by £3.7m cost of industrial action which would not be covered by national funding, and £3.2m of pay overspends.

TR noted that the way of working with West Yorkshire delegating money and responsibility to places was good, but sometimes made places reliant upon West Yorkshire decisions and policies for which the timelines did not align (such as, for example, with the weight management and neurodiversity services). This would be noted in the Alert section of the committee's AAA Report.

PG asked whether commissioning of the third sector had been considered as part of deconstructing the block of contracts. AC responded that there was a move away from activity-based towards outcome-focussed contracts.

DB noted the CHC efficiencies and suggested that early intervention would give future savings. TR commented that Home First Phase 2 looked into the prevention space, supporting people to be healthier for longer, with the consequence of reducing need for CHC.

The Chair commented that, nationally, there were areas of inequity for CHC provision. She asked how the efficiencies would affect that inequity in Leeds, and how decisions were made in respect of who did and did not receive the provision.

TR responded that there was a clear national framework for assessment, but wide variation in expenditure from place to place, with West Yorkshire being slightly above the average. There was also a dependency upon the relationship with the care sector due to the need to work closely with adult social care in setting rates. There was also a lot of demand for two-

to-one care, with a need to consider whether this was required 24 hours a day or for smaller time slots. There was therefore a whole set of factors and work was being undertaken to ensure that differential decisions were not being made.

The Leeds Committee of the WY ICB:

- **RECEIVED** and **REVIEWED** the ICB in Leeds month 4 position including key risks and mitigations, the Leeds Place month 4 position, and the West Yorkshire ICS Financial Position.

(The meeting was adjourned for a break at 3.00 pm and reconvened at 3.10 pm.)

(DBa and NE joined the meeting.)

33 PROCUREMENT OF NEW CONTRACT FOR INTERIM PROVIDER OF SHORT-TERM COMMUNITY BEDS

(A number of partners were potential providers of this service. In addition to seeking the approval of the procurement process, the report recommended reinvestment of the current spend on beds into an integrated model. As prospective providers, AO and GW declared direct financial interests and withdrew to the public gallery during the consideration of the item.)

TR presented a report, on behalf of Helen Lewis, outlining the recommended procurement route for the Short-term Community Beds. The committee was asked to approve the choice of the selected Provider Selection Regime (PSR) process, in line with the WY ICB financial scheme of delegation as the contract value exceeded £5m. The scheme of delegation required 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 was competitive process through the Provider Selection Regime, which would allow the ICB to assess the capability of all interested providers.

The spend related to the contract was classified as current spend, rather than new or repurposed spend, as there were several existing service providers and the service was a key element of the journey of care for Leeds, to ensure improved outcomes both on discharge and admission avoidance. The community bed service was a core element of intermediate care in line with national guidance. Considerable improvement work had taken place over the previous two years, with further efficiencies having been embedded, which had led to a lower spend and better outcomes. Having previously been judged as having too much dependency on bed-based rehabilitation, the system had 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 would be £17,600,000 (at 2025/26 prices). This embedded the recurrent QIPP achieved in 2024-26 but had also been adjusted to allow for a higher dependency of patients through some of the beds. This contract value consolidated additional staffing, so reducing 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 was 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 was in recognition that the service was an essential element of intermediate care provision and part of a complex set of service interactions which could and should change over time.

YK welcomed the move to a 10-year contract cycle but wondered whether the initial eight-year period should be shorter; she asked about measures to address delivery, performance and accountability, as well as alignment with equality of access and outcomes.

Addressing the point on alignment with equality of access and outcomes, TR advised that the purpose element could be strengthened; in respect of the eight-plus-two contract period, he gave assurance that there were sufficient levers around the contract to address poor performance.

The Chair asked whether the opportunity for financial renegotiation would be included, and TR responded that this would be for both parties, but was usually based upon mutual agreement.

The Leeds Committee of the WY ICB:

(1) **APPROVED** the Provider Selection Regime (PSR) route for the Short-term Community Bed service;
(2) **NOTED** that the recommended route for procurement was Provider Selection Regime: Competitive Process;
(3) **APPROVED** the reinvestment of the current spend on beds into an integrated model; and
(4) **DELEGATED** the approval of the selected provider to the Accountable Officer and Director of Operational Finance in consultation with the Chair, as this stage of the process would be due around 17 December and could not wait until the next formal meeting of the committee for approval as this would delay award and mobilisation.

34 DIRECTOR OF PUBLIC HEALTH REPORTS

Marmot City Update

TF provided a verbal update on this work. The Institute of Health Equity (IHE) was very engaged in the work and keen to continue working closely with partners in Leeds. Further information on the forthcoming event would be available soon. Work was ongoing around the indicator set, healthy housing, place and regeneration, and the Best Start initiative (for 0–5-year-olds). There was a lot of alignment with other health inequalities work and the Health and Care Inequalities Oversight Group was heavily involved.

The Leeds Committee of the WY ICB:

- **RECEIVED** and **NOTED** the update.

Director of Public Health Annual Report – "Heat In The City: Our Health in a Warming Leeds"

DBa presented a report providing 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.

The report gave an outline of opportunities for citywide, system collaboration to achieve the recommendations within the 2025 Director of Public Health Annual Report. It also set out key findings and recommendations contained within the Director of Public Health Annual Report 2025, focussing on actions to address the health impact of rising temperatures through a holistic approach.

Also provided was 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).

YK asked about implementation of the recommendations and noted the existence of similar issues in hospitals. The impacts were on the wider system rather than just communities. She also asked how the system could hold itself accountable.

DB observed that the same social gradient tended to be constant across all things. He noted that trees on streets could mitigate the effect of heat, and that the cycle of refreshing school buildings was a slow one. Community spaces (including churches) had a role to play and there was a need for other strategic alignment.

MH was attempting to understand where these responsibilities rested in terms of governance within Leeds and acknowledged that partners could not solve these issues individually. DB suggested that progress could only be made strategically in steps, and asked whether data was available to indicate who was most at risk.

DBa advised that there was a lot of data available and attempts were being made to be as specific as possible about the impact of heat and who was most vulnerable. She drew the committee's attention to the annual report's first recommendation – that Leeds City Council, Leeds Health and Care Partnership, anchor organisations and the third sector work collaboratively to promote and implement the advice and actions in the UK Health Security Agency Adverse Weather and Health Plan. The report had been presented to the Health and Wellbeing Board, which was responsible for the overall governance.

TF added that the annual report included feedback on the recommendations from that of the previous year's. TR suggested that each partner be required to feed back to the Health and Wellbeing Board to advise what actions it was taking to address the annual report's first recommendation.

The Leeds Committee of the WY ICB:

(1) **NOTED** the key findings and recommendations of the 2025 Director of Public Health Annual Report, Executive Summary Report, and film 'Heat In The City: Our Health in a Warming Leeds'; and

(2) **COMMITTED** to exploring opportunities for city-wide, system collaboration to achieve the recommendations within the 2025 Director of Public Health Annual Report.

(DBa left the meeting.)

35 HEALTH INEQUALITIES CORE20PLUS5 UPDATE

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

The report sought to provide assurance that the ICB in Leeds was exercising its functions in respect of the need to reduce health inequalities and to highlight the evolution of the Core20+5 approach within Leeds. The committee was 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.

The Chair observed that ICBs were changing but health inequalities would remain. YK asked how the twice-yearly reporting would be undertaken in the future. NE responded that it would be ensured that corporate performance metrics had a lens which cut across inequalities. YK suggested it was useful to have a starting point as well as a trajectory. TF concurred with this and believed that the work of the Healthcare Inequalities Oversight Group had been really important and it was essential to recognise this. This would be noted in the Assure section of the committee's AAA Report. PG added that the group had undertaken a good piece of work around the provider collaborative.

JM was pleased to see that this would be a part of core business; the dashboard would flag areas where there was a need to dive deeper.

The Leeds Committee of the WY ICB:

(1) **RECEIVED** the assurance that the ICB in Leeds was, in the exercise of its functions, having regard to the need to reduce health inequalities; and
(2) **NOTED** 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.

36 WORK, SKILLS AND HEALTH PROGRAMME UPDATE – HEALTHY WORKING LIFE

NE presented a report providing an awareness and update on the Leeds Healthy Working Life Programme (previously known as Health and Growth). The report aimed to provide an update on progress to date and the key learning.

NE advised that a further report would be brought to the committee in February if funding were received for the coming year.

AO observed that it was important to obtain buy-in to the programme from the outset.

NE explained that evaluation took place at the level of the national programme, the West Yorkshire component, and the Leeds element. The target metrics were really clear.

DB spoke of the importance of marrying up the symptom and prevention work, and PG observed that it was different for some organisations because they did not have the money or certainty of funding.

TR asked how much of the money was being held up by ICB governance mechanisms. NE advised that this was not known specifically in relation to the money, but on speed of decisions West Yorkshire was moving very quickly.

The Leeds Committee of the WY ICB:

(1) **RECEIVED** the update on the Work, Skills and Health Programme with a focus on the Leeds Healthy Working Life Programme;
(2) **ACKNOWLEDGED** the very positive work and implementation that had been completed in a relatively short timescale by all providers; and
(3) **AGREED** that, if recurrent monies be confirmed for 2026/27, a recommendation be brought by the ICB matrix team to the ICB committee in February 2026 regarding the schemes that might be continued, stood down, or modified.

(The Chair stepped out of the meeting briefly and CH took the Chair.)

37 RISK REGISTER (CYCLE 2 2025/26)

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

The report included the Cycle 2 review of the Board Assurance Framework (BAF) for all five places; 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.

TR remarked that most of the high-level risks set out in the report had been picked up in other reports at the meeting.

Referring to Risk 2550 (the risk that initial health assessments for children in care would not be completed within the statutory time frames), AS advised that this had been added to all place risks registers, although there was some variation in score between places. TR added that the longer length of contracts would take into account health inequalities, social values and quality impact assessments. PG suggested that the reduction in third sector provision would lead to a need constantly to check and challenge. JM asked specifically about the delays in initial health assessments for looked after children, and JH advised that there was a potential delay between the identification of need and capacity being allocated.

The Leeds Committee of the WY ICB:

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

38 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 Wheatfields Hospice, Maternity Service at Leeds Teaching Hospitals NHS Trust, Month 4 Financial Position, delivery of West Yorkshire priorities in place, and partnership working on health inequalities.

(The Chair returned to the meeting but CH remained in the Chair for its remainder.)

39 FORWARD WORK PLAN 2025/26

TR advised that planning submissions would be considered at the forthcoming meetings, with the planning guidance being brought in November and the final version of the plan coming in February. The development session scheduled for 24 September would be postponed.

The Leeds Committee of the WY ICB:

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

40 ANY OTHER BUSINESS

PG advised that she would be circulating to members details of an event celebrating the work of the Leeds Poverty Truth Commission, to be held from 4.00 to 6.00 pm on Monday 3 November 2025 at Leeds Civic Hall.

41 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 19 November 2025 at HEART: Headingley Enterprise and Arts Centre, Bennett Road, Headingley, Leeds, LS6 3HN.

The meeting concluded at 4.30 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.	6
Meeting date:	19th November 2025
Report title:	Are you keeping every door open? Ensuring access beyond digital in health and care.
Report presented by:	Jane Mishcenko and Jonathan Phillips – Co-chairs, Healthwatch Leeds.
Report approved by:	
Report prepared by:	Harriet Wright, Development and Sustainability Manager, Healthwatch Leeds

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

Previous considerations:

The briefing paper builds on previous Healthwatch Leeds reports, including Digitising Leeds: Risks and Opportunities for Reducing Health Inequalities in Leeds (2020, Healthwatch Leeds and People's Voices Partnership) and the accompanying briefing focusing on people at risk of health inequalities, Digitising Inclusion Leeds: How does it feel for me? The briefing also touches on digital in the context of reports that Healthwatch Leeds has written about people's experience of cost of living, repeat prescriptions, and digital appointments.

Executive summary and points for discussion:

This is our sixth report that considers people's experience of digital. Digital exclusion has and continues to be one of the key issues that we hear about when people talk about their experiences of trying to access health and care.

The briefing paper considers why it is essential that we need to get the move from analogue to digital (as set out in the NHS's Fit for the Future – 10 year health plan for England, 2025) right for people, particularly those who are more likely to be digitally excluded. It identifies six key risks to people if this isn't done properly:

- Making it more difficult for some people to access care.
- Widening existing health inequalities.
- Reducing independence and placing additional pressure on families and carers.
- Lowering motivation to engage with services or self-manage health due to remote consultations.
- Negatively affect communication and understanding between professionals and people accessing care.
- Increasing the risk of people relying on inaccurate or unsafe information, including from Artificial Intelligence (AI).

It also outlines five key recommendations:

1. **Ensure non-digital options are always made available.**
    - Ensure that paper-based, in-person, and phone options remain available alongside digital services and make sure these are proactively communicated to people.
2. **Make sure that digital modes of delivery aren't compromising quality or engagement.**
    - People's feedback on digital or virtual service delivery should be actively and continuously sought and acted on to ensure services are meeting needs and that digital delivery doesn't compromise the quality of experience or engagement.
    - Levels of engagement with digital or virtual services should be monitored, and where people have disengaged, efforts should be made to understand why.
3. **Improve digital support and training**
    - Provide accessible support and training for those wanting to learn how to use digital healthcare services, ideally within GP practices.
    - Increase digital confidence-building initiatives, especially for older people and those with language barriers.
    - When things become digitised, or online platforms or apps change, make sure people are kept up to date and provided with any support needed to manage the change.
4. **Healthcare staff awareness**
    - Staff should be trained to understand digital exclusion, ask about needs and not make assumptions about people's level of digital skills and confidence.
5. **Ensure inclusive digital services**
    - Systems should be co-designed and tested with people and their carers to ensure they are user-friendly and inclusive for users with low literacy, disabilities, and limited digital access.
    - Improve the functionality for unpaid carers or family members managing multiple profiles on digital healthcare systems.
    - Ensure alternative contact methods (text, online chat) are available for those who cannot use phonelines.

We will be writing to all key NHS providers and the local authority with a request for them to individually respond to these recommendations.

We would also like to know how you as the Leeds Committee can help us to really move forward with these recommendations and would be happy to work with you on this.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)
The Leeds Committee of the West Yorkshire Integrated Care Board is asked to: 1. Consider how it can work with Healthwatch to help it move forward with the recommendations.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
Appendices
1.
Acronyms and Abbreviations explained
1.

What are the implications for?

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

Keeping every door open: Ensuring access beyond digital in health and care.

September 2025

Contents

1. Introduction

With the NHS 10-year plan published this year focusing on the shift from analogue to digital in health services, this briefing considers why we need to get this move right for people, what services can do to help and the risks to people if it isn't done properly.

It draws on people's experiences of accessing health and care digitally and by phone in Leeds. It is based on feedback from the public shared with Healthwatch Leeds between January 2020 and September 2025 via their information and advice service, outreach to healthcare and community organisations, and the West Yorkshire Voice Network.

The briefing builds on previous Healthwatch Leeds reports, including Digitising Leeds: Risks and Opportunities for Reducing Health Inequalities in Leeds (2020, Healthwatch Leeds and People's Voices Partnership) and the accompanying briefing focusing on people at risk of health inequalities, Digitising Inclusion Leeds: How does it feel for me? The briefing also touches on digital in the context of reports that Healthwatch Leeds has written about people's experience of cost of living, repeat prescriptions, and digital appointments.

1.1 Terms used in this report

Digitisation means the adaptation of a system or process to be operated with the use of computers and the internet. In the context of this report, it refers to the use of digital platforms to deliver, manage, and receive care and includes (but is not limited to):

- **GP appointment booking services** (e.g. NHS App, PATCHs, SystmOne, Patient Access).
- **Online hospital appointment booking systems.**
- **Remote consultations** via video or phone.
- **Online repeat prescription services**.
- **Patient portals** give people access to their records and test results.
- **Automated messaging** for appointment reminders or similar.
- **Digital tools to manage health** such apps and equipment to manage medical conditions, such as monitoring of blood sugar levels for diabetes.

Digital inclusion ensures that people have equal access to devices, skills, and the confidence to use digital systems. In healthcare, this means removing barriers so people can benefit from digital health and care services if they choose to.

Digital exclusion occurs when people cannot access these services. Digital exclusion can happen to anyone and often has a variety of factors contributing to it.

The 2020 Digitising Leeds report identifies eight key risk factors for digital exclusion. These are backed up by national research from the Good Things Foundation, Health inequalities and mitigating risks of digital exclusion (2024). This is well worth a read in terms of the specific barriers often faced by people with protected characteristics and others who are more at risk of digital exclusion.

1. **Low incomes.**
2. **Older age.**
3. **Literacy, language barriers and communication.**
4. **Skills, confidence and motivation.**
5. **Socially excluded / health inclusion groups** – people experiencing homelessness, substance misuse, asylum seekers, sex workers, those in contact with the criminal justice system, Gypsy, Roma, and Traveller communities, and victims of modern slavery.
6. **Privacy** – not having a private place to access digital/phone interactions that can make it difficult to discuss medical information or disclose sensitive issues.
7. **Disability, impairments and health conditions.**
8. **Trust in digital.**

- Concerns around data privacy and security (e.g. data breaches).
- Concerns about the accuracy of digital tools used in tests/diagnostics.
- Confidence in the thoroughness/appropriateness of virtual consultations.

"How can a doctor see my health over the phone?"

"I've been diagnosed with a medical condition for which I now have been recommended to take medication for the rest of my life based on one phone call. That doesn't feel properly investigated or substantiated."

Many people will have several of these risk factors, which can increase their level of digital exclusion.

2. What the national context says

A framework published by NHS England in 2023, NHS England's Inclusive Digital Healthcare Framework, provides guidance to NHS staff on ensuring that digital health services are accessible to all, and complementary to non-digital services, rather than replacing them. This framework

emphasises the need to design services that are centred on people's preferences and experiences. It recognises that giving people the opportunity to choose an option that works for them is essential when designing services that are equitable and inclusive.

More recently in 2025, Fit for the Future – 10 year health plan for England boldly outlined the 'radical shift' from Analogue to digital, with a vision for the NHS to be a leader in the technological revolution of healthcare. The plan describes how by 2028 "The NHS App will be the front door to the NHS," and how people will be able to use it to book and manage appointments, order prescriptions, view their data, and communicate with their health team. The focus on the plan is on digital inclusion and making digital accessible to as many people as possible.

For example, it outlines plans to codesign and test aspects of the NHS App with people to make sure it is inclusive and user-friendly. It also talks about providing people with the support they need for digital access.

"A digital NHS will be a force for inclusion, by giving voice, control and choice to those otherwise denied it... Our commitment is that people who have not previously been able to access and use healthcare on their own terms will, through digital technology, be able to."

Whilst the emphasis in the plan is clearly to encourage as many people as possible to use, and want to use digital, there is an acknowledgement in the conclusion that: "For those who prefer or rely on in-person care, that choice will remain."

3. The good stuff - what people tell us they like about digitisation

We want to start with the good stuff. We know from what people tell us that for many people, digitised health and care services can make their experience of interacting with health and care services better in the following ways:

- Being able to do tasks remotely can give people a greater degree of convenience, flexibility, and autonomy.

"I like using e-forms and systems when contacting my NHS GP as it saves hanging on to a telephone and means I can request most things without having to go into the surgery."

- Booking appointments online or via an app can work better for people when their health condition or disability makes it difficult to text or answer a phone call.

- Patient portals like the NHS App can give people easy access to medical records, appointments, prescriptions, and test results, helping them actively manage and engage with their health.

"It's so much easier ordering from the [NHS] app, it makes it clear when I need to order again."

- Many health services in Leeds now offer virtual phone or video appointments. Speaking to a GP over the phone can be more comfortable for some people than attending an in-person appointment. It may also reduce the need to travel.

"I could book a telephone appointment which was easier for me due to work commitments."

- Trusted digital platforms can provide some people with easier access to reliable information about their health and how to manage their health and care.

4. Why choice still matters

It is clear from the 10-year plan that there is real push towards 'digital by default' both to improve efficiencies in the NHS but also leading for better experiences for many as outlined above. This is alongside a clear

commitment to try and make digital ways of accessing healthcare accessible for as many people as possible.

However, the commitment to offering choice is still stated in the plan, and it is absolutely vital that this is not lost in the shift from analogue to digital. There is a significant proportion of the population who either rely on or prefer non-digital ways of accessing health and care support. This will inevitably continue to be the case, despite all the promises in the ten-year plan to upskill people and communities and make digital technology more accessible. There are some people for whom digital will always remain out of reach.

There are various reasons why people now and, in the future, will continue to need the choice of non-digital ways of engaging with healthcare including:

- Wanting in-person human interaction or the ability to have a two-way conversation about certain aspects of their healthcare.
- Communication, cognitive or accessibility needs or personal situations result in barriers to digital access.
- Lack of digital skills and confidence.
- Personal preference.
- Mistrust of digital tools and systems.

Healthwatch Leeds has heard of health and care services completely replacing or reducing non-digital ways of accessing care and support. For example, currently, there is no way to make initial contact with Leeds City Council's Adult Social Care service face-to-face. Instead, people looking for information about support or wanting to make a referral are directed online or to a phoneline.

Someone recently contacted us with concerns that their GP was no longer allowing them to phone and make appointments, instead asking everyone to book online via PATCHS. Although non-digital options were offered – either to phone and go through the online triage form with a receptionist or walk to the surgery to fill out a paper triage form - they felt that these options made it more difficult for people without digital access to book an appointment.

"Older people are not techno-savvy. Others who have technology may well have older laptops, etc, that are very slow. My own laptop does not allow me to fill in forms online…. This is ageist and unfair to all age groups, especially those on low incomes."

We are hearing about a reduction in face-to-face offers across the health and care system in Leeds. When a phone is the only 'non-digital' option provided, this can also be difficult for people, especially when they are

experiencing mental health distress. We have heard this especially in relation to autistic people and the organisations that support them.

"When I am in crisis, I can sometimes lose my ability to speak, so have nowhere to go. I would go for text services like SHOUT or Samaritans for their text service, but there isn't a local option."

Deaf people and those with other health needs can also face barriers when healthcare services rely solely on phonelines to make appointments. Without alternative contact methods, they risk missing out on care.

"I'm judged, feel frustrated and can't access because of autism and hearing loss."

While some people like elements of phone appointments, others face logistical barriers to them, including:

- Appointments being given a wide timeframe which can make it difficult for people to ensure their availability, particularly those who are working.
- Unreliable signal or lack of phone credit.
- Can reduce the quality of interactions feel impersonal.

"When I phone, I forget what to say, and it feels rushed. I prefer face to face."

“It's difficult to describe a pain over the phone as you can't show them where it is. It doesn't work.”

If choice in how to access services is lost, there will be real risks to many people and their health.

5. Risks of the shift from analogue to digital for people

We have identified the following six risks to people and their carers associated with the increasing shift from analogue to digital.

- **Making it more difficult for some people to access care.**
- **Increasing health inequalities.**
- **Reducing independence and placing additional pressure on families and carers.**
- **Virtual consultations affecting people’s motivation to engage with services and self-management of health.**
- **Communication – negatively affecting understanding and interpretation of information.**
- **People accessing incorrect information from unreliable sources and Artificial Intelligence (AI).**

5.1 Making it more difficult for some people to access care.

By not offering meaningful non-digital alternatives to make and attend appointments, we are making it more difficult for people who are digitally excluded to access care. This is particularly an issue for people trying to access their GP and can lead to people delaying or giving up seeking treatment or seeking alternatives such as going to A&E or calling NHS 111.

Even for people with some level of digital skills and confidence, apps and online systems are not always well designed and user-friendly, which can result in poorer access and user experience.

5.2 Increasing health inequalities.

Our 2020 Digitising Leeds report highlighted that those already facing health inequalities due to other factors are also more likely to be digitally excluded.

People on lower incomes are at greater risk of experiencing digital exclusion (UK Consumer Digital Index, 2024). This can be due to costs associated with accessing devices, Wi-Fi, or mobile data. Current engagement by Healthwatch Leeds on neighbourhood health (2025) shows that low income is a factor affecting people of all ages, with

younger people on state benefits more likely to report not being able to use the internet daily compared to the general population.

As technology continually changes, devices and systems become obsolete within a few years. People who aren't able to regularly buy new devices or keep systems up to date are at a disadvantage.

"I have an old phone that uninstalls apps to save on memory. I ended up missing out on being referred into an important chest x-ray because I was only sent a message on the NHS App and never received a notification."

Low literacy, complicated healthcare jargon, and language barriers impact access to digital healthcare. 18% of adults in the UK struggle to understand written information (Literacy Trust, 2024), and over 4 in 10 people find health content hard to understand (Health Education England).

In 2024, West Yorkshire Voice spoke to women supported by ASHA Neighbourhood Project in South Leeds. Many of the women said they relied on family or community groups to navigate healthcare due to their limited ability to read and write English.

"I can't read much of English, so I am confident with using my usual paper routine. Having to use the app would throw me off

completely. I prefer to talk by phone/in person, it's where I feel most confident and can still advocate for myself."

For some people with disabilities or health conditions, the lack of non-digital appointment booking options makes accessing GP services challenging.

"I think this is discriminatory as not everyone can use and has access to digital technology, e.g. my parents can't use online services. My father has had a stroke, and my mother has mobility problems with her hands."

Navigating online services can also be challenging for those experiencing poor mental health.

"If you've got a mental health condition, how are you going to access the internet, you're struggling just to get through."

One person told us that due to mental health difficulties, they often lock themselves out of their PATCHs account, meaning that they must regularly travel to their GP surgery for support from the receptionist to unlock it. Even when they can log in, they still struggle to make a booking independently and rely on their partner for help.

Digital confidence and lack of digital skills are real issues for many people, with 23% of adults in the UK identified as having "very low digital capability" (UK Consumer Digital Index, 2024). This is especially the case for older people who often feel left behind, as evidenced by the 2024 Age UK report Offline and Overlooked. With older people already facing health inequalities and as the main users of health and social care services (British Geriatrics Society, 2025), we really need to be thinking about how to get it right for them.

Some people tell us that there is limited help to understand and use digital technology.

"I have tried the surgery reception for IT help but they "don't know" and there is no go to NHS IT Helpdesk, so I'm left at times struggling with a system that isn't intuitive for me."

"I had to register on an app so that my [blood sugar] readings could be accessed by professionals. It took three hours to register and work out."

With systems frequently changing, people don't always feel kept up to date about what's changed, and this can feel confusing.

"I tried to book an appointment [...] went on the NHS App and it directed me to PATCHS, when I went there it said, 'your surgery

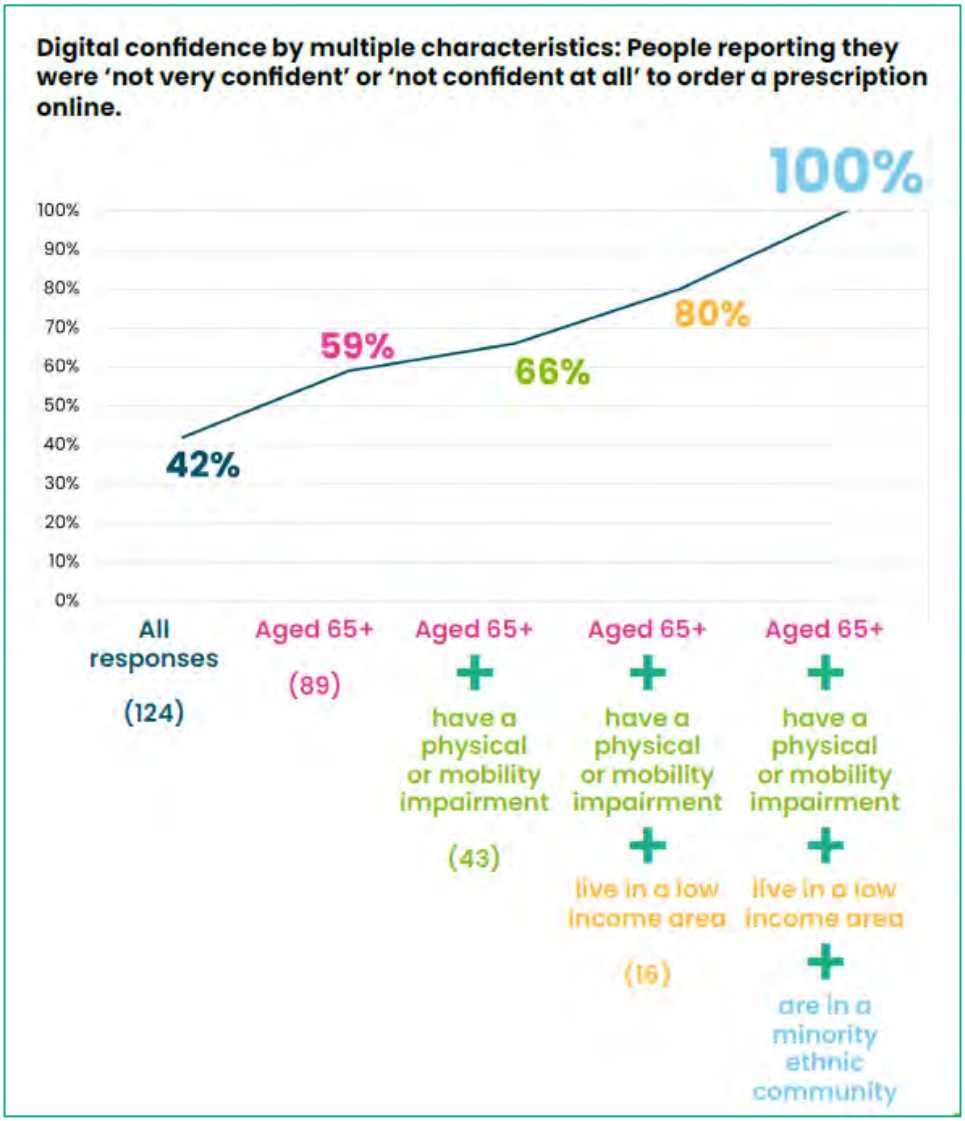
does not use this service' so that I went back and it sent me to PATCHS with the same message."

Whilst there are initiatives in Leeds, such as 100% Digital and Solidaritech (see Appendix 1), that are doing good work to support digital inclusion, there is still a vast amount to do in order to achieve anywhere near the vision of digital inclusion outlined in the ten-year plan.

There can be the incorrect assumption that just because people own a digital device, that they are confident to use it for everything, including managing their healthcare. This is absolutely not the case, as demonstrated by the 2024 Healthwatch Leeds Check-in report that explored people's experience of ordering repeat prescriptions, which ran a targeted survey with people who were more likely to face digital barriers. Whilst 82% of survey respondents said they owned a digital device such as a smartphone or tablet, only 58% said they had some degree of confidence in ordering a prescription digitally.

"My mother-in-law has a phone, but she doesn't know how to use it to do stuff online. She was made to feel that she was being difficult and that the GP surgery had to make an exception for her because she couldn't do it online."

In this report, we also found a correlation between people experiencing multiple factors relating to health inequality and lower confidence in using digital. The findings showed that the more 'health inequality factors' that were relevant to a person, the lower their reported confidence was in using online prescription services. This can be seen in the chart below.



If we don't get the move to digital right and make sure that there are meaningful non-digital alternatives in place, we face a real risk of

increasing health inequalities of people who are already at risk of poorer access, outcomes and experiences of health and care.

5.3 Reducing independence and placing additional pressure on families and carers.

Digital exclusion leads to a loss of autonomy, which can negatively impact people's relationship with accessing healthcare. With the increasing shift to digital, many people who have independently managed their health needs for years, are now feeling reliant on the support of others.

"Technology has stopped me being able to order it by myself"

"My parents really struggled when they were told about the change. They are not used to using technology and are not a fan of everything being forced online. For the first time, they needed my help. […] I worry that not everyone has someone available to show them how to place an online order."

Digital exclusion also places additional pressure on unpaid carers or family members to navigate online systems. This can be particularly challenging when carers have other commitments, such as work or family and are not always on hand to support.

“It feels they are forcing us to do everything via PATCHs and if we cannot use it, they don't care if it makes life difficult for us. I am a carer, and it's just another thing I have to worry about.”

Having to rely on others also compromises people’s privacy, as they may not want to have to share confidential health details with family members. For those who don’t have family or carers who can help, it is even more difficult or impossible. Some turn to community groups for help, but again, there are privacy issues, with people feeling uncomfortable sharing personal health information with people they don’t know.

Carers can also face barriers when managing digital healthcare on behalf of others. Many systems lack the functionality for handling multiple profiles. This can lead to confusing messages and unclear information about who is being contacted.

“My number is the contact number for myself and my mum as she is deaf […] I get texts from the GP practice for both of us. Texts can be hard to understand as they don’t address who they are trying to contact.”

5.4 Virtual consultations affecting people's motivation to engage with services and self-management of health.

Whilst meeting with a healthcare professional over the phone or via a video call is more convenient for some, remote consultations don't work for everyone. Receiving diagnoses or test results over the phone can feel impersonal, and the practical and logistical aspects of phone consultations can also affect motivation and engagement.

"A family friend made the brave decision to ask for mental health and alcohol dependency support to be only offered with calls in the daytime, whilst at work, and in both scenarios, not at times when he could hear or take the calls. The mental health support was closed after missing three calls due to my friend not being able to pick up. An opportunity to support someone who is finally reaching out to seek support lost by poor access processes and now he has given up again."

Other people told us how the move to phone consultations for things like physiotherapy affects their motivation to do their exercises.

"I think it's the phone appointments. I saw him [physiotherapist] once, and then he just rings me once a

month to check I've done my exercises. I always say 'yes', but I can't feel a difference, and don't know if I'm doing them right, so I end up not doing them, and he has no way of checking if I'm doing the right things over the phone."

5.5 Digital communication – negatively affecting understanding and interpretation of information.

Some people tell us how digital and virtual modes of communication can feel very different from face-to-face, affecting how they understand information. Some people have told us that being given information via a phone consultation can feel overwhelming and that it feels harder to ask questions. Another talked about the move of their group therapy session online.

"When you move [it] onto Zoom, you take away all the things in my opinion that made it a supportive, safe, engaging place to be. It's very hard to speak on Zoom because everyone's scared of interrupting each other, and it feels forced. You can't even get eye contact or gauge someone's body language, or clock if someone is maybe dropping off a bit during the session."

Some deaf people have told us that the digital BSL interpretation service used by GP services lacks the nuance of an in-person interpreter, which can lead to people missing vital information or relying on family or friends to provide clarity.

We increasingly have instant digital access to our medical records via the NHS App and other patient portals. People tell us that sometimes they don't understand information that is written about them or feel that what's written about them isn't done in a compassionate and person-centred way. Many people find out test results via their digital patient record, and without a wider explanation, which can be confusing or cause anxiety. It's important to see patient-facing digital records as an extension of someone's care and give the same consideration to communication and compassion as for face-to-face interactions.

5.6 People accessing incorrect information from unreliable sources and Artificial Intelligence (AI).

Digital healthcare information can be a vital resource. We have been told that some people get more healthcare information from their NHS App than from their GP surgery. However, there is a danger of misinformation when people turn to search engines, social media, and AI platforms to understand their healthcare. 1 in 10 UK adults have been affected by health

misinformation (Patient Information Forum, 2024), rising to 1 in 5 for people from diverse communities. Additionally, 8 in 10 adults agree that access to trusted health information would help them manage their health.

A report by the King's Fund (2024) shows that Artificial Intelligence (AI) platforms present further concerns, as they have been found to produce health-related information with fake references, misleading information, incorrect advice, and fabricated testimonials.

Worryingly, a recent study by UNESCO (2024) found GPT-2, Llama2, and ChatGPT have a tendency to reinforce harmful gender and racial stereotypes across education, healthcare, and employment.

These findings highlight the risks of AI amplifying historical biases, particularly those disadvantaging women and marginalised groups. If people cannot access trusted healthcare sources, they may turn to AI-driven platforms that could perpetuate misinformation and inequalities in medical advice.

6. Conclusion

Digital healthcare has the potential to offer convenience and efficiency, but for many, digital exclusion creates significant barriers to care.

Many services assume their users have the digital access, skills, connectivity, and confidence to use digital technology. However, those unable to use digital services can struggle to book appointments, access prescriptions, or receive timely medical support. This is especially true for older adults, people with disabilities and communication needs, people with low literacy, language barriers or on low incomes, and socially excluded groups.

When healthcare services rely too heavily on digital systems without alternatives, existing health inequalities worsen, leaving some without essential care.

To ensure equitable access, healthcare must offer both digital and non-digital options. Digital inclusion initiatives can help people develop confidence and skills, but services must also maintain accessible, offline pathways.

Without this balance, the shift towards digital risks widening disparities in healthcare access, making it harder for the most vulnerable to get the care they need.

7. Recommendations

1. **Ensure non-digital options are always made available.**

   - Ensure that paper-based, in-person, and phone options remain available alongside digital services and make sure these are proactively communicated to people.

2. **Make sure that digital modes of delivery aren't compromising quality or engagement.**

   - People's feedback on digital or virtual service delivery should be actively and continuously sought and acted on to ensure services are meeting needs and that digital delivery doesn't compromise the quality of experience or engagement.

   - Levels of engagement with digital or virtual services should be monitored, and where people have disengaged, efforts should be made to understand why.

3. **Improve digital support and training**

   - Provide accessible support and training for those wanting to learn how to use digital healthcare services, ideally within GP practices.

   - Increase digital confidence-building initiatives, especially for older people and those with language barriers.

- When things become digitised or online platforms or apps change, make sure people are kept up to date and provided with any support needed to manage the change.

4. **Healthcare staff awareness**

- Staff should be trained to understand digital exclusion, ask about needs and not make assumptions about people's level of digital skills and confidence.

5. **Ensure inclusive digital services**

- Systems should be co-designed and tested with people and their carers to ensure they are user-friendly and inclusive for users with low literacy, disabilities, and limited digital access.
- Improve the functionality for unpaid carers or family members managing multiple profiles on digital healthcare systems.
- Ensure alternative contact methods (text, online chat) are available for those who cannot use phonelines.

6. **Read our recommendations in conjunction with Health Inequalities and mitigating risks of digital exclusion (Good Things Foundation, 2024).**

This short publication aligns with the recommendations above, but provides more detailed solutions and mitigations to the risk of digital

exclusion. It is helpfully segmented into recommendations for different roles in the health and care system: system or strategic commissioning; service implementation or delivery; workforce development or management, and service design or user research.

Appendix 1: Initiatives helping with digital inclusion

Initiatives like 100% Digital Leeds and Solidaritech are championing programmes that aim to improve digital inclusion in Leeds.

100% Digital Leeds collaborates with partners across healthcare, VCSE, and the public sector to promote equal opportunity to digital tools and services. Their work helps people access digital aspects of health and care services by:

- Raising awareness among health and care staff about digital exclusion and how it impacts access to services.
- Providing support to frontline staff to support people to learn about digital tools, such as developing training for staff at Lingwell Croft Surgery to increase their confidence in supporting people to use PATCHs and general discussions of digital inclusion.
- Offering access to loaned devices, through Leeds Libraries and partner organisations, and skills training to help people manage their health more independently.
- Collaborating with Local Care Partnerships to develop Digital Health Hubs which offer 22 spaces in Leeds (as of November 2023) for people to access health and care services digitally in a safe and supported setting. Solidaritech refurbishes tech devices to give to digitally excluded asylum seekers and refugees, providing a much-

needed lifeline to access online education, health care, and other community services helping people to set up lives in the UK.

Bradford City Council, as a City of Sanctuary, set a strong example of good practice by donating their old devices to Solidaritech, enabling them to be repurposed for digitally excluded people.

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 15 October 2025

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

Date of meeting reported to: 19 November 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: Multi-provider incident The Sub-Committee was informed that the ICB would be convening a system-wide learning exercise following a multi-provider incident in Leeds in August 2025. The exercise was underway to bring together internal investigations, with outcomes to be reported into the WY ICB Patient Safety Oversight Group. Following the appropriate redaction of identifiable information, the findings and system learning from the exercise would be shared with QPEC Sub-Committee for assurance. **Post-meeting Note -** Due to the complexity of the incident and the number of organisations involved, NHS England (NHSE) have advised that it meets the criteria for an External Review. Due process is being followed with support from NHSE's independent investigations team and the ICB Patient Safety Specialist. **Quality Highlight Report – Maternity and Neonatal Services Update** The Sub-Committee received an update on the quality improvement work in Maternity and Neonatal maternity services at Leeds Teaching Hospitals NHS Trust (LTHT) following the publication of the final Care Quality Commission (CQC) inspection report in June 2025. A subsequent CQC well-led inspection in September 2025 had resulted in LTHT receiving a Requires Improvement rating, with the CQC report highlighting concerns regarding leadership and culture, particularly around how patients, their families and staff were listened to. LTHT would be one of 14 Trusts included in a national maternity investigation to be led by Baroness Valerie Amos. The investigation was underway and visits would commence early in 2026. A number of leadership changes had been made at LTHT to lead the improvement work. These included the appointment of a new Trust Chair, an interim Chief Executive, an interim Chief Nurse and an interim Chief People Officer. QPEC members sought assurance regarding the status of the proposed Improvement Board and improvement plan. An Independent Chair had been appointed and would undertake a thematic review into the issues raised by families. However, the Improvement Board was not yet operational. A first draft of the

improvement plan would be shared with the QPEC Sub-Committee in November 2025.

Following discussion, the QPEC Sub-Committee agreed on a position of 'reasonable assurance' in light of the improvement plan and actions being taken, in addition to ongoing monitoring and reporting to NHSE.

Advise:

People's Voice
The Sub-Committee watched a video as part of the Healthwatch How Does It Feel For Me? series featuring Diane, who was deaf, and her daughter Gemma who reflected on their experiences of healthcare services. The video illustrated the positive impact of third sector support from Leeds BID and Welfare Rights in enabling access to digital health tools for people who might otherwise face digital exclusion. Diane and Gemma highlighted the importance of tailored communication, such as the use of British Sign Language (BSL).

With regard to the Healthwatch Leeds report, 'Keeping every door open: Ensuring access beyond digital in health and care', members discussed the findings and recommendations including the importance of ensuring alternative (non-digital) access was available to people who were digitally excluded. There was a discussion regarding the rapid pace of digital change and the risk of it exacerbating health inequalities. The Sub-Committee wished to advise that the rapid pace of digital change, driven by financial constraints, needed to be managed by the system as a whole.

Assure:

Update on Measles Outbreak and MMR Vaccination Uptake
The Sub-Committee received an update on childhood measles, mumps and rubella (MMR) vaccination uptake for children following a significant measles outbreak in Leeds between September 2024 and April 2025. The system-wide response involving Public Health, NHSE, the ICB, third sector and community partners had received recognition nationally in bringing the outbreak under control.

Childhood MMR vaccination uptake in Leeds was below the national average with UK Health Security Agency (UKHSA) annual COVER (cover of vaccination evaluated rapidly programme) data from 2024/25 showing coverage for MMR1 at two years of age at 84.4%. There was significant variance in uptake across Leeds with low uptake of 30% correlating closely to areas of deprivation.

The Sub-Committee was assured that targeted programmes were ongoing to understand and address low vaccine uptake including work with Community Champions to co-produce bespoke communications and engage face-to-face with specific communities to build trust.

Complaints Reports
The Sub-Committee received the West Yorkshire Integrated Care Board (WY ICB) Complaints Annual Report 2024/25 and the Leeds Primary Care Complaints Report for Q1 2025/26. While there had been a decrease in formal complaints, there had been a significant increase in contacts requiring signposting via the Patient Advice

and Liaison Service (PALS). QPEC members made a number of suggestions regarding improving system coordination, demographic data collection and capturing compliments for incorporation into future reports. Members discussed the complexity of the complaints system and welcomed the complaints reports as an additional means of oversight for the Sub-Committee.

WY Mental Health Services Review
The Sub-Committee received an update on the action plans developed by the ICB and each of the Trusts to address the recommendations set out in the CQC report and the Independent Homicide Review which followed the conviction of Valdo Calocane in Nottingham in 2023. The action plans had been developed following reviews of mental health (MH) providers' policies and an ICB self-assessment exercise to identify potential gaps and barriers to good care. The work of the Assertive Outreach Team at Leeds and York Partnership Foundation Trust (LYPFT) had been highlighted as an example of good practice.

In terms of governance, the ICB provided NHSE biannually with assurance that actions to fulfil the recommendations from the CQC and homicide review were being progressed. The most recent submission had been completed in August 2025.

Quality Highlight Report
The Sub-Committee was informed that Wheatfields Hospice remained under enhanced monitoring following its closure in August 2024. A phased reopening of up to six beds had commenced, with more beds to be reopened dependent on progress against agreed performance metrics. Members were assured that the ICB Quality Team continued to monitor key areas including staffing, medicines management and culture via fortnightly review meetings with partners and the CQC.

The Sub-Committee was informed that placements at Claremont Care Home remained suspended due to safeguarding and quality concerns. Assurance was given that bi-weekly oversight remained in place.

Members welcomed the news that suspension measures had been lifted at Paisley Lodge and Park Avenue Care Homes due to significant improvements having been made under new leadership.

The Sub-Committee congratulated Leeds City Council's (LCC) Children's Services which had been rated 'Outstanding' under the inspecting local authority children's services (ILACS) framework for the third consecutive year. In addition, the CQC had rated LCC's adult social care provision as 'Good', following a site visit in May 2025. The report highlighted a number of strengths in LCC's work to support people to live as well and independently as possible. The assessment had been the first for the local authority to be carried out as part of the CQC's new powers under the Health and Care Act 2022.

With regard to the action plan for the oversight and escalation of children and young people with complex needs, the Sub-Committee was assured that the WY Quality Committee had received full assurance that all of the recommendations from the independent review had been completed. The QPEC Sub-Committee agreed to close the action.

Risk Management Report (Leeds Place risks 2569, 2568, 2487)
The Sub-Committee received the Leeds Place risk report for risk cycle 3 of 2025/26. 12 high-scoring risks were aligned to the QPEC and two risks were shared with the Finance, Value and Performance Sub-Committee.

Two new risks had been added to the Leeds Place risk register. Risk 2569 – 'There is a risk that there will be insufficient inpatient hospice capacity in Leeds for a period', was due to quality improvement in Wheatfields Hospice following a CQC inspection and changes in staffing and leadership, as well as planned remedial fire door work at St Gemma's Hospice. Assurance was given that mitigations were in place. The second new risk was Risk 2568 – 'There is a significant risk of an inability to deliver the statutory functions of the ICB with regard to All Age Continuing Care (AACC) in Leeds due to challenging workforce pressures and being unable to source high-quality cost-effective care which could result in reputational damage, financial inefficiency, complaints, challenges and appeals, and staff burnout'. Risk 2568 was a consolidation of two previous risks relating to AACC, which had since been closed due to duplication.

Risk 2487 relating to the financial risk to adult hospices had been closed. Hospices in Leeds had not signalled that they were under immediate financial pressures which could result in a reduction in services relating to funding.

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 22 October 2025

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

Date of meeting reported to: 19 November 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:
N/A
Advise:
People's Voice The Sub-Committee watched a video as part of the Healthwatch 'How Does It Feel For Me?' series featuring Diane, who was deaf, and her daughter Gemma who reflected on their experiences of healthcare services. The video illustrated the positive impact of third sector support from Leeds BID and Welfare Rights in enabling access to digital health tools for people who might otherwise face digital exclusion. Members also received the Healthwatch Leeds report, 'Keeping every door open: Ensuring access beyond digital in health and care' which prompted discussion regarding digital transformation and the risk of digital exclusion further exacerbating health inequalities. While noting the benefits of digital transformation, members wished to highlight the importance of achieving the Accessible Information Standard and the potential risk of digital exclusion further widening health inequalities which require further scrutiny and discussion at system level. **Financial Position Update for Month 6** The Sub-Committee received an update on the Month 6 financial position for the ICB in Leeds, Leeds Health and Care Partnership (LHCP) and the Integrated Care System (ICS). At Month 6, the ICB in Leeds was reporting a year to date (YTD) £1.2m surplus financial position. However, this showed as c.£1.4m behind plan at Month 6, due to the stretch targets of Providers included in the ICB plans, with delivery showing in Provider positions. The ICB in Leeds was still forecasting a balanced full year forecast position to deliver the stretched plan of a £2.5m surplus, which showed as £2.7m adverse due to Provider full year stretch.

Main areas of overspend continued to be Mental Health (MH), Community and Acute services. In terms of MH, key areas were Neurodivergence (ND) services, increased pressures relating to S117 and a high cost out of area package. An overspend of nearly £1m in Community services was driven by a number of high cost complex care packages in Neuro-rehab. An overspend forecast of c£2.7m in Acute services was due to increased independent sector (IS) spend on elective services. Activity plans were being agreed with providers and mitigations were in place to address the overspend. Overspends were being offset by underspending in Primary Care, ICB running costs (£1.2m) and continuing healthcare (£0.7m).

The Sub-Committee noted key risks to the delivery of the financial plan as: IS elective activity; right to choose in ND services; high cost care packages arising in the second half of 2025/26; prescribing volatility; and winter pressures.

The LHCP had reported a Month 6 position of £23.8m deficit which was £11.1m adverse to plan. The deficit was driven by the position in Leeds Teaching Hospitals NHS Trust (LTHT) which was £10.5m adverse to plan due mainly to investment in Maternity and Neonatal services and loss of the maternity investment rebate, increased referral demand driving elective activity above planned value at additional cost, bed capacity required to accommodate level of NRTR patients and maintain safety and delivery of its waste reduction programme.

With regard to the Mid-Year Review, work was ongoing with Directors of Finance to examine how the ICS would deliver on finance, performance and quality in the latter half of 2025/26. Possible scenarios ranged from a c.£40m gap at the end of the year to Leeds Place delivering the financial plan. The Leeds Place Finance Lead would provide a full update on the Mid-Year Review process at the next Finance, Value and Performance Sub-Committee meeting in January 2026.

Members acknowledged the need to allow LTHT sufficient space to implement its recovery plans. Members also noted NHS England (NHSE) oversight of performance management and the Trust Board's work in implementing recovery plans. While the Sub-Committee was assured that actions were being taken, the Sub-Committee remained PARTIALLY ASSURED on meeting the financial target.

Leeds Quarterly Performance Report - Leeds NHS Planning Framework
The Sub-Committee received the Leeds Quarterly Performance Report which highlighted that LTHT had been placed into Tier 1 escalation for elective care and cancer performance. An elective care recovery plan had been developed and mitigating actions were being taken in both areas.

The Quarterly Performance Report included CORE20PLUS5 metrics which highlighted areas of improvement around children's asthma and diabetes. Members discussed the CORE20PLUS5 metrics in terms of health inequalities work and agreed to review the future performance reporting approach and the assurance role of the Sub-Committee in light of new system arrangements.

The Sub-Committee was updated on the NHS Planning Framework which was intended as a strategic guide to shape medium-term plans aligned to the 10 Year Health Plan. Following the transition period, the NHSE regional team would take on

an oversight and support role with providers and be responsible for signing off of commissioner and provider plans. Members were assured that work had begun on the implementation of the Framework. Concern was expressed regarding the tight timescale for the change.

Members expressed concern that further significant efficiencies and difficult decisions would be required in order to achieve targets that were not currently being achieved. The Sub-Committee agreed there needed to be robust prioritisation in order to balance both local priorities and national ones given the underlying position.

Assure:

Risk Management Report (Leeds Place Risks 2508, 2487, 2529)
Members received a report on the Risk Register for risk cycle 3 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).

One risk score had been reduced: Risk 2508 – 'There is a risk of overspend against the All Age Continuing Care (AACC) budget due to increasing service demand and rising care costs which could result in Leeds place financial targets not being met.' The risk score had reduced from 20 to 12 due to AACC meeting their rates of spend and review of care packages.

One risk had been closed: Risk 2487 - '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'. This was due to Leeds's hospices not signalling any immediate financial pressures which could result in a reduction in services relating to funding.

With regard to risk 2529 – 'There is a risk that the ICB in Leeds will not deliver the 2025/26 financial requirement of breakeven', the ICB in Leeds was on track to deliver its financial plan and the risk score would be likely to reduce following the mid-year review process.

The Sub-Committee agreed to provide PARTIAL ASSURANCE to the Leeds Committee which reflected confidence in mitigating actions, but uncertainty regarding delivering against financial and performance plans. The Sub-Committee noted that the position of partial assurance due to uncertainty in the financial position was not consistent with other Places in West Yorkshire.

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	11
Meeting date:	19th November 2025
Report title:	Financial Position Update Month 6
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 6 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 6 the ICB in Leeds is reporting a year to date (YTD) £1.2m surplus financial position. However, this is showing as c.£1.4m behind plan at month 6, due to the stretch targets of Providers included in the ICB. The ICB in Leeds is still forecasting a balanced full year forecast position to deliver the stretched plan of a £2.5m surplus (showing as £2.7m adverse against plan due to Provider full year stretch).

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

- Overall, the Leeds Place is reporting a £23.8m deficit at Month 6, which is c£11.1m adverse to plan. This is driven by the position in LTHT (£10.5m adverse to plan).

  Overall, the Leeds Place is forecasting delivery of a £4.3m surplus position which is £0.9m behind plan due to the forecast non-delivery of the stretch target at LTHT. At Month 6 LCH and LYPFT have shown improved forecast positions in line with the stretch target.

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

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

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 6 position including key risks and mitigations
- Review and comment on the Leeds Place month 6 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 ICB

Leeds Place Financial Position

Month 6 2025/26

NHS West Yorkshire
Integrated Care Board

Contents

ICB in Leeds Integrated Care Board (ICB) Month 6 Financial Position

ICB in Leeds Month 6 Position

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	889,915	889,915	0	1,781,519	1,781,519	0
Allocation - Primary Care Co-Commissioning	95,231	95,231	0	190,356	190,356	0
Allocation - Running Costs	3,070	3,070	0	6,141	6,141	0
Allocation - Specialist Commissioning	0	0	0	0	0	0
TOTAL RESOURCE	**988,217**	**988,217**	**0**	**1,978,016**	**1,978,016**	**0**
SPEND						
Acute	482,252	482,471	(220)	965,586	966,036	(450)
Mental Health	156,555	158,303	(1,747)	312,878	316,800	(3,923)
Community	104,834	106,585	(1,751)	212,367	213,185	(819)
Continuing Care Services	46,021	45,679	342	92,041	91,363	678
Prescribing and Primary Care	93,070	92,597	473	186,100	185,228	872
Primary Care Co-Commissioning	97,700	95,739	1,962	195,295	193,178	2,117
Other	3,393	3,069	324	6,786	6,264	523
Specialised Commissioning	0	0	0	0	0	0
Programme Reserves	(1,277)	225	(1,502)	(4,377)	(1,418)	(2,959)
Subtotal Programme spend	**982,547**	**984,667**	**(2,121)**	**1,966,675**	**1,970,635**	**(3,960)**
Running Costs	3,070	2,307	764	6,141	4,880	1,261
TOTAL SPEND	**985,617**	**986,974**	**(1,357)**	**1,972,816**	**1,975,516**	**(2,700)**
Surplus / (Deficit)	**2,600**	**1,243**	**(1,357)**	**5,200**	**2,500**	**(2,700)**

ICB in Leeds Month 6 – Key headlines

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At month 6 the ICB in Leeds is reporting a year to date (YTD) £1.2m surplus financial position. However, this is showing as c.£1.4m behind plan at month 6, due to the stretch targets of Providers included in the ICB plans (with delivery showing in Provider positions). The ICB in Leeds is still forecasting a balanced full year forecast position to deliver the stretched plan of a £2.5m surplus (showing as £2.7m adverse due to Provider full year stretch).

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

- Mental Health has a forecast overspend of £3.9m (£1.7m YTD), driven by demand pressures on Neurodiversity services (£5.8m) increasing LD pool package costs (mainly CHC), increasing s117 pressures and a high-cost package pressure of c£1m, which are partly offset by non-recurrent benefits/uncommitted budgets.
- Acute Services are showing a forecast overspend of £0.5m (£0.2m YTD), due to increased independent sector spend on elective services above activity plans (£2.7m) offset by non-recurrent prior year and other benefits. This position is potentially at further risk (£2.5m) if indicative activity plans sent to IS Providers is not adhered to, including plans to equalise waiting times in the independent sector.
- Community Services are showing a forecast overspend of £0.8m, driven by spend on Neuro-rehab packages.

These are being offset by underspends within:

- Primary Care is showing a forecast underspend of £2.9m. This is due to identification of further efficiency savings of within GPIT which is included within our stretch efficiency plan and several prior year and non-recurrent benefits (prior year and in year).
- CHC is currently showing a forecast underspend of £0.7m driven by lower than planned activity growth and on track delivery of the efficiency programme (however we should note pressures on LD CHC).
- Running costs are showing a forecast underspend of £1.2m against budget.

ICB in Leeds Month 6 – Efficiencies YTD

NHS West Yorkshire Integrated Care Board

Efficiencies	YTD Plan	YTD Saving	YTD Variance
	£000's	£000's	£000's
Acute	4,665	900	(3,765)
Community	2,016	2,670	654
Continuing Care Services	3,342	2,502	(840)
Mental Health	2,874	2,196	(678)
Primary Care	4,998	6,607	1,609
Other	0	1,645	1,645
Total	**17,895**	**16,520**	**(1,375)**

At month 6 the ICB in Leeds is reporting behind plan YTD by £1.4m on efficiency delivery.

The YTD adverse variance continues to be 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 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 6 – Risks and mitigations/actions

NHS West Yorkshire Integrated Care Board

Key risks

•IS Elective

•ND and impact of right to choose

•CHC, LD pool and other new high-cost packages in H2

•Prescribing volatility

•Children Services - Council

•Winter Pressures

Key actions

• Focus on delivery of overall efficiency plan (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
- Focus on supporting system transformation priorities to create long term financial sustainability

Leeds Place
Month 6 Financial Position

Leeds Place - Month 6 Financial Position

NHS West Yorkshire Integrated Care Board

Organisation	YEAR TO DATE - M6 I&E reported Month 6 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	2.6	1.2	(1.4)	5.2	2.5	(2.7)
Leeds and York Partnership NHS Foundation Trust	0.0	0.2	0.2	0.0	0.9	0.9
Leeds Community Healthcare NHS Trust	0.0	0.7	0.7	0.0	0.9	0.9
Leeds Teaching Hospitals NHS Trust	(15.3)	(25.8)	(10.5)	0.0	0.0	0.0
Leeds Place Total	**(12.7)**	**(23.8)**	(11.1)	**5.2**	**4.3**	(0.9)

Overall, the Leeds Place is reporting a £23.8m deficit at Month 6, which is c£11.1m adverse to plan. This is driven by the position in LTHT (£10.5m adverse to plan).

Overall, the Leeds Place is forecasting delivery of a £4.3m surplus position which is £0.9m behind plan due to the non-delivery of the stretch target at LTHT. At Month 6 LCH and LYPFT have shown improved forecast positions in line with the stretch target.

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

Leeds Place Month 6 – Efficiencies

NHS West Yorkshire
Integrated Care Board

Organisation	YTD Plan	YTD Saving	YTD Variance	Annual Plan	Forecast Saving	FOT Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Leeds ICB	17,895.00	16,519.86	(1,375.14)	35,872.00	35,872.50	(0)
Leeds and York Partnership NHS Foundation Trust	8,625	8,293	(332)	18,500	18,501	0
Leeds Community Healthcare NHS Trust	7,002	7,002	0	14,000	14,000	0
Leeds Teaching Hospitals NHS Trust	32,499	30,123	(2,376)	89,000	89,000	0
Total	**66,021**	**61,938**	**(4,083)**	157,372	157,374	0

Overall, the Leeds Place has delivered £61.9m savings at Month 6, which is £4m adverse to plan. The main adverse variances are in the ICB in Leeds and LTHT.

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

West Yorkshire ICS
Month 6 Financial Position

West Yorkshire ICS Financial position - Month 6

NHS West Yorkshire Integrated Care Board

Organisation	YEAR TO DATE - M6 I&E reported Month 6 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	2.4	(0.7)	(3.0)	4.7	(3.2)	(7.9)	(6.1)	0.0	(7.9)	(24.1)
Calderdale ICB	2.2	3.0	0.8	4.4	4.9	0.5	0.5	0.0	0.5	(1.9)
Kirklees ICB	4.3	4.3	0.0	8.7	8.7	(0.0)	0.0	0.0	(0.0)	(5.1)
Leeds ICB	2.6	1.2	(1.4)	5.2	2.5	(2.7)	(2.7)	0.0	(2.7)	(20.2)
Wakefield ICB	1.3	0.4	(0.9)	2.6	0.9	(1.7)	(1.7)	0.0	(1.7)	(9.4)
WY ICB	(5.1)	(0.5)	4.5	(10.1)	(0.1)	10.0	9.9	0.0	10.0	(1.9)
West Yorkshire ICB Total	**7.7**	**7.7**	**0.0**	**15.4**	**13.6**	**(1.8)**	**(0.0)**	**-**	**(1.8)**	**(62.7)**
Airedale NHS Foundation Trust	(6.6)	(8.3)	(1.7)	(3.6)	(3.6)	(0.0)	0.0	0.0	(12.8)	(22.2)
Bradford District Care NHS Foundation Trust	(0.9)	(0.8)	0.1	2.0	2.0	0.0	0.0	0.0	(1.1)	(2.3)
Bradford Teaching Hospitals NHS Foundation Trust	(9.2)	(10.4)	(1.3)	(2.7)	(2.7)	0.0	0.0	0.0	(7.5)	(27.7)
Calderdale And Huddersfield NHS Foundation Trust	(2.5)	(2.4)	0.1	(3.0)	(3.0)	0.0	0.0	0.0	0.0	(39.2)
Leeds and York Partnership NHS Foundation Trust	0.0	0.2	0.2	0.0	0.9	0.9	0.9	0.9	0.9	0.0
Leeds Community Healthcare NHS Trust	0.0	0.7	0.7	0.0	0.9	0.9	1.1	0.0	0.9	(1.7)
Leeds Teaching Hospitals NHS Trust	(15.3)	(25.8)	(10.5)	0.0	0.0	0.0	0.0	0.0	(38.7)	(70.0)
Mid Yorkshire Teaching NHS Trust	(0.7)	(4.9)	(4.2)	(8.1)	(8.1)	0.0	0.0	0.0	(7.5)	(17.9)
South West Yorkshire Partnership NHS Foundation Trust	(2.7)	(1.0)	1.8	0.0	0.0	0.0	0.0	0.0	0.0	(4.7)
Yorkshire Ambulance Service NHS Trust	0.7	1.5	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
West Yorkshire Provider Total	**(37.2)**	**(51.3)**	**(14.1)**	**(15.4)**	**(13.6)**	**1.8**	**2.0**	**0.9**	**(65.8)**	**(185.8)**
West Yorkshire ICS Total	**(29.5)**	**(43.6)**	**(14.1)**	**(0.0)**	**0.0**	**0.0**	**2.0**	**0.9**	**(67.6)**	**(248.5)**

West Yorkshire ICS Month 6 – Key Headlines

NHS West Yorkshire Integrated Care Board

- The month 6 YTD position for the ICS was an £43.6m deficit against a planned £29.5m deficit; a shortfall/adverse variance against plan of £14.1m.
- The month 6 adverse variance of £14.1m has deteriorated from the adverse variance at month 5 of £9.3m, a deterioration of £4.8m.
- The deterioration in month is mainly due to a one-off £2.7m clawback of the Maternity Incentive Scheme (MIS) for year 5 at LTHT, plus continued efficiency slippage in providers.
- The key drivers of the YTD adverse variance continue to be industrial action, pay overspends and slippage on delivery of waste reduction/efficiencies, part offset by underspends in other areas.
- Above position includes assumed receipt of Deficit Support funding of £24.6m (6/12ths of total annual value of £49.2m)
- The ICS continues to forecast a balanced plan to NHSE at Month 6 (based on receipt of £49.2m deficit support funding)

Recommendations

NHS West Yorkshire
Integrated Care Board

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

- Review and comment on the ICB in Leeds month 6 position including key risks and mitigations
- Review and comment on the Leeds Place month 6 position
- Review and comment on the West Yorkshire ICS Financial Position
- Consider any specific areas that they wish to escalate to other Committees or forums for follow up

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	12
Meeting date:	Wednesday 19th November 2025
Report title:	NHS Planning Framework
Report presented by:	Sabrina Armstrong
Report approved by:	Sabrina Armstrong
Report prepared by:	Joanna Howard

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

Previous considerations:

N/A

Executive summary and points for discussion:

This paper informs the Leeds Committee of the West Yorkshire Integrated Care Board of the publication of the NHS Planning Framework, and subsequent publication of supporting guidance, which introduces a rolling five-year planning horizon and a continuous, integrated planning process across systems and providers. It outlines the expectations for the Leeds Committee, WY ICB and its partners.

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

The paper provides

- An overview of the collaborative approach to meeting the requirements of the NHS England Planning Framework and supporting guidance
- Details for our local approach to implementation
- Assurance on governance and sign off arrangements

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 publication of the NHS Planning Framework and supporting guidance
2. **Review and confirm** support of the proposed approach for this year, ensuring appropriate forums are used to enable timely delivery within current circumstances
3. **Endorse** the proposal to work with the Leeds Accountable Officer and Leeds Committee Chair to provide final sign-off on behalf of the Leeds Committee, including the Board Assurance Statement (subject to published national guidance)

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:

An effective approach to planning will support the mitigation and assurance for key risks within our Board Assurance Framework (BAF). This relates to strategic risks associated with delivery, health inequalities and financial sustainability – specifically risks 1.2, 1.3, 3.1 and 3.2 within the BAF.

Appendices

1. **Appendix 1: Overview of West Yorkshire Approach to Phase 1 and Phase 2 of the planning framework:**
2. **Appendix 2: NHS Medium Term Planning Framework - operational performance headline targets**

Acronyms and Abbreviations explained

1. HNA – Health Needs Assessment
2. HWb – Health and Wellbeing
3. HWBB – Health and Wellbeing Board
4. ICB – Integrated Care Board
5. ICS – Integrated Care System
6. INH – Integrated neighbourhood Health
7. JSNA – Joint Needs Assessment
8. LCC – Leeds City Council
9. LHCP – Leeds Health and Care Partnership
10. MTPF – Medium Term Planning Framework
11. NHSE – NHS England
12. QEIA – Quality and Equality Impact Assessment
13. VCSE – Voluntary, Community and Social Enterprise
14. WY – West Yorkshire
15. WY ICB – West Yorkshire Integrated Care Board
16. 10YHP – 10 Year Health Plan

What are the implications for?

Residents and Communities	The new planning framework will enable more coherent, efficient and strategic planning across our partnership which will result in better service delivery, improved alignment of resources to population needs and integrated care in local communities.
Quality and Safety	The framework includes a transformed approach to quality, including setting out what good looks like in key clinical areas and rolling out data-led monitoring, starting in maternity services.
Equality, Diversity and Inclusion	The framework supports improved access, experience and outcomes ensuring equitable to all with a focus on local population needs.
Finances and Use of Resources	The framework includes a new financial regime which distributes funding more fairly and ensures payment schemes support new models of care including shift to community. A renewed approach to improving productivity, reducing unwarranted variation, transforming pathways and maximising the use of technology to speed up processes.
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	The revised planning process supports transformational change, delivering the three shifts set out in the 10 year Health Plan and taking advantage of innovation.
Environmental and Climate Change	N/A
Future Decisions and Policy Making	The planning process supports delivery of the 10 Year Health plan and our approach to delivery at a local level e.g. Neighbourhood Health Plans
Citizen and Stakeholder Engagement	As outlined in the paper, insight from stakeholders, people and communities has been used to inform plans and will be used extensively in the development and co-design of our local approach.

1. Introduction

1.1 The 10 Year Health Plan (10YHP) sets out changes to the way health services are organised, delivered and funded across England. To support this a new planning framework has been introduced – one that is collaborative, iterative and longer term.

1.2 NHS England published the National Planning Framework in September 2025, setting out an ask for all organisations to prepare credible integrated five-year plans, replacing previous one year plans, within the context of the new NHS operating model outlined in the 10YHP.

1.3 The framework provides a significant shift towards integrated, evidence-based planning that is co-produced across systems and providers with a strong emphasis on population health, financial sustainability and transformation.

1.4 The framework is supported by several guidance documents, such as the Medium-Term Planning Framework – delivering change together published 24th October. As at time of writing this paper we are still anticipating the publication of:

- Technical Guidance which includes the details for plan submission and financial allocations (due October 2025)
- New Quality Strategy and National Care Delivery Standards (due March 2026)
- A draft Model Neighbourhood Framework, Neighbourhood Health Planning Framework and Neighbourhood Health Centre Archetype (due November 2025)
- The 10 Year Workforce Plan and Management and Leadership Framework (due Spring 2026)
- Draft Foundation Trust Framework (due for consultation November 2025)
- Model Integrated Health Organisation Blueprint (due November 2025)

1.5 As the wider West Yorkshire Integrated Care System commences the planning process for 2026/27 and beyond, this paper outlines the key context, roles and responsibilities for the WY ICB Board and the wider system.

1.6 The paper aims to provide an update to members of the Leeds Committee in regard to the requirements of the revised planning cycle and assurance on the process to deliver it. The work is being undertaken at pace, ahead of the full publication of national guidance (as noted above) and during a period of

national and local organisational change. The paper therefore seeks support for a flexible approach in undertaking the planning round this year.

2. The NHS Planning Framework

2.1 The NHS Planning Framework establishes a continuous, iterative planning process that aligns strategic and operational planning across organisational, place and system levels. It sets out five core principles for effective planning: outcome focussed; accountable and transparent; evidence-based; multi-disciplinary; and credible and deliverable.

2.2 Key changes from previous years include:

- A shift from annual planning to a rolling five-year horizon
- Separate plan submissions from ICBs and providers, replacing previous system-wide return
- Regional NHS England teams assuming responsibility for plan assurance and acceptance
- A two-phase planning cycle: foundational work and plan development (see appendix 1)

2.3 The framework outlines principles and key planning activities to be adapted based on local needs and circumstances. The approach for West Yorkshire is set out in table 1 below:

Table 1. Core outputs, roles and responsibilities

	WY ICB Core	WY ICB Integrator – Place	Providers and collaboratives
Roles and responsibilities	Develop **five-year strategic commissioning plan** to improve population health, access and quality	Develop **Neighbourhood Health Plan** and supporting place-based delivery plans	Develop a credible, **integrated five-year plan** that demonstrates how national and local priorities will be delivered, including securing financial sustainability
Scope	• Assess population needs and inequalities • Review quality and performance • Forecast demand • Generate insights	• Assess local needs drawing on insight from JSNA, HWb strategies • Co-design integrated services develop local delivery plans	• Clinical service reviews • Evaluate services and capabilities • Set financial baseline • Identify variation and opportunities

	• Develop commissioning intentions • Integrate local plans into a system wide plan • Conduct QEIAs • Align resources	• Outline collaborative working arrangements • Integrate public health, social care, and the Better Care Fund. • Focus on joint design and delivery of neighbourhood health services.	• Redesign services and pathways • Forecast demand and capacity • Develop service-level plans Triangulate plans with resource • Conduct QEIAs • Align resources
Lead	West Yorkshire Strategy and Partnership Directorate	Place Accountable Officers	Trust leads supported by Provider Collaborative Directors
Governance Sign Off	ICB Board	Health and Wellbeing Boards	Provider Boards
	The ICB is to co-ordinate system response to nationally determined NHS planning requirements, working with region and providers.		

3. Five-year strategic commissioning plan

3.1 As a strategic commissioner ICBs are expected to improve population health and access to high quality services. Plans are required to outline new care models and investment programmes aligned with the 10 Year Health Plan and show how resources will be aligned to meet population needs. The plans must be evidenced based, focussing on population health needs and ICBs will be required to develop supporting population health improvement plans to address health inequalities, building on local neighbourhood health plans.

3.2 The plans will be refreshed annually as part of the five-year planning cycle and detail how the ICB will build the core capabilities described in the ICB blueprint. This annual refresh will provide us with the opportunity to amend and update our plans if required as well as reflecting our increasing maturity towards the end state system.

3.3 Partners across the system have come together to discuss and plan our approach to developing the five-year strategic commissioning plan, emphasising the importance of aligning system strategy, planning, operational and neighbourhood health planning. It is acknowledged that there will need to be a staged approach whilst we focus on returning to and delivering core standards in year.

3.4 The following actions have been completed, or are nearing completion, to inform the development of an outline five-year strategic plan working collaboratively with partners:

a. Population health needs assessment

i. A rapid West Yorkshire population health needs assessment has been completed, adopting a life course approach covering prevention alongside health inequalities and the impact of population health need on healthcare service demand.

ii. A high-level Leeds population health needs assessment has been completed building on the WY needs assessment and previous documents e.g. people's insight, joint needs assessment and Director Public Health report.

iii. This will build an evidence base and inform the development of population health outcomes that the ICB aims to contribute towards improving over the next 5 years which will in turn inform our commissioning intentions

b. **Involvement and engagement**

i. WY ICB recently engaged across places and Healthwatch to support the development of the Integrated Neighbourhood Health and Urgent and Emergency Care blueprints

ii. Extensive public engagement as part of informing the 10-Year Health Plan

iii. Local engagement in Leeds to understand local community views on neighbourhood health services and wider engagement drawn from the insight library and Healthwatch reports.

iv. All insight will be used to help inform our approach to the national planning guidance, ensuring local voices are reflected in future service design

c. Review and assimilation of existing strategies

i. Work to review existing strategies and plans at WY level and Leeds level (Leeds Ambitions, Health and Wellbeing Strategy, LHCP transformation programmes etc.) have been undertaken since the publication of the 10 Year Health plan and have been mapped against the national requirements. These reviews have provided significant assurance that we have strategic alignment to national direction.

d. Demand and capacity

i. Work has been undertaken within each provider, Leeds Place and across West Yorkshire to understand forecasting, capacity and demand modelling based on population need.

ii. As we mature as a strategic commissioner we will continue to work with provider collaboratives to further develop our approach to modelling to inform one and five year plans.

e. Specialised services; Health and Justice, Vaccinations and Immunisations and Screening

i. Currently working closely with NHSE to ensure these areas are reflected within our plans ahead of these services being transferred to the ICB in April 2026 and April 2027.

4. Neighbourhood Health Plans

4.1 Whilst we await the detailed guidance and supporting frameworks, work has already started in developing our Neighbourhood Health Plan in Leeds. The plan builds on the existing work that is already successfully underway in Leeds and will be developed in collaboration with our partners. The plans will outline how organisations, including the NHS, Local Authority, social care providers and the VCSE sector, will work together to design and deliver neighbourhood health services. The Leeds Health and Wellbeing Board will provide the governance to oversee development and sign off this plan.

4.2 Our local plan will build on the strategic vision within Leeds, the Leeds Ambitions, and as set out as part of the West Yorkshire Integrated Neighbourhood Health Blueprint, reflecting system consensus for our neighbourhood health approach including the enablers required to support implementation.

4.3 Within Leeds we have used local evidence (data and insight) to identify priority population cohorts and delivery will be measured through the two Healthy Leeds Plan goals (also the WY ICB 'North Star' metrics); reduce preventable unplanned care utilisation and increase early identification and intervention. This sets clear targets and trajectories that inform our operational and financial planning to support shift from hospital to community.

5. Integrated Five Year Plans

5.1 Providers are required to develop a credible, integrated 5-year plan that demonstrates how national and local priorities will be delivered, including setting out how they will secure financial sustainability.

5.2 Work is underway within providers with recent and ongoing clinical service reviews helping to inform these plans through the identification of key pieces

of transformational work and service reconfiguration alongside quality and efficiency opportunities and where working together may have a benefit.

5.3 Integrated provider plans will be developed on an organisational basis, whilst also having a common narrative around shared opportunities and service reconfiguration as well as setting out how they connect into neighbourhood health plans.

6. Approach to delivering the Medium Term Planning Framework

6.1 The Medium Term Planning Framework (MTPF) is ambitious and seeks to return the NHS to much better health over the next 3 years with waiting times dramatically reduced, access to local care restored to the level patients and communities expect, and unnecessary bureaucracy removed.

6.2 Building on the 10 Year Health Plan it sets our how the NHS can deliver the three shifts and sets out the new way of working (see fig. 1).

Fig. 1

Hospital to Community	Sickness to prevention	Analogue to digital
• Accelerating progress on neighbourhood health • Same day appointments for urgent cases in general practice • Increasing community service capacity and productivity • Greater use of community pharmacy • 700,000 extra urgent dental appointments a year	• Tackling obesity, including continued rollout of weight loss medicines and weight management services • Supporting the target of a 25% reduction in CVD-related premature mortality • Implementing opt-out models of tobacco dependency services • Reducing antibiotic use and polypharmacy	• Making full use of the NHS app to communicate with and support patients to better access and manage the care and services they need • Using the NHS Federated Data platform to improve care through better use of data • Deploying AI tools like ambient voice technology and digital therapeutics
These shifts will be supported by: 1. Transforming approach to quality 2. New operating model for the NHS 3. New financial regime 4. Renewed approach to improving productivity		

6.3 An overview of the headline trajectories that must be delivered can be found in Appendix 2. The delivery of these plans will be challenging given the timescales available, but work has started on developing our plans based on high level trajectories outlined within the framework using the same process as previous years. Whilst this year's planning return shifts from a system return in previous years to separate ICB and Provider returns this year, we continue to develop our plans as a system, working together.

6.4 The first submission is due mid-December and includes:

- 3 year revenue and 4 year capital plan return
- 3 year workforce return
- 3 year operational performance and activity return
- Integrated planning template showing triangulation and alignment of plans
- Board assurance statements

7. Aligning and triangulating plans

7.1 Coordination, alignment and triangulation is critical given the pace and complexity involved in the development of the plans. There has been, and continues to be, a strong drive to working collaboratively across the system to translate strategic intentions into measurable plans, ensuring operational trajectories meet both national targets and the commitment of the West Yorkshire five-year plan.

7.2 West Yorkshire ICB, supported by place, is required to lead system-level strategic planning, coordinate responses to national requirements, and support providers in developing credible, triangulated plans. Providers will develop their own strategic, operational and financial plans, aligned to commissioning intentions and system priorities, but triangulated across the system and wider plans, informing our approach to delivering neighbourhood health.

7.3 All plans must demonstrate how health inequalities will be addressed and how financial sustainability will be secured over the medium term.

8. Governance and sign off

8.1 The planning framework articulates that a robust integrated planning process is essential to ensure that the plan is well-informed, broadly supported and feasible to implement. To support this integrated planning processes and governance arrangements are required at organisation, place and system level. The framework states that Executives and Boards should ensure that structures and processes are in place to support integrated planning. It also

says that organisations' boards should also be engaged in the development of plans and are expected to complete board assurance statements demonstrating that they are satisfied that plans are robust and deliverable. An overview of the governance and sign off aligned to each plan is provided in table 1.

8.2 Each provider organisation has established robust governance arrangements to support development of their plans, ensure Board engagement throughout the planning cycle and to enable sign off including the Board Assurance Statements.

8.3 The WY ICB Board is expected to play an active and strategic role in the planning process, supported by place committees. This includes setting the direction, reviewing and constructively challenging draft plans, and ensuring alignment with system strategy and national ambitions. The WY ICB Board will be responsible for signing off our collective place plans, supported by assurance from place Committees that plans have been developed in accordance with the guidance and support delivery of local priorities. The details of the Board Assurance Statements and requirements are yet to be published.

8.4 **The Committee is asked to endorse the proposal to work with the Leeds Accountable Officer and Leeds Committee Chair to provide final sign-off on behalf of the Board, including the Board Assurance Statement (subject to published national guidance)**

8.5 The WY ICB Board will have an active role in overseeing the planning process by:

- Promoting an evidence based and realistic approach that supports continuous improvement
- Enabling the development of improvement capability across all levels of the organisation
- Embedding transformation priorities such as digitisation, productivity and shifting care closer to communities with planning activities
- Facilitating collaboration across system partners through shared data, joint scenario development and integrated governance mechanism.

8.6 The Leeds Committee is expected to have a role in support the planning cycle and provide assurance to the WY Committee, which includes:

- Supporting development of neighbourhood health plans over the next 6 months, led and signed off by the Leeds Health and Wellbeing Board
- Ensuring place-based priorities are reflected within the strategic commissioning intentions

- Promoting co-production with LCC and VCSE partners, recognising their deep community insight and delivery role
- Using the committee and the HWB as a strategic forum to align public health, social care and ensure that neighbourhood level insight and priorities are embedded in system wide planning.

9. The Leeds Committee is asked to review and confirm support of the proposed approach for this year, ensuring appropriate forums are used (as detailed below) to enable timely delivery in the current circumstances.

9.1 High level overview of local and system groups established to support the development of local plans and ensure adherence to the NHS Planning Framework, in addition to the governance and assurance processes in place within provider organisations:

- **West Yorkshire Integrated System Planning Group** – Includes members of all providers, place planning leads and West Yorkshire ICB core teams. Its role is to support the development of all plans across the wider system and the triangulation of plans.
- **Leeds Finance, Value and Performance Sub-Committee** – responsible for supporting the Leeds Committee of the WYICB in scrutinising and tracking the delivery of service priorities, outcomes and targets as specified in our strategic and operational plans, and overseeing performance of operational plan delivery, NHS Oversight Framework and local standards, targets and priorities.
- **Leeds City Wide Planners** – This includes all planning leads (activity, finance and workforce) from across Leeds partnership to work together in developing our local plans, ensuring triangulation and providing mutual aid support throughout the planning process.
- **Neighbourhood Health Planning Group (tbc)** – This group will consist of strategic leads from across our partnership to support the development of our delivery plan, building on the work already underway within the local authority, Local Care Partnerships, LHCP transformation programmes and the National Neighbourhood Health Implementation programme.

10. Key system risks

- **Financial and performance challenges** – system continues to face significant pressures across both financial and performance domains, and these are expected to intensify with tighter financial margins coinciding with rising expectations for improved performance metrics
- **Organisational disruption**: changes across the ICB, provider organisations, LCC and NHSE may impact on capacity

- **Commissioning and contracting changes**: evolving framework introduces financial risks, particularly where increased activity drives higher costs. Limited time to make contractual changes ahead of year end.
- **Accelerated timescales**: moving the planning cycle to Q3 has reduced time available for development and assurance
- **National guidance uncertainty**: delays and lack of clarity in national guidance may hinder timely and effective planning

11. Next Steps

11.1 Continue to develop and triangulate 5-year Strategic Commissioning Plan, 5 Year Integrated Delivery Plan, and Planning return to meet the milestones detailed below:

Event	Purpose	Date
West Yorkshire System Triangualtion workshop	Review emerging plans and ensure triangulation across plans	26th November 25
West Yorkshire ICB Board	Sign off ICB plans ahead of submission to NHSE	16th December 25
NHSE Submission	First submission: 3-year revenue and 4 year capital plans 3 year workforce return 3 year operational performance and activity return Integrated planning template Board Assurance Statements	18th / 19th December 25 (tbc)
Full Plan Submission	Updated numerical plans and Board Assurance Statements 5 Year plans	Early February 2026 (tbc)
Neighbourhood Health Plans	Detailed delivery plans including BCF	End of March (tbc)

12. Recommendations

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

- **Note** the publication of the NHS Planning Framework and supporting guidance
- **Review and confirm** support of the proposed approach for this year, ensuring appropriate forums are used to enable timely delivery within current circumstances
- **Endorse** the proposal to work with the Leeds Accountable Officer and Leeds Committee Chair to provide final sign-off on behalf of the Board, including the Board Assurance Statement (subject to published national guidance)

13. Appendices

Appendix 1: Overview of West Yorkshire Approach to Phase 1 and Phase 2 of the planning framework:

<table>
<tr><th></th><th>ICB</th><th>Provider</th><th>Place Partners</th></tr>
<tr><td rowspan="2">Phase one:
Setting the foundations</td><td colspan="2">Summary:
• Refresh the clinical / organisational strategy to reflect national policy or local context
• Establish appropriate governance structures and agree responsibilities and ways of working to support the integrated planning process, including engagement with patients and local communities</td><td rowspan="2">Provide place-level input on population needs and local priorities including JSNA</td></tr>
<tr><td>• Assess population needs, identifying underserved communities and surfacing inequalities, and share with providers
• Review quality, performance and productivity of existing provision using data and input from stakeholders
• Develop initial forecasts and scenario modelling for demand and service pressures
• Generate actional insights to inform service and pathway design with providers
• create outline commissioning intentions for discussion with providers</td><td>• Review quality, performance and productivity at service level as well as organisations underlying capabilities workforce, infrastructure, digital and technology)
• Establish a robust financial baseline
• Identify key sources of unwarranted variation and improvement opportunities through benchmarking and best practice
• Identify service and pathway redesign opportunities
• Undertake core demand and capacity analysis and develop initial forecasts and scenario modelling.</td></tr>
<tr><td rowspan="2">Phase two:
Integrated Planning</td><td>• Develop 5-year strategic commissioning plan to improve population health, access and quality
• Bring together neighbourhood health plans into a population health improvement plan in discussion with people, communities and partners
• Finalise commissioning plans to inform provider plan development</td><td>• Develop a credible integrated 5-year plan that demonstrates how national and local priorities will be delivered, including securing financial sustainability
• Develop clear service level plans that meet national and local priorities, including implementation plans best practice care pathways
• Triangulate and finalise finance, workforce, activity and quality plans</td><td rowspan="2">• Lead the codesign of integrated service models at place level
• Develop Neighbourhood Health Plan and supporting place-based delivery plans</td></tr>
<tr><td colspan="2">• Iterate initial forecasting and scenario modelling for demand and service pressures and to reflect service redesign opportunities
• Undertake QEIAs
Ensure improvement resources are aligned to the priority areas of the plan and delivery plans</td></tr>
</table>

Appendix 2: NHS Medium Term Planning Framework - operational performance headline targets

	Success Measure	2026/2027 target	2028/2029 target
Elective, cancer, diagnostics	Improve the percentage of patients waiting no longer than 18 weeks for treatment	Every trust delivering a minimum 7% improvement in 18 week performance or a minimum of 65%, whichever is greater	Achieving the standard that at least 92% of patients are waiting 19 weeks or less for treatment
	Improve performance against cancer constitutional standards	Maintain performance against the 2 day cancer faster diagnosis standard at the new threshold of 80%	
		Every trust delivering 94% performance for 31-day and 80% performance for 62-day standards	Maintain performance against the 31-day standard at 96% and 62-day standard at 85 from March 202
	Improve performance against the DM01 diagnostics 6-week wait standard	Every system delivering a minimum 3% improvement in performance or performance of 20% or better, whichever level of improvement is greater	Achieving the standard that no more than 1% of patients are waiting over 6 weeks for a test
Urgent and emergency care	4-hour A&E performance	Every trust to maintain / improve to 82% by March 2027, with no lower than 80% as an average across the year	National target of 85% as the average for the year
	12-hour A&E performance	Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26	Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours
	Category-2 response times	Improve upon 2025/26 standard to reach an average response time of 25 minutes	Further improvement so that by the end of 2028/29 the average response time is 18 minutes, with 90% of calls responded to within 40 minutes
Primary care	Same day appointments for all clinically urgent patients (face to face, phone or online)	90% (to be consulted on)	
	Improved patient experience of access to general practice (ONS Health Insights Survey)	Year on year improvement	

	Deliver 700,000 additional urgent dental appointments against the July 2023 – June 2024 baseline period	Each ICB to deliver their share of the urgent dental appointment target every year (2026/27 – 2028/29)	
Community Health Services	Address long waiting times for community health services	At least 78% of CHS activity occurring within 18 weeks	At least 80% of CHS activity occurring within 18 weeks
Mental Health	Expand coverage of Mental Health Support Teams in schools and colleges	77% coverage of operational MHSTs and teams in training	94% coverage of operational MHSTs and teams in training, reaching 100% by 2029
	Meet the existing commitments to expand NHS Talking Therapies and IPS	63,500 accessing IPS by the end of 26/27 805,000 courses of Talking Therapies by the end of 26/27 with 51% reliable recovery rate and 69% reliable improvement rate	73,500 accessing IPS by the end of 28/29 915,000 courses of Talking Therapies by the end of 28/29 with 53% reliable recovery rate and 71% reliable improvement rate
	Eliminating inappropriate out of area placements	Reducing the number of out of area placements	Reducing or maintaining at zero the number of inappropriate out of area placements
Learning Disability and Autism	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people	Deliver a minimum 10% reduction year on year	
Workforce	Reduce use of bank and agency staffing	Trust to reduce agency and bank use in-line with individual trust limits as set out in planning templates, working towards zero spend on agency by 29/30 Annual limits will be set for trusts individually based on a national target of 30% reduction agency in 26/27, and 10% year on year reduction in spend on bank staffing	

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	13
Meeting date:	Wednesday 19 November 2025
Report title:	Chapel Allerton Hospital New Elective Care Centre
Report presented by:	Robert Hakin, Director of Healthcare Planning, Leeds Teaching Hospitals NHS Trust
Report approved by:	Robert Hakin, Director of Healthcare Planning, Leeds Teaching Hospitals NHS Trust
Report prepared by:	Robert Hakin, Director of Healthcare Planning, Leeds Teaching Hospitals NHS Trust

Purpose and Action			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations:			
None			
Executive summary and points for discussion:			

In May 2025 Leeds Teaching Hospitals received notification that capital funding had been made available to deliver our planned elective care hub schemes at Chapel Allerton Hospital. The scheme comprises of the following elements and implications for the Trust:

- a 23 bedded ward, 2 operating theatres with associated recovery space and other infrastructure improvements around replacement non-clinical estate and car parking.
- a total capital estimate is £32.0m.
- an increase in revenue spend of £12.7m.
- an increase of 142 WTE staff.
- The case increases our elective operating capacity by 1,666 cases per year split between spinal surgery and orthopaedic surgery.

As the case has now been approved by the Leeds Teaching Hospitals Trust Board, we are asking partner organisations for support to submit our Full Business Case.

The Committee is asked to support the submission of the Trust's Full Business Case to NHSE and approve a cover letter to be sent to Leeds Teaching Hospitals.

The letter would cover the following items:

- Operational capital/revenue envelopes: Where the trust/ICS/ICB is part funding the scheme, confirmation that this is affordable within operational capital envelopes and revenue envelopes.
- Estates strategy: Confirmation that the capital investment fits within the ICB plan and supporting estates strategy
- Digital strategy: Confirmation that the capital investment fits within the ICB plan and supporting digital strategy.

- Overall support: Confirmation that the scheme is a priority for the ICB and has its full support.

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. The Committee is asked to support the submission of the Trust's Full Business Case to NHSE and approve a cover letter to be sent to Leeds Teaching Hospitals.

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:

Risk ID 2530 m: 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.

Appendices

1. None

Acronyms and Abbreviations explained

1. FBC – Full Business Case
2. CAH – Chapel Allerton Hospital

What are the implications for?

Residents and Communities	**Increased options for access to elective care in the region.**
Quality and Safety	**Reduced waiting times for spinal surgery patients at Leeds Teaching Hospitals**
Equality, Diversity and Inclusion	**Positive. Accessible modern environment with the addition of a multi faith room**
Finances and Use of Resources	**Improved productivity for delivering elective operating at Leeds Teaching Hospitals**
Regulation and Legal Requirements	**None**
Conflicts of Interest	**None**
Data Protection	**None**
Transformation and Innovation	**Supporting increased care in the community**

Environmental and Climate Change	**Business Case has a full BREEAM assessment and will meet required standards**
Future Decisions and Policy Making	**None**
Citizen and Stakeholder Engagement	**The project structure for this case involved a communications plan with key stakeholders. The overall brief has been developed in conjunction with clinical teams and site leads to ensure it delivers the best for patient care. Patient engagement and feedback has been incorporated, with plans for further engagement on specific areas once the FBC is approved.**

1. Summary

In May 2025 Leeds Teaching Hospitals received notification that capital funding had been made available to deliver our planned elective care hub schemes at Chapel Allerton Hospital.

The scheme comprises of the following elements and implications for the Trust:

- a 23 bedded ward, 2 operating theatres with associated recovery space and other infrastructure improvements around replacement non-clinical estate and car parking.
- a total capital estimate is £32.0m.
- an increase in revenue spend (since mitigated)
- an increase of 142 WTE staff.
- The case increases our elective operating capacity by 1,666 cases per year split between spinal surgery and orthopaedic surgery.

As the case has now been approved by the Trust Board, we are asking partner organisations for support to submit our Full Business Case. The below document details the main elements of our case for assurance of the group.

The business case follows the Treasury five case model with the following sections:

- Strategic Case: Establishes the case for change, aligns with strategic objectives, policies, and priorities, Defines desired outcomes and benefits
- Economic Case: Appraises options to deliver best public value, uses cost-benefit analysis (CBA) or similar techniques, Identifies the preferred option
- Commercial Case: Examines commercial viability and procurement strategy, Assesses supplier market, risk allocation, and contracts, Ensures deal is deliverable and sustainable
- Financial Case: Tests affordability within budgets and funding constraints, Outlines capital and revenue implications, Considers impact on balance sheet and cash flow
- Management Case: Demonstrates deliverability and governance arrangements, Details project planning, risk management, and monitoring, Explains how benefits will be tracked and realised.

2. ICB Context

The overall aim of the case is to increase overall operating capacity within the region with a specific focus on delivering repatriation of independent sector work for orthopaedics and reduction of the overall spinal surgery backlog to deliver 18 week compliance in that specialty. This is achieved two years after opening of the centre, approximately 2027/28, at which point the Trust would look to our overall operating capacity to ensure the case remain revenue neutral in the long term.

However, it is important to note that significant changes in funding models and partnership working could take place over that time and the Trust remains open to discussions around how this facility could support other organisations with specialty specific issues understanding that these are frequently driven as much by patient choice as they are by resource availability.

No additional revenue funding is being asked of the ICB as growth funds for this case are being sources from specialised commissioned teams and have been agreed for the described services.

3. Strategic Case

The output of the strategic case is to agree the project investment objectives, these are listed below:

No.	Investment Objective	Specific Improvement
1a	Increase the capacity and efficiency of the surgical hub for orthopaedic surgery	Increase capacity for orthopaedic capacity by 784 patients per year. Deliver theatre utilisation of 85% within the new unit.
1b	Increase the capacity and efficiency of the surgical hub for spinal surgery	Increase capacity for spinal surgery patients by at least 882 patients per year. Deliver theatre utilisation of 85% within the new unit.
2	Develop ability to care for increased acuity patients	Reduction in cancellation of high acuity patients from 0.8 to 0.4 per patient on waiting list.
3	Improve the environment and facilities for staff	Improved staff satisfaction scores, showing increase of 5%.
4	Improve our estates utilisation and sustainability position	Provide over 2000m^2 of new clinical accommodation with a low percentage <20% of associated non clinical support rooms to achieve best use of estate

Table 3-1: Investment Objectives

Other Benefits

Whilst tangible benefits are key to a successful programme the organisations is keen to highlight other benefits of delivering these theatres, these are summarised below set against the Trust's multi year goals:

Trust Multi Year Goal	Business Case Benefit
Deliver a sustainable surplus by becoming the most efficient teaching hospital	• Outsourcing a significant proportion of orthopaedic activity carries reputational and financial risk, as long waits and transfers are perceived as lack of capacity.
Deliver fit for purpose healthcare infrastructure	• Maintaining sufficient case volume and complexity is essential to sustain staff skills, morale, and recruitment appeal. • Additional theatre capacity at Chapel Allerton will ensure the Trust absorbs this growth and remains the primary provider of complex orthopaedic care, rather than ceding activity to external organisations. • Increased theatre capacity provides opportunities to refurbish existing aged estate on our main sites.
Be in the top quartile for holistic health performance	• Reduced waits decrease clinical risk, particularly for revision cases, where patients typically present with poorer health and more complex surgical needs. • Increased capacity will support the regional demand for revision orthopaedics which is projected to increase by 20%, driven by demographic change and an ageing population. • Increased capacity will support the regional demand for spinal surgery which has grown by 16% over the last five years and is expected to grow by 6% per annum over the next decade.
Be a leading academic healthcare institution	• The increased high volume low complexity lists at CAH deliver more capacity for complex surgery at LGI, both increasing training opportunities.

Have an embedded culture of service improvement and innovation	• The development improves the Trust's elective hub designation, supporting our vision for the site.
Have a consistent, high-performing and sustainable workforce	• Consultant Morale and Job Planning, an increased of guaranteed case mix and theatre access supporting consultant morale which also drives secure job planning which supports recruitment and retention. • Maintaining sufficient case volume and complexity is essential to sustain staff skills, morale, and recruitment appeal. • The development will provide a significant morale boost for our spinal surgery consultants.
Ensure people receive person-centred care in the most appropriate environment and setting	• Expanding on-site capacity will help retain patient confidence, protect the Trust's clinical reputation, and reduce reliance on external providers.

Table 3-2: Non Core Benefits

4. Economic Case

The main outputs for the economic case are the agreed preferred option and cost:benefit analysis.

Our preferred solution is to develop ward accommodation internally at CAH with theatres and support accommodation housed within a new build adjacent to the existing theatres unit.

A guide from NHSE is that this should be at least 4.0. Work has been ongoing to develop our cost:benefit ratio which exceeds this minimum level.

Figure 4-1: Revised CAH Layout

Figure 4-2: Artist Impression of New Block

5. Commercial Case

The works packages in the FBC are:

Revised
1. Ancillary works (NOECPC Minor Works DPS) a. Decant provision for clinical genetics. b. Support areas. 2. Main Contract (Procure 23): a. Road and service diversions. b. New-build theatre & office building and car parking (not decked). c. Refurbished clinical accommodation.

Table 5-1: FBC Works Packages

BREEAM ratings have been updated because of the change from a new build to an extension and further design development:

Revised
The new build extension is now targeting Very Good. The scheme relies on some existing services / plant and due to the nature of the occupancy (theatres) there is requirement for mechanical ventilation, reducing the available BREEAM benefits / points.
The ward (internal works) is now targeting BREEAM Good. The overall scope for this piece of work is minimal. Although the scheme is replacing windows there is very little impact the scheme can have to achieve BREEAM benefits/ points.

Table 5-2: FBC BREEAM ratings

In addition to the above the following key progress points have been made:

- Since submission of the original OBC, Kier has been appointed as the Trust's Procure 23 Principal Supply Chain Partner (P23 PSCP).
- An application has now been made for planning approval for the car parking element and for permitted development for the theatre extension. The development of the theatre extension has been granted and a determination of the carparking is expected imminently.
- RIBA Stage 4 designs have been completed.

Key commercial risks & issues

Key commercial risks & issues are:

- Agreement of the final Guaranteed Maximum Price (GMP) figure has been reached so this commercial risk has reduced.

- Financial allocation has been made in the cost plan of £150k for re-providing car parking, pending agreement of a solution to this issue.

6. Financial Case

During the Trust Finance & Performance Committee meeting on 27 August 2025 the team was asked to review the original revenue impact of the case with a specific focus on the following areas:

- A further scrutiny on overall revenue costs.
- Establish cost mitigation which could be put in place, such as:
    - Options to close existing theatres to reduce revenue costs
    - Review of theatre productivity and how this will inform this case and other decisions given the significant revenue implications.

Financial Resolutions

The financial resolutions included a further review of the staffing model, assessment of theatres productivity and existing estate and a reduction of the bed base in the new ward. The intention is also to delivery orthopaedics activity that is currently being sent to the Independent Sector in the additional capacity. A financial summary of the incremental income and expenditure position to 2029/30 is provided below. Further details are available in the Full Business Case. No additional revenue funding is being asked of the ICB as growth funds for this case are being sourced from specialised commissioned teams and have been agreed for the described services.

	2025/26 £m	2026/27 £m	2027/28 £m	2028/29 £m	2029/30 £m
Contract Income			5.2	9.3	10.3
Other Operating income			0.0	0.0	0.0
Sub Total - Income	**0.0**	**0.0**	**5.2**	**9.3**	**10.3**
Pay Costs		(0.2)	(3.8)	(3.7)	(3.9)
Non Pay Costs		0.0	(2.8)	(4.8)	(4.8)
Sub Total - Expenditure	**0.0**	**(0.2)**	**(6.6)**	**(8.5)**	**(8.7)**
EBITDA	**0.0**	**(0.2)**	**(1.3)**	**0.8**	**1.7**
Depreciation			(0.3)	(0.6)	(0.6)
Interest					
PDC			(0.4)	(0.8)	(0.8)
Impairment					
Gain / Loss on Disposal					
Retained Surplus/ (Deficit)	**0.0**	**(0.2)**	**(2.0)**	**(0.6)**	**0.3**
Technical Adjustments					
Adjusted Surplus /(Deficit)	**0.0**	**(0.2)**	**(2.0)**	**(0.6)**	**0.3**

The changes made to the case requested by NHSE and Finance and Performance Committee to address financial constraints have required material changes to be made to our investment objectives as detailed below:

No.	Investment Objective	Specific Improvement	Impact of Financial Resolutions
1a	Increase the capacity and efficiency of the surgical hub for orthopaedic surgery	Increase capacity for orthopaedic capacity by 784 patients per year. Deliver theatre utilisation of 85% within the new unit.	Although an increase of LTHT orthopaedic capacity would be delivered this would be through repatriating independent sector work and therefore would have no nett benefit on our waiting list position.
1b	Increase the capacity and efficiency of the surgical hub for spinal surgery	Increase capacity for spinal surgery patients by at least 882 patients per year. Deliver theatre utilisation of 85% within the new unit.	Our spinal surgery capacity would increase for the first two years of the development to address our RTT backlog position. At that point spend on elective operating must reduce either through reduction in allocation to spinal surgery or other services reducing their resources.
2	Develop ability to care for increased acuity patients	Reduction in cancellation of high acuity patients from 0.8 to 0.4 per patient on waiting list.	None
3	Improve the environment and facilities for staff	Improved staff satisfaction scores, showing increase of 5%.	None
4	Improve our estates utilisation and sustainability position	Provide over 2000m^2 of new clinical accommodation with a low percentage <20% of associated non clinical support rooms to achieve best use of estate	None

Table 6-1: Impacts on Investment Objectives

Capital

The total capital cost of the scheme is estimated at £32m.

£25.384 million is available from the NHSE Return to Constitutional Funding 2025/26 allocation, pending final approval of the FBC. The WY ICS has agreed that this funding will be brokered across financial years as required to support the scheme.

The WY ICS has agreed in principle to top-slice the remaining required funding from operational capital allocations in the 2027/28 financial year. Based on current projections this would be £6.6m.

There have been very limited changes in scope and design detail since the previously agreed designs were developed. Increases in cost since OBC are mainly related to:

- Project remobilisation and re-work
- Inflation
- Changes in planning legislation (biodiversity net gain)
- Revised equipment requirements to support both spinal and orthopaedic surgery.

7. Management Case

The assumed solution for the decant of clinical genetics is a move to a vacant area in Joseph's Well already leased by the Trust, for the duration of the construction period.

Element	Date
FBC Summary Presented to Executive Management Group	04/08/2025
FBC Approved by Finance and Performance Committee	27/08/2025
FBC Approved by Trust Board	25/09/2025
FBC Submitted to NHSE	25/09/2025
FBC Approval (assumed 8-week NHSE period)	20/11/2025
Main Contract Award	01/12/2025
Ancillary works start	01/12/2025
Main works work start	26/01/2026
Go-live	19/11/2027

Table 7-1: Project Timetable

8. Workforce Case

The table below outlines the WTE requirements initially presented, which will be updated to reflect the reduced bed capacity and workforce model proposed to deliver the balanced financial position.

Staff group	2025 WTE Monday to Friday 2 session days
Nursing	87.41
Medical	12.60
AHP*	30.94
Support staff	11.35
Total	**142.30**

**Includes Pharmacy*

Table 8-1: Workforce Position

The development of the workforce plan has been undertaken in conjunction with Clinical management teams with input from the HR Transformation Lead and professional workforce leads as appropriate. The plan is based on a multidisciplinary team approach built around patient need.

A range of strategies will be undertaken to recruit to the additional roles required but we are confident that due to location of Chapel Allerton Hospital being only a short distance from Leeds City Centre this will benefit our recruitment strategy.

Governance on the workforce is through the CAH Project Board and CAH Programme Board.

Current Project Risks

A project risk log is included as part of the FBC and is available upon request; the current main risks for the project are as follows:

	Prior to Mitigation				Mitigation		
Risk Description	**Prob (1-5)**	**Imp (1-5)**	**Risk Rating (1-25)**	**Measures to Mitigate Risk**	**Prob (1-5)**	**Imp (1-5)**	**Risk Rating (1-25)**
Reduced onsite parking for staff	5	5	25	Site logistics plan provided by Kier highlighting areas required for construction. Potential provision of offsite parking to be arranged by the trust, previous solution no longer available so search is ongoing	5	2	10
Operating Costs	5	5	25	Revenue implications making the project unachievable, significant improvement work and project objectives changes have addressed these challenges.	3	4	12
Decant of Clinical Genetics	5	5	25	Move of the CG team to appropriate location, and confirmation of the works required to retain BAU	4	4	16
Construction works commence Jan 26 pending enabling works completed by the Trust	5	4	20	Asbestos removal works to be completed prior to the Ward works progressing and timely decant of Clinical Genetics	4	4	16
Operation of current hospital / clinical facilities being adversely impacted by physical Construction of the new facilities.	4	5	20	Construction phase plan to be agreed. Ensure Ops Centre and key stakeholders are kept aware of progress planned works. Agree sequencing of works in advance for 'disruptive' elements of work. Agree/implement patient movement requirements.	3	5	15
Inability to recruit required additional workforce (main scheme)	5	4	20	Inability to recruit sufficient staff in programme timeframe	3	4	12
Floor, ceiling and wall lines/levels between existing rooms differ following demolition	4	4	16	Early level surveys and review of as built info in less accessible areas.	4	4	16
NHS England	4	4	16	Changing of the NHSE structure and how approval timings will be impacted	4	4	16
Changes in guidelines and legislations during construction or design phase	4	4	16	Guidelines and legislation that the Stage 4 design is based on to be clearly identified by the PSCP, any changes to these guidelines/regulations are to be notified and a subsequent decision made by the trust in relation to acceptance or not. Likely to be Water Safety Changes made post contract award requiring significant design change process to be implemented	4	4	16

Table 0-1: Project Risks

9. Communication and Involvement

The project structure for this case involved a communications plan with key stakeholders. The overall brief has been developed in conjunction with clinical teams and site leads to ensure it delivers the best for patient care. Patient engagement and feedback has been incorporated, with plans for further engagement on specific areas once the FBC is approved.

10. Equality Analysis

A full equality impact assessment has been carried out as part of the case which demonstrates improvements in health inequalities due to this investment.

11. Publication Under Freedom of Information Act

This paper is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

12. Recommendation

The committee is asked to review the details contained within this paper and approve the case for submission to NHSE in November 2025.

13. Supporting Information

None

14. Authors

Robert Hakin –**Director of Healthcare Planning**
04/11/2025

Meeting name:	Leeds Committee of the West Yorkshire Integrated Care Board
Agenda item no.	14
Meeting date:	19 November 2025
Report title:	Proposal for merger/closure of Ashton View Medical Centre and Conway Medical Centre
Report presented by:	Kirsty Turner (Associate Director of Primary Care)
Report approved by:	Kirsty Turner (Associate Director of Primary Care)
Report prepared by:	Cat Wilkinson (Manager Primary Care Integration)

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

Previous considerations:

In August 2024 the Primary Care Operational Group (PCOG) approved a proposal from Ashton View Medical Centre and Conway Medical Centre to consult with patients and stakeholders regarding the merger of their two sites and the potential future closure of Ashton View Medical Centre. This proposal was initially paused by the practices before further approval to proceed was requested and subsequently approved by PCOG in May 2025.

A period of engagement was undertaken in July/August 2025 and the outcome of the engagement was presented to the Primary Care Operational Group (PCOG) on 16 October 2025. PCOG reviewed the findings of the engagement report and gave approval for the merger request to proceed to the Leeds Committee of the WYICB.

Executive summary and points for discussion:

Ashton View Medical Centre (AVMC) currently serves a list of 5,241 patients and Conway Medical Centre (CMC)of 4,628 patients (July 2025).

There are several drivers for this application to merge. Both practices are relatively small premises with limited room availability. The only GP Partner at Ashton View Medical Centre is approaching retirement and this combined with increasing demand for primary care will make it increasingly difficult for the practices to continue to provide good patient care on their own. A merger will allow the practices to share staff and resources thereby making them more flexible and adaptable in the future to help meet their patients' needs.

The practices are located 0.2 miles apart. The proposal is to transfer all patients to the Conway Medical Centre site with appointments continuing to be available at the Ashton View Medical Centre site until extension/reconfiguration work at Conway has been undertaken and both practice staff and patients are assured that all patient needs can be safely and effectively met.

A robust engagement exercise has taken place over a period of 6.5 weeks. This paper summarises the key outcomes from the feedback gathered, the practice responses to this and the impact the merger of the two practices will have. It sets out the recommendations for the Leeds Committee of the ICB to consider.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

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

1. NOTE the feedback from patients and local stakeholders around the impact of the merger and subsequent closure.
2. NOTE the recommendation from the Primary Care Operational Group to approve the merger.
3. APPROVE the application from Conway Medical Centre and Ashton View Medical Centre to merge on 1 April 2026 and the subsequent closure of the Ashton View site.

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

Not applicable.

Appendices

1. Engagement Report
2. Boundary Maps
3. Equality and Impact Assessment (EIA)

Acronyms and Abbreviations explained

1. AVMC – Ashton View Medical Centre
2. CMC – Conway Medical Centre
3. ICB – Integrated Care Board
4. EIA – Equality Impact Assessment
5. PCOG – Primary Care Operational Group

What are the implications for?

Residents and Communities	AVMC patients will be automatically registered with CMC and in the short term all patients will be able to access services at both the Conway and Ashton View sites. Once extension/reconfiguration work at the Conway site has been undertaken and they are assured that all patient needs can be safely and effectively met, the Ashton View site will close. Patients will be kept informed about the progress of the plans to extend/reconfigure the Conway site and will have the opportunity to comment on the proposed changes. The two practices are 0.2 miles apart, a five minute walk. CMC is accessible by public transport from both Harehills Lane and Harehills Road. GP home visits are currently, and will continue to be, offered to patients as appropriate. Cases will be reviewed on an individual basis.
Quality and Safety	None identified.
Equality, Diversity and Inclusion	None identified.
Finances and Use of Resources	Discussions regarding future estate arrangements of the practices are ongoing. There are no immediate financial and resource implications.
Regulation and Legal Requirements	The application to merge the practices has been enacted in line with section 8.11.25 of the Policy and Guidance Manual.
Conflicts of Interest	None identified.
Data Protection	None identified.
Transformation and Innovation	None identified.
Environmental and Climate Change	None identified.
Future Decisions and Policy Making	None identified.
Citizen and Stakeholder Engagement	The engagement report in Appendix 1 gives a detailed account of the engagement process undertaken and a full breakdown of the feedback.

1. SUMMARY OF PROPOSAL

1.1 This paper outlines an application from Conway Medical Centre (CMC) and Ashton View Medical Centre (AVMC) to merge their practices from 1 April 2026; with a view to a future closure of the Ashton View site subject to alterations at Conway Medical Centre. The paper also outlines the engagement the practices have completed to support their application.

1.2 There are several drivers for this merger application. AVMC is a single-handed practice, and the GP is approaching retirement. Both practice premises are relatively small with limited room availability. Increasing demand for primary care, along with fewer resources, have been making it harder for the practices to continue to provide quality patient care on their own. Sharing staff and resources will allow the practices to be more flexible and adaptable in the future to help meet their patient needs.

1.3 If the merger goes ahead, the intention is to reconfigure the CMC site to offer all patients appointments in one building. The AVMC site would remain open while this work is taking place, allowing patients access to appointments at both sites in the short term. Patients will be kept informed about the planned changes to both the Conway and Ashton View sites along with proposed timescales and will be given the opportunity to provide feedback on the proposals.

The practices have confirmed that there will be no reduction in service provision and that AVMC will not close until they are assured that all patient needs can be safely and effectively met,

1.4 A robust engagement exercise has taken place over a period of 6.5 weeks. This paper summarises the key outcomes from the feedback, the practices response and the impact the merger will have.

2. PRACTICE INFORMATION

2.1 CMC currently serves a list of 4,628 patients and AVMC a list size of 5,241 (July 2025).

2.2 The current and proposed boundary maps can be seen in Appendix 2.

2.3 The distance between CMC and AVMC sites is 0.2 miles. For many of the AVMC patients CMC will be the closest alternative surgery however during the engagement it was made clear to patients at AVMC that they have the choice to re-register with another practice should they prefer to do so.

2.4 Public transport is available to both sites with the closest bus stops being 0.2 miles from each.

2.5 The practices' premises meet all current DDA and infection control standards.

2.6 Neither of the sites are a dispensing location.

2.7 Accessible car parking is available at CMC and AVMC.

3. PATIENT ENGAGEMENT

3.1 The engagement process began on 14 July 2025 and closed on the 27 August 2025 (6.5 weeks).

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

3.3 A letter outlining the proposed changes was posted to all households with patients registered at each practice. This letter included an outline of the merger plans, including the proposed closure of AVMC and an invitation to take part in the engagement activities.

3.4 A survey was developed that was available to patients online with a link in the letter, or as a hard copy available in the practices to ensure those unable to access the survey online were still able to provide feedback. Surveys in alternative formats or different languages were available on request.

3.5 The proposed changes were outlined on both practice websites with a link to the online survey.

3.6 The practices organised and held two face to face public Q&A events at The Point in Harehills on 16 and 17 July (one at lunch time and one in the evening) and one virtual event on 22 July, for people to attend to find out more about the proposed changes.

3.7 A text reminder was sent to all patients registered at both practices over the age of 18 years with a message about the proposal and a reminder to fill out the survey.

3.8 The practices responded to informal queries raised by patients in person and over the phone.

3.9 A total of 104 people formally engaged in the engagement process through either attending a meeting or submitting a survey. All responses via the survey were from patients – 53% from AVMC and 47% from CMC.

- 9 people attended the public meetings at The Point.
- 1 person attended the lunchtime online meeting.
- 94 people completed the survey, including 6 paper copies.

3.10 An FAQ document was created with responses to patients' queries and concerns. This was updated throughout the engagement process in response to survey feedback and questions raised at the public events. A breakdown of the responses and assurances given to the concerns raised can be found in the full engagement report in Appendix 1.

3.11 The engagement identified some key themes, including:

- Access & appointment availability – importance of the availability of on the day appointments and the need for responsiveness and prioritisation.

- Continuity of care and relationships / emotional and trust considerations – perceived safety net of long-standing relationships, some concerns about the potential loss of access to preferred GPs.
- Quality of care and funding – potential for a merger to degrade quality and access over time.
- Facilities and logistics – practical factors such as transport, car parking and accessibility and improved infrastructure such as bigger waiting areas and more toilets noted as points that must be considered.
- Communication, transparency and accountability – a desire for reassurance and clarity around what to expect from the transition to a merged practice.
- Cautious Optimism - the merger could bring benefits - like more clinicians, better resourcing, and possibly streamlined care.

3.12 The Engagement Report details the engagement process and outcomes and the practice response to the feedback received (see Appendix 1).

3.13 AVMC and CMC have previously attempted to engage patients in a PPG in each practice. The survey shared as part of the engagement provided the practices with an opportunity to encourage patients to register interest. A significant number of patients left their details and the practices will be contacting these patients with a view to discussing the establishment of a PPG.

4. COMMUNICATIONS AND INVOLVEMENT

4.1 Plans for the merger were shared with local councillors and MPs. One councillor responded to offer any support needed with engagement for the proposed merger.

4.2 Plans for the merger were shared with local practices within the PCN and local Pharmacies. No feedback has been received from these practices or pharmacies.

5. PRACTICE RESPONSE AND CONSIDERATIONS

5.1 The patient engagement process conducted by the practices was a robust and thorough process which allowed patients to access various engagement methods to provide feedback. As stated above, 104 registered patients contributed to the engagement, equating to just under 1% of the total practice population.

5.2 The feedback from many of the patients from AVMC show sadness at losing a familiar GP in the long term and some anxiety at the prospect of the merger of the two practices. The main concerns were around access, including availability of appointments, building capacity and transport to a different site.

5.3 The practices have provided a response to the feedback received and provided an overview of how they will manage and mitigate the concerns of patients. The full practice response can be seen in the Engagement Report in Appendix 1.

5.4 The practice informed stakeholders, including practices within the PCN, local pharmacies and local councillors and MPs about the proposed merger and longer-term closure of the AVMC site. To date the Primary Care team has not been approached by any of the stakeholders with any queries or concerns.

6. PROPOSAL

Option	Benefits	Risks
Reject the application to merge Ashton View Medical Centre and Conway Medical Centre and the longer-term plans to reconfigure the Conway site/close the Ashton View site.	Patients registered at AVMC continue in the short term to have access to a familiar GP.	There are concerns around the long-term ability of both practices to continue to provide quality care for patients. The GP at AVMC is a single-handed GP and there is no succession plan regarding a replacement when he retires in the near future.
Approve the application to merge Ashton View Medical Centre and Conway Medical Centre and the longer-term plans to reconfigure the Conway site/close the Ashton View site.	Supports the practice plans for long term sustainability. Supports practice populations by maintaining workforce and capacity to deliver services.	The mitigations put in place by the practices fail to address the issues raised through the engagement.

7. FINANCIAL IMPLICATIONS AND RISK

7.1 It is anticipated that there are no significant financial implications of the merger as this is based on the existing financial envelope.

7.2 Finance colleagues will continue to be involved to provide future financial planning and analysis and to pick up any issues throughout the process

8. STATUTORY / LEGAL / REGULATORY / CONTRACTUAL

8.1 The PGM summarises in Section 8.11.25 what should be considered by the commissioner when deciding on practice mergers.

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

9. WORKFORCE

9.1 The practice does not plan to reduce their staffing levels. All staff would be employed by CMC and initially work across the two sites (Conway and Ashton View), as appropriate.

10. NEXT STEPS

10.1 The Primary Care Operational Group approved the application to merge Conway Medical Centre and Ashton View Medical Centre on 16 October 2025. Approval is now sought from the Leeds Committee of the ICB Meeting in November 2025 for ratification and sign off. Following approval, the Primary Care Team will ensure the merger of the two practices will be enacted in line with NHS England's Policy and Guidance Manual (PGM, Part B, section 8.11.25) which sets out what commissioners should consider when deciding on practice mergers.

10.2 If the merger is approved, the practice will be asked to develop and implement their mobilisation plan. In addition, the Primary Care team will use the standard checklist for practice mergers to ensure all aspects of the merger are addressed. This covers formal patient and stakeholder communication, IT actions, and other operational aspects of the merger.

10.3 If the merger is approved, patients will be informed, and the Primary Care Team will work with the practice to ensure that patients are supported through this transition.

10.4 The official notification letter to patients will be sent out once agreed with the practices along with the FAQs. Patients identified as requiring additional support will be contacted directly by the practice.

10.5 The proposed merger date is 1 April 2026. The closure of the Ashton View site will follow the reconfiguration of the Conway site and patients will be kept informed of the plans and timescales relevant to the closure which will not take place until all parties are assured that all patient care can be met. The Primary Care Team at the ICB will support the practice through mobilisation meetings up to the date of the merger and the 3 months thereafter.

11. Recommendations

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

11.1 **NOTE** the feedback from patients and local stakeholders around the impact of the merger and subsequent closure.

11.2 **NOTE** the recommendation from the Primary Care Operational Group to approve the merger.

11.3 **APPROVE** the application from Conway Medical Centre and Ashton View Medical Centre to merge on 1 April 2026 and the subsequent closure of the Ashton View Centre.

12. Appendices

Appendix 1 – Engagement Report

Appendix 2 – Boundary Maps

Appendix 3 – EIA

Ashton View Medical Centre and Conway Medical Centre, Leeds

(Proposed practice merger and closure of Ashton View Medical Centre)

Report on feedback to the patient engagement 14 July – 27 August 2025

Publication date: September 2025

Executive Summary

Ashton View and Conway Medical Centres are located 0.2 miles apart - a five-minute walk from each other in Harehills in Leeds, approximately one mile north-east of the city centre.

Both practices premises are relatively small with limited room availability, and increasing demand for primary care, along with fewer resources, have been making it harder for our practices to keep providing good patient care on their own.

With the only GP Partner at Ashton View Medical Centre coming up for retirement, a merger, or a joining together of both practices is being proposed. Sharing staff and resources will make us more flexible and adaptable in the future to help meet our patients' needs.

The NHS West Yorkshire Integrated Care Board, which organises the delivery of NHS services in Leeds (the ICB in Leeds), accepted a request from both practices to engage with our patients to ask for their opinions about this proposal.

This report provides some background to our proposal to merge practices and outlines how we engaged with our patients about these plans. The report details what people told us during the engagement and outlines how we are responding to their feedback and what will happen next.

The engagement ran from 14 July to 27 August 2025, and aimed to:

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

Both Ashton View Medical Centre and Conway Medical Centre sent a letter to every household explaining the proposal to merge the two practices. Details on the letters included the proposal to merge and a copy of the website page to our practice website indicating where they could find a link to the survey for patients to complete.

Overall over 4400 households were informed about the engagement, with 94 people completing our survey, 9 attending face-to-face events and 1 patient joined the virtual meeting to find out more and to have their say.

This report will be shared with those involved in the engagement and will be made available on the practice websites. The information gathered from people's feedback will also support the general development of local health and care services in Leeds.

Contents Page

Background

Conway Medical Centre and Ashton View Medical Centre together provide primary care services to around 10,000 people in the Harehills area of Leeds.

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

Both our practices are quite small and Dr Wong, who is the only GP at Ashton View, is coming up for retirement. We want to ensure that a local GP would be in place to offer continued care for his patients.

This has been a long thought through decision and Dr Wong believes the idea of a practice merger is the best possible outcome for patients registered at his practice.

If the West Yorkshire Integrated Care Board, which organises the delivery of NHS services in our area (known as the ICB in Leeds), agrees with our proposal, we plan to extend the Conway Medical Centre site in order to offer all our patients' appointments in one building in new facilities. The Ashton View site would remain open while the work was taking place.

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

Neither practice currently has an active patient participation group (PPG). However, as part of the engagement process (and at any time) there has been an opportunity for patients to express interest in joining a practice PPG. This will be followed up after completion of the engagement.

Involving patients and wider stakeholders

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

The engagement ran from 14 July to 27 August 2025.

- **Staff engagement** –
  - All staff across both sites have been informed of the merge and encouraged to provide feedback and questions/concerns they may have.
  - Ashton View's Practice Manager has answered all questions ensuring transparency across questions/concerns that have arisen. Staff are kept up to date with the merge process ensuring all are given the same information and will continue to receive this up until the time we merge practices. Conway Medical staff whilst they haven't raised any questions/concerns are kept updated via verbal conversation with the Practice Manager.
  - Answers to the concerns/questions raised:

Who will be my manager	Both sites currently have a practice manager, and it is expected that this will remain.
Will our practice manager still be around	Yes, the practice manager will be TUPED across in the same way as all other staff will be.
Will we have to work from Conway site	Services initially will be run from both sites until the building work has been completed at Conway Medical Centre. Until that time staff from across both sites will work from across the two sites of Ashton View and Conway.
What will happen to Ashton Views name	Ashton View Medical name will be retired as of 18:00 31st March 2026. The merged practices will continue under the trading name of Conway Medical centre.
Will Ashton View Staff only work from Ashton View site with nothing changing other than the merge and surgery name change?	Ashton View staff will be working over both sites.

- **Stakeholder engagement**
  - We shared our plans with local councillors and MPs, one councillor responded to offer any support needed with engagement for the proposed merger.
  - We also informed local practices within the PCN and local Pharmacies via the ICB's Medicines Optimisation team. To date no response has been received from practices or pharmacies.

- **Patient Engagement**
  - We wrote to 4418 registered patient households to outline our plans, and to invite them to take part in our engagement activities.
  - We sent a text to all registered patients over the age of 18 years with a message about the proposal and a reminder to fill out the survey.
  - We ran an online survey and shared the survey link with registered patients, on our website.
  - We provided people the opportunity to fill in a paper copy of the survey at both practice premises, with different formats / translated copies available on request.
  - We held two face-to-face public meetings, both at The Point in Harehills, a local community venue on 16 and17 July, as well an online virtual patient engagement session on the 22 July.
  - We developed a Frequently Asked Questions (FAQ) document to share and published it on our website.

Who did we hear from?

Altogether, there were 3 engagements with our involvement activities. Some people may have been involved in more than one way:

- We emailed all the local councillors and the MP and received one message of support from a local councillor
- A total of 9 people attended the face-to-face public meetings at The Point on the 16 and 17 July
- 1 person attended the virtual engagement meeting held on 22 July
- 94 people completed the survey, including 6 paper copies.

The Survey

The survey opened on 14 July 2025 and was available for just over six weeks until 27 August 2025.

All households with someone registered at Ashton View and Conway Medical Centres were sent a letter providing information on the proposal and including a link to the online survey. Text messages were sent to all patient aged 18 and over reminding them to complete the survey to provide their feedback regarding the merge.

Paper copies of the survey were also available at the practice reception desks, and six people filled these out. Surveys in alternative formats or different languages were available on request.

At the end of the engagement process 94 survey responses had been received. Details about the survey respondents are shown below:

Question 1: Responses to the first survey question showed a very even split between patients of Conway Medical Centre and patients of Ashton View:

I am currently a patient of Ashton View Medical Centre	50	53%
I am currently a patient of Conway Medical Centre	44	47%

Two people stated that in addition to being patients themselves they were also the carer for another patient at one of the practices.

Equality monitoring data

The survey included a standard section with equality monitoring questions. This section is optional, and some people (15% of all respondents) chose not to provide any information in this section. However, the majority of respondents did, although several provided answers to some questions and not others. The answers that were given provide the following detail:

Gender

49 respondents (52% of those who responded to this question) stated they were Male

37 respondents (39% of those who responded to this question) stated they were Female

Age range

Nine people stated they were between 16 – 25 years old

Nine people stated they were between 26 – 35 years old

13 people stated they were between 36 – 45 years old

19 people stated they were between 46 – 55 years old

17 people stated they were between 56 – 65 years old

Seven people stated they were between 66 – 75 years old

Five people stated they were between 76 – 85 years old

15 respondents did not provide an answer to this question

Disability

34 respondents said Yes, they were disabled. Further detail was provided as follows:

Eleven people said they had a physical disability (27% of responses provided)

Three people said they had a hearing impairment (8% of responses provided)

Eight people said they had a mental health condition (20% of responses provided)

Eleven people said they had a long-term condition (27% of responses provided)

Seven people said they had another disability and conditions listed included COPD, diabetes and APS-Lupus.

Some respondents ticked more than one type of disability, indicating they had multiple conditions.

Caring responsibilities

Several respondents stated that they have caring responsibilities, with 19 people saying they care for a child or children, and 5 saying they provide unpaid care or support for someone who is older, disabled or has a long-term condition.

Ethnic group

The Harehills area is one of the most diverse in the city, and this is reflected in the ethnicities reported by respondents to the survey.

Arab	2
Asian or Asian British - Chinese	2
Asian or Asian British - Indian	2
Asian or Asian British - Pakistani	20
Black or Black British - African	13
Black or Black British – Caribbean	2
Mixed - White and Black African	4
White - English, Welsh, Scottish, Northern Irish or White British	18
White - Other White	4

Employment

20 people stated they were in full-time employment

4 people stated they were employed part-time

13 people stated they were in receipt of state benefits

7 people stated they were not in employment

13 people stated they were retired

1 person stated they were self-employed

2 people stated they were students

What did people tell us?

The survey was divided into two sections. The first section asked people to tell us their thoughts about the proposals to merge Ashton View and Conway Medical Centres, and then the plan to close the Ashton View site. The second section asked them more general questions about their experiences of general practice.

Section one – Feedback about the proposed practice merger

Question 2: We asked people how they felt about the possibility of their GP practice merging with another practice.

	Very positive	Somewhat positive	Neutral	Somewhat negative	Very negative	Totals
Patients at Ashton View	9	15	8	3	14	49
	AV generally positive - 24			AV generally negative - 17		
Patients at Conway	16	5	7	5	9	42
	C generally positive - 21			C generally negative - 14		
Totals	25	20	15	8	23	91
	Generally positive - 45			Generally negative - 31		

Where respondents left us comments about their answer, the main themes (generated by ChatGPT AI) were:

• Communication and transparency are vital - patients want clear details on how the merger will affect them.

• Appointment access, continuity of care, and accessibility are top concerns.

• Trust in familiar doctors and fear of “impersonal” large practices are recurring themes.

• A carefully managed transition, with strong reassurances and visible improvements, will be important to win public support.

(A full transcript of all responses is available at Appendix A)

Question 3: We asked respondents how our plan to merge practices would affect them.

	It wouldn't affect me	I'm not sure it would affect me	Neutral	It might affect me	It would affect me a lot	Totals
Patients at Ashton View	9	14	6	7	14	50
Patients at Conway	15	6	6	8	6	41
Totals	24	20	12	15	20	91

Where respondents left comments, the main themes (generated by ChatGPT AI) were:

• The merger could bring benefits - like more clinicians, better resourcing, and possibly streamlined care.

• Potential loss of personal relationships and continuity, which are particularly meaningful to long-term and vulnerable patients.

• Potential decline in access and satisfaction, as observed in larger GP practices.

• Uneven effects, with some patients benefiting and others facing new barriers.

(A full transcript of all responses is available at Appendix B)

Question 4: We asked respondents how they thought our plan to close the Ashton View site in the future would affect them.

	It wouldn't affect me	I'm not sure it would affect me	Neutral	It might affect me	It would affect me a lot	Totals
Patients at Ashton View	10	9	4	13	13	49
Patients at Conway	23	5	6	3	5	42
Totals	33	14	10	16	18	91

Where respondents left us comments, the main themes (generated by ChatGPT AI) were:

• Concerns around accessibility, continuity of care, safety of location, appointment availability, and a perceived drop in service quality if the merge occurs.

• There is also a strong emotional connection to Ashton View, especially among more vulnerable or long-term patients.

• Some respondents report no impact.

(A full transcript of all responses is available at Appendix C)

Question 5: We asked respondents if there was anything else they thought we needed to consider when we are thinking about our plans. Where respondents left us comments, the main themes (generated by ChatGPT AI) were:

1. Access & Appointment Availability

- People emphasize the need to be seen and answered when required, especially during illness.
- Strong desire for on-the-day appointments rather than waiting weeks.
- Some note that Conway's infrastructure must support additional patients without increasing wait times.

2. Continuity of Care & Relationships

- Concerns about losing access to preferred GPs, such as Dr. Wong.
- Maintaining established patient-doctor relationships is important to patients—changing doctors or buildings can cause anxiety.

3. Quality of Care & Funding

- Worry that merger could degrade quality and access unless properly funded.
- A desire that services don't decline after 2 years; clarity on exit plans if outcomes worsen.

4. Facilities & Logistics

- Suggestions for improved infrastructure: bigger waiting areas, more toilets, consultation rooms, admin staff.
- Practical factors such as transport, car parking, and accessibility must be considered.

5. Triage & Efficiency

- Several respondents proposed implementing a triage system by a medical professional to improve responsiveness and prioritization.

6. Cautious Optimism & "If It's Better" Sentiments

- Some would support the merger only if it leads to better facilities, appointment access, and funding.
- Preference to "keep things as they are" if the current setup works well.

7. Scepticism & Opposition

- Some respondents are opposed to the merger:
- “No”, “Scrap the plan”, “I don’t support the merge.”
- Suspect the merger may be more about cost-cutting than improvement.

8. Communication, Transparency & Accountability

- People want long-term accountability, not just short-term “efficiencies.”
- Need for clear, concrete plans—not just hopeful language.
- Desire transparency around impacts, funding, continuity, and recourse if the merger fails.

9. Emotional & Trust Considerations

- Statements like “Walking together with another Medical Centre For better Future” reflect hope, yet also reliance on trust.
- Concern that change may break the perceived safety net of long-standing relationships (e.g., “If I have to start with a new Dr unfamiliar with my medical issues that would cause great anxiety for me”).
- Expressions of resignation: “I do not feel my views will count,” suggesting disengagement or lack of trust.

Section 2 – Feedback about general practice

Question 6: We asked people how they usually get to their GP appointments

Options	**Number of responses**
I don’t attend the practice – I have telephone appointments	8
I drive	24
Someone else drives me	8
I walk	40
I get the bus	7
I ride my bike	1
Other (taxi)	2

Question 7: We asked if people use online services to contact their practice (e.g. online appointment booking or ordering repeat medication)?

35 people said they did

48 people said they didn’t

Some people provided further comments about using online services:

- I'm dyslexic, I have a tracheostomy someone has to ring the GP for me. I don't use the internet someone has to do it for me.
- I recently use the NHS app to order my prescriptions
- Medications repeat when they can be bothered to do it
- The NHS app and MyGP app
- When there is a need I book my appointment online
- NHS app is revolutionary. So much easier to understand GP advise. check meds and know what meds were prescribed during previous visits for same condition
- I live within walking distance. I am not sure how to use or access the online booking system.
- I get better patient outcomes from speaking to staff
- It is easy to order online etc takes forever on phone
- The online services NEVER work
- Ordering medication online
- As it is quite near to where I live, I usually walk and don't use the online system.
- I do not use online services, unfortunately I don't understand the technology.
- I am more face-to-face person, never used online NHS as I think it's more complicated.
- I have never needed to go online.

Question 8: We asked which three things are most important to people when they make an appointment at their GP practice.

Options	**Number of responses**
Getting an appointment quickly	66
The quality of care I receive	51
Same day appointments	36
Good communication	32
Seeing a specific person at the practice	29
Feeling that it is a safe environment	20
Being able to access a range of different services locally	11
The opening times of the practice	9
Other: ('Expand calling times for appointments' and 'Just appointment quickly')	2

Question 9: We asked respondents if they had heard of, or were signed up to use, the NHS App.

Options	**Number of responses**
I haven't heard of it	12
I've heard of it, but haven't signed up to it	21
I have signed up to it, but don't really use it	16

I have signed up to it, and find it helpful	29
Other: • 'I would probably use it if I had a computer' • ' I am 79 years old and have difficulty using it' • 'Not helpful with booking appointments and requesting for repeat prescriptions' • 'I have signed up to it but never able to access gp services'	7

Question 10: We asked respondents if they knew that every GP practice has a Patient Participation Group (PPG).

23 people said Yes

58 people said No

Question 11: We asked people who were interested in finding out more about getting involved with the PPG at their practice to tick a box and leave their contact details.

43 people left their contact details, although only 23 ticked the box.

Practice response to feedback received

We appreciate the time patients spent attending both face to face and virtual consultations to discuss their queries, concerns and questions about the two Practices Merging to become one bigger practice with the understanding of maintaining the two buildings with a view to closing Ashton View site in the near future.

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

Ashton View Medical Centre is a single partner practice in Leeds working from leased premises whilst Conway Medical Centre is owned by the partners at Conway Medical Centre. This gives us the advantage to look to extend the current building/reconfigure the current structure at Conway to ensure that we can improve on patient capacity, improve patient flow and waiting times, future proof for patients and staff alike and to be able to provide day to day services along with additional services to benefit patients registered.

Whilst the planning and building is completed, we will continue to work from both Ashton View and Conway site. We don’t anticipate that the building work will impact on patients being seen at Conway.

Looking at our current data and staffing levels we believe that together, we have adequate staffing levels to deal with the volume of telephone calls and patients

presenting in practice with requests for appointments or any queries. We will continue to monitor once the merge has taken place.

We will continue to provide triage on the day ensuring all urgent medical needs are consulted on the same day. With the merge of the two practices we will have more clinicians ensuring more clinical capacity which will allow us to split our appointments into pre-bookable and same day appointments

It is anticipated that patients will be able to book in with a preferred named GP for a planned appointment at the surgery unless their request is seen as urgent and, in this case, would be booked with a GP that is available on the day.

We acknowledge some patients registered at Ashton view have fedback their concerns regarding the ‘good’ doctor/patient longstanding relationship with Dr Wong and for their desire for this to continue. Patients will still be able to book in with Dr Wong to see him once the merge takes place up until the time he chooses to take his retirement. Within this time patients from Ashton View will have had the chance to see/meet the partners/staff working at Conway Medical Centre.

We are aware that there will be an increase in our patient list size, however we will monitor, review and adapt accordingly to the needs of the patient population.

The practice won’t see a decline of appointments once the merge has taken place. Patient care will still be centred care from all staff within the surgery, this won’t change.

If you are a patient who, due to medical reasons is unable to leave the house to attend the surgery, we will continue to provide home visits where appropriate. This won’t be affected by the merge, cases will be reviewed individually.

Staff currently employed with Ashton View Medical centre will transfer to Conway medical centre ensuring more resources for patients and resilience for the practice given that the two separately have a relatively small team with limited room availability as separate practices.

We understand currently that both buildings are not big enough to run from one site.

Building plans for Conway Medical Centre have previously been submitted to Leeds City Council for approval but unfortunately time has lapsed and a resubmission is required. For the time being we will still be running services from both Ashton View and Conway sites. Patients will be kept informed of plans to extend the site at Conway and our plans to permanently close Ashton View site.

One of the biggest concerns we have heard from patients through the survey response is about accessing the Conway site, which would involve a car journey or a bus journey. Conway Medical Centre is accessible by public transport from both Harehills Lane and Harehills Road. The distance between Ashton view and Conway is a five minute walk. For those travelling by car, the site at Conway has on street parking and a car park available to the back of the practice. Whilst still utilising Ashton View parking is available to both front and back of the surgery. Disabled

parking with a blue badge is available on the street where it is currently parking permit only.

Next steps

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

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

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

www.ashtonviewmedical.co.uk www.conwaymedicalleeds.co.uk

Appendix A

Question 2 - How do you feel about the possibility of your GP practice merging with another practice?

(Further detail generated using ChatGPT AI)

Main Themes Identified:

1. Access to Appointments & Waiting Times

Many respondents are worried that merging will lead to longer waiting times, harder access to appointments, and overstretched resources.

- “It’s already such a struggle to get through... I only anticipate that to get much worse.”
- “More patients will lower the amount of appointments.”
- “I feel it will be harder to get appointments as it's difficult at the moment.”

2. Continuity & Quality of Care

Some respondents fear a dilution of personalised care, particularly from smaller, more familiar practices.

- “A small friendly GP surgery means a good relationship… I strongly object to robotic receptionists.”
- “Dr Wong has been amazing… If he supports it, I support it.”
- “I think my care will be diluted in a larger patient base.”

3. Past Negative Experiences with Mergers

Several respondents referenced prior mergers that promised improvement but led to service decline.

- “Service had dropped even though the same picture was painted.”
- “Improvements may not be sustainable long-term… past experiences with similar mergers.”

4. Location & Accessibility Concerns

Mobility and Travel Issues: Particularly important to elderly and disabled patients who find it hard to travel.

- “I will have further to go. Can’t walk far, so would have to get a taxi.”
- “I have serious mobility issues… Conway is not accessible or safe for me.”

5. Potential Benefits of Merger

Some see potential in resource sharing, more appointments, and better services, though usually with caution.

- “Combining resources can benefit patients by allowing more flexibility.”
- “Hopefully shorten waiting time for appointments.”
- “It makes a lot of sense… could use Ashton View for a play group.”

6. Trust in Specific Doctors or Current Services

Some patients express strong loyalty to doctors or satisfaction with current care.

- “I have been a patient of Dr Wong for over 30 years.”
- “Very happy with services I currently receive… would hope this continues.”

7. Concerns About Facilities & Infrastructure

Scepticism about how the physical spaces and staffing will support a larger merged practice.

- “Conway building won’t be adequate for all these services.”
- “Toilet hygiene at Ashton View needs improvement.”

8. Neutral or Unsure Opinions

Some respondents are unsure or indifferent, citing lack of experience or information.

- “Unsure what the impact of a merger would be.”
- “I don’t mind because I never had a problem getting in to see a doctor.”

Appendix B

Question 3 - How do you think our plan to merge practices would affect you?

(Further detail generated using ChatGPT AI)

Main Themes Identified:

1. Continuity of Care & Personal Relationships

Many patients fear losing the familiarity and trust built with their current GPs.

- “I think this will be less personal I have been with this practice 42 years…”
- “I’m scared I won’t be able to get same day appointments like I have previously received with Dr Wong.”

2. Access & Appointment Challenges

Concerns prevail about longer waiting times, difficulty securing appointments, and potential strain on phone lines.

- “I already feel it is very difficult to get an appointment… this will just compound that further.”
- “Longer queues to reception. More difficult to get appointment times.”

3. Travel & Convenience

While some are unconcerned due to short walking distances, others are anxious about longer journeys and poorer transport links.

- “It won’t affect me because it’s only around 2 minutes longer…”
- “No buses near.”

4. Potential Upsides

A few note potential benefits, such as more doctors available, better options, or improved efficiency.

- “I think the availability of more doctors to see is a good thing.”
- “In the short term, I hope the merger could ease the current strain on appointments and streamline care.”

5. Unequal Impact on Vulnerable Patients

Carers and those less confident with digital tools express fear that increased scale may amplify existing access issues.

- “Again as a carer and a patient… more patients will only add to this problem.”

Appendix C

Question 4 - How do you think our plan to close the Ashton View site in the future would affect you?

(Further detail generated using ChatGPT AI)

Main Themes Identified:

1. **Impact on Access & Convenience**

Many are concerned about travel and accessibility.

Ashton View is "a 10-minute walk" — very convenient.

Conway is further away, requiring transport, possibly costly taxis (e.g., “would cost me over £5 each way”), and walking there is a “few minutes walk away”—though public transport may be needed.

Some fear unsafe areas near Conway, not feeling confident in traveling there.

2. Continuity of Care & Relationships

Multiple respondents value long-term relationships with GPs at Ashton View.

Concern over losing trusted, friendly, welcoming staff if forced to go to Conway.

Anxiety about seeing a GP of choice or receiving “same day appointments” like with Dr Wong.

3. Capacity & Service Quality

Worries that Conway may not have capacity to absorb extra patients.

Larger practices may lead to longer waits: “larger practices tend to mean it is more difficult to get appointments,” “the more patients there are the longer the wait for appointment.”

Some respondents believe service may already be good and worry it could worsen.

4. Emotional / Psychological Impact

One respondent notes psychological distress: “It’s affecting me already. I won’t be able to see a GP of my choice or speak to a real friendly…person.”

5. Safety & Environment Concerns

Conway’s location is described negatively: “an area that I would not feel safe,” “next to a dirty park used by drug addicts.”

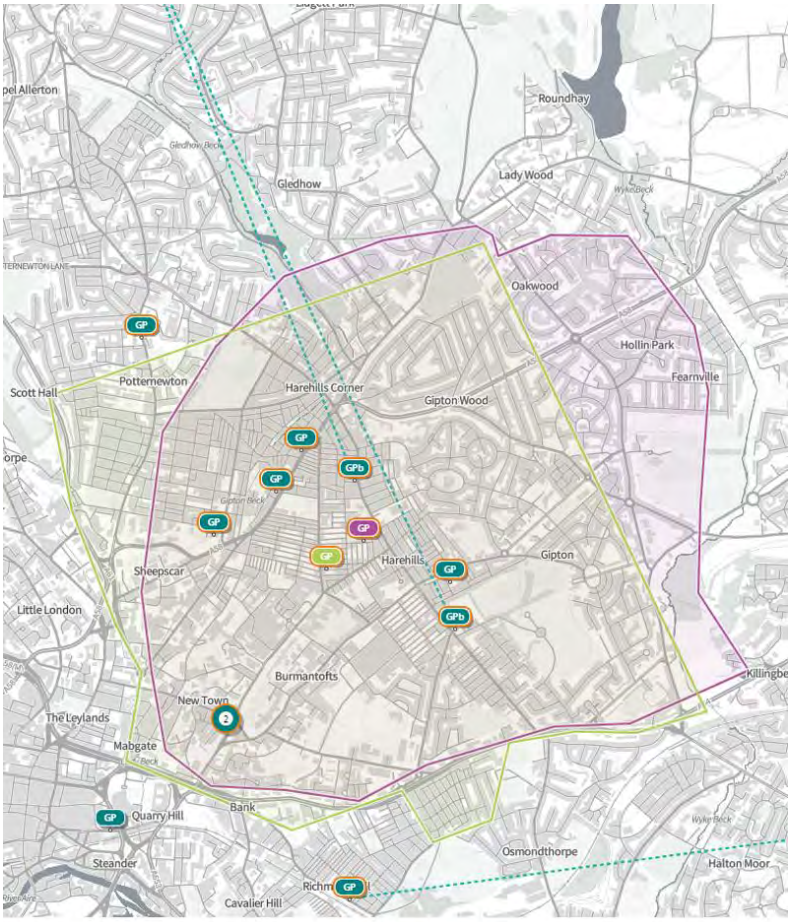
6. Lack of Impact for Some

A few say it “wouldn’t affect me” (not registered with Ashton View or not attending frequently).

Some suggest minimal difference in distance and perceive no impact unless staffing changes.

7. Family-Related Accessibility Issues

A carer or family member highlights difficulties: e.g., “my mother-in-law is a patient…she is very fragile” and needs accompaniment, which makes reaching Conway harder.



Current Boundaries Green-AV Purple- CMC

Proposed New Boundary

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Equality Impact Assessment (EIA)

1. Project Summary Information

Project name	Conway Medical Centre and Ashton View Medical Centre Engagement and Merger (Including long term plan for closure of one site)
Organisation/s	Ashton View Medical Centre Conway Medical Centre NHS Integrated Care Board (ICB) in Leeds
Date	Start date: 23/07/24

Project Lead	Kate Bennison (Practice Manager - Ashton View) Martina Dalton (Practice Manager - Conway Medical Centre) Cat Wilkinson (Manager, Primary Care Team) Vicky Annakin (Senior Manager Primary Care Integration)
Clinical Lead	N/A
Equality Lead	Sharon Moore (Senior Equality, Diversity and Inclusion Manager)
Senior Responsible Owner (SRO)	Joanne Evans (Senior Lead – Delegated Primary Medical Services)

Project proposal / objectives
Ashton View and Conway Medical Centres would like to merge to become one provider. Ashton View is currently run by a single GP (a single-hand practice), and this is seen as succession planning. Both practices are relatively small and increased demand for primary care along with reduced resources are making it increasingly difficult for the practices to provide care alone. By merging the practices they will be able to share staff and resources making them more flexible, adaptable and resilient in the future. The long-term plan is to extend and improve the facilities at Conway Medical Centre and close the Ashton View site once the practices are confident that patient needs can be met. Patients should not see any change in service apart from access to more GPs and nurses due to a combined workforce.

Project proposal / objectives
In order to gather patient and stakeholders' views on the proposed merger, the practices will: • engage with patients and stakeholders on the proposed merger of Conway Medical Centre and Ashton View Medical Centre. • engage with patients and stakeholders around the potential closure of one site (Ashton View medical Centre), on the proviso that the needs of the patient population will continue to be met. The practices will consider all feedback, and this will be used to make a decision about the plans and put in place plans to reduce any potential negative impacts (mitigations). Boundary maps for both sites are attached.

2. Evidence Base

What evidence has been used to inform this assessment?

In the table below please provide details of all the evidence that has been used to inform this assessment, e.g., service user equality monitoring data, patient experience intelligence, national and local research, engagement and consultation with patients, service users and the wider community, information from partner agencies, staff and any other interested groups

National and local research

Local demographics / Census data Provide in this section local demographic and/or Census data
Gipton and Harehills Local Ward (as of 2022 - using the Overview - Ward | Gipton & Harehills | Report Builder for ArcGIS (leeds.gov.uk)) Total Population - 31,757: female 15,786 and male 15,917. 80% of the population are over the age of 15. Index of Multiple Deprivation (IMD) rank – Decile 1. **Practice Profiles (Correct as of July 2025)** Both practices are in IMD- 1 **Ashton View Medical Centre Patient Demographics:** **Total patients**: 5241 Male- 3131 Female- 2110 **Breakdown of age of population:** 0 - 15 - 1553 16 -18 - 269 19 - 65 - 3289 66 - 75 - 86

Local demographics / Census data

Provide in this section local demographic and/or Census data

76 + - 44

Top 10 Ethnicities within the practice

1. Romanian
2. African
3. Pakistani
4. British or Mixed British
5. Indian
6. Gypsy Roma
7. White/Black African
8. Chinese
9. Polish
10. Bangladeshi

Top 10 first Languages within the practice

1. Romanian
2. English
3. Tigrinya
4. Urdu
5. Kurdish
6. Arabic
7. Czech
8. Polish
9. Portuguese
10. Slovak

Patients documented with a disability:

Mental Health- 38

Learning Disability - 15

Accessible Information Standard (AIS)- Awaiting information

Conway Medical Centre Patient Demographics:

Total patients: 4628

Male- 2451

Female- 2177

Breakdown of age of population:

0-15 – 1227

16-18- 252

19-65- 2942

66-75- 125

76+ - 82

Top 10 Ethnicities within the practice

1. Pakistani
2. Romanian
3. African
4. Indian

Local demographics / Census data

Provide in this section local demographic and/or Census data

5. British
6. Gypsy/Romanian
7. Polish
8. Bangladeshi
9. Iranian
10. Caribbean

Top 10 first Languages within the practice

1. English
2. Urdu
3. Romanian
4. Punjabi
5. Arabic
6. Kurdish
7. Polish
8. Czech
9. Slovak
10. Pashto

Patients documented with a disability:

Mental Health (SMI)- 54 Patients

Learning Disabilities- 17 patients

Service user equality monitoring data:

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

Demographic data for patients/ service users at both practices is detailed in the section above

Patient experience data:

Friends and family Test: May-July 2025

Conway Medical Centre

Date	Total Responses	Percentage Positive	Percentage Negative	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Don't Know
July 2025	17	76%	0%	5	8	4	0	0	0
June 2025	0	NA	NA	0	0	0	0	0	0
May 2025	13	100%	0%	0	13	0	0	0	0

Ashton View Medical Centre

Date	Total Responses	Percentage Positive	Percentage Negative	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Don't Know
July 2025	1	*	*	*	*	*	*	*	*
June 2025	2	*	*	*	*	*	*	*	*
May 2025	No data								

Care opinion

Patient experience data:

Ashton View – 11 stories told over the last Six years (good response rate to stories by the practice)

- Mixed experiences reported
- Comments around only being one GP and it is a small practice, which can lead to access issues

Conway – 23 stories told over the last eight years (most recent ones have responses from the practice)

- Mix of positive and negative stories (The negative stories are prior to the current manager)
- Most recent are mainly positive quoting excellent service

National GP survey 2024

Ashton View Medical Centre: 79% describe their overall experience at the practice as good.

Top 3 areas on the survey:

- 98% knew what the next step would be within two days of contacting their GP practice
- 90% were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment
- 87% had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment

Three areas for improvement:

- 38% were offered a choice of time or day when they last tried to make a general practice appointment
- 58% say they have had enough support from local services or organisations in the last 12 months to help manage their long-term conditions or illnesses
- 62% felt they waited about the right amount of time for their last general practice appointment

Conway Medical Centre: 75% describe their overall experience at the practice as good.

Top three areas on the survey:

- 91% The patient was involved as much as they wanted to be in decisions about their care and treatment
- 94% The healthcare professional had all the information they needed about the patient
- 94% The patient had confidence and trust in the healthcare professional they saw or spoke to

Three areas for improvement:

- 38% Easy to contact this GP practice using their website
- 44% Easy to contact this GP practice on the phone
- 61% Good overall experience of contacting the GP practice.

Engagement and Consultation activity

Engagement period, 14 July 2025 to 27 August 2025.

A full breakdown of engagement activity is outlined below:

- The practices wrote to 4418 registered patient households to outline their plans, and to invite patients to take part in the engagement activities.

Engagement and Consultation activity

- The practices sent a text to all registered patients over the age of 18 years with a message about the proposal and a reminder to fill out the survey.
- The practices ran an online survey and shared the survey link with registered patients, on the practice websites.
- The practices provided people the opportunity to fill in a paper copy of the survey at both practice premises, with different formats / translated copies available on request.
- The practices held two face-to-face public meetings, both at The Point in Harehills, a local community venue on 16 and17 July, as well an online virtual patient engagement session on the 22 July.
- The practices developed a Frequently Asked Questions (FAQ) document to share and published it on the practice websites

Neither Practice has a Patient Participation Group (PPG) however as part of the engagement process, there is opportunity for patients to express interest in joining a PPG with the practices.

The survey included a standard section with equality monitoring questions. This section is optional, and some people (15% of all respondents) chose not to provide any information in this section. However, most respondents did, although several provided answers to some questions and not others. The answers that were given provide the following detail:

Gender

- 49 respondents (52% of those who responded to this question) stated they were Male
- 37 respondents (39% of those who responded to this question) stated they were Female

Age range

- Nine people stated they were between 16 – 25 years old
- Nine people stated they were between 26 – 35 years old
- 13 people stated they were between 36 – 45 years old
- 19 people stated they were between 46 – 55 years old
- 17 people stated they were between 56 – 65 years old
- Seven people stated they were between 66 – 75 years old
- Five people stated they were between 76 – 85 years old
- 15 respondents did not provide an answer to this question

Disability

- 34 respondents said Yes, they were disabled. Further detail was provided as follows:
- Eleven people said they had a physical disability (27% of responses provided)
- Three people said they had a hearing impairment (8% of responses provided)
- Eight people said they had a mental health condition (20% of responses provided)
- Eleven people said they had a long-term condition (27% of responses provided)
- Seven people said they had another disability and conditions listed included COPD, diabetes and APS-Lupus.
- Some respondents ticked more than one type of disability, indicating they had multiple conditions.

Caring responsibilities

- Several respondents stated that they have caring responsibilities, with 19 people saying they care for a child or children, and 5 saying they provide unpaid care or support for someone who is older, disabled or has a long-term condition.

Ethnic group

Engagement and Consultation activity

The Harehills area is one of the most diverse in the city, and this is reflected in the ethnicities reported by respondents to the survey.

- Arab - 2
- Asian or Asian British – Chinese - 2
- Asian or Asian British – Indian - 2
- Asian or Asian British – Pakistani - 20
- Black or Black British – African - 13
- Black or Black British – Caribbean - 2
- Mixed - White and Black African - 4
- White - English, Welsh, Scottish, Northern Irish or White British - 18
- White - Other White - 4

Employment

- 20 people stated they were in full-time employment
- 4 people stated they were employed part-time
- 13 people stated they were in receipt of state benefits
- 7 people stated they were not in employment
- 13 people stated they were retired
- 1 person stated they were self-employed
- 2 people stated they were students

Information from other agencies

Provide in this section relevant information from other agencies that would add value to the assessment for example Healthwatch, Community Groups, Local authority, third sector organisations.

A paper will be taken to the Primary Care Operations Group following completion of the engagement period. This Group is made up of various other agencies who will be able to provide any feedback and discussion around the proposal.

The Primary Care Operational Group (PCOG) is an established steering group, as part of the Leeds Place arrangements, to support the quality, accessibility, and resilience of Primary Care.

The Primary Care Operational Group supports the ICB in delivering the following statutory and/or corporate functions:

- Delegated responsibilities relating to Primary Medical Services
- Improvements in quality of services (primary care focus)
- Reducing inequalities (primary care focus)
- Public involvement (primary care focus)

PCOGs primary role is to oversee the delivery of the work programme for primary care, ensuring the ICB fulfils its duties in relation to the delegated responsibilities for primary medical services.

Any other evidence

Provide in this section any additional information that would add value to the assessment

No other evidence

3. Equality Impact Assessment

Describe the actual or potential impact (positive and negative) of any proposed changes on **the groups listed in the table below.** Include the impact and evidence used to make this decision and any actions / mitigations that should be put in place.

Group	Impact and evidence used	Actions / Mitigation
General Issues	Reduction in capacity and ability to see all patients at the Conway site following the proposal to close the Ashton View site	Ashton View Medical Centre is a single partner practice in Leeds working from leased premises whilst Conway Medical Centre is owned by the partners at Conway Medical Centre. The practices are exploring the opportunity to extend the current building/reconfigure the current structure at Conway to improve on patient capacity, improve patient flow and waiting times, future proof for patients and staff alike and to be able to provide day to day services along with additional services to benefit patients registered. Whilst the planning and building is completed, patients will be able to access care from both Ashton View and Conway site. Should the practices decide not to extend or reconfigure the Conway site, both practices will remain open until a solution is found to ensure all patients can be accommodated appropriately All staff will continue to work across both sites and there will be no reduction in capacity. The practice has worked hard to understand the capacity needed to match the demand and will continue to work through this throughout the mobilisation period considering any reconfiguration building works and/or new ways of working.
	Travelling to the Conway site	Some patients expressed concern at travelling to the Conway site due to this being uphill and being unable to walk there. The practice has confirmed that the Ashton View site will remain open for

Group	Impact and evidence used	Actions / Mitigation
		the foreseeable future. The practice is working through capacity and space requirements and will assess what is needed before making any decision to close the Ashton View site. The practice will continue to review on a case-by-case basis all those patients eligible for home visits and work with patients to ensure individual needs are considered.
	Continuity of Care for patients registered with Ashton View Patients hugely value the care that Dr Wong has provided and expressed some concerns that they will be cared for in the same manner following his retirement.	Dr Wong will remain a salaried GP at the practice following the merger and will continue to see patients for the foreseeable. The partners and Dr Wong will work together and inevitably get to know the patients at both sites and share experience and combined ways of working to ensure a seamless transition of care as and when Dr Wong choses to retire.
Age	Travelling to the Conway site	Despite the two premises being only around 5 minutes walking distance from each other, some older patients who live very close to the Ashfield premises have expressed some concern at being able to get to the Conway site.
Disability	Travelling to the Conway site	Despite the two premises being only around 5 minutes walking distance from each other, some disabled patients who live very close to the Ashfield premises have expressed some concern at being able to get to the Conway site. The practice will work with patients and their families / carers through the transition period to provide reassurance and ensure support is in place for ongoing access to the services they require.
	Accessible information and communication (people with disabilities, impairments, or sensory loss.)	The practice will continue to ensure that throughout the transition period, all patients are provided with appropriate and accessible information and communication about the changes

Group	Impact and evidence used	Actions / Mitigation
		taking place, specifically in relation to compliance with the Accessible Information Standard. The provision of accessible information and communication will continue once the changes have taken place
Gender reassignment	No impacts have been identified in relation to gender reassignment	No actions/ mitigation required
Marriage and civil partnership (employment only)	Marriage and civil partnership are relevant to employment only	No actions/ mitigation required
Pregnancy and maternity	No impacts have been identified in relation to pregnancy and maternity	No actions/ mitigation required
Ethnicity	The patient demographic data for both practices show a high percentage of diversity in relation to ethnicity and languages spoken For a significant number of patients registered at both Conway and Ashton View, English is not the first language	The practice will continue to ensure that throughout the transition period, all patients are provided with appropriate and accessible information and communication about the changes taking place. The provision of language interpretation and translation services will continue once the changes have taken place
Religion or belief	No impacts have been identified in relation to religion or belief	No actions/ mitigation required
Sex	No impacts have been identified in relation to sex	No actions/ mitigation required
Sexual orientation	No impacts have been identified in relation to sexual orientation	No actions/ mitigation required
Carers	There are several carers of patients registered at both Conway and Ashton View, for whom English is not their first language.	The practice will continue to ensure that throughout the transition period, all patients and their families / carers, where relevant, are provided with appropriate and accessible information about the changes taking place. The provision of language interpretation and translation services will continue once the changes have taken place
Any other groups e.g., people from low-income	No impacts have been identified	No actions/ mitigation required

Group	Impact and evidence used	Actions / Mitigation
backgrounds, rural communities, homeless people, asylum seekers and refugees		
Human Rights	No impacts have been identified in relation to Human Rights	No actions/ mitigation required
Health Inequalities Refer to Public Health Information such as Joint Strategic Needs Assessment (JSNA)	No impacts have been identified in relation to Health Inequalities	No actions/ mitigation required

4. Action Plan

In the table below describe the actual or potential impact (positive and negative) of any proposed changes on the following groups and the actions that will be undertaken to address the impact

Impact	Action	Timescale	Lead
Reduction in capacity and ability to see all patients at the Conway site following the proposal to close the Ashton View site.	Staff will continue to work across both sites with no reduction in capacity. The practice understands the capacity needed to match the demand and will continue to work through this throughout the mobilisation period considering any reconfiguration building works and / or new ways of working.	Lead up to and through mobilisation and implementation period, with regular monthly reviews	Practice Partners and Practice Managers
Travelling to the Conway site for older or disabled patients living near Ashton View.	The practice will work with patients and their families / carers through the transition period to provide reassurance and ensure support is in place for ongoing access to the services they require.	Lead up to and through mobilisation and implementation period, with regular monthly reviews	Practice Partners and Practice Managers
For a significant number of patients, and their families /	The practice will continue to ensure that throughout the transition period, all patients	Lead up to and through mobilisation and	Practice Partners and Practice Managers

Impact	Action	Timescale	Lead
carers, registered at both Conway and Ashton View, English is not the first language.	(and their families / carers) are provided with appropriate and accessible information about the changes taking place.	implementation period, with regular monthly reviews	
Provision of information and communication support that is accessible to people with disabilities, impairments, or sensory loss.	The practice will continue to ensure that throughout the transition period, all patients are provided with appropriate and accessible information and communication about the changes taking place, specifically in relation to compliance with the Accessible Information Standard. The provision of accessible information and communication will continue once the changes have taken place	Ongoing	Practice Managers

5. Implementation

Detail in the table below how the actions will be embedded into mainstream activity, impact and effectiveness monitoring process for actions, and who will be responsible for reviewing the outcome of proposed changes.

Action Implementation	Name of individual, group or committee	Role	Frequency
How will the impact and effectiveness of the actions be monitored and reviewed?	The practice – monthly area leads meeting. Will include reviews of patient feedback.	Review	Monthly
How will these actions be embedded into mainstream activity?	The practice – included in monthly area leads meeting. Regular review of patient feedback.	Review	Monthly
Who will review the outcome of the proposed changes and when?	The practice will review at monthly area leads meeting.	Review	Monthly

6. For Equality Lead Only

Equality Lead to sign off in table below

Equality Lead	Sharon Moore

Recommendations	Ensure all potential negative impacts and subsequent mitigating actions identified within this equality impact assessment are robustly and regularly monitored
Sign off date	06 October 2025

7. For SRO Only

SRO to sign off in table below

SRO	SRO to complete this section
Recommendations	Any recommendations from SRO to be included in this section
Sign off date	Enter sign off date

Meeting name	Leeds ICB Committee
Agenda item no	15
Meeting date	19 November 2025
Report title	Leeds Place Risk Register Report – Cycle 3 2025/26
Report prepared by	Asma Sacha, Risk Manager, West Yorkshire ICB
Report approved by	Sue Baxter, Head of Partnership Governance
Report presented by	Asma Sacha, Risk Manager, West Yorkshire ICB

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

Previous considerations:

Quality and People's Experience (QPEC) Sub-Committee – 15 October 2025
Leeds Directors meeting – 22 October 2025
Finance, Value and Performance (FVP) Sub-Committee – 22 October 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 3, 2025/26) in Appendix 1. The total number of Place risks for consideration and 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 first draft of the Cycle 3 review of the Board Assurance Framework (BAF) which is attached at Appendix 3. The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks.

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:

1. **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Leeds following any recommendation from the relevant sub-committees.

2. **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.
3. **RECEIVE** and **NOTE** the Board Assurance Framework for Cycle 3 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 3 2025/26
Appendix 2: Leeds Place Risk on a Page Report, Cycle 3 2025/26
Appendix 3: West Yorkshire ICB Board Assurance Framework, Cycle 3 2025/26

Acronyms and abbreviations explained:

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

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, Strategy and Framework 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 – 25 November 2025
- West Yorkshire ICB Quality Committee – 25 November 2025
- West Yorkshire ICB Board – 16 December 2025

2.5 The Cycle 2, 2025/26 Corporate Risk Register, the common risk mapping across the five places and the Cycle 2 Board Assurance Framework was presented to West Yorkshire Integrated Care Board on 23 September 2025.

3 Key points

3.1 This report at Appendix 1 sets out the risk profile of the Leeds Place risks during risk cycle 3 2025/26 which commenced on 24 September 2025 and will end after the WY ICB Board meeting on 16 December 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.

3.3 There are 19 risks on the Leeds Place risk register:

- Eleven risks are aligned to the Quality and People's Experience (QPEC) Sub-Committee
- Five risks are aligned to the Finance, Value and Performance (FVP) Sub-Committee
- Three risks are aligned to both the QPEC and FVP Sub-Committees

The following updates have been made:

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

3.4 High Scoring Risks

There are eight high scoring risks in Cycle 3, 2025/26:

Risk	Sub-Committee	Cycle 3 2025/26	Update for Cycle 3 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	16 (I4xL4)	Static – 2 cycles No further update for Cycle 3.

Risk	Sub-Committee	Cycle 3 2025/26	Update for Cycle 3 2025/26
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: - 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).	Finance	16 (I4xL4)	Static – 2 cycles There is a possibility for the plan to be met in 2026 and the risk score will be reviewed in Cycle 4, 2025/26.
2494 - There is a risk that children and young people (CYP) when in crisis could be admitted to inappropriate settings including hospital, due to services inability to manage the child's complex care package and escalating needs. This could lead to further deterioration in the child's health and wellbeing, change in care placement, poor quality of care and further pressures across the health and social care system.	QPEC	16 (I4xL4)	Static – 1 cycle Children with Complex Needs is now a transformation programme priority reporting into PLT. Workstreams include earlier identification of children and young people with complex and escalating needs and the development of children with no onward destination protocol for all providers to work to.

Risk	Sub-Committee	Cycle 3 2025/26	Update for Cycle 3 2025/26
2480 - There is a risk that our current commissioned Tier 3 weight management service will not have sufficient capacity to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligations. This could result in an increased number of referrals to right to choose providers and associated expenditure and potential detrimental impact on the quality and suitability of services for the population in Leeds. There is a medium-term risk around the increasing and unsustainable cost pressure from medication and the need to ensure patients are adequately and safely supported. This could be exacerbated by increases in prices, transfer from private providers, high clinical complexity of early cohorts, poorly commissioned services, and lack of tier 2 and other non-medicine support offers.	QPEC	16 (I4xL4)	Static – 3 cycles The risk description has been updated to reflect the medium-term risk around the increasing and unsustainable cost pressure from medication and the need to ensure patients are adequately and safely supported. This could be exacerbated by increases in prices, transfer from private providers, high clinical complexity of early cohorts, poorly commissioned services, and lack of tier 2 and other non-medicine support offers.
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	Finance	16 (I4xL4)	Static – 6 cycles The risk score remains the same, finance teams meet bi-weekly to update the position.

Risk	Sub-Committee	Cycle 3 2025/26	Update for Cycle 3 2025/26
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.			
2019 - There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk. In combination with the risk of harm to those people who remain in hospital when they no longer have a reason to reside from hospital-related harms and deconditioning while they wait for ongoing services, where their wait is longer than 72h.	QPEC	16 (I4xL4)	Static – 10 cycles There is currently no change given early winter pressures are emerging across the system.
2354 - There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways for adults (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which leads to significant financial impact and poor value/outcomes for people.	QPEC/ Finance	15 (I3xL5)	Static – 10 cycles A neurodiversity working group that has been established, as part of the CMH Transformation programme, they have produced recommendations as to how to improve access to CMHT hubs and mental health services for people who are neurodivergent. This will help people who are on the diagnostic waiting lists to have their needs met - to 'wait well'.

Risk	Sub-Committee	Cycle 3 2025/26	Update for Cycle 3 2025/26
			Transformation board will consider recommendations for implementation. Report is also being taken to LYPFT forum for discussion. The lack of a commissioning policy is a significant gap in controls and the commissioning policy is ready for consultation.
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.	QPEC	15 (I3xL5)	Static – 11 cycles LCH and Northpoint are working together to reduce the ND waiting list and to offer support to those children and young people who would benefit from a need led provided offer. Actions in place to develop a directory of services available.

3.5 New risks

There are two new risks in Cycle 3, 2025/26

ID	Risk Score	Committee	Risk Description
2569	12 (I3xL4)	QPEC	There is a risk that there will be insufficient inpatient hospice capacity in Leeds for a period, due to quality improvement in Wheatfields following a CQC inspection and changes in staffing and leadership, and some planned remedial fire door work at St Gemma's, leading to people staying longer in hospital or not being able to access specialist palliative or end of life care when they need it from home.
2568	12 (I4xL3)	QPEC	There is a significant risk of an inability to deliver the statutory functions of the ICB with regard to All Age Continuing Care (AACC) in Leeds due to challenging workforce pressures and being unable to source high-quality cost-effective care which could result in reputational damage, financial inefficiency, complaints, challenges and appeals, and staff burnout.

3.6 Change in risk score – decrease in risk score

One risk has decreased in risk score in Cycle 3:

Risk	Sub-Committee Alignment	Cycle 2 2024/25	Cycle 3 2025/26	Update for Cycle 3 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	20 (I5xL4)	12 (I4xL3)	The risk score has reduced from 20 to 12. The risk was reviewed by the senior team on 22 October 2025 and it was agreed that although there are pressures in CHC, there is an underspend in the team and it was agreed to reduce the risk score.

3.7 Closed risks

Three risks have closed in Cycle 3:

ID	Committee	Risk Description	Reason for closure
2510	QPEC	There is a risk of an inability to deliver all of the statutory functions of the ICB in regard to All Age Continuing	Risks 2510 and 2509 have been merged to create a new risk under ID 2568.

ID	Committee	Risk Description	Reason for closure
		Care (AACC) in Leeds due to challenging workforce pressures which could result in reputational damage, financial inefficiency, complaints, challenges and appeals, and staff burnout.	
2509	QPEC	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.	
2487	QPEC	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.	The hospices in Leeds have not signalled that they are in immediate financial pressures which could result in a reduction in services relating to funding. There are other capacity pressures on the hospice which has been reflected in the new risk under ID 2569.

3.8 Emerging risks

The following risk is being developed on the Leeds place risk register for Cycle 4, 2025/26:

- General Practitioners in Leeds and Bradford District and Craven have raised concerned about the risk of patient harm following the Laboratory Information Management System (LIMS) transition in December 2024 and the physical relocation of the laboratory from Leeds General Infirmary to St James University Hospital in June 2025. The risk is also being developed on the Bradford District and Craven Place risk register and the West Yorkshire ICB corporate risk register.

4 Board Assurance Framework

4.1 The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks. These risks are owned by members of the Executive Management Team.

4.2 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** review the risks during **risk cycles 1 and 3**. EMT are currently undertaking the cycle 3 review, and the complete report will be presented to the West Yorkshire Integrated Care Board on 16 December 2025.

4.3 The draft Board Assurance Framework reviewed in Cycle 3 2025/26 by WY ICB Executive Directors is attached at Appendix 3 and changes are highlighted using blue font.

5 Next Steps

5.1 The risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 16 December 2025.

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

6 Recommendations

The Leeds ICB Committee is asked to:

- **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in Leeds.
- **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.
- **RECEIVE** and **NOTE** the Board Assurance Framework for Cycle 3 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
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 - 2 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 - 2 Archive(s)
2494	25/03/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	16	(I4xL4)	9	(I3xL3)	Emily Carr	Helen Lewis	There is a risk that children and young people (CYP) when in crisis could be admitted to inappropriate settings including hospital, due to services inability to manage the child's complex care package and escalating needs. This could lead to further deterioration in the child's health and wellbeing, change in care placement, poor quality of care and further pressures across the health and social care system.	1 Oversight and proactive management of individual cases via frequent 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.	1. Opportunity for greater connectivity between local controls and pressures including in Health/LA & Provider Collaborative where appropriate 2. No 'spare' capacity is available to meet the needs of all children in crisis at all times	1. Actions agreed and implemented from meetings and escalations 2.When a young person placed is placed in an inappropriate setting the CQC are informed. 3. Safeguarding colleagues are aware and additional resource and support is put in place for the young person	1. Regular supervisory/escalation meetings supporting blocks in the system 2. 1/7 Partners are now escalating cases much sooner to allow for the planning and solutions to be made and agreed. 3. Recruitment of Positive Support Service underway to help provide capacity for more proactive work. 6/10/25 4. Recruitment completed except for the OT. Following notice periods and induction, service expected fully functioning by 1/4/2025. 5. Children with Complex Needs is now a transformation programme priority reporting into PLT. Workstreams include earlier identification of CYP with complex and escalating needs and the development of child with no onward destination protocol for all providers to work to.	1. Timely escalation - without delays 2. 1/7 Identification of placements can be a challenge if the CYP becomes looked after whilst in hospital 3. 1/7 Lack of providers that match the needs of the CYP 4. New bespoke 2/4 bedded children's home has been commissioned and estate procurement is ongoing, expected to open in 2027. 5. 6/10/2025 there will always be a risk of a CYP being presented at PED -despite the best efforts of the transformation work.	Static - 1 Archive(s)
2480	14/01/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	16	(I4xL4)	9	(I3xL3)	David Edeson	Helen Lewis	There is a risk that our current commissioned Tier 3 weight management service will not have sufficient capacity to meet demand due to limited local budget and workforce and the introduction of new drugs for weight management and associated NICE technology appraisals increasing demand and legal obligations. This could result in an increased number of referrals to right to choose providers and associated expenditure and potential detrimental impact on the quality and suitability of services for the population in Leeds. There is a medium-term risk around the increasing and unsustainable cost pressure from medication and the need to ensure patients are adequately and safely supported. This could be exacerbated by increases in prices, transfer from private providers, high clinical complexity of early cohorts, poorly commissioned services, and lack of tier 2 and other non-medicine support offers.	1. Revised contract and specifications to help future planning facilitated by funding (ICB Leeds) 2. Recovery plans and efficiency plans in place 3. Leeds Specialist Weight Management service reopened to referrals in Apr 2025 4. Business case to start to develop new model of delivery to DTM mid October- Interface Hub in collaboration with Leeds Specialist Management service and Leeds GP confederation 5. NICE TA medicines policy and funding variation for agreement at Transformation Committee in July 2025 6. Right to choose monitoring 7. Feasibility studies for four models of primary care delivery of Tirzepatide 8. Aligned SWMS criteria to WY Commissioning Statement eligibility criteria from 29th July 2025	1. Meeting with LCH SWMS in Oct 2025 to agree changes to service spec (WY ICB Commissioning Statement eligibility criteria and performance monitoring) 2. Awaiting guidance and support from WY core team - WY ICB Commissioning Statement published 29th July 2025, Service Specification still to be developed 3. Limited ability to mitigate referral to Right to Choose - but now limited to those in line with commissioning statement. Capacity increased from 250 healthy lifestyle pathway and 108 medication pathway to 550 healthy lifestyle patients and 216 medication pathway. 4. Media influence and public demand 5. No local governance contract mechanisms with national right to choose provider(s) 6. Lack of Weight Management Programme leadership and governance at a West Yorkshire level 7. Lack of Tier 2 commissioned services 8. NHSE allocated funding does not match Tirzepatide cohort numbers	1. Currently discussed and reviewed via Leeds long term conditions population board with updates to Leeds Scrutiny committee and Leeds LMC 2. Local service offer in place in Leeds 3. Quality measures in place for the local offer and developing evaluation frameworks	See above	1. Not receiving quality data from right to choose (only referral numbers received though some BMI data now received) 2. Gaps in data from Leeds data model and inconsistent coding affecting accuracy 3. Gap in LCH SWMS performance data (Q1 2025/26), has been requested 4. Inconsistent coding in primary care 5. NHSE funding data does not align with local data regarding cohort numbers	Static - 3 Archive(s)
2414	20/03/2024	Finance and Best Value Committee	Enhance productivity and value for money	16	(I4xL4)	6	(I3xL2)	Matthew Turner	Alex Crickmar	There is a risk that measures being taken to control expenditure in Leeds City Council will have an impact on other place partners, due to the financial pressures being 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 - 6 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 Ongoing communications work with Public to suggest alternatives to ED Investment in HomeFirst services and in assessment capacity through Better Care Fund Winter capacity plans for 25/26 in place to support discharge capacity Improvements in pathways, processes and in hospital waiting times for social workers and care act assessments have reduced the length of time people wait on pathways 1 & 3 where a care act assessment is required for long-term care. Improved capacity for Same Day Emergency Care at St James's and virtual ward capacity significant improvements in waiting time for rehab beds driven by major productivity gains LTHT internal improvement/efficiency 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 (weekly from Nov-Mar)) Reviewed Silver Action cards Revised System Resilience Structure System Visibility dashboard in place and driving change Strong programme of Home First work in place and HF 2 programme being finalised Timed pathways being developed to drive further pace and reduce waste Big and sustained improvements in pathway 2 (rehab beds)	OPEL reporting system under development for ASC but not yet finalised or shared. Recruitment and retention remain significantly challenging and given funding constraints there is significantly limited ability to create additional capacity, Still too many people over 6 and over 12 hours in ED which we know is linked to risk of harm Patients in 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 system plan to improve flow out of Stroke wards SW capacity remains a key risk alongside groups such as therapists but retention has improved and the ICB has contributed additional funding to support resilience	Static - 10 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 leads to significant financial impact and poor value/outcomes for people.	1. 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. 2. Additional funding has also been secured via the Health and Work accelerator to help address some of the prescribing backlogs and test out interventions around supporting people with ADHD to access work or make reasonable adjustments with their employers 3. Leeds Autism Diagnostic Service has improved pathway efficiency and waiting times. The increased number of people diagnosed is putting strain on post-diagnostic offer. 4. The first round of WY accredited provider selection has been completed. Activity plan information and mobilisation plans for the providers are in the process of being finalised. the new capacity will be used for longest waiters to help equalise patient experience. Operational details of transfer from LYPFT are being worked through including waiting list validation. This also aims to improve patient outcomes and experience when seeking treatment and entering shared care in the local area. 4. Indicative Activity Plans negotiated which will reduce the rate of growth by limiting activity in providers to their outturn position (10% higher for locally accredited providers) 5. A neurodiversity working group that has been established as part of the CMH Transformation programme has produced recommendations as to how to improve access to CMHT hubs and mental health services for people who are neurodivergent. This will help people who are on the diagnostic waiting lists to have their needs met - to 'wait well'. Transformation board will consider recommendations for implementation. Report is also being taken to LYPFT forum for discussion. 6. Working to reinforce data capture requirements via accreditation and other lead commissioners, but needs national push too to improve tracking and understanding 7. WY Commissioning Policy consultation is still under discussion.	1. Spend is driven by the high numbers of people already in the system and high rates of new referral. 2. The "ADHD Single point of access hub" is being piloted to support patients meet needs before they enter the assessment pathway. Referral and outcome data is being captured including patient experience. Early reports are that demand for the service is higher than originally thought. Investment and funding to be explored as part of the proposal. 3. Awaiting proposal from LYPFT about their proposals for their ongoing service; service specifications 4. There is no ring-fenced investment/funding into ADHD or autism development. 5. Data collection by all IS providers remains patchy which makes it impossible to really track referral demand or how current needs are being met 6. 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 7. demand into ADHD pilot offer already significantly higher than anticipated, so would need more funding to cover Autism referrals too 8. No commissioning strategy yet developed for how to prioritise demand in line with available funding	1. ND Strategic Oversight Group - Provider data reporting 2. WY ND programme guidance and resources 3. Autism and ADHD diagnostic waiting list times 4. ADHD treatment waiting list times 5. ADHD annual review waiting list times. 6. ND service annual quality report. 7. Service specification reviews 8. Oversight of Right to Choose ND diagnostic pathway referrals and spend 9. Leeds Autism Strategy 10. Leeds data model including ADHD and autism data to steer priorities.	1. Service annual quality board 2. ND Strategic Oversight group programme plan outlining key workstreams and work progressing	1. Lack of targeted/identified recurrent funding streams provide ongoing challenge for sustainable improvement through non-recurrent mechanisms. 2. WY Commissioning policy not yet in place and now being re thought 3. National Task Force set up, but potentially then risks local solution development as people wait for national steer - however looking unlikely that it will be radical	Static - 10 Archive(s)

2301	16/05/2023	Quality and People's Experience Committee	Tackle inequalities in access, experience, outcome	15	(I3xL5)	6	(I3xL2)	Emily Carr	Helen Lewis	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of 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 provison and place provision at cluster level being developed. 3. 6/10/25 LCH and Northpoint working together to reduce the ND waiting list and to offer support to those CYP who would benefit from a needs led provided offer. Actions in place to develop a directory of services available. Developing a universal offer across Leeds place, exploring services already inplace and gaps.	1. Capacity in IS confirmed for highest risk cases 2. ICB establishing a clinical reference group to support model design 3. Written to all families on the waiting list to sign post to additional resources that will offer support - need to progress work on contacting everyone on the SPA backlog. Data relating to wait times more readily available and referral numbers to Right to Choose being used to model some of the cluster offer proposals. 4. 6/10/2015 Processes agreed and being put in place to reduce the waiting list, and to offer support. Whilst initially was to develop a test and learn of provision across the cluster , now drive to develop a universal offer across all Leeds place. Links with the Adult ND collaborative work being made and explored.	Trying to balance risks to individual children and families of not receiving a diagnosis, with the costs of the diagnostic capacity and the need to provide support not just diagnosis	Static - 11 Archive(s)
2569	13/10/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(I3xL4)	4	(I2xL2)	Helen Smith	Helen Lewis	There is a risk that there will be insufficient inpatient hospice capacity in Leeds for a period, due to quality improvement in Wheatfields following a CQC inspection and changes in staffing and leadership, and some planned remedial fire door work at St Gemma's, leading to people staying longer in hospital or not being able to access specialist palliative or end of life care when they need it from home.	1. Daily and weekly capacity calls 2. Access to out of area hospices (Sue Ryder and Marie Curie Bradford in particular and others if required) 3. Careful prioritisation by clinical teams	See above	1. Wheatfields has a development plan to ensure that new staff are successfully trained and the service model is expanded safely to be back up to usual levels by December 2. ICB colleagues are meeting regularly with Wheatfields to review KPIs and progress 3. St Gemma's has a tightly managed plan to enable the work to be delivered without major impacts and this is in line with its planned timetable	1. Weekly meetings to track people delayed in any setting 2. ICB has funded additional capacity out of area	See above	New - Open
2568	07/10/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Andrea Dobson	Jason Broch	There is a significant risk of an inability to deliver the statutory functions of the ICB with regard to All Age Continuing Care (AACC) in Leeds due to challenging workforce pressures and being unable to source high quality cost effective care which could result in reputational damage, financial inefficiency, complaints, challenges and appeals, and staff burnout.	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 5. Market Management and Sustainability activity in place in collaboration with Local Council 6. Direct conversation with Independent Sector Providers relating to gaps in local provision and areas for development 7.Cost setting activity is consideration of National Living Wage, Consumer Price Index as well as increased costs related to needs of someone eligible for NHS CHC.	1. Sickness absence due to work-related conditions 2. Inability nationally to recruit into clinical posts 3. Inability to retain all staff due to high workload 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. Inability to block contract reduces possibility of making cost effective commissioning decisions at Place 2. Spot Purchase costs are often higher than block contract arrangements 3. Gaps in local markets and closures of care homes 4. Out of area placements required for individuals with specialist needs - no ability to influence this market where at a distance from commissioner 5. Providers will identify alternative methods for income generation (i.e. 1-1 costs).	1. Capacity and Demand modelling will identify any potential areas of efficiency/inefficiency 2. Ability to consider economies of scale with development of WY wide functions 3. Where possible, robust care management arrangements are in place to support reviews of needs. 4. Relationships have been developed with the Market to support ongoing working arrangements 5. Move to a WY ICB is supporting wider discussions regarding costs and uplifts and may support block contract arrangements in the WY area. 6. Contribution to the local Market Position Statement	1. Increased number of applicants for clinical posts 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. 4. Case Management activity 5. Knowledge of overdue review lists and potential impact 6. Developing standard specifications for AACC care contracts	1. Significant staffing gaps remain, particularly 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 4. Requirement for a cost setting tool to support standardised cost setting for base fees for all care home providers 5. Risk of not accessing a placement for an individual if cost 'demands' are not met. 6. Risk of paying more for weekly fee via 1-1 support or other over commissioned package if inflationary uplifts do not meet requirements of the sector.	New - Open
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. 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. LCH intention is to use senior trainees in these clinics following an appropriate training and shadowing period (from 2025 until March 2026) 10. Robust weekly escalation in place between health and CSWS to speed up consent for IHNA. This has scrutiny from CPB. 11. Team is looking at producing leaflets and videos for young people and their careers explaining the value of an iHNA appointment and what the appointment entails. 12. Team is also looking at some suitable alternative venue for some of the bigger families, where multiple siblings need to be seen. If all siblings are in one school, it may prove useful to see them in the school then the carer is not attending a clinic site with multiple young people waiting to be seen.	1. Timeliness of requests for IHNA from CSWS.	1. Monthly performance data produced by LCH business support showing IHNA delivery against KPI's. 2. DN accesses LA and Health data monthly to gain assurance of data congruence. 3. Robust systems in place that give live information of clinic availability and waiting times. Escalation process in place to notify head of service should there be CYP waiting for IHNA appointments. 4. Quarterly data is shared by LCH with NHSE and this data is collated into WYICB dashboard which is shared at the WY CiC group for oversight. 5. Ensure regular review of the WY ICB corporate risk at the bi-monthly WY CiC group meeting. 6. Ensure regular reporting into place provider Safeguarding Committees, Corporate Parenting Boards and WY ICB Safeguarding Oversight and Assurance Partnership for oversight. 7. Connecting with relevant Regional and National Groups 8. One off extra clinic capacity commissioned to reduce backlog which was completed in May 2025.	See assurance on controls.	1. Assurance that LCH has resilience of clinic capacity to cover holiday/sickness.	Static - 1 Archive(s)
2511	01/04/2025	Quality and People's Experience Committee	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Andrea Dobson	Jason Broch	There is a risk that the ICB will not meet its statutory duties in the delivery of the Court of Protection Deprivation of Liberty Safeguarding for those eligible for NHS Continuing Health Care (CHC) living in the community in their own homes. This is due to a significant lack of Lead Nurses leading to reduced capacity to complete the application documentation and gain appropriate evidence. 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 the workforce as identified. 2. The uncertainty around ICB organisational change increases the risk of losing experienced staff or losing sight i due to the actual restructure process.	Static - 2 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	Closed - Merged with another risk (please link to merged risk)
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.	Closed - Merged with another risk (please link to merged risk)
2508	01/04/2025	Finance and Best Value Committee	Enhance productivity and value for money	12	(I4xL3)	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 the ability to make placements for CHC-eligible individuals at standard rates due to the higher complexity and intensity of needs for this cohort. 4. Care Providers looking to increase income via requests or demands for 1-1 support. 5. Challenging financial position of Local Councils resulting in increased referrals for 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.	Decreasing

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.	Static - 1 Archive(s)
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. Additional bed now available in reopened Oasis house 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 recruited 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 - deputy director of commissioning raising this with Housing and actively supporting in this area but very significant local deficits	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 - 5 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 - 2 Archive(s)
2487	27/01/2025	Quality and Finance Sub-Committee / Leeds Committe	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I3xL2)	Lindsay Mcfarlane	Helen Lewis	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. Regular reporting to the group Quality sub committee 5. West Yorkshire Palliative End of Life Care Steering Group: Regular reporting to the group	See above	None identified at this stage.	Closed - Risk no longer relevant to the CCG

WY ICB Leeds Place, Cycle 3 - 2025/26
Risk on a Page Report

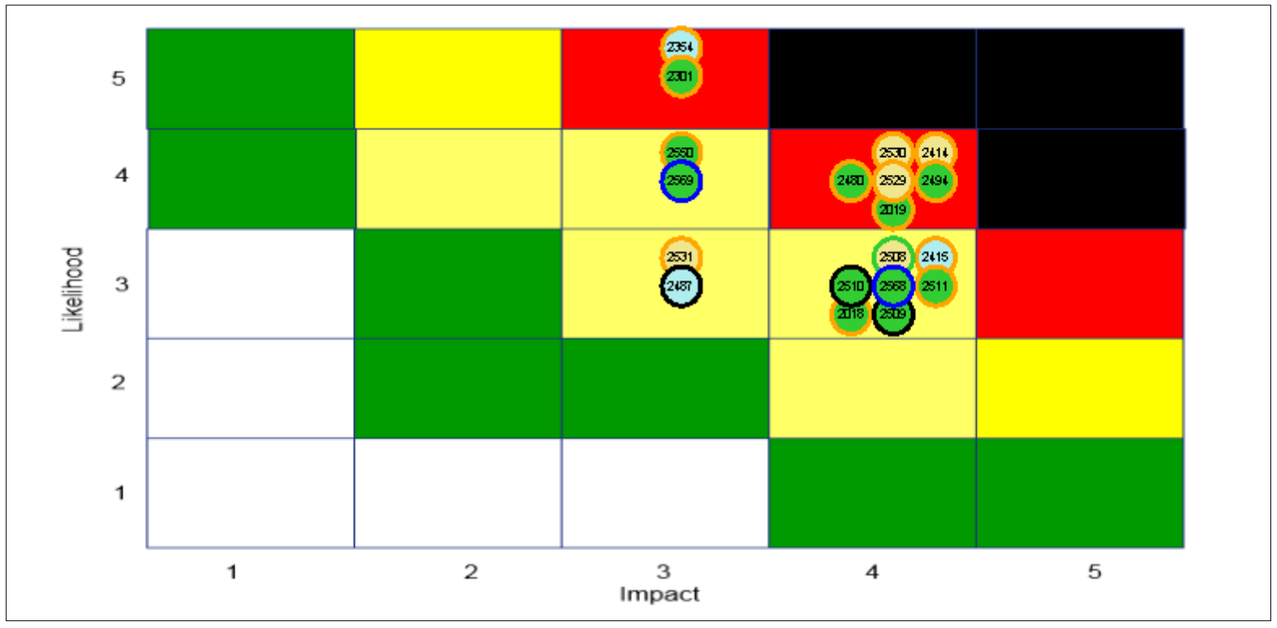
Leeds Health & Care Partnership

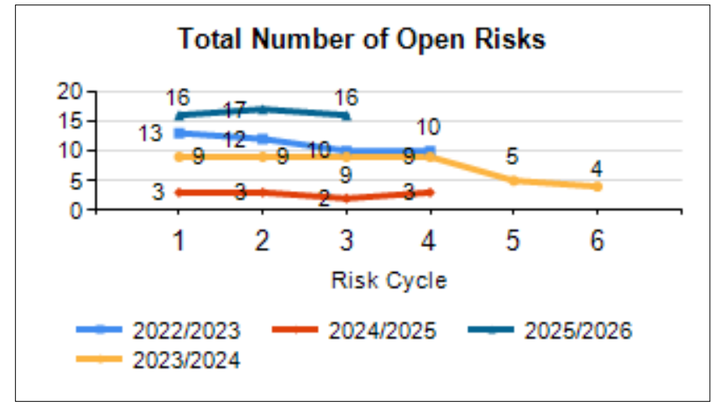
NHS West Yorkshire Integrated Care Board

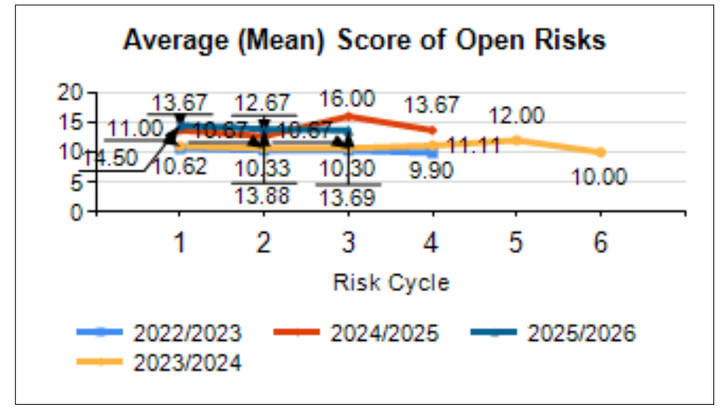
Total Risks	19
Finance & Performance	5 risks
Quality	11 risks
Finance and Quality	3 risks

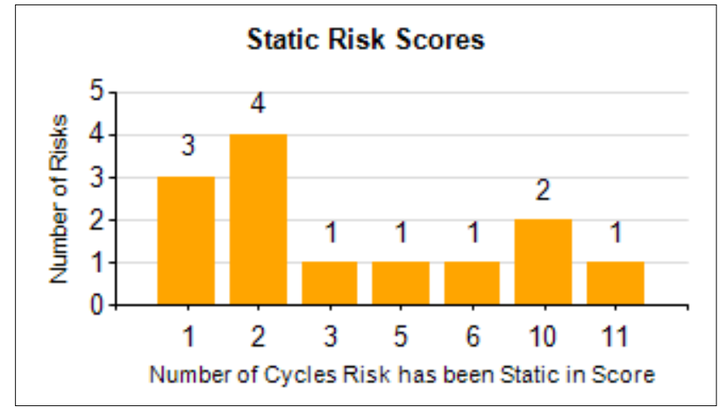
Movement of Risks		Risk Score Increasing	0
New	2	Risk Score Decreasing	1
Marked for Closure	3	Risk Score Static	13

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 12, 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	

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: 12	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	12	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	Quality Committee
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Lou Auger / Shaukat Ali Khan	Transformation Committee
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.	Open	12	16	Ian Holmes	Transformation Committee

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 12													
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	12	8	8	8	8	8	12	8	12	8	8
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	6	9	8	12
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required

WYICB - Board Assurance Framework - ICB and places							Version: 12	6 October 2025
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.						**Lead committee / board**	ICB Board (linked to place committees)
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Inequalities have widened in recent years due to broader social and economic factors. Our health and care partnership will make a positive contribution on these issues, there are a range of factors outside of our control that are likely to make narrowing inequalities more challenging. No change to risk score.	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**		
	Impact	**4**		**Impact**	**4**			

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

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Integrated Care Partnership Board - agenda items, discussions, evidenced by minutes	**2120** - reduction/loss of VCSE services; **2402** - access GP services; **2106** - Cancer health inequalities; **2308** - Neurodivergent population **2503** - maternity
2	ICB Board - four deep dives into health inequalities during 2024/25 - agenda and minutes	
3	ICB Board - six monthly performance dashboard metrics against 10 Big Ambitions - agenda and minutes	
4	System Oversight and Assurance Group - rolling programme of metrics reported - agenda and minutes	
5	WYCA / ICB Quarterly Leadership Team meeting to oversee MOU	
6	Internal Audit review of Health Inequalities Partnering Arrangements - Significant Assurance (June 2024)	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Sohail Abbas (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 - 2025/26 2. EDI work and Anti-Racism Strategy development in Bradford District and Craven (2025 ongoing). 3. The economic accelerator programme has started from April 2025, work ongoing (2025/26) 4. Core20Plus5 initial evaluation is complete, we are now working on the economic evaluation of the programme (2025/26)
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.	
9	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	

	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 this 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	No mitigating actions at present. Next review will take place from 17 December 2025.
2	Reducing inequalities is a key ambition of the partnership	
3	Council Director of Public Health is lead for health inequalities work across Calderdale	
4	Calderdale council run a cost of living programme (2022 - ongoing)	
5	Public have produced population data packs for each PCN and Integrated Neighbourhood health team.	

	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	**Links to Place Risk Register;** 2224, 2476, 2149, 1998, 1493, 62, 2469, 2484,

Kirklees			**Place lead:**	**Vicky Dutchburn**		**Nominated lead for this 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 control, however the partners are committed to addressing this through the work that they do.	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**	
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions**
1	Kirklees Health and Wellbeing strategy	1. Progressing on the work of the inclusive community framework (one of top tier partnership strategy) Power of one, power of many, working other for equity and fairness linked to the inclusive communities framework (2025/26)
2	Health and Wellbeing Plan	
3	Kirklees Economic, Environment and Inclusive Communities Strategies.	
4	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	
2	Regular reports to Partnership Forum / ICB committee/ and other place governance	
3	Project reports	**Links to place risk register:** 2475, 2240, 2445
4	The Kirklees ICB committee committed to continue with their work and actions were agreed as part of this work	

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	No mitigating actions at present. The next review will take place from 17 December 2025.
2	The Delivery and Inequalities Sub-Committee - highlighting impact of wider factors	
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	
5	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)	
	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	**Links to place risk register:** 2415, 2354, 2301, 2018
4	Financial accounts recording proportion of spend in this area	
5	Continued participation and support for Leeds City Council's Marmot City ambition	

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. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26) 3. Wakefield is working with funding from Health Determinants Research Collaborative (HDRC) to establish research capacity around health inequalities (2025/26) 4. The development of our integrated neighbourhood health model (2025/26)
2	Economic Strategy is in place led by the local authority. Elements that impact on health inequalities are reported to Health and Wellbeing Board	
3	Joint post working across health and the Local Authority addressing inequalities is in place	
4	Joint Steering Group established	
5	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**
3	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 12	7 October 2025
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes / Jonathan Webb
Strategic risk 1.2	There is a risk that operational pressures and priorities impact our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			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. As part of developing the ICB operating model we are building a strategic commissioning function that will help ensure that the organisation has the right focus on reducing health inequalities and improving outcome - 2025/26
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.	
7	EQIA process on any proposed service change and commissioning policy change (2025/26).	
8	As part of the economic accelerator programme we are focusing on improving economic participation in communities where inequalities and poor outcomes are highest.	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Partnership Board focus on 10 big ambitions	**Risk 2309** - demand for CYP mental health services; **2451** - Delays in gender identity specialist services; **2525** - delays in health assessments of CiC; **2479** - children's hospice care
2	ICB Board - performance dashboard and deep dives into health inequalities	
3	SOAG updates against 10 big ambitions	
4	ICB Annual Report summarises work on improving outcomes and reducing inequalities	
5	Internal Audit 'Health Inequalities Partnership Working' review - Significant Assurance - June 2024	
6	Integrated neighbourhood health board	
7	Health and wellbeing boards (sign off integrated neighbourhood healthcare plans)	

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

	Sources of assurance *(Where is the evidence that the controls work?)*	
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	
		Links to Place Risk Register
		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. Change programme and new ICB operating model will impact on this risk and will be monitored.
2	Tackling inequalities is a core requirement of all papers to comment upon, particularly contract awards / service improvement.	
3	Measurement of health inequalities for elective recovery has been key component for CHFT and its delivery of its waiting lists.	
4	Financial pressures continue to be monitored and savings identified recurrently to ensure underlrying position does not deteriorate.	

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

1	Regular report to HWBB (as above) and CCPB.
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

Links to Place Risk Register:
2224, 1338, 2476, 2149, 1998, 1493, 62, 2092

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

ICB risk appetite	Place risk scores	Target (Kirklees)		Current (Kirklees)		
OPEN	Likelihood	2	6	Likelihood	3	12
	Impact	3		Impact	4	

Rationale for current place score

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.

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	Target (Leeds)		Current (Leeds)		
OPEN	Likelihood	3	9	Likelihood	4	16
	Impact	3		Impact	4	

Rationale for current place score

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.

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 (2025/26)
2.Review approach to incentives in line with strategic commissioning role towards the end of this financial year (March 2026)
3. Provide both challenge and support to emerging HealthCare Inequalities Oversight Group, which has a partnership focus across providers (2025/26)

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	Target (Wakefield)		Current (Wakefield)		
OPEN	Likelihood	3	9	Likelihood	4	16
	Impact	3		Impact	4	

Rationale for current place score

Reflects the Integrated Care Board position. Local places have limited powers to reduce likelihood.

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: 12	6 October 2025
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 1.3 (previously 1.4)	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.						**Lead committee / board**	ICB Board *(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. There are three pilot programmes running across WY (Leeds, BDC and Wakefield) the learning from these pilots will be shared with other areas and nationally (Approved 2025, work ongoing from 2025/26).
2	ICB medium term financial plan supports a differential investment towards primary and community care.	
3	All places are developing integrated neighbourhood healthcare plans which will respond to the ICB blueprint and describe and quantify the improvements that will be made locally. These plans will be signed off by the health and wellbeing boards.	
4	Quality Committee and ICB Board receive Integrated Performance Dashboard which reflects progress made towards integrating services and neighbourhoods.	
5	In line with the future strategic commissioning responsibilities the ICB is developing commissioning intentions and contractual mechanisms to enable and incentivise integrated models of healthcare.	
6	Places continue to develop their models of collaboration with a view to implementationin shadow form from Apr 2026.	

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

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Sohail Abbas (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	2221, 2486
2	Reducing Inequalities Alliance reporting to Exec and BDC HCP Partnership Board	
3	Development of our health and care strategy; co-production with Bradford LA on the district plan (delivery oversight by the Health and Wellbeing Board); ongoing work with NY LA via our localities	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**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. Identified accelerator site to commence first INT on 2 July 2025, system partners are ready to facilitate engagement and support for accelerator site. 2. 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) 3.Planned refresh of the objective within the health and care plan (2025/26) 4. Neighbourhood level data being extracted from primary care and supported by linked data sets to facilitate a population health management approach. Next steps to share with accelerator site and other INTs (2025/26)
2	Addressing inequalities is and will continue to be written into the scope and terms of reference for all place based work areas, to ensure that the focus on inequalities is a common theme to all our work	
3	INT data packs developed and data sharing agreements in place	
4	A number of services including VCSE already aligned around communities	
5	Regular fortnightly call in place with SROs for 6 core components of integrated neighbourhood health	
6	Programme plan in place to fully implement integrated neighbourhood teams and improve integrated neighbourhood health in line with 2025/26 planning guidance	
7	Business case developed for accessing West Yorkshire SDF funds (non-recurrent) to assist with accelerating pace of implementation	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to place risk register**
1	Published Health and Wellbeing Strategy	2475
2	The local Health and Care Plan follows directly on from the Health and Wellbeing Strategy	
3	Extensive engagement (lead by Healthwatch) with local people to inform strategy and plans to ensure they meet the needs of the local population	
4	ICB Committee meetings - notes	
5	Delivery collaborative - notes	
6	PCN meetings - notes	
7	Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground.	
8	WY INH Board in place	

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

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	2	8	Likelihood	3	12	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.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Strong LCPs and PCNs.	1. Developing integrated neighbourhood clinics 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)
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.	
		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						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	2	8	Likelihood	3	12	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.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Wakefield Transformation and Delivery Collaborative established supported by a network of Provider Alliances with responsibility for joining up services and addressing inequalities	1. The development of a neighbourhood model enables a targeted and more planned approach to care (2025/26) 2. The reducing healthcare inequalities steering group is taking forward the development of the VCSE strategy for the district (work ongoing 2025/26) 3. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26)
2	Core Senior Leadership team established across Wakefield place with distributed leadership responsibilities	
3	Action plan to address the gaps following the publication of the Fuller report	
4	This work is connected to the work to develop a neighbourhood model	
5	The reducing healthcare inequalities steering group is connected into the VCSE collaborative	
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	**Links to Place Risk Register**
3	Medical Director for Integrated Community Services attends Fuller Board	2397, 2429

WYICB - Board Assurance Framework - ICB and places							Version: 12	31-Oct-25
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Kate Sims
Strategic risk 2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.						**Lead committee / board**	Transformation Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Workforce recruitment and retention remains a challenge across the system. The current workforce reduction programmes within both the ICB and provider Trusts will impact on the ability to attract and retain staff across the workforce. In addition, the system awaits further detail in relation to any potential growth as part of the NHS long term workforce plan, currently undergoing calls for evidence, and Adult Social Care workforce strategy.	
OPEN	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**16**		
	Impact	**2**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	WY People Board (multi-sector) oversight of priority programmes, The ICB EMT organisational change programme board - a system wide overview of the responses to the workforce challenges under the West Yorkshire People Plan	1. WY People Strategy is being refreshed during 2025. Draft revised People Strategy will be presented to the WY People Board on 26 November 2025.
2	WY Mental Health and Well Being Hub - a system wide offer to all staff across the WY partnership to ensure that access to Mental Health Wellbeing is available to all - with regular reporting into People Board.	2. Workforce Strategy and Planning Team - primary agenda is aligned with Strategic Workforce Transformation Forum, and as this develops they will provide a level of workforce transformation capacity 2025/26
3	WY Strategic Workforce Transformation Forum established (system wide) to have strategic overview to ensure readiness against long term workforce plan and adult social care workforce strategy	3. One of the agreed terms of reference for the Strategic Workforce Transformation Forum centres on influencing regionally and nationally. The Forum has now agreed its core 4 priorities with delivery groups established to respond to each - 2025/26 - work is ongoing.
4	Workforce Place Leads and place-based plans (for further details, see Place BAF below)	4. The ICB has commenced a review of its operating model (Apr 2025) in response to the further targetted reduction of 50% of costs. There will be a large scale organisational change programme to deliver the required response to this announcement. This is currently paused and awaiting further national guidance.
5	Creating Global partnerships for the supply of International recruits into challenged areas - to ensure ethical and sustainable international recruitment, education pathway and to offer system support. Dedicated global team working directly with NHS England. International recruitment is currently very low.	5. NHS providers across West Yorkshire are also required to review their growth in corporate service costs since 2019/2020 and reduce these by 50%. This is in addition to the workforce reductions indicated within the operating planning submission. ICB to monitor the impact of this - 2025-27.
6	Active leadership on workforce part of annual operating plan cycle, with ongoing assurance through Finance Investment and Performance Committee, Transformation Committee and ICB Board.	6. ICB workforce strategy team responding to national call for evidence, which is part of the process to refresh the NHS Workforce Plan (2025/2026)
7	The ICB received detail from each NHS provider of their current workforce planning and control mechanisms. These will be used to help NHSE monitor each Trusts workforce position against its operating planning submission (2025/26)	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Transformation Committee; Strategic Workforce Forum; People Board - agenda, papers and minutes	**2296** - YAS workforce; **2108** - cancer workforce; **2402** - general practice workforce; **2557** - ICB workforce, **2535** - ICB workforce **2537** - ICB workforce
2	Place leads meet with local NHS providers to ensure progress is monitored across WY against the operating planning submission. WY People Team actively attend Place workforce committees. Director of People is a member of Yorkshire and Humber Workforce Steering Group for adult social care.	
3	NHS sickness absence and turnover is reported to ICB Board via Integrated Performance Report.	
4	Active data flow across wider People agenda, which is presented to the People Board and Strategic Workforce Transformation Forum.	
5	(NHS specific) Staff Survey annual results	

Bradford District and Craven (BD&C)	**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 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 - 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.	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	'People' is one of five strategic priorities for BDC HCP which means that additional focus and resource applied to delivery of the People Plan. Reported on at Partnership Leadership Executive and Partnership Board. With CEO lead Foluke Ajayi in place.	3. Working across the system within partners including Higher Education Institutions to develop a pipeline for registered health and care roles (Ongoing 2025/26)
4	We have made progress in supporting the social care workforce with initiatives to help retain staff.	

	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Triple A report from SFPC to Partnership Board	
2	Highlight reports from the People Programme through a Programme Board	**Links to Place Risk Register:** None

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	Operating model is in place	2. Local group looks at recruitment and development 2025/26

	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Update to the partnership board	**Links to Place Risk Register;**
		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?)*	
1	Kirklees actively engaged in West Yorkshire arrangements.
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?)*	
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.

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

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.

Link to place risk register:
2498

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?)*	
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.
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?)*	
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

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

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)

Link to place risk register:
None.

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?)*	
1	Wakefield People Alliance oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the Wakefield People Plan. Ths is through the Pillars 1 - 3 programme.
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.

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

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. 2025/26
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. 2025/26
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

3	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. 2025/26 **Links to Place Risk Register** 2129

WYICB - Board Assurance Framework - ICB and places							Version: 12	30-Oct-25
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	James Thomas
Strategic risk 2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.						**Lead committee / board**	Quality Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Continued formal assurance is needed through Transformation Committee and Partnership Board. With the changes in Digital leadership, we are assured that there is maintained links between digital and innovation. Uncertainty around the implications of current changes with ICBs and the impact on the WY ICB research and innovation function, risk score remains the same in Cycle 3, 2025/26.	
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. Annual review to bring additional rigour with lens on innovation and research (2025/26)
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	
7	Develop assurance mechanisms to Transformation Committee and Partnership Board. Continues in 2025/26	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Agenda and minutes of meetings listed as controls	**2108** - Cancer workforce plan
2	SOAG oversight of innovation and research networks	
3	Clinical and Care Professional Forum	

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.Development of the dashboard to include patient outcomes to be used as a source of assurance operational is ongoing (2025/26) 2. 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)
2	The Innovation Hub working alongside the development of improves as one portal and accompanying process identifies proven best practice and supports local teams to adopt and adapt across the BDC HCP	
3	Model of Distributive leadership in place in Bd&C with HCP for Chief Nurse which provides opportunities to provide assurance and oversight, share best practice, learning and improvement opportunities between partner organisations	
4	Prioritisation framework and WY ICB wide QEIA process has been implemented alongside strategic principles that have been produced by the BDC System Strategy working group to try and narrow the gap	
5	Quality requirements are represented with all providers and monitored through the contract management process	
6	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)	
7	Governance system structures and alignment to support the wider collaborative have been revised including workstreams for integrated neighbourhood health.	**Links to Bradford place risk register:** 2419
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
	Likelihood	**2**	**4**	**Likelihood**	**2**	**6**	

OPEN	**Impact**	**2**		**Impact**	**3**		WY data/analytics for system overview. No significant resource locally to compare with other resource. Recognise work ongoing to produce consistent WY data.

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.	No mitigations actions at present. The risk will be reviewed from 17 December 2025.
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.	**Links to Place risk register;** 1338, 2476, 2163, 2149, 1493, 62, 1977, 2092
5	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.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Regular reporting to Calderdale Care Partnership Board.	

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)**			Kirklees place reflects the current WYICB wide score.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**2**	**8**	
	Impact	**2**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Kirklees ICB Transformation Sub-Committee, supported by the Kirklees Delivery Collaborative as mechanism to enable shared learning across providers	1. Increase visibility and understanding of the West Yorkshire Innovation Leadership Collaborative and the interface between this network and place (Review 2025/26) 2. Establish clearer connections between the WY ICB and the West Yorkshire Innovation Leadership Collaborative (Review 2025/26) 3. Chief Digital and Information Officer attending Kirklees Board Development Session to share learning, next steps (Q2, 2025/26)
2	Working across places and with WY programmes to share learning and experience, identify variation, and opportunities for improvement	
3	Clear governance around Quality oversight in place with providers, working collaboratively to share learning and report via System Quality Group and ICB Quality Sub-Committee	
4	Active participation in WY networks and programmes with evidence of having shared learning from Kirklees, and adopted it from elsewhere.	**Link to place risk register:** 2445
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Evidence of early adoption and innovation in place e.g. UCR, Lung Health Checks, approach to neighbourhood working.	
2	Reports to Kirklees Sub-Committees demonstrating provider collaboration, examples of innovation and shared learning. Papers and Mins.	
3	System Quality Group and ICB Quality Sub-Committee. Papers and Mins.	

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

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			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.
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	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).	1. 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. 2. All Leeds partnership across Leeds health and social care were working collaboratively with the University of Leeds to develop a research project (SEISMIC) to bring academic rigour to system improvements and integration for people with long term conditions and mental illness, facilitating the use of innovative technology. Unfortunately Leeds was unsuccessful in the bid but there is ongoing conversation to see how the partnership can capitalise on the work so far anyway.
2	Regular contribution and representation at the ICB Quality Committee and System Quality Group	
3	Regular contribution and representation at the WY ICB Safeguarding Oversight and Assurance Partnership	
4	Leeds Academic Health Partnership membership with representation at Board and implementation levels.	
5	As a partner with Leeds Academic health partnership identifying opportunities from health professionals,	
6	The Clinical Professional Executive Group (CPEG) meet monthly and has been reviewing a system approach to risk and learnings from escalated cases to make sure there is a Leeds based approach to those learnings and that partners can better manage system risk collectively	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Regular arrangements to evaluate the effectiveness of the Sub-Committees.	
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	**Link to place risk register:** 2480, 2487
6	The Clinical Professional Executive Group (CPEG) meet monthly	

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)**			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.
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	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	No mitigating actions at present. The risk will be reviewed from 17 December 2025.
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	
6	District plan has been agreed	
7	Clinical and professional engagement takes place and is collated and monitored.	
8	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	**Links to Place Risk Register**
4	Local perfomance dashbords and improvement plans	None.
Note in Cycle 3, 2025/26: The target risk for all five Places for Risk 2.2 is currently 4 (low) and the risk appetite is OPEN (willing to take reasonable risks with a focus on safe delivery, tolerance for uncertainty is limited, accept limited risk). The target score will be reviewed again with senior managers during the BAF review in Cycle 4, 2025/26.		

WYICB - Board Assurance Framework - ICB and places							Version: 12	29-Sep-25
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Lou Auger
Strategic risk 2.3	There is a risk that we cannot measure and assess performance across the system in a timely and meaningful way, which impacts our ability to respond quickly as issues arise.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			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.	
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 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. As the federated data platform matures, oversight of performance will be enhanced (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	
6	High focus areas are published and shared in national and regional NHSE data packs so we all have the same information and can be used to improve performance (continuous, 2025/26)	

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

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

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			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.
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**2**	**4**	
	Impact	**2**		**Impact**	**2**		

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

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

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

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Established performance monitoring process across commissioners and providers. Recognise we have potential BI capacity issues but we are currently performing as expected.
OPEN	**Likelihood**	**1**	**2**	**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	Oversight framework used as base of performance monitoring at CCPB.	No mitigating actions at present. The risk will be reviewed from 17 December 2025.
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
2	Joint UECB across CHFT footprint monitoring urgent care performance, including winter, discharge and	

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)**			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.
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**2**	**8**	
	Impact	**2**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	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?)*
1	Minutes of Finance and Performance Sub-Committee and Kirklees Health and Care Partnership Board

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%

Link to place risk register:
None.

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
6	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.
7	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.

Mitigating actions *(What more are we/should we be doing at place?)*
No mitigating actions at present. The risk will be reviewed from 17 December 2025.

	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.

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

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

	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.

Link to Place Risk Register
None

WYICB - Board Assurance Framework - ICB and places		Version: 12	7 October 2025
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**	**Lead director(s) / board lead**	Jonathan Webb / Shaukat Ali Khan
Strategic risk 2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	**Lead committee / board**	Finance, Investment and Performance. Transformation Committee - for Digital.

ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			This risk relates to two specific areas; - significant backlog maintenance, unsuitable and aged physical estate and medical equipment replacement delays. - the risk that ICB / organisational IT have insufficient capacity to implement ICB and regional solutions due to increasing demands for solutions and the prioritisation of local vs regional projects, resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement ICB / regional solutions at scale.
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.Continue to consider approaches to 'carve out' an element of operational capital to support schemes more strategic in nature (specifically including a currently assessed shortfall on the Calderdale Royal Hospital development). 2. Work with NHS England NEY and WY NHS Providers on the arrangements that will be put in place in 2026-27 in relation to management, decision making and oversight of all capital allocations and expenditure (as signalled in the model ICB blueprint) 3. Digital investments to be aligned with the model region and model ICB blueprints, and in addition to be increased to support the NHS 10 year plan. 4. (Digital) - evaluating the current operating model in alignment with the restructuring of digital, data and technology according to model region and model ICB blueprints (2025- 2027) 5. Seeking more clarity from NHSE for overall structure of digital, data and technology in delivering the 10 year plan (2025/26)
2	Regular oversight and assurance from ICS infrastructure strategy oversight group.	
3	Digital Programme 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 Infrastructure Strategy Oversight Group; ICS Finance Forum; Digital Programme Board	**2165** - There is a risk that place IT teams have insufficient capacity to implement regional solutions due to increasing demands for digital solutions and the prioritisation of local vs regional projects **2036 -** Airedale Hospital plan **2522** - NHS infrastructure investment
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.	

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. More emphasis on the better use of our existing estate as opposed to looking at new build solutions, unless there is no alternative option (2025/26)
2	Estates is an enabler in BDC HCP (place) operating model and is key to supporting the shift of services into the community.	
3	BDC HCP continues to be supported by the BDC Digital Programme Board 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.	
4	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.	
5	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.	
6	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.	

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.	
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.	**2314, 2312, 2482, 2215**

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?)*		
1	Reports to Committee	**Link to place risk register** 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 the Kirklees Estates, which will create unwarranted variation of services for the Kirklees place.
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**16**	
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Estates Strategy	1. Estates lead continues to focus on key developments in estates within the place and wider ICB. 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. Work with partners and stakeholders to access capital resources to support development in primary care (2025/26)
2	IT Strategy	
3	Estates and IT leads	
4	Kirklees - one public estates forum now established	
5	On going round table meeting of senior leaders to support the ongoing development of the CHFT reconfiguration	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Estates Forums	**Link to place risk register:** None.
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	

Leeds		**Place lead:**	**Tim Ryley**		**Nominated lead for this risk:**	**Tim Ryley 26.06.2025)**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			The new hospitals scheme for Leeds General Infirmary rebuild is critical to the transformations in the Leeds Health and Care system. Currently we have only limited assurance that, despite all the processes completed to secure NHSE approval to proceed, the scheme will be allowed to finally proceed. Primary Care expansion of roles and the ambition for a neighbourhood health model is placing greater strain on estates in Primary Care with little access to capital. Risk score increased from 12 to 16 due to delayed funding for LTHT scheme.
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**16**	
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Leeds City Strategic Estates Board and its Specific Programme Boards meet	1. LTHT working through medium term alternatives to the Leeds Way due to national delays until 2030 and beyond, this includes working with Leeds City Council to consider alternatives to the innovation hub. 2. 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)
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.	**Link to place risk register:** 2530
2	Minutes of Strategic Estates and Programme Boards.	

Wakefield		**Place lead:**	**Mel Brown**		**Nominated lead for this risk:**	**Colin Speers (02.07.2025)**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**
				Current (Wakefield)			There is currently no process or forum for bringing together a total estates strategy across Wakefield Place. There is no identified capital resources for any estates across the sectors. The Digital Strategy is in delivery phase for place. 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.
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**	
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Wakefield Place Digital Strategy in place and now being aligned across partners	No mitigating actions at present. The risk will be reviewed from 17 December 2025.
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	
4	Place digital forum brings together all sector and it delivers on the place digital strategy (2025/26)	
5	Both business as usual replacement and innovation investment.	
Sources of assurance *(Where is the evidence that the controls work?)*		**Link to place risk register:**
1	Minutes from Digital Programme Board	2481, 2440
2	Place nominated lead on West Yorkshire groups	
3	Digital maturity assessments (annually) - national programme	

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 12	29-Sep-25
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Lou Auger
Strategic risk 2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			The likelihood of a future pandemic is certain; the scale, severity and impact is unknown. This risk is based on the potential impact of a serious pandemic, based on learning from Covid. The scoring mirrors the regional NHS England score of 16 (4Lx4I).	
AVERSE	**Likelihood**	**4**	**16**	**Likelihood**	**4**	**16**		
	Impact	**4**		**Impact**	**4**			

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

WYICB - Board Assurance Framework - ICB and places							Version: 12	7 October 2025
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.1	There is a risk that we do not invest resources in a way which prioritises community, primary & prevention programmes and so doesn't maximise value for money.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			There has been a disproportionate increase of resource in recent years into acute hospital services in West Yorkshire and no clear plan to remedy this.	
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**12**		
	Impact	**3**		**Impact**	**3**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Board approved Finance Strategy which sets out intentions.	1. ICB Board to consider issuing direction to all Places that there should be a shift of investment from acute hospital services to community, primary and prevention programmes as part of 2026/27 and medium term plans (2025-27) 2. Place Committees and the emergent Place provider collaboratives to develop plans in line with this intent (2026/27)
2	ICS Financial Plan	
3	ICB Medium Term Financial Plan and Annual Plan	
4	Local plans implemented through Health and Wellbeing Strategy, Health and Wellbeing Boards and Place Committees	
	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Internal Audit Plan, Head of Internal Audit Opinion and individual internal audit reviews	None
2	External Audit VFM opinion	
3	Performance Report alongside Finance Report into Finance Investment and Performance Committee and ICB Board	
4	Mental Health Investment Standard independent review	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Karen Parkin (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.
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.	
4	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.	
5	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.	**Link to Place risk register:** 2447, 2386, 2227, 2486, 2040
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Better Care Fund submission 2025/26 and monitoring overseen by the Planning and Commissioning Forum	
2	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 this 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?)*	**Link to place risk register:** 2163, 2469
1	Finance and performance a key component of partnership board meetings. Papers and Minutes.	

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)**			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, 2025/26
2	Financial Strategy has been developed to support how resources are utilised within the place, which links to the overarching West Yorkshire Strategy	
3	Development of PMO function to enable investment are review in order to ensure value for money and consideration of specific service impact.	
	Sources of assurance *(Where is the evidence that the controls work?)*	

1	Kirklees Finance Sub-Committee and Transformation Sub-Committee to agree on utilisation of resources. Papers and Minutes.	**Link to place risk register:** None.
2	All investments reviewed via a priority matrix	
3	PMO reports and financial review against Value for Money criteria	

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**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)**			
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	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.
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Integrated finance reports through LHCP governance - Leeds Finance and Best Value Committee oversees Leeds System Financial and Commissioning positions.	1. A programme of work is underway to continue to develop our joint approach to financial planning and decision-making to allow us to make the most value-driven decisions on resource allocation across the LHCP. To be actioned within the medium term financial plans (2025/26)
2	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?)*		**Links to Place Risk Register**
1	Finance sub-committee receives financial planning and decisions. Papers and Minutes	2414
2	DOFs at LHCP Partnership Exec Group. Papers and Minutes	
3	Benefits realisation assessments for priority programmes	

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

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**4**	**12**	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.
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Partnership Committee comprises of partner organisations and Integrated Assurance Committee looks in more detail at financial decision making	No mitigating actions at present. The risk will be reviewed from 17 December 2025.
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	
7	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).	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place Risk Register**
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	None.
4	Monthly review at Wakefield Senior Leadership Team meeting	

WYICB - Board Assurance Framework - ICB and places							Version: 12	7 October 2025
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	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 for 2025-26 agreed by FIPC	1. Continued Chief Executive, Chair and Director of Finance targeted meetings with any NHS provider showing significant risk of non delivery of plan (2025-27). 2. Joint process with NHS England for the mid year reviews scheduled for Oct 2025. 3. Development of a robust and credible medium term financial plan (2025-27)
2	All Plans are signed off by the organisational Boards	
3	Escalation and joint approach with NHS England for Trusts.	
4	Finance Forum, SOAG, FIPC, EMT and Board all have oversight	
5	Place Committees and their finance sub-committees have oversight and provide assurance upwards	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Quarterly review meetings with NHS England and outcome letters	**2521** - Financial risk
2	Quarterly ICB led mutual accountability meetings with all five places and outcome letters	
3	Internal Audit and External Audit	
4	External review commissioned into Finance by WYAAT (July 2024) and across the ICS (November 2024).	
5	Agendas, reports and minutes of all meetings above	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Karen Parkin (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. 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. 2025/26 2. 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. 2025/26
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	
6	Difficult decisions list established and being prioritised	**Alignment to place risk register:** 2433, 2337, 2314, 2039, 2047

	Sources of assurance *(Where is the evidence that the controls work?)*
1	SF&PC minutes. Place financial performance reported to System F&P on a regular basis and key messages reported to BDC Health and Care Partnership Board.
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**		
	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	**Link to place risk register:** 2163, 2469

	Sources of assurance *(Where is the evidence that the controls work?)*
1	Financial Framework as agreed by FIPC.
2	Bi-monthly monitoring at CCPB, evidenced in minutes. Detailed board reports.

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**		
	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. Develop priority setting of resources within Kirklees place (2025/26) 2. Review of all contracts commissioned by the ICB as to whether they can be stopped or reduced (2025/26)
2	Review of Financial position and plans by Kirklees Finance Sub-Committee and ICB Committee, both locally and at a West Yorkshire level.	
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.	

6	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)
7	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)
8	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

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Financial plan will be signed off by the ICB Committee and risks identified
2	PMO function to support financial recovery for the ICB and its wider system
3	Aligned to West Yorkshire ICB approach to planning and final plan signed off by WY Committees

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

ICB risk appetite	Place risk scores					
	Target (Leeds)			Current (Leeds)		
CAUTIOUS	Likelihood	3	9	Likelihood	4	20
	Impact	3		Impact	5	

Rationale for current place score
Due to the current financial pressures there is a significant risk that Leeds Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.

Key controls *(What helps us mitigate the risk?)*	
1	Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.
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.

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

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					
	Target (Wakefield)			Current (Wakefield)		
CAUTIOUS	Likelihood	3	9	Likelihood	4	20
	Impact	3		Impact	5	

Rationale for current place score
Due to the current financial pressures there is a real risk that Wakefield Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.

Key controls *(What helps us mitigate the risk?)*	
1	Monthly monitoring of Integrated Care Board delegated financial position to assurance committee including efficiency savings
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	Review of difficult decisions/choices across organisations/place (ongoing first draft was submitted February 2025)
6	Consistency Checks within Wakefield against other places.

Mitigating actions *(What more are we/should we be doing at place?)*
1. Set financial plans in line with planning guidance (2025/26)
2. Agree Quality, Improvement and Performance Productivity (QIPP) to identify savings and reduce pressures whilst improving patient quality (2025/26)

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Minutes from Wakefield District Health and Care Partnership and Integrated Assurance Committee meetings
2	Financial plans or any amendments to financial plans presented and discussed at partnership committee.
3	Principles already established at Wakefield District Health and Care Partnership Committee

Links to Place Risk Register
2329

WYICB - Board Assurance Framework - ICB and places							Version: 12	9 October 2025
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Rob Webster
Strategic risk 3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			The changes to the arrangements in NHS England, Regions, ICB and providers are now much more aligned, with timescales that are much more likely to deliver capacity and resources in the right places. There are substantial risks of delays causing gaps in capacity, hence the need for agility and prioritisation. The EMT and Board have worked closely with partners to understand and mitigate risks. However, the current arrangement suggest the impact on our work of changes could have a higher impact than the target score. Risk score remains the same.	
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**		
	Impact	**3**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	An agreed operating model, approved through the Board and set out in the constitution and handbook	1. Organisational development work to across Executives to support level of agility and prioritisation required in current context - continuing 2025-26. 2. Place Partnership Delivery (led by Anthony Kealy) to support the development of Place model and infrastructure will be implemented by April 2026.
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 intentions received in October 2025 with subsequent development programmes.	
5	MAUs with provider collaboratives specifying their responsibilities for delivery	
6	Structured programme for organisational change overseen by EMT and Board Committees.	
7	Organisational development work to across Executives to support level of agility and prioritisation required in current context.	
8	Co-production with region of the model region and ICB to ensure smooth transition.	

	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 **2522** - Infrastructure risk Links also to organisational change risk register.
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	
4	Outputs of the programme board	

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)**			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.
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	The Partnership Leadership Executive oversee the deployment of resources (including ICB capacity) in pursuit of the BDC HCP strategy agreed by the Partnership Board	1. Utilise strength of our Health and Care Partnership, building on current joint roles, to identify opportunities for further targeted shared and aligned resources across Place (February – September 2025) 2. Annual business planning process to align resources to required activity/ priorities (April/ May 2025) 3. Priority Programme and Programme Board oversight of key system transformation plans (including workforce) and related activity, to review resource requirements against transformation delivery plans (February – September 2025) 4. Place level 'difficult decisions' programme to target resources at activity that delivers strategic and financial priorities (February – Apr 2026) 5. Work has begun locally on the development of a BDC provider collaborative approach to be implemented by September 2025 (2025/26).
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.	
8	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)	
9	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.	
10	Specific Integrated Neighbourhood Team (INT) development work is underway across the BDC system is ongoing (2025/26)	
11	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

	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)**		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.	
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**4**	**16**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Work undergoing with neighbouring places to ensure resilient finance function.	No mitigating actions at present. Risk will be reviewed from 17 December 2025.
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.	
4	Transformation delivery plans list seven key priorities and discussions are ongoing at operational and senior leadership meetings (2025/26)	
5	Senior Leadership team continue to monitor risks relating to resource, intensified given NHS changes and 50% cuts.	
6	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
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 parts of the health and care partnership and the transition period could lead to uncertainty. Time will have to dedicated to establish new working relationships when leadership changes take effect. The impact of the operating model changes are still being felt and challenges remain in some functions.	
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Weekly SLT meetings to discuss current priorities and ensure capacity is dedicated to the right areas	1. 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
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)	

Leeds			**Place lead:**	**Tim Ryley**		**Nominated lead for this risk:**	**Sabrina Armstrong (30.06.2025)**
ICB risk appetite	**Place risk scores**					**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**		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.	
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**4**	**16**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Agreed Operating Model with WY ICB and Leeds Health & Care Partnership	1. Action plan on staff survey results most pertinent to Leeds, 2025/26 2. Leeds Directors will continue to review capacity and reprioritise as necessary (2025/26) **Link to place risk register:** None
2	Capacity aligned to Healthy Leeds Plan and LHCP objectives	
3	Director accountabilities finalised and objectives set by end of April	
4	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.	
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	
4	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)	
5	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	

Wakefield			**Place lead:**	**Mel Brown**		**Nominated lead for this risk:**	**Mel Brown 27.06.2025**
ICB risk appetite	**Place risk scores**					**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**		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.	
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*

1	Agreed operating model in place aligned to Integrated Care Board structures and went live in April 2024, some reviews have been underway due to leadership changes	1. Continue to review gaps in strategic capacity across the leadership team at Wakefield and confirm these objectives through PDR processes in the summer of 2025 2. Reviewing everyones PDR objectives to ensure any areas that need capacity are appropriately addressed such as EDI leadership (End of Summer 2025) 3. Contributing to the organisational change programme in place across WY ICB to shape the integrator teams 2025/26
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	Regular one to ones between Accountable officer and Cheif Executive WY ICB	**Links to Place Risk Register**
5	Contribute to the annual governance review.	None.

WYICB - Board Assurance Framework - ICB and places		Version: 12	6 October 2025
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**	**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.1	There is a risk that partnership working on wider societal issues is deprioritised to meet current operational pressures as a result of the organisational change programme and the reduced ICB capacity.	**Lead committee / board**	ICB Board

ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**
	Target (ICB)			**Current (ICB)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus. The organisational change programme and ICB blueprint will mean that there is significant less capacity within the ICB and a narrower remit. We will need to carefully prioritise our partnership working in this area to maximise value. Increased likelihood from 2 to 3, increasing the risk score from 8 to 12. Target score and risk appetite remains the same. Recommend amendment to the risk description.
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	
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.
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.
6	Director objectives, subsequently cascaded to teams, reflect partnership working.
7	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.

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

1. As part of the organisational change programme, we are working to redesign wider partnership governance with partners including Local Authorities and the Combined Authority. These governance arrangements will continue to ensure we have the right focus on wider societal issues - 2025/26

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Progress against the strategy and 10 big ambitions is overseen by the Partnership Board, together with deep dives - evidenced in agenda and minutes
2	ICB Board receives six monthly updates on 10 big ambitions - agenda / minutes
3	SOAG - minutes evidence review of progress against 10 big ambitions

Links to ICB risk register *(Reference numbers/brief description)*

2535 - Organisational change

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)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**	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.
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	
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.
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)
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.
6	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

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

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. 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)

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/

Link to place risk register:
2317, 2386, 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)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**	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.
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	
1	Joint membership of HWBB and CCPB by each chair to ensure societal issues continue across.
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.
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

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

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)

Link to place risk register:
None

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Progress against health and wellbeing priorities is undertaken at every meeting. Evidenced by papers and minutes.
2	We also have an inclusive economy strategy led by the local authority.

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**

ICB risk appetite	Target (Kirklees)			Current (Kirklees)		
OPEN	Likelihood	2	8	Likelihood	3	12
	Impact	4		Impact	4	

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.

	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 four strategies assigned to partnership boards or forums.
3	Partnership Executive in place which includes business, education in addition to health, care and Local Authority.
4	Commitment to the four top tier strategies reiterated at the Kirklees partnership executive. There is a programme of work agreed for 2025/26 overseeing by the partnership executive.

	Sources of assurance *(Where is the evidence that the controls work?)*
1	Reporting to the relevant board/partnership forum on progress against each of the four 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?)*

No current mitigating actions. The risk will be reviewed from 17 December 2025.

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	Leeds Health and Care Partnership have signed off four priority programmes all with a strong health inequality focus including links to wider social determinants
5	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. 2025/26
4. Implement action plan arising from Marmot city programme led through public health (2025 - 2027)

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.

Link to Place Risk Register

None.

WYICB - Board Assurance Framework - ICB and places							Version: 12	6 October 2025
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.						**Lead committee / board**	Quality Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			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 by 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. 2025/26. 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	Development of commissioning intentions that reflect our ambitions around equity and fairness.	
3	EDI Oversight Group maintains oversight of statutory requirements and objectives	
4	ICB People Plan, with a strong focus on inclusivity	
5	EQIA process embedded to inform decision-making	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Internal Audit Review 2023/24	None identified
2	People Plan had ICB Board sign off in September 2024	
3	Staff survey data	
4	WRES data	
5	EMT discussion and oversight of priorities and responses to audit actions	
6	Agenda and minutes of EDI Oversight Group	
7	Examples of reports and minutes showing consideration of EQIAs during decision-making	
8	Transformation Committee discussion and oversight of strategy action plan.	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Kez Hayat (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.	1. 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 which was chaired by Professor Dame Donna Kinnair.
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.	
3	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.	**Link to place risk register:** None
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.	No mitigating actions at present. Risk will be reviewed from 17 December 2025.
2	Supporting the EDI strategy in West Yorkshire (2025/26)	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Outcomes of staff survey is discussed at Calderdale senior leadership team meetings	**Link to place risk register:** None

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 overseen by the Partnership Board including a number of objectives which have been developed for delivery by the WY Partnership Board (2025/26).
2	EQIAs embedded as part of PMO functions	
3	Community champions / Community voices	**Link to place risk register:** None
4	The Kirklees objectives of the EDI strategy have been developed and agreed and work is progressing in 2025/26.	

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 subsequent 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, 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. .	
BOLD	**Likelihood**	**2**	**6**	**Likelihood**	**3**	**9**	
	Impact	**3**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*	
1	Compliance with the requirements of the Equality Act 2010 Public Sector Duties in relation to our workforce and commissioning responsibilities.
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	Suporting the EDI strategy in West Yorkshire (2025/26) and leading on the development of Leeds EDI priorities
5	Increased focus on personal wellbeing within objective setting which will include EDI components (2025/26)
6	Ongoing interaction/partnership working in relation to our insights, communication and involvement team and equality, diversity, and inclusion.

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

No mitigating actions. Risk will be reviewed from 17 December 2025.

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Development of ICB in Leeds equality, diversity, and inclusion (EDI) priorities; annual contribution to WYICB Public Sector Equality Duty Report; equality impact assessments completed for commissioning programmes/projects and in relation to decisions.
2	Ongoing partnership working across Leeds Health and Care partnership and the wider WYICB partnership in relation to the EDS transition and development of key priorities. WYICB WRES; WDES; GPG actions plans.
3	Continuation of ICB in Leeds REN; continued implementation of the REN recruitment and selection procedure/ guidelines.

Link to place risk register:
None.

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)**		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.	
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*	
1	Equality, Diversity and Inclusion network established for place
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	Supporting delivery of WY wide equality and fairness strategy through localised objectives. The delivery will be monitored via the People Panel.
7	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)
8	Communication, Involvement and EDI at place

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

Sources of assurance *(Where is the evidence that the controls work?)*	
1	People panel (partnership committee) receives and scrutinises delivery of equality agenda
2	Formal reports - WRES,DES, PSED, Equality Delivery System to People Panel
3	Equality and fairness strategy has been presented to the People Panel, to place management team and Healthcare Inequalities Steering Group

Link to place risk register:
None.

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 12	7 October 2025
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Shaukat Ali Khan/ Lou Auger
Strategic risk 4.3	There is a risk that 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 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?)*
1	Engagement with all partners and direct alignment to WY Resilience Forum
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
10	Directorates and Places have completed Business Impact Assessments in June 2025 to support further development of business continuity plans.
11	Data Security Protection Toolkit in Apr 2025 is complete.
12	Cyber Security Discovery exercise is complete: we have undertaken a cyber security discovery to identify risks and mitigation to improve cyber security resilience. An action plan has been developed and implementation by June 2025.

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

1. Evaluating impact of recent NHS strucutural changes and the delivery of digital data and technology mandate across the ICB (2025-27)
2. Consolidation of BI and GPIT (2025-27)
3. To ensure resilience of the ICB on-call rota, we are consulting on a new potential structure which we will take to Social Partnership Forum (SPF) on 28 October 2025 for discussion and wider consultation with staff throughout November 2025.
4. We are currently reviewing the learning following business continuity incidents impacting on some GP practices in Bradford and Craven from which the learning will be used to inform our West Yorkshire EPRR processes (Update SOAD in Nov and full report in December 2025).

	Sources of assurance *(Where is the evidence that the controls work?)*
1	Reporting of EPRR Compliance to Board
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

Links to ICB risk register *(Reference numbers/brief description)*

2547 - 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

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 12	6 October 2025
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.						**Lead committee / board**	Transformation Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			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	1. There is a degree of uncertainty on future roles and responsibilities in relation to the green agenda as set out in the ICB blueprint. We will continue to work closely with partners to ensure that any changes in role and responsibilities is managed effectively, review 2025/26.
2	Regular meetings and data submission to national Greener NHS team	
3	Transformation Committee will take oversight of ICB organisational response.	
4	Board Level Net Zero Leads network and the Operational Leads Network.	
5	Regional Greener NHS steering group.	
6	NHS greener plan was agreed in priniciple at the September 2025 Board meeting.	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Minutes of Partnership Board focus on Big Ambition number 9 (climate change)	None identified.
2	Dashboard received by ICB Board on 10 big ambitions	
3	Quarterly data submission to the National Greener NHS team	
4	Minutes of the Transformation Committee	

Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

LEEDS COMMITTEE OF THE WEST YORKSHIRE INTEGRATED CARE BOARD
WORK PROGRAMME 2025-26

ITEM	May 25	Sep 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
Operational Planning			X	X	SA
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	X	HL
Implications of changes to ICB and 10-year plan		X			TR
Director of Public Health Annual Report		X			VE