**AGENDA**  
NHS Leeds CCG  
Governing Body Meeting – Held in Public

**Date:**  
Wednesday 29 January 2020

**Time:**  
13:30 – 17:00

**Venue:**  
Pudsey Civic Hall, Dawsons Corner, Leeds, LS28 5TA

Please note: agenda timings are approximate

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Lead</th>
<th>Paper</th>
<th>Time</th>
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</thead>
</table>
| GB 19/94 | Welcome and Apologies  
*Purpose:* To record apologies for absence and confirm the meeting is quorate. | Gordon Sinclair | N | 13:30 |
| GB 19/95 | Declarations of Interest  
*Purpose:* To record any Declarations of Interest relating to items on the agenda:  

a) **Financial Interest**  
Where an individual may get direct financial benefit from the consequences of a decision they are involved in making;  

b) **Non-Financial professional interest**  
Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making;  

c) **Non-financial personal interest**  
Where an individual may benefit personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of the decisions they are involved in making; and  

d) **Indirect Interests**  
Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making. | Gordon Sinclair | Y | |
| GB 19/96 | Questions from Members of the Public  
*Purpose:* To receive questions from members of the public | Gordon Sinclair | N | 13:35 |
| GB 19/97 | Minutes of the Governing Body Meeting held on 27 November 2019  
*Purpose:* To receive the minutes for approval | Gordon Sinclair | Y | 13:45 |
| GB 19/98 | Matters Arising  
*Purpose:* To consider any matters arising that are not considered elsewhere on the agenda | Gordon Sinclair | N | |
<table>
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<tr>
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</thead>
</table>
| GB 19/99  | **Action Log**  
*Purpose: To review the outstanding actions* | Gordon Sinclair    | Y     | 13:50 |
| GB 19/100 | **Corporate Risk Register**  
*Purpose: To receive the corporate risks for review* | Sabrina Armstrong | Y     | 13:55 |
| GB 19/101 | **Governing Body Assurance Framework**  
*Purpose: To receive the Governing Body Assurance Framework for review* | Sabrina Armstrong | Y     |       |
| GB 19/102 | **Leeds Mental Health Strategy**  
*Purpose: To receive and endorse the citywide Leeds Mental Health Strategy* | Helen Lewis       | Y     | 14:05 |
| GB 19/103 | **Leeds Dementia Strategy**  
*Purpose: To receive and comment on the draft Dementia Strategy* | Helen Lewis       | Y     | 14:20 |
| GB 19/104 | **People & OD Strategy 2018-21; report on progress and developments in the first year**  
*Purpose: To receive and approve the refreshed People & OD Strategy* | Sabrina Armstrong | Y     | 14:35 |
| GB 19/105 | **Smart Cities/Digital Technology**  
*Purpose: To inform the Governing Body on the place based Smart Cities work to discuss how it will contribute to better Health and Wellbeing outcomes and the “left shift” in Leeds* | Dylan Roberts     | Y     | 14:55 |
| GB 19/106 | **Primary Care Commissioning Committee – 4 December 2019**  
*Purpose: To receive the summary for information and assurance* | Sam Senior        | Y     | 15:15 |
| GB 19/107 | **Audit Committee – 22 January 2020**  
*Purpose: To receive the summary for information and assurance* | Sue Brear         | Y     |       |
| GB 19/108 | **Quality & Performance Committee – 15 January 2020**  
*Purpose: To receive the summary for information and assurance* | Phil Ayres        | Y     |       |
## COMMISSIONING & FINANCE

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Lead</th>
<th>Paper</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>GB 19/109</td>
<td><strong>Integrated Quality &amp; Performance Report (IQPR)</strong></td>
<td>Helen Lewis/Katherine Sheerin</td>
<td>Y</td>
<td>15:25</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To receive the IQPR and consider any issues escalated by the Quality &amp; Performance Committee</em></td>
<td></td>
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<tr>
<td>GB 19/110</td>
<td><strong>Finance Report</strong></td>
<td>Visseh Pejhan-Sykes</td>
<td>Y</td>
<td>15:35</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To receive the finance report for information</em></td>
<td></td>
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<tr>
<td>GB 19/111</td>
<td><strong>Ratification of Urgent Action</strong></td>
<td>Helen Lewis</td>
<td>Y</td>
<td>15:45</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To ratify the urgent decision</em></td>
<td></td>
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</tr>
<tr>
<td>GB 19/112</td>
<td><strong>Chief Executive’s Report</strong></td>
<td>Tim Ryley</td>
<td>Y</td>
<td>15:50</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To receive an update on key issues from the CCG’s Chief Executive</em></td>
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## GOVERNANCE

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<tbody>
<tr>
<td>GB 19/113</td>
<td><strong>Review of Operational Scheme of Delegation</strong></td>
<td>Visseh Pejhan-Sykes</td>
<td>Y</td>
<td>16:00</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To approve the Operational Scheme of Delegation</em></td>
<td></td>
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</tr>
<tr>
<td>GB 19/114</td>
<td><strong>Questions from Members of the Public</strong></td>
<td>Gordon Sinclair</td>
<td>N</td>
<td>16:15</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To receive questions from members of the public</em></td>
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<tr>
<td>GB 19/115</td>
<td><strong>Forward Work Programme 2019/20</strong></td>
<td>Gordon Sinclair</td>
<td>Y</td>
<td>16:25</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To receive the forward work programme for 2019/20</em></td>
<td></td>
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<tr>
<td>GB 19/116</td>
<td><strong>Any Other Business</strong></td>
<td>Gordon Sinclair</td>
<td>N</td>
<td>16:30</td>
</tr>
</tbody>
</table>

Exclusion of the public - it is recommended that the following resolution be passed: “That representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”

### Confidential Section - Held in private

<table>
<thead>
<tr>
<th>Item</th>
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<tbody>
<tr>
<td>GB 19/117</td>
<td><strong>Confidential Minutes of the Governing Body held on 27 November 2019</strong></td>
<td>Gordon Sinclair</td>
<td>Y</td>
<td>16:35</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To receive the minutes for approval</em></td>
<td></td>
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<tr>
<td>GB 19/118</td>
<td><strong>Staff Survey Update</strong></td>
<td>Sabrina Armstrong</td>
<td>N</td>
<td>16:40</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To receive a verbal update</em></td>
<td></td>
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</tr>
<tr>
<td>GB 19/119</td>
<td><strong>Update on Governance &amp; Finance – Burley Willows Scheme</strong></td>
<td>Helen Lewis</td>
<td>N</td>
<td>16:50</td>
</tr>
<tr>
<td></td>
<td><em>Purpose: To receive a verbal update on the governance &amp; finance</em></td>
<td></td>
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<td>Lead</td>
<td>Paper</td>
<td>Time</td>
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<tr>
<td>IF1.</td>
<td>Minutes of the West Yorkshire &amp; Harrogate Joint Committee – 5 November 2019</td>
<td>Gordon Sinclair</td>
<td>Y</td>
<td>N/A</td>
</tr>
</tbody>
</table>

_Purpose: To receive the minutes for information_

**Dates of Future Meetings:**
- 25th March 2020
<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Job Title (where applicable)</th>
<th>Role</th>
<th>Practice &amp; Code (Practice Only)</th>
<th>Declared Interest - (Name of the organisation and nature of business)</th>
<th>Type of Interest</th>
<th>Is the interest direct or indirect?</th>
<th>Interest From</th>
<th>Interest Until</th>
<th>Action Taken to Mitigate Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Angela Collins</td>
<td>Lay Member for Patient and Public Participation</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Nil Declaration</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dr</td>
<td>Ben Browning</td>
<td>Member Representative</td>
<td>Governing Body Member</td>
<td>BB86020</td>
<td>GP Partner at Lofthouse Surgery</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/02/2019</td>
<td>01/04/2020</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops</td>
</tr>
<tr>
<td>Dr</td>
<td>Ben Browning</td>
<td>Member Representative</td>
<td>Governing Body Member</td>
<td>BB86020</td>
<td>Shareholder in Leeds Care Ltd (now dormant)</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>N/A</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops</td>
</tr>
<tr>
<td>Dr</td>
<td>Ben Browning</td>
<td>Member Representative</td>
<td>Governing Body Member</td>
<td>BB86020</td>
<td>Member of Leeds Care LLP (Shell Company)</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/02/2019</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops</td>
</tr>
<tr>
<td>Dr</td>
<td>Ben Browning</td>
<td>Member Representative</td>
<td>Governing Body Member</td>
<td>BB86020</td>
<td>Spouse is a locum GP</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>01/01/1997</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops</td>
</tr>
<tr>
<td>Dr</td>
<td>Ben Browning</td>
<td>Member Representative</td>
<td>Governing Body Member</td>
<td>BB86020</td>
<td>Spouse is city-wide lead for Disability Services (NHS Leeds CCG)</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>01/01/2011</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops</td>
</tr>
<tr>
<td>Dr</td>
<td>Gordon Sinclair</td>
<td>GP Partner / Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86030</td>
<td>GP Partner at Burton Croft Surgery</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/1993</td>
<td>Ongoing</td>
<td>Declare conflict or perceived conflict within context of any relevant meeting or project work</td>
</tr>
<tr>
<td>Dr</td>
<td>Gordon Sinclair</td>
<td>GP Partner / Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86030</td>
<td>Burton Croft Surgery is a shareholder of Leeds West Primary Care Network Ltd.</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/2016</td>
<td>Ongoing</td>
<td>Declare conflict or perceived conflict within context of any relevant meeting or project work</td>
</tr>
<tr>
<td>Dr</td>
<td>Gordon Sinclair</td>
<td>GP Partner / Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86030</td>
<td>Partner of Viva Healthcare LLP</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/2012</td>
<td>Ongoing</td>
<td>Declare conflict or perceived conflict within context of any relevant meeting or project work</td>
</tr>
<tr>
<td>Dr</td>
<td>Gordon Sinclair</td>
<td>GP Partner / Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86030</td>
<td>Headingley Pharmacy LLP – Viva Healthcare has a 25% interest</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/2012</td>
<td>Ongoing</td>
<td>Declare conflict or perceived conflict within context of any relevant meeting or project work</td>
</tr>
<tr>
<td></td>
<td>Dylan Roberts</td>
<td>Chief Digital and Information Officer - LCC and CCG</td>
<td>Band 8d and above or Employee Decision Maker</td>
<td>N/A</td>
<td>Employee of Leeds City Council although responsible for delivery of Digital, Information and Data at CCG and Primary Care</td>
<td>Non-Financial Professional Interests</td>
<td>Direct</td>
<td>16/12/2019</td>
<td>01/04/2021</td>
<td>Declare any potential conflict of interest at relevant meetings.</td>
</tr>
<tr>
<td>Helen Lewis</td>
<td>Interim Director of Acute &amp; Specialist Commissioning</td>
<td></td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Trustee, Leeds Jewish Welfare Board</td>
<td>Non-Financial Personal Interests</td>
<td>Direct</td>
<td>01/12/2017</td>
<td>Up to 9 year term</td>
<td>Declaration of interest at all relevant meetings</td>
</tr>
<tr>
<td>Dr</td>
<td>Ian Cameron</td>
<td>Director of Public Health, Leeds City Council</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Director of Public Health, Leeds City Council</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/04/2016</td>
<td>Ongoing</td>
<td>Any decisions affecting joint working with Leeds City Council including policy and resource decisions</td>
</tr>
<tr>
<td>Dr</td>
<td>Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86022</td>
<td>Partner at Oakwood Lane Medical Practice</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/2006</td>
<td>Ongoing</td>
<td>Declare any potential conflict/Interest at relevant Governing Body/Committee meetings</td>
</tr>
<tr>
<td>Dr</td>
<td>Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86022</td>
<td>Director Amjo Healthcare Ltd</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/2007</td>
<td>Ongoing</td>
<td>Declare any potential conflict/Interest at relevant Governing Body/Committee meetings</td>
</tr>
<tr>
<td>Dr</td>
<td>Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86022</td>
<td>Spouse business Artlight International Ltd</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>10/05/2012</td>
<td>Ongoing</td>
<td>Declare any potential conflict/Interest at relevant Governing Body/Committee meetings</td>
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<tr>
<td>Dr</td>
<td>Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86022</td>
<td>Spouse business Nails 17 Ltd</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>10/05/2012</td>
<td>Ongoing</td>
<td>Declare any potential conflict/Interest at relevant Governing Body/Committee meetings</td>
</tr>
<tr>
<td>Dr</td>
<td>Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86022</td>
<td>Director Leeds Jewish Free school</td>
<td>Non-Financial Personal Interests</td>
<td>Direct</td>
<td>16/01/2014</td>
<td>Ongoing</td>
<td>Declare any potential conflict/Interest at relevant Governing Body/Committee meetings</td>
</tr>
<tr>
<td>Dr</td>
<td>Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>Governing Body Member</td>
<td>BB86022</td>
<td>Director/Trustee Brodetsky Primary School Foundation</td>
<td>Non-Financial Personal Interests</td>
<td>Direct</td>
<td>17/06/2014</td>
<td>Ongoing</td>
<td>Declare any potential conflict/Interest at relevant Governing Body/Committee meetings</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Governing Body Member</td>
<td>Non-Financial Personal Interests</td>
<td>Financial Interests</td>
<td>Dates</td>
<td>Note</td>
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<tr>
<td>Dr Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>BB6022</td>
<td>Chair of Governor’s Brodetsky Primary School</td>
<td>Non-Financial Personal Interests</td>
<td>Direct</td>
<td>01/09/2012 Ongoing</td>
<td>Declare any potential conflict/interest at relevant Governing Body/Committee meetings</td>
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<tr>
<td>Dr Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>BB6022</td>
<td>Founding Fellow of the Faculty of Clinical Informatics</td>
<td>Non-Financial Professional Interests</td>
<td>Direct</td>
<td>01/05/2018 Ongoing</td>
<td>Declare any potential conflict/interest at relevant Governing Body/Committee meetings</td>
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<tr>
<td>Dr Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>BB6022</td>
<td>Gartner UK - Clinical Advisor</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/06/2018 Ongoing</td>
<td>Declare any potential conflict/interest at relevant Governing Body/Committee meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>BB6022</td>
<td>Calibre Care Partners Ltd OILMP is a member of this GP federation, which is part of Leeds GP Confederation</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/06/2018 Ongoing</td>
<td>Declare any potential conflict/interest at relevant Governing Body/Committee meetings</td>
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<tr>
<td>Dr Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>BB6022</td>
<td>Shareholder / Director Chapeloak Services Ltd</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/2019 Ongoing</td>
<td>Declare any potential conflict/interest at relevant Governing Body/Committee meetings</td>
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<tr>
<td>Dr Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>BB6022</td>
<td>Leeds Acupuncture Clinic - Father’s and brother’s business</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>10/05/2012 Ongoing</td>
<td>Declare any potential conflict/interest at relevant Governing Body/Committee meetings</td>
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</tr>
<tr>
<td>Dr Jason Broch</td>
<td>Assistant Clinical Chair</td>
<td>BB6022</td>
<td>Clinical Lead - Yorkshire &amp; Humber Local Health &amp; Care record Exemplar, inc membership of NHS Clinical Advisory Group</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/11/2018 Ongoing</td>
<td>Declare any potential conflict/interest at relevant Governing Body/Committee meetings</td>
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</tr>
<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>Joint Chair of the NHSCC National Nurses Forum</td>
<td>Non-Financial Professional Interests</td>
<td>Direct</td>
<td>01/07/2019 Ongoing</td>
<td>Declare any conflict of interest at relevant meetings/workshops.</td>
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</tr>
<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>GP Partner at Leeds Student Medical Practice</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/2016 Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings</td>
<td></td>
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</tr>
<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>Leeds Local Medical Committee Member</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/09/2013 Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>Spouse is a Director of Leeds Haematology Ltd</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>01/05/2013 Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>Spouse is a trustee of UK Myeloma Forum</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>01/01/2013 Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>Spouse is an employee of the University of Leeds</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>01/01/2015 Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings</td>
<td></td>
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</tr>
<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>GP lead for Leeds Primary Care Workforce and Training Hub</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/05/2018 Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings</td>
<td></td>
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<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>Spouse has an honorary contract with Leeds Teaching Hospitals NHS Trust</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>01/01/2015 Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings</td>
<td></td>
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<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>Shareholder of Leeds West Primary Care Limited</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/10/2015 Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings</td>
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<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>I am a member of LSMP and The Light PCN</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/07/2019 Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Julianne Lyons</td>
<td>GP Member Representative</td>
<td>BB6110</td>
<td>Daughter employed by Leeds Student Medical Practice, Project Co-ordinator for Leeds Primary Care Workforce Hub</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>01/07/2019 Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Katherine Sheerin</td>
<td>Director of System Integration (Interim)</td>
<td>N/A</td>
<td>Director, Ambition Health Ltd (Health consultancy)</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>10/09/2017 Ongoing</td>
<td>Ambition Health Ltd. Not to bid for or undertake work in the West Yorkshire and Harrogate area.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Position / Membership</td>
<td>N/A</td>
<td>Financial Interests</td>
<td>Non-Financial Professional Interests</td>
<td>Non-Financial Personal Interests</td>
<td>Indirect Interests</td>
<td>Direct Interests</td>
<td>Start Date</td>
<td>End Date</td>
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</tr>
<tr>
<td>Katherine Sheerin</td>
<td>Director of System Integration [Interim]</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Part of the role of Director of System Integration is to work for the NHS Providers in Leeds to support integration of services. The role is part funded by these providers as follows - Leeds Community Healthcare NHS Trust; Leeds Teaching Hospitals NHS Trust; Leeds and York Partnership NHS Foundation Trust; Leeds GP Confederation.</td>
<td>Non-Financial Professional Interests</td>
<td>Direct</td>
<td>01/04/2019</td>
<td>31/03/2020</td>
<td>Declare any interest/potential conflict of interest at relevant meetings/workshops. Declare any possible interest/potential conflict of interest at relevant meetings/workshops. Declare any possible conflict at relevant meetings/workshops.</td>
<td></td>
</tr>
<tr>
<td>Dr Keith Miller</td>
<td>GP Member Representative</td>
<td>Governing Body Member</td>
<td>886109</td>
<td>Spouse - Advanced Nurse Practitioner, LTHT</td>
<td>Financial Interests</td>
<td>Indirect</td>
<td>01/01/2008</td>
<td>Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings.</td>
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</tr>
<tr>
<td>Dr Keith Miller</td>
<td>GP Member Representative</td>
<td>Governing Body Member</td>
<td>886109</td>
<td>GP Partner at Kirkstall Lane Medical Centre</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/2010</td>
<td>Ongoing</td>
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<tr>
<td>Dr Keith Miller</td>
<td>GP Member Representative</td>
<td>Governing Body Member</td>
<td>886109</td>
<td>Shareholder in Leeds General Practice Limited</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/2014</td>
<td>Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings.</td>
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<tr>
<td>Dr Keith Miller</td>
<td>GP Member Representative</td>
<td>Governing Body Member</td>
<td>886109</td>
<td>NHS Leeds Clinical Commissioning Group – Member Representative</td>
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<td>01/01/2018</td>
<td>Ongoing</td>
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<tr>
<td>Dr Keith Miller</td>
<td>GP Member Representative</td>
<td>Governing Body Member</td>
<td>886109</td>
<td>Member of GP Confederation</td>
<td>Non-Financial Professional Interests</td>
<td>Direct</td>
<td>01/01/2018</td>
<td>Ongoing</td>
<td>Declare any potential conflict of interest at Governing Body/Board, sub committees and relevant meetings.</td>
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<tr>
<td>Dr Keith Miller</td>
<td>GP Member Representative</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>I have personal friendships with two members of the Rawdon Surgery team.</td>
<td>Financial Interests</td>
<td>Indirect</td>
<td>01/01/2017</td>
<td>Ongoing</td>
<td>Declare any potential conflict of interest.</td>
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</tr>
<tr>
<td>Dr Keith Miller</td>
<td>GP Member Representative</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>I am a management consultant and may work with providers in the city on clinical leadership development</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/06/2018</td>
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<td>Declare any potential conflict of interest at relevant meetings/workshops.</td>
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<tr>
<td>Dr Keith Miller</td>
<td>GP Member Representative</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Personal friendship with the Chief Executive of Leeds Community Healthcare</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>17/11/2019</td>
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<tr>
<td>Sabrina Armstrong</td>
<td>Director of Organisational Effectiveness</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Personal friendship with a non-executive director of Leeds Community Healthcare NHS Trust.</td>
<td>Non-Financial Personal Interests</td>
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<td>01/05/2019</td>
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<tr>
<td>Sabrina Armstrong</td>
<td>Director of Organisational Effectiveness</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Close friend works as Director of System Capability and Operations at NHS England.</td>
<td>Indirect Interests</td>
<td>Direct</td>
<td>01/01/2014</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops.</td>
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<tr>
<td>Sabrina Armstrong</td>
<td>Director of Organisational Effectiveness</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Pool member with NHS Interim Management and Support (NHS England).</td>
<td>Non-Financial Professional Interests</td>
<td>Direct</td>
<td>01/01/2014</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops.</td>
<td></td>
</tr>
<tr>
<td>Sam Senior</td>
<td>Lay Member for Primary Care Co-Commissioning</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Lay Member for Primary Care Bassetlaw CCG</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/09/2013</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops.</td>
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<tr>
<td>Sam Senior</td>
<td>Lay Member for Primary Care Co-Commissioning</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Lay Representative National School of Healthcare Science</td>
<td>Financial Interests</td>
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<td>01/05/2016</td>
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<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops.</td>
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<tr>
<td>Sam Senior</td>
<td>Lay Member for Primary Care Co-Commissioning</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Lay Advisor Health Education England (West Midlands)</td>
<td>Financial Interests</td>
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<tr>
<td>Sam Senior</td>
<td>Lay Member for Primary Care Co-Commissioning</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Patient and Public Panel Member - National Institute for Health Research</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/04/2017</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops.</td>
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<tr>
<td>Sam Senior</td>
<td>Lay Member for Primary Care Co-Commissioning</td>
<td>Governing Body Member</td>
<td>N/A</td>
<td>Chairperson - Brampton United Junior Football Club (563 888)</td>
<td>Non-Financial Personal Interests</td>
<td>Direct</td>
<td>01/05/2013</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops.</td>
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<tr>
<td>Name</td>
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<td>Position</td>
<td>Interests</td>
<td>Financial/Non-Financial</td>
<td>Start Date</td>
<td>End Date</td>
<td>Notes</td>
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<tr>
<td>Sam Senior</td>
<td>Lay Member for Primary Care Co-Commissioning</td>
<td>Governing Body Member</td>
<td>Independent Lay Member to Rotherham Federation Connect Healthcare</td>
<td>Non-Financial Professional Interests</td>
<td>Direct</td>
<td>29/05/2019</td>
<td>Ongoing</td>
<td>Declare conflict or perceived conflict within context of any relevant meeting or project work</td>
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<tr>
<td>Sam Senior</td>
<td>Lay Member for Primary Care Co-Commissioning</td>
<td>Governing Body Member</td>
<td>Non-Exec Director Rotherham Federation Connect Healthcare</td>
<td>Non-Financial Professional Interests</td>
<td>Direct</td>
<td>29/03/2019</td>
<td>Ongoing</td>
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<tr>
<td>Sam Senior</td>
<td>Lay Member for Primary Care Co-Commissioning</td>
<td>Governing Body Member</td>
<td>Trustee of Corton Wood Miners Welfare (5730TU)</td>
<td>Non-Financial Personal Interests</td>
<td>Direct</td>
<td>15/10/2019</td>
<td>Ongoing</td>
<td>Declare conflict or perceived conflict within context of any relevant meeting or project work</td>
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<tr>
<td>Dr Simon Stockill</td>
<td>Medical Director</td>
<td>Governing Body Member</td>
<td>Partner at Sleights and Sandsend Medical Practice, Whitby (Hambleton, Richmondshire &amp; Whitby CCG)</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/04/2016</td>
<td>Ongoing</td>
<td>Declare any conflict or perceived conflict within context of any relevant meeting or project work</td>
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<tr>
<td>Dr Simon Stockill</td>
<td>Medical Director</td>
<td>Governing Body Member</td>
<td>GP Appraiser, NHS England (Yorkshire &amp; Humber)</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/12/2013</td>
<td>Ongoing</td>
<td>Declare any conflict or perceived conflict within context of any relevant meeting or project work</td>
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<tr>
<td>Dr Simon Stockill</td>
<td>Medical Director</td>
<td>Governing Body Member</td>
<td>Clinical Lead for Quality Improvement, Royal College of GPs</td>
<td>Non-Financial Professional Interests</td>
<td>Direct</td>
<td>01/09/2016</td>
<td>Ongoing</td>
<td>Declare any conflict or perceived conflict within context of any relevant meeting or project work</td>
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<tr>
<td>Dr Simon Stockill</td>
<td>Medical Director</td>
<td>Governing Body Member</td>
<td>Clinical Director, Whitby Coast &amp; Moors Primary Care Network</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/07/2019</td>
<td>Ongoing</td>
<td>Declare any conflict or perceived conflict within context of any relevant meeting or project work</td>
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<tr>
<td>Susan Brear</td>
<td>Lay Member for Audit and Conflict of Interest</td>
<td>Governing Body Member</td>
<td>Sole Director Educational Services Company marking insurance and accountancy assignments at degree level</td>
<td>Financial Interests</td>
<td>Direct</td>
<td>01/01/1999</td>
<td>Ongoing</td>
<td>Declare any potential or perceived conflict of interest at relevant meetings/workshops</td>
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<tr>
<td>Tim Ryley</td>
<td>Chief Executive</td>
<td>Governing Body Member</td>
<td>Nil Declaration</td>
<td></td>
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<tr>
<td>Visheh Pejhan-Sykes</td>
<td>Chief Finance Officer</td>
<td>Governing Body Member</td>
<td>Niece works for CCG as Digital Communications Officer</td>
<td>Indirect Interests</td>
<td>Indirect</td>
<td>12/12/2017</td>
<td>Ongoing</td>
<td>Not to participate in any decisions which may affect this post, eg cut budget.</td>
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# Minutes

**NHS Leeds CCG – Governing Body Meeting**  
Wednesday 27 November 2019  
2.15 – 5.00pm  
The Old Fire Station, Gipton Approach, Leeds, LS9 6NL

## Members

<table>
<thead>
<tr>
<th>Members</th>
<th>Initials</th>
<th>Role</th>
<th>Present</th>
<th>Apologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Gordon Sinclair (Chair)</td>
<td>GS</td>
<td>Clinical Chair</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Dr Phil Ayres</td>
<td>PA</td>
<td>Secondary Care Specialist Doctor</td>
<td>✔️</td>
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</tr>
<tr>
<td>Sue Brear</td>
<td>SB</td>
<td>Lay Member – Audit &amp; Conflicts of Interest</td>
<td>✔️</td>
<td></td>
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<tr>
<td>Dr Jason Broch</td>
<td>JB</td>
<td>Assistant Clinical Chair</td>
<td>✔️</td>
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</tr>
<tr>
<td>Dr Ben Browning</td>
<td>BB</td>
<td>Member Representative</td>
<td>✔️</td>
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</tr>
<tr>
<td>Angela Collins</td>
<td>AC</td>
<td>Lay Member – Patient &amp; Public Involvement</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Jo Harding</td>
<td>JH</td>
<td>Executive Director of Quality and Nursing</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Dr Julianne Lyons</td>
<td>JL</td>
<td>Member Representative</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Dr Keith Miller</td>
<td>KM</td>
<td>Member Representative</td>
<td>✔️</td>
<td></td>
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<tr>
<td>Visseh Pejhan-Sykes</td>
<td>VPS</td>
<td>Executive Director of Finance</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Tim Ryley</td>
<td>TR</td>
<td>Chief Executive</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Samantha Senior (Deputy Chair)</td>
<td>SS</td>
<td>Lay Member – Primary Care Co-Commissioning</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Dr Simon Stockill</td>
<td>SS&amp;t</td>
<td>Medical Director</td>
<td>✔️</td>
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</table>

### Additional Attendees

- Sabrina Armstrong  
  **SA**  
  Director of Organisational Effectiveness  
  ✔️

- Dr Ian Cameron  
  **IC**  
  Consultant in Public Health Medicine  
  ✔️

- Dylan Roberts  
  **DR**  
  Chief Digital and Information Officer  
  ✔️

- Susan Robins  
  **SR**  
  Director of Acute & Specialist Commissioning  
  ✔️

- Katherine Sheerin  
  **KS**  
  Director of System Integration  
  ✔️

- Laura Parsons  
  **LP**  
  Head of Corporate Governance & Risk  
  ✔️

- Sam Ramsey  
  **SRa**  
  Corporate Governance Manager  
  ✔️

## Members of the Public Observing the Meeting – 2

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda Item</th>
<th>Action</th>
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</thead>
</table>
| GB 19/69 | Welcome and Apologies  
GS welcomed everyone to the Governing Body meeting. Apologies were received on behalf of JL and BB. |        |
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<th>No.</th>
<th>Agenda Item</th>
<th>Action</th>
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<tbody>
<tr>
<td></td>
<td>The Chair confirmed that the meeting was quorate.</td>
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</table>
| GB 19/70 | **Declarations of interest**  
Members were asked to raise any declarations of interest in relation to agenda items. |        |
|      | No further items were raised.                   |        |
| GB 19/71 | **Questions from Members of the Public**  
There were no questions asked from the members of the public present. |        |
| GB 19/72 | **Minutes from Previous Meetings**  
GS presented the minutes from the NHS Leeds Governing Body held on 25 September for approval. |        |
|      | The Governing Body:  
(a) **approved** the minutes of the NHS Leeds Governing Body held on 25 September. |        |
| GB 19/73 | **Matters Arising**  
SA highlighted that at the previous meeting, members were informed that the Communications team had been nominated for two awards. The Communications team had since received both of these awards and were congratulated on their achievement. |        |
| GB 19/74 | **Action Log**  
The Governing Body reviewed the action log and noted the following updates:  
18/73 – Due to Purdah and guidelines issues by NHS England, the Mental Health Strategy had been deferred to the January 2020 Governing Body meeting.  
19/68 – The revised Procurement Policy would return to a future Governing Body meeting. |        |
| GB 19/75 | **Corporate Risk Register**  
SA presented the report and highlighted the changes within the paper since the last iteration. Members were informed that there were 57 active risks on the register; however there were currently no red risks recorded which was a reduction from 1 to 0. Risk 651 had been reduced from 15 (red) to 12 (amber), reflecting a reassessment of the impact of this risk.  
A query was raised in relation to the reduction of the risk and how this was calculated and members were informed that there had been a deep dive into the associated GBAF risk. |        |
It had been acknowledged that the CCG had put a lot of investment into Primary Care, however it was recognised that there were still issues. The risk was considered to be in pockets rather than a risk to the whole city.

The Governing Body:
  a) noted the changes to the risk register.

**Governing Body Assurance Framework (GBAF)**

SA presented the GBAF for the Governing Body to review, highlighting that lead Directors had reviewed and updated their risks. Members were reminded that the GBAF focused on principal risks to achievement of the CCG’s strategic commitments and the Governing Body should be assured that controls were operating to seek to reduce the risks to acceptable levels.

The Governing Body was informed that Risk 5 had been presented to the Audit Committee on 16 October as a deep dive to provide assurance on the management of the risk. The Audit Committee had requested that Risk 3 was presented to the next Committee meeting in January 2020.

A query was raised as to whether it was the intention of the Audit Committee to review all the GBAF risks as a deep dive, and the Chair of the Audit Committee confirmed they would be reviewed over a cycle to receive assurance of each strategic risk.

The Audit Committee Chair highlighted climate change as an emerging risk and queried whether this should be included on the GBAF. SA informed members that a paper would be brought to the Governing Body in March 2020 to provide further information on the actions being taken in response to climate change. Climate change would be considered as part of the annual review of the GBAF as to whether it should be reflected across all risks or required a separate risk on the GBAF.

The Governing Body was informed that Risk 7 had been increased to the target score to reflect the need to take more opportunity to work with partners, including the requirements of national guidance on the role of CCGs in the Integrated Care System (ICS) and working towards becoming a strategic commissioner.

A query was raised in relation to risk 6 and whether the score of 12 was appropriate. Members were assured that the risk had been fully reviewed and considered the schemes in place including the introduction of a citywide workforce board, however the risk would be continuously reviewed to ensure the actions and controls were being met. Members discussed the associated metrics and highlighted that there was further work to be done in order to capture the additional roles within Primary Care.
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<tr>
<th>No.</th>
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<tbody>
<tr>
<td></td>
<td>It was noted that the risk was specifically related to Primary Care workforce and further consideration should be given as to whether the wider workforce should also be reflected in this risk.</td>
<td>KS/JH</td>
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<tr>
<td></td>
<td>The Governing Body:</td>
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<tr>
<td></td>
<td>a) <strong>reviewed</strong> the Governing Body Assurance Framework;</td>
<td></td>
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<tr>
<td></td>
<td>b) <strong>considered</strong> the controls and assurances;</td>
<td></td>
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<tr>
<td></td>
<td>c) <strong>noted</strong> the review and assurance processes; and</td>
<td></td>
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<tr>
<td></td>
<td>d) <strong>noted</strong> that the Audit Committee had requested Risk 3: Failure to achieve financial stability and sustainability, to be presented to the next Audit Committee meeting to provide assurance on this risk.</td>
<td></td>
</tr>
<tr>
<td>GB 19/77</td>
<td>Committee Chair’s Summary - Primary Care Commissioning Committee – 5 October 2019</td>
<td></td>
</tr>
<tr>
<td>GB 19/77</td>
<td>The Governing Body received the report for information and no further queries were raised.</td>
<td></td>
</tr>
<tr>
<td>GB 19/77</td>
<td>The Governing Body:</td>
<td></td>
</tr>
<tr>
<td>GB 19/77</td>
<td>a) <strong>received</strong> the report.</td>
<td></td>
</tr>
<tr>
<td>GB 19/78</td>
<td>Committee Chair’s Summary – Remuneration &amp; Nomination Committee – 9 October 2019</td>
<td></td>
</tr>
<tr>
<td>GB 19/78</td>
<td>SSE presented the report and highlighted that the recruitment for the Clinical Chair was progressing and an interview date would be set for January 2020.</td>
<td></td>
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<tr>
<td>GB 19/78</td>
<td>The Governing Body:</td>
<td></td>
</tr>
<tr>
<td>GB 19/78</td>
<td>a) <strong>received</strong> the report.</td>
<td></td>
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<tr>
<td>GB 19/79</td>
<td>Committee Chair’s Summary – Audit Committee – 16 October 2019</td>
<td></td>
</tr>
<tr>
<td>GB 19/79</td>
<td>SB presented the report and highlighted that there had been some changes to the format of the Audit Committee and there would be a deep dive of a GBAF risk to each Audit Committee.</td>
<td></td>
</tr>
<tr>
<td>GB 19/79</td>
<td>The Governing Body:</td>
<td></td>
</tr>
<tr>
<td>GB 19/79</td>
<td>a) <strong>received</strong> the report.</td>
<td></td>
</tr>
<tr>
<td>GB 19/80</td>
<td>Committee Chair’s Summary – Auditor Panel – 18 September 2019</td>
<td></td>
</tr>
<tr>
<td>GB 19/80</td>
<td>The Governing Body received the report for information and no further queries were raised.</td>
<td></td>
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<tr>
<td>GB 19/80</td>
<td>The Governing Body:</td>
<td></td>
</tr>
<tr>
<td>GB 19/80</td>
<td>a) <strong>received</strong> the report.</td>
<td></td>
</tr>
<tr>
<td>GB 19/81</td>
<td>Committee Chair’s Summary – Quality &amp; Performance Committee – 13 November 2019</td>
<td></td>
</tr>
<tr>
<td>GB 19/81</td>
<td>PA presented the Committee Chair’s Summary for the Quality &amp; Performance</td>
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<tr>
<td>No.</td>
<td>Agenda Item</td>
<td>Action</td>
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<td></td>
<td>Committee held on 13 November 2019 and highlighted that the Committee was considering the way it receives assurance and the linkage with the Audit Committee.</td>
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<tr>
<td></td>
<td>The Quality &amp; Performance Committee had received the Emergency Planning Statement of Compliance as assurance that the CCG had robust EPRR arrangements. It was recommended that the Governing Body sign the statement of compliance for submission and this was formally approved by the Governing Body with the agreement that this would be signed by the Accountable Officer.</td>
<td></td>
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<tr>
<td></td>
<td>IC highlighted that the submission last year had been partial compliance and acknowledged the progress that had been made and the significant amount of work to move from partial to substantial compliance.</td>
<td></td>
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<tr>
<td></td>
<td>PA also highlighted that the amended terms of reference would be presented for approval at agenda item GB 19/85.</td>
<td></td>
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<tr>
<td></td>
<td>Members had noted the challenges in relation to Children and Young People’s Mental Health and Wellbeing within the summary and recognised the successes in Hertfordshire CCG and Doncaster CCG and whether there could be any learning for Leeds.</td>
<td></td>
</tr>
</tbody>
</table>
|     | The Governing Body:  
 a) received the report; and  
 b) approved and signed the Emergency Planning Statement of Compliance. |        |
| GB 19/82 | Integrated Quality & Performance Report (IQPR) SR presented the Integrated Quality & Performance Report (IQPR) and confirmed to members that this had been reviewed in detail by the Quality & Performance Committee. |        |
|     | Members were informed that the A&E target was currently being exceeded due to the high number of A&E attendances. The Chief Executive highlighted the pressure on the urgent care system. |        |
|     | Members acknowledged the improved performance in Continuing Care in relation to the percentage of eligibility decisions made within 28 days. |        |
|     | The mobilisation of the Primary Care Mental Health Service was discussed and it was noted that the workforce recruitment had been positive. NHS England was aware and there was an expectation of a significant improvement by February 2020. |        |
|     | A query was raised in relation to the high number of paediatric attendances at A&E and whether this could be correlated with waiting times in primary care. Members were informed that the majority of attendances were in relation to |        |
respiratory illness and presentation at primary care, and attendances at walk in centres had also increased. It was suggested that it was likely to be a reflection of demand across the whole system and not linked to waiting times in primary care. It was iterated that additional GPs would be present in the primary care element of A&E.

A further query was raised in relation to the increased two week referrals and whether this was translating into a benefit overall. SS summarized that the conversion rates seemed to be similar; however it may be too early to consider if this has resulted in earlier diagnoses of cancer, which is the reason behind the push on two week referrals.

The Governing Body:
| a) **received** and **reviewed** the IQPR dashboards; |
| b) **discussed** the information; and |
| c) **noted** the current areas of underperformance and mitigating action. |

**Finance Report**

VPS presented an update on the financial performance of NHS Leeds CCG for the seven months to 31 October 2019 and the expected outturn position for the 2019-20 financial year.

Members were informed that the CCG was on target to achieve its financial control total of £1.3bn. VPS highlighted that there was a risk of non-delivery of QIPP due to the non achievement of the additional capacity wards scheme of £5.5m. It was planned that this would be covered from reserves.

Members were informed that in terms of income allocations, there was an additional £1.1m for mental health and £336k for adults and children palliative care.

The Governing Body:
| a) **noted** the Month 7 financial position. |

**Chief Executive’s Report**

TR presented the Chief Executive’s Report and highlighted the key areas within the report.

The Governing Body was informed that the CCG and partners were working with the Council to consider how the NHS could contribute to the Climate Change Emergency. It was reiterated that a report on Climate Change would be presented to the Governing Body in March 2020. Members recognised the importance of climate change and raising awareness as a commissioning organisation.

The importance of the ‘think family’ theme at the CCG staff away day and awards was highlighted and it was acknowledged that future commissioning should consider the ‘think family’ concept.
<table>
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<tr>
<th>No.</th>
<th>Agenda Item</th>
<th>Action</th>
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<tbody>
<tr>
<td></td>
<td>Members were informed of the funding obtained to support the LeDeR process across the WY&amp;H ICS. The Governing Body recognised the importance of this and that it linked directly back to health inequalities.</td>
<td></td>
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<td></td>
<td>The Chief Executive advised members that the West Yorkshire &amp; Harrogate Joint Committee of CCGs development session would consider the role of CCGs at West Yorkshire level and at place level. Work was ongoing and the Governing Body would continue to be updated through the Chief Executive’s report.</td>
<td></td>
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</tbody>
</table>
|     | **The Governing Body:**  
|     | a) **received** the Chief Executive’s report. | |
| GB 19/85 | **Update to Committee Terms of Reference & Scheme of Reservation & Delegation**  
GS presented the update to the Committee terms of reference, and highlighted the move of responsibility of Information Governance from the Quality & Performance Committee to the Audit Committee. This had also been updated in the Scheme of Reservation & Delegation. Members were informed that the Audit Committee terms of reference had also been updated in line with best practice and the Audit Committee Handbook. | |
|     | **The Governing Body:**  
|     | a) **reviewed** and **approved** the proposed amendments to the Quality & Performance Committee Terms of Reference, Audit Committee Terms of Reference and the Scheme of Reservation and Delegation. | |
| GB 19/86 | **Policy Approval**  
i. **Visible Policy Statement**  
Michelle Van Toop presented the report and explained that the policy statement was hosted by the Women’s Counselling and Therapy Services and was supported by Leeds City Council and partners. It was summarised that NHS Leeds CCG had been involved in the work from the outset and the Workforce and Diversity Group had unanimously agreed to oversee the implementation of the policy statement if adopted by the Governing Body.  
SA informed members that this was a policy statement which would have an action plan and guidance for line managers, and she was fully supportive of the approach.  
The Governing Body unanimously supported the adoption of the policy statement. | |
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<tr>
<th>No.</th>
<th>Agenda Item</th>
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<tbody>
<tr>
<td></td>
<td>The Governing Body:</td>
<td></td>
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<tr>
<td></td>
<td>a) <strong>adopted</strong> the policy statement and committed to its implementation;</td>
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<td></td>
<td>and</td>
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<td></td>
<td>b) <strong>agreed</strong> that the Workforce and Diversity Group would oversee the</td>
<td></td>
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<tr>
<td></td>
<td>implementation of the Policy Statement in the CCG.</td>
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<tr>
<td></td>
<td>ii. Managing Conflicts of Interest Policy and Standards of Business</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct Policy</td>
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<tr>
<td></td>
<td>In line with statutory guidance on Managing Conflicts of Interest, the</td>
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<td></td>
<td>Conflicts of Interest and Standards of Business Conduct policies had been</td>
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<tr>
<td></td>
<td>reviewed and minor amendments proposed. The main amendment to the</td>
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<tr>
<td></td>
<td>Conflicts of Interest policy was the inclusion of a confidentiality and</td>
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<tr>
<td></td>
<td>conflicts of interest form, which members of procurement panels would be</td>
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<tr>
<td></td>
<td>required to complete.</td>
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<td></td>
<td>Members were informed that the Audit Committee had reviewed the policies</td>
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<tr>
<td></td>
<td>at the October Committee meeting and queried naming third parties within</td>
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<td></td>
<td>the declaration of interest form in line with GDPR. In light of this, the</td>
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<td></td>
<td>form had been amended to ask for the relationship only and those declared</td>
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<td></td>
<td>would not be named.</td>
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<td></td>
<td>The Governing Body:</td>
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<tr>
<td></td>
<td>a) <strong>approved</strong> the proposed amendments to the Managing Conflicts of</td>
<td></td>
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<tr>
<td></td>
<td>Interest and Standards of Business Conduct Policies.</td>
<td></td>
</tr>
<tr>
<td>GB</td>
<td>Questions from Members of the Public</td>
<td></td>
</tr>
<tr>
<td>19/</td>
<td>There were no questions asked from the members of the public present.</td>
<td></td>
</tr>
<tr>
<td>GB</td>
<td>Forward Work Programme 2019/20</td>
<td></td>
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<tr>
<td>19/</td>
<td>The Governing Body’s work programme was presented for information.</td>
<td></td>
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<tr>
<td>GB</td>
<td>Any Other Business</td>
<td></td>
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<tr>
<td>19/</td>
<td>The Chair highlighted that this would be Sue Robins’ final Governing Body</td>
<td></td>
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<tr>
<td>GB</td>
<td>meeting as she would retire in January 2020. On behalf of the Governing</td>
<td></td>
</tr>
<tr>
<td>19/</td>
<td>Body the Chair expressed gratitude to Sue for all the hard work in</td>
<td></td>
</tr>
<tr>
<td>GB</td>
<td>contributing to the success of the organisation.</td>
<td></td>
</tr>
<tr>
<td>19/</td>
<td>Minutes of the West Yorkshire &amp; Harrogate Joint Committee – 1 October</td>
<td></td>
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<tr>
<td>IFI1</td>
<td>There were no questions asked from the members of the public present.</td>
<td></td>
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<tr>
<td></td>
<td>The Governing Body:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) received the minutes for information.</td>
<td></td>
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</tbody>
</table>
Date of next meeting: Wednesday 29th January 2020

Approved and signed by:

Dr Gordon Sinclair, Clinical Chair, NHS Leeds CCG

Date:
<table>
<thead>
<tr>
<th>ITEM NO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB 18/73</td>
</tr>
<tr>
<td>25 September 2019</td>
</tr>
<tr>
<td>27 November 2019</td>
</tr>
<tr>
<td>19/68</td>
</tr>
<tr>
<td>19/76</td>
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<tr>
<td>19/76</td>
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<table>
<thead>
<tr>
<th>ACTION NO:</th>
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<tbody>
<tr>
<td>1</td>
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<td>1</td>
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<tr>
<td>2</td>
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<table>
<thead>
<tr>
<th>ACTION:</th>
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<tbody>
<tr>
<td>Chief Executives Report</td>
</tr>
<tr>
<td>Approval of Procurement Plan</td>
</tr>
<tr>
<td>Governing Body Assurance Framework</td>
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<tr>
<td>Governing Body Assurance Framework</td>
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<thead>
<tr>
<th>ACTION BY:</th>
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<tbody>
<tr>
<td>SR</td>
</tr>
<tr>
<td>MVT</td>
</tr>
<tr>
<td>SRa</td>
</tr>
<tr>
<td>KS/JH</td>
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<thead>
<tr>
<th>COMPLETED/UPDATE</th>
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<tbody>
<tr>
<td>Complete.</td>
</tr>
<tr>
<td>To be discussed at agenda item GB 19/102.</td>
</tr>
<tr>
<td>In progress.</td>
</tr>
<tr>
<td>Policy update underway. Will be brought to a future Governing Body meeting.</td>
</tr>
<tr>
<td>Complete.</td>
</tr>
<tr>
<td>Added to forward work plan.</td>
</tr>
<tr>
<td>Complete.</td>
</tr>
<tr>
<td>Following discussion at the Governing body and further consideration by EMT, it is suggested that Risk 6: Insufficient Primary Care Workforce Capacity, Capability and Adaptability to Deliver the Ambitions, is broadened to reflect the challenges across the wider workforce, and the impact these challenges would have on the CCG delivering its strategic aims if they are not met. This will be considered as part of the annual GBAF review process.</td>
</tr>
</tbody>
</table>
NHS Leeds CCG Governing Body Meeting

Date of meeting: 29 January 2020

Title: Corporate Risk Register (Operational Risks)

<table>
<thead>
<tr>
<th>Lead Governing Body Member: Sabrina Armstrong, Director of Organisational Effectiveness</th>
<th>Category of Paper</th>
<th>Tick as appropriate (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Author: Anne Ellis Playfair, Risk Manager</td>
<td>Decision</td>
<td></td>
</tr>
<tr>
<td>Reviewed by EMT/Date: 19 December 2019</td>
<td>Discussion</td>
<td>✓</td>
</tr>
<tr>
<td>Reviewed by Committee/Date: Quality and Performance Committee 15 January 2020</td>
<td>Information</td>
<td></td>
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<tr>
<td>Primary Care Commissioning Committee 4 December 2019</td>
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<table>
<thead>
<tr>
<th>Checked by Finance (Y/N/N/A - Date): N/A</th>
<th>Approved by Lead Governing Body member (Y/N): Y</th>
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</thead>
<tbody>
<tr>
<td>Leeds Health &amp; Wellbeing Strategy Outcomes – that this report relates to:</td>
<td></td>
</tr>
<tr>
<td>1. People will live longer and have healthier lives</td>
<td>✓</td>
</tr>
<tr>
<td>2. People will live full, active and independent lives</td>
<td>✓</td>
</tr>
<tr>
<td>3. People’s quality of life will be improved by access to quality services</td>
<td>✓</td>
</tr>
<tr>
<td>4. People will be actively involved in their health and their care</td>
<td>✓</td>
</tr>
<tr>
<td>5. People will live in healthy, safe and sustainable communities</td>
<td>✓</td>
</tr>
</tbody>
</table>

NHS Leeds CCG Strategic Commitments

We will focus resources to:

1. Deliver better outcomes for people’s health and wellbeing | ✓ |
2. Reduce health inequalities across our city | ✓ |

We will work with our partners and the people of Leeds to:

3. Support a greater focus on the wider determinants of health | ✓ |
4. Increase their confidence to manage their own health and wellbeing | ✓ |
5. Achieve better integrated care for the population of Leeds | ✓ |
6. Create the conditions for health and care needs to be addressed around local neighbourhoods | ✓ |

Assurance Framework – which risks on the GBAF does this report relate to:

1. Inadequate patient and public engagement results in ineffective decisions and challenge | ✓ |
2. Failure to assure the delivery of high quality services, leading to commissioned services not reflecting best practice and improving care | ✓ |
3. Failure to achieve financial stability and sustainability | ✓ |
4. Lack of provider and clinical support for change will impact on the development and implementation of the CCG strategy | ✓ |
5. Resources are not targeted effectively to areas of most need, leading to failure to improve health in the poorest areas | ✓ |
6. Insufficient workforce capacity, capability and adaptability to deliver the ambitions | ✓ |
7. Failure to enable partners to work together to deliver the CCG commitments | ✓ |
8. Failure of system to be adaptable and resilient in the event of a significant event | ✓ |
EXECUTIVE SUMMARY:

The CCG uses Datix as an internal risk management system which enables operational risks to be recorded and managed by all members of staff. Risks are aligned to the appropriate CCG committee for overview and scrutiny.

The risks are included on the CCG operational risk register and reviewed within individual directorates on a regular basis. In line with the Risk Management Strategy, the Executive Management Team (EMT) and relevant CCG Committees receive and review the operational risks rated as high amber (12) and above. The CCG Governing Body receives the corporate risk register (all red operational risks scored at 15 and above) for review at each meeting, supported by the CCG committee chair updates.

Summary Table

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Previous (November 19)</th>
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<tbody>
<tr>
<td>Total Risks</td>
<td>59</td>
<td>57</td>
</tr>
<tr>
<td>Red Risks 15+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amber 12+</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Accepted Risks</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>New Risks</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Closed Risks</td>
<td>0</td>
<td>3</td>
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</table>

Accepted Risks

There are currently 59 active risks on the CCG risk register, 27 of these risks are categorised as ‘Accepted’ risks. This means that the current level of risk is deemed acceptable. Accepted risks are risks that are at, or below, the target risk score (approved by the responsible Director) or are green on the risk matrix below. These risks are reviewed by management at least on an annual basis or when the CCG becomes aware of a change to the risk. High amber (12) or red risks are unlikely to be accepted and will continue to be reported to the relevant Committee and Governing Body.

Impact score

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td></td>
<td>Insignificant</td>
<td>Minor</td>
<td>Moderate</td>
<td>Major</td>
<td>Catastrophic</td>
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<tr>
<td>5 Almost Certain</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>4 Likely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>3 Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2 Unlikely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>1 Rare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>
**Corporate Risks**
There has been no change in the number of corporate risks, there are currently no red risks (corporate risks) recorded on the operational risk register.

**NEXT STEPS:**
- All operational risks will be reviewed as per the bi-monthly cycle in accordance with the CCG risk management strategy and presented to the assigned committee for review. The Corporate Risk Register will be presented to the CCG Governing Body at each meeting.

**RECOMMENDATION:**
**The Governing Body is asked to:**
(a) **NOTE** the Corporate Risk Register.
Leeds & Wellbeing Strategy Outcomes – that this report relates to:

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People’s quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities

NHS Leeds CCG Strategic Commitments

We will focus resources to:

1. Deliver better outcomes for people’s health and wellbeing
2. Reduce health inequalities across our city

We will work with our partners and the people of Leeds to:

3. Support a greater focus on the wider determinants of health
4. Increase their confidence to manage their own health and wellbeing
5. Achieve better integrated care for the population of Leeds
6. Create the conditions for health and care needs to be addressed around local neighbourhoods

Assurance Framework – which risks on the GBAF does this report relate to:

1. Inadequate patient and public engagement results in ineffective decisions and challenge
2. Failure to assure the delivery of high quality services, leading to commissioned services not reflecting best practice and improving care
3. Failure to achieve financial stability and sustainability
4. Lack of provider and clinical support for change will impact on the development and implementation of the CCG strategy
5. Resources are not targeted effectively to areas of most need, leading to failure to improve health in the poorest areas
6. Insufficient workforce capacity, capability and adaptability to deliver the ambitions
7. Failure to enable partners to work together to deliver the CCG commitments
8. Failure of system to be adaptable and resilient in the event of a significant event
EXECUTIVE SUMMARY:

1. The Governing Body Assurance Framework (GBAF) provides a structure and process that enables the CCG to focus on the principal (strategic) risks to achieving its strategic commitments and be assured that adequate controls are operating to reduce these risks to acceptable levels (the risk appetite).

2. The GBAF format enables the Governing Body to review each of the risks, analyse the controls and assurances, clearly identify any gaps and the actions needed to address them. The graph illustrates the movement of the risk score throughout the year in relation to the target risk score. The target risk score is the total impact of risk the CCG is prepared to accept in pursuit of its strategic commitments and has been agreed for each risk, based on the risk appetite.

3. As part of the review cycle, each of the principal risks have been reviewed and updated by the director leads. Updates made since the previous version are highlighted in bold italics.

4. There are currently a number of risks in which the CCG is operating above the agreed risk appetite. For these risks a number of mitigating actions have been identified and once implemented, the risk level should reduce to the level of risk appetite the CCG has agreed to tolerate.

5. The Risk Management Strategy includes a review of the assurances provided by the GBAF. The review is designed to provide assurance to the Audit Committee that the CCG can place reliance on the assurances provided by the GBAF. The strategy states that principal risks outside risk appetite will be reviewed in detail at least once a year to assess the adequacy and completeness of the assurances. The Audit Committee received Risk 3: Failure to achieve financial stability and sustainability at the meeting on 22 January 2020.

6. The Governing Body will receive assurance from the Audit Committee Chair in relation to the GBAF assurance paper as part of the Audit Committee Chairs summary.

7. Following discussion at the Governing body and further consideration by EMT, it is suggested that Risk 6: Insufficient Primary Care Workforce Capacity, Capability and Adaptability to Deliver the Ambitions, is broadened to reflect the challenges across the wider workforce, and the impact these challenges would have on the CCG delivering its strategic aims if they are not met. This will be considered as part of the annual GBAF review process.

8. The GBAF risks will be reviewed for 2020/21, including; how risks are aligned to the Commitments and CCG duties, how the risks are articulated and to ensure the strategic risks reflect the challenges and changes faced by the CCG; this will be undertaken with the lead directors and EMT and presented to the Governing Body for approval in May 2020.
NEXT STEPS:

The Governing Body will continue to review the GBAF at each meeting and directors will continually monitor and update their risks accordingly.

RECOMMENDATION:

The Governing Body is asked to:

(a) **REVIEW** the Governing Body Assurance Framework;
(b) **CONSIDER** whether the controls and assurances are sufficiently robust;
(c) **AGREE** any further actions required to manage the risks to the target set; and
(d) **NOTE** the review and assurance processes.
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Governing Body Assurance Framework (GBAF)

Introduction
The Governing Body Assurance Framework (GBAF) sets out how the CCG will manage the principal risks to delivering the strategic commitments. The GBAF enables the Governing Body to corporately assure itself (gain confidence, based on evidence). The framework aligns principal risks with the commitments, and highlights key controls and assurances.

Where gaps are identified, or key controls and assurances are insufficient to reduce the risk of non-delivery to acceptable levels (within the CCG risk appetite), action needs to be taken. Planned actions will enable the Governing Body to monitor progress in addressing gaps or weaknesses and to ensure that resources are allocated appropriately.

Governing Body responsibility for the GBAF
It is for the Governing Body to:
- Establish strategic commitments.
- Identify the principal risks that threaten the achievement of these aims.
- Identify and evaluate the design of key controls intended to manage these principal risks.
- Set out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk.
- Evaluate the assurance across all areas of principal risk.
- Identify positive assurances and areas where there are gaps in controls and / or assurances
- Put in place plans to take corrective action where gaps have been identified in relation to principal risks.
- Maintain dynamic risk management arrangements including a well-founded risk register.

Assurance
The Executive Management Team and Governing Body receive the GBAF bi-monthly. The Audit Committee annual work plan will ensure that principal risks outside risk appetite are reviewed in detail at least once a year, to assess the adequacy and completeness of the assurances, the Governing Body will receive a copy of the assurance provided to the Audit Committee.

The GBAF provides the basis for the preparation of a fair and representative Annual Governance Statement. It is the subject of annual review by both Internal and External Audit.

CCG Commitments:
We will focus our resources to:
- Deliver better outcomes for people’s health and well-being
- Reduce health inequalities across our city

We will work with our partners and the people of Leeds to:
- Support a greater focus on the wider determinants of health
- Increase their confidence to manage their own health and well-being
- Achieve better integrated care for the population of Leeds
- Create the conditions for health and care needs to be addressed around local neighbourhoods

CCG Risk Appetite Statement
NHS Leeds CCG recognises that the long-term health of its population depends upon the delivery of its strategic ambitions and its relationships with its service providers, staff, public and partners. As such, NHS Leeds CCG will not accept risks that have a material adverse impact on quality of healthcare, health inequalities or life expectancy.

NHS Leeds CCG has a greater appetite to take considered risks in relation to opportunities where positive gains can be anticipated such as clinical and contractual innovation, where necessary, testing the constraints of the regulatory environment.
<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk to delivering the CCG commitments</th>
<th>Risk Appetite</th>
<th>Initial Score</th>
<th>Current Score</th>
<th>Target Score</th>
<th>Key changes since last review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inadequate patient and public engagement results in ineffective decisions and challenge</td>
<td>Averse</td>
<td>20</td>
<td>4</td>
<td>4</td>
<td>No change to current score, actions ongoing.</td>
</tr>
<tr>
<td>2</td>
<td>Failure to assure the delivery of high quality services, leading to commissioned services not reflecting best practice and improving care</td>
<td>Averse</td>
<td>20</td>
<td>8</td>
<td>6</td>
<td>No change to current score; controls updated. One action added in relation to Review of new AQP quality assurance process.</td>
</tr>
<tr>
<td>3</td>
<td>Failure to achieve financial stability and sustainability</td>
<td>Cautious</td>
<td>20</td>
<td>9</td>
<td>9</td>
<td>Current score reduced to target score in line with annual risk profile. The Audit Committee will receive assurance through a deep dive into this risk in January 2020.</td>
</tr>
<tr>
<td>4</td>
<td>Lack of provider and clinical support for change will impact on the development and implementation of the CCG strategy</td>
<td>Medium</td>
<td>16</td>
<td>9</td>
<td>9</td>
<td>No change to current score, actions ongoing.</td>
</tr>
<tr>
<td>5</td>
<td>Resources are not targeted effectively to areas of most need, leading to failure to improve health in the poorest areas</td>
<td>Averse</td>
<td>20</td>
<td>16</td>
<td>6</td>
<td>No change to current score, actions ongoing.</td>
</tr>
<tr>
<td>6</td>
<td>Insufficient workforce capacity, capability and adaptability to deliver the ambitions (Primary Care)</td>
<td>Medium</td>
<td>16</td>
<td>12</td>
<td>8</td>
<td>No change to current score, controls updated. Actions ongoing. Following discussion at the Governing body and further consideration by EMT, it is suggested that this risk is broadened to reflect the challenges across the wider workforce, and the impact these challenges would have on the CCG delivering its strategic aims if they are not met. This will be considered as part of the annual GBAF review process.</td>
</tr>
<tr>
<td>7</td>
<td>Failure to enable partners to work together to deliver the CCG commitments</td>
<td>Open</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>No change to current score, actions ongoing.</td>
</tr>
<tr>
<td>8</td>
<td>Failure of system to be adaptable and resilient in the event of a significant event</td>
<td>Averse</td>
<td>20</td>
<td>12</td>
<td>8</td>
<td>No change to current score, actions ongoing.</td>
</tr>
</tbody>
</table>
**Risk 1: Inadequate patient and public engagement results in ineffective decisions**

**Risk Appetite:** The CCG has an **averse** risk appetite for public engagement; this means that the CCG is not prepared to take risks in this area.

**Lead Director/risk owner:** Sabrina Armstrong, Director of Organisational Effectiveness

**Relevant commitments:** All

**Date last review:** January 2020

### Risk Rating

(consequence x likelihood)

<table>
<thead>
<tr>
<th>Initial score:</th>
<th>Current score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>4x5 = 20</td>
<td>4x1 = 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>4x1 = 4</td>
</tr>
</tbody>
</table>

**Rationale for current risk score:**

All appropriate controls are in place to plan and deliver effective patient and public involvement (PPI). However the consequence of these controls failing has the potential to result in challenge and ultimate referral by Scrutiny board to judicial review. This would impact on the CCG’s reputation as well as delaying any proposed changes.

**Rationale for target score:**

A target score of 4 reflects an averse risk appetite. It would not be possible to reduce the risk to a score lower than 4. This is due to the potential consequence of a control failure supplemented by circumstances outside our control.

### Controls (what are we currently doing about the risk?):

- Volunteer panel in place (PAG): Remit to provide assurance around engagement and/or consultation plans.
- Significant and major engagement/consultation plans taken to Scrutiny Board for discussion and approval to proceed.
- CCG has recruited further expertise to the engagement team – a full complement of staff in place to support engagement activity.
- Communications and engagement incorporated into Commissioning for Value (CIV) template.
- The engagement plan template includes the Equality and Quality Impact Assessment to identify impact on protected characteristics and discrete communities.
- Contract with Voluntary Action Leeds (VAL) to undertake asset-based engagement in harder to reach/engage communities. VAL is continuing to recruit to their volunteer Health Champions.
- CCG has a lead role in continuing to develop the citywide engagement hub which includes engagement colleagues from provider teams.
- CCG works closely with Healthwatch as part of the People’s Voice network.
- CCG community network continues to grow.
- Bi-monthly communications and engagement reports published and shared

### Mitigating actions (what more should we be doing?):

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Due by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure communications or engagement team reps co-opted onto appropriate commissioning steering groups to ensure the patient voice is heard.</td>
<td>Strategy and Commissioning teams</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Further enhance our approach to engagement and involvement activity beyond our statutory duties. Our focus will be on proactive, ongoing conversations with communities and individuals to build a foundation of evidence that supports commissioning plans for health outcomes.</td>
<td>Communications and Engagement Team</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

### Assurances (how do we know if the things we are doing are having an impact?):

**Internal Assurance**

- Evaluation reports written and provided to commissioning teams to incorporate in their plans and influence service change.
- Reports published on the CCG website and shared with members of the public who expressed an interest for further detail: “You said, we did”.
- Regular liaison with, and attendance as appropriate at, Scrutiny Board to support commissioning colleagues.
- Annual PPI review published in July 2019
- Monthly VAL contract meetings and VAL KPIs reviewed quarterly.

### Gaps in assurances (what additional assurances should we seek):
<table>
<thead>
<tr>
<th><strong>Independent Assurance</strong></th>
<th><strong>Link to Risk Register:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal stakeholder engagement audit October / November 2018; this has been rated High Assurance (highest rating).</td>
<td></td>
</tr>
<tr>
<td>NHS Leeds CCG invited by NHS England to present examples of good practice to Amber rated CCGs at a North of England workshop on Improvement and Assessment Framework (IAF) for engagement and community involvement.</td>
<td></td>
</tr>
</tbody>
</table>
Risk 2: Failure to assure the delivery of high quality services, leading to commissioned services not reflecting best practice and improving care

Risk Appetite: The CCG has an adverse risk appetite for service quality; this means that the CCG is not prepared to take risks in this area.

Lead Director/risk owner: Jo Harding, Executive Director of Quality and Nursing

Date last review: January 2020

Mitigating actions (what more should we be doing?):

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Due by</th>
</tr>
</thead>
</table>
| New statutory requirements for Designated Doctor for Child Deaths and Named GP for Adult Safeguarding - paper to EMT in November | Head of Safeguarding | Complete
| Review of new AQP quality assurance process to completed and presented to the Quality and Performance Committee in September 2020 | Deputy Director of Nursing | September 2020 |

Rationale for current risk score:
The CCG has in place quality standards, and measures quality outcomes via a range of methods and processes to assure the quality of care we commission for our patients.

Rationale for target score:
A target score of 6 has been applied to this risk as the CCG aims to minimise the likelihood and consequence of the risk occurring. This reflects an adverse risk appetite.

<table>
<thead>
<tr>
<th>Risk Rating (consequence x likelihood)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial score: 5 x 4 = 20</td>
</tr>
<tr>
<td>Current score: 4 x 2 = 8</td>
</tr>
<tr>
<td>Target score: 2 x 3 = 6</td>
</tr>
</tbody>
</table>

Controls (what are we currently doing about the risk?):
- Quality Surveillance tool is being utilised across the CCG (including primary care) to monitor quality and performance of our providers enabling the CCG to identify issues and offer additional support at an early stage to ensure service improvements
- Process now in place, approved by Q&P, to quality assure small providers (AQP’s)
- CCG Quality Visit schedule agreed for all providers and in place for 2019/20. This includes a checklist for what will be covered.
- Commissioning for Quality and Innovation (CQUIN) framework in place to incentivise providers for quality improvement and includes contract penalties where failure occurs
- Clear national and local quality expectations and standards agreed and included in contracts
- OPEA tool developed for use across WY&H and has been adopted for use by the CCG. This tool has been incorporated in to the CCG’s Commissioning for Value toolkit to ascertain risk of commissioning/decommissioning decisions by the CCG
- Contractual requirement for providers to provide regular quality performance reports on key quality, safety and experience measures
- Process developed and supporting measures in place to seek assurance on and assess quality impact of provider Cost Improvement Plans
- Establishment of joint city wide health and local authority care home group to support quality improvement and introduction of supporting and joint processes as outlined in the care home protocol.
- Various care home network meetings in place to share intelligence across the system, including CCG, LCC, commissioning and robust processes in place to support joint suspensions as and when required
- Shared database (PAC) developed enabling an ‘at a glance view’ of current status of care homes and quality/safeguarding assurance of contract information
- Safeguarding Key Performance Indicators and Safeguarding Standards Framework developed to monitor performance of provider organisations in terms of both safeguarding children and adults at risk.
- Safeguarding Team is cited on all safeguarding DATIX reports and Serious Incidents.
- A GP Safeguarding Standards Framework has been developed to monitor annually the performance of primary care in terms of both safeguarding children and adults at risk.
- Oversight of Serious Incidents via STEIS and DATIX.


- New system quality group for Leeds established with representatives across health and social care, with initial focus being capturing real time patient experience
- Patient Insight Group has been relaunched in October 2019, an advertised drop in session will be held in November and regular meeting commence in January 2020.
- New Leeds LeDeR panel established to quality assure LeDeR reviews, share good practice and inform future commissioning plans
- Extra resource agreed to support MCA and DOLS in Safeguarding team and the move to new liberty protection safeguards – new post recruited to.
- New statutory requirements for Designated Doctor for Child Deaths and Named GP for Adult Safeguarding – paper to EMT in November, funding agreed and recruitment in process.

Assurances (how do we know if the things we are doing are having an impact?):

<table>
<thead>
<tr>
<th>Internal Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Clinical Quality Review Groups (CQRG) review key quality requirements, expectations and performance requesting remedial action plans where required using a systematic and robust methodology of review and challenge</td>
</tr>
<tr>
<td>Primary Care Quality Surveillance group monitors key quality performance information and standards of quality of primary care provision, monitoring remedial action plans where required</td>
</tr>
<tr>
<td>Director of Quality and Safety attends West Yorkshire Quality Surveillance Group (QSG) where oversight of quality across West Yorkshire is discussed</td>
</tr>
<tr>
<td>Contract Management Board receives quality update briefing from Providers identifying any key areas of concern/under performance and associated remedial actions.</td>
</tr>
<tr>
<td>Integrated Quality and Performance Report, including all pathways and primary care, is reported to the CCG Quality and Performance Committee with highlights and exceptions then reported to the Governing Body</td>
</tr>
<tr>
<td>Reporting of all providers under enhanced surveillance to the Quality and Performance Committee</td>
</tr>
<tr>
<td>Robust governance structure in place within the CCG provides assurance on the quality of services to Governing Body</td>
</tr>
<tr>
<td>Annual assurance required from providers that Cost Improvement Proposals have been assessed for impact on quality and signed off by provider medical and nursing directors</td>
</tr>
<tr>
<td>Safeguarding Team review and monitor the GP Safeguarding Standards Framework on an annual basis, providing advice and support where practices are non-</td>
</tr>
</tbody>
</table>
compliant.

- Safeguarding Team attend Clinical Quality Review Groups to review and gain assurance in respect of Quarterly Key Performance Indicators and the Annual Safeguarding Standards Framework which includes Section 11 assurance regarding provider safeguarding children responsibilities.
- Development of the safeguarding annual declaration for care homes
- Safeguarding annual declaration for private hospitals now embedded within contracts
- MCA KPI’s developed; will be monitored through CQRG processes
- Quarterly patient experience reports of the Leeds Health and Care system reported to the Quality and Performance committee and annually to the Governing Body

**Independent Assurance**

- CQC inspection programme – reports and action plans are monitored via provider quality meetings
- In 2018/19, Internal audits of Individual Funding Requests and Patient Experience provided High assurance and Internal Audits of Personal Health Budgets, Safeguarding, Continuing Healthcare and Performance Reporting provided Significant assurance.
- In 2019/20, Internal audits of Contract Management and the Mental Capacity Act have provided Significant assurance.

**Additional Comments:**
The Internal Audit plan for 2019/20 includes the following audit designed to provide assurance against this risk:

- Incident Reporting

**Link to Risk Register:**
- 28 – Learning from medication related incidents (12)
- 676 – Care Home capacity (Dementia) (12)
- 688 – Utilising patient experience data to inform commissioning decisions (6)
- 695 - Learning Disabilities Mortality Review Programme LeDeR (12)
- 707 – System Flow (12)
- 664 – Community Care Beds – Medicine Review (9)
- 334 – Amber Drug Monitoring via Neptune (8)
Risk 3: Failure to achieve financial stability and sustainability

Risk Appetite: Given the statutory nature of financial duties of the CCG, the CCG has a cautious risk appetite for financial efficiency; this means the CCG will accept a low level of risk in this area.

Relevant commitments: We will focus our resources to -
- Deliver better outcomes for people’s health and well-being
- Reduce health inequalities across our city

Rationale for current risk score:
- Risk levels revised at the start of each financial year when risks of financial delivery for the next year are at their highest.
- Failure to achieve financial stability could lead to a breach in our statutory duties and have an adverse effect on our local population.
- NHSE is increasingly concerned about rapidly deteriorating finances in CCGs where previously healthy year end projections have spiralled into deficit positions in-year, often due to a lack of scrutiny and understanding of the CCG’s underlying recurrent financial position under its Governance processes.
- Whilst the CCG has a number of key financial controls and financial contingencies in place to monitor and deliver financial performance in 2019/20, it’s longer term financial stability is predicated either on the delivery of a significant QIPP programme, or a significant increase in allocations to around 5%+ per annum.
- The system is increasingly being assessed on financial delivery at Place level to include all NHS providers in the City. Therefore the CCG shares the risks of delivery for its NHS Providers as well. Currently the level and magnitude of CIP at LTHT alone is circa 6% of their total income of over £1.3bn.
- Projections of the CCGs financial plans into the next 5 years suggest that from 2019/20 and thereafter, the CCG and Leeds as a Place is facing significant financial pressures with cost reduction schemes still to be identified, evaluated and negotiated across the system.

Rationale for target score:
- Commissioners are facing significant and increasing risks from changes to NHS policy such as Transforming Care Partnerships, as well as demographic challenges at a time where annual investment in the NHS is at its lowest. Our local acute provider has significantly ageing estates stock requiring at least £350m of investments to modernise and ensure that care can be provided in the most effective configuration conducive to patient care. There are simply not enough resources available in Leeds to meet all current needs and demands. By December, most risks have either crystallised and mitigated or are no longer a risk to the system. The remaining risk score reflects the winter period and associated financial risks as well as end of year whole NHS position uncertainties.
- The rationale behind the reduced risk (post assessment of risk appetite) is that Leeds does have the option to consult on rationing the provision of healthcare – a measure that is already being implemented in other areas and Leeds is also making progress on risk alignment across the health system to change clinical decisions that can improve system efficiency and reduce system costs. Allowing flexibility for increased investment towards the end of the financial year.

Controls (what are we currently doing about the risk):
Continued in depth and rigorous monthly financial reporting to budget holders, NHS England, the Governing Body and executives.
Business Intelligence data now much more sophisticated for Leeds and the wider system using RAIDR and the Urgent Care Dashboard
Budgetary and governance control systems for identifying and controlling financial risks – ranked high assurance by the Internal Auditors every year
Detailed financial policies and budgetary control framework outlines responsibilities and ground rules
Commissioning for Value Delivery Board to oversee delivery of QIPP
Aligned Incentive Contract with main Acute Provider – major success stories published and year 2 agreed
Regular CFO meetings across Leeds, West Yorkshire and Y&H
Scheme of financial delegation and detailed financial policies
Monthly budget reports are issued and discussed at budget holder meetings
Budgetary control framework in place and rated high in assurance by Internal Auditors

Assurances (how do we know if the things we are doing are having an impact?):

Internal Assurance
- Monthly financial report to EMT, Audit Committee and Governing Body identifying any current financial risks
- Prescribing finance position included in monthly finance updates
- Escalation of exception reports from Commissioning for Value Delivery Board to Governing Body
- Procurement Programme monitoring and delivery reporting
- Lead commissioner monthly forecasting

Financial impacts of primary care commissioning appear to be less significant at current stage of planning

Independent Assurance
- Internal and external audit reports provide high assurance every year – latest is for 2018/19.
- NHSE assurance meetings have resulted in the Leadership of the CCG across all areas being rated Green

Mitigating actions (what more should we be doing?):

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Due by</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 year planning horizon process for the CCG to include potential and detailed spend reduction plans to be identified, evaluated, consulted on and implemented</td>
<td>Governing Body</td>
<td>Complete</td>
</tr>
</tbody>
</table>

Gaps in assurances (what additional assurances should we seek):
- Health and social care economy in Leeds is financially challenged and the magnitude of values involved in one of the largest “places” in the UK means that the challenge is of significant financial value (and potentially unmanageable) nationally and locally if the system spirals into deficit.
- Within the context of the West Yorkshire and Harrogate Integrated Care System (ICS), Leeds is also the only place that is seen to have financial headroom due to it higher historic surplus retention and agreed drawdown for 2091/20 position and is therefore potentially expected to shoulder the added burden of “propping up” other places by considering exceeding its control total delivery in 2019-20.
- A shared control total for West Yorkshire and Harrogate does however offer potential (if delivered in its totality) to attract significant transformational resources into the ICS footprint which will benefit all parties to the ICS. Much of this is outside of Leeds’ control to deliver with the added potential burden of having to hold peers to account to ensure securing these funds in addition to “keeping our own house in order.”
### Additional Comments:
The CCG has to ensure value in commissioning spend – some relates to areas of limited clinical value, others around more effective commissioning. Some decommissioning of services will need to be considered and whilst this will be overseen by the Commissioning for Value delivery board, Commissioning Teams have in essence been set their spending envelopes initially for 2019-20 and for the next 4 years by the autumn of 2019. Developments and changes in the mix of services commissioned to meet national targets and remain within their envelopes are therefore delegated to them as a package. However, ownership of these decisions must still clearly and visibly sit with the Governing Body via the Commissioning for Value Board. The risks associated with financial stability will potentially be reduced later in the year as risks either crystallise, disappear or are mitigated in 2019-20 for the CCCG and for Leeds as a Place. However, longer term risks still remain across Leeds and the challenge for Leeds now is to develop the NHS Estates with some potentially significant investments at the Leeds General Infirmary which will need to be affordable in recurrent revenue terms. The LTHT financial planning assumptions include some very ambitious waste reduction plans to ensure that the requisite revenue headroom is created prior to the start of the Final Business Case approval process.

The Internal Audit plan for 2019/20 includes the following audits designed to provide assurance against this risk:
- Budgetary control and reporting and key financial controls
- QIPP

### Risk register:
- 661 – Citywide overspend against prescribing budget (9)
- 681 – Impact of IFRS16 (9)
Risk 4: Lack of provider and clinical support for change will impact on the development and implementation of the CCG strategy

Lead Director/risk owner: Katherine Sheerin, Director of System Integration

Date last review: January 2020

Relevant commitments:
We will focus resources to:
- Deliver better outcomes for people’s health and well-being
- Reduce health inequalities across our city
We will work with our partners and the people of Leeds to:
- Achieve better integrated care for the population of Leeds
Create the conditions for health and care needs to be addressed around local neighbourhoods.

Risk Rating (consequence x likelihood)
Initial score: 4 x 4 = 16
Current score: 3 x 3 = 9
Target score: 3 x 3 = 9

Rationale for current risk score:
Likelihood - through the providers’ Committees in Common approach (Leeds Providers’ Integrated Care Collaborative - LPICC), Provider Partnership Board and supporting clinical strategy groups, there are strong arrangements in place to ensure strategic support and alignment between commissioning priorities and provider development. Whilst there is a positive reception among providers the greater engagement of clinicians and working through of the necessary detail still needs to take place.

Consequence - the failure to gain support of all major providers will significantly limit a number of key objectives of the strategy in particular greater integration.

Rationale for target score:
Whilst the support of providers is key to delivering the changes articulated in the CCG strategic plan, it is unlikely that we will have full support of all clinicians for all the changes we need to make. There will be trade-offs to be made as we place more emphasis on prevention, early identification, proactive care and treatment of people closer to home, and the risks of these trade-offs need to be understood and managed whilst not detracting us from the strategic aims.

In addition, the move in Leeds from an individual organisational focus to system focus means that the development and implementation of the CCG strategy is equally dependent on the alignment of the CCG’s commissioning approach with the Local Authority.

Controls (what are we currently doing about the risk?):
- Leaders of main provider organisations come together with commissioning and care leaders across the city as the Partnership Executive Group. This aims to ensure coherence of strategy and approach across the city, and delivery of the goals set out in the Health and Wellbeing Strategy.
- The Clinical Senate (co-chaired by the CCG Medical Director) meets on a bi-monthly basis to bring clinical leaders together.
- A Committees in Common is in place across all 4 NHS providers, with the Local Authority (provider) and 3rd sector representation. There is a work plan (aligned to the CCG Strategic Plan) with some clinically led work to re-design services across organisations, for example Frailty.
- There are other examples of clinically led work supported by the CCG, for example in Long Term Conditions.
- The CCG System Integration Team supports much of this work, with a director level joint appointment (Director of System Integration) and senior expertise.
- The CCG is actively supporting the development of PCNs and LCPs, and has participated in a 20 week intensive population health management programme. This clinically led approach to service improvement will now be rolled out across the city.
- A second phase to introduce PHM at local level has commenced with a further 8 LCPs participating.
- Project team established to produce the ‘left shift blue print’. This will be led by the CCG, co-produced with partners.
- Clinical leaders to be engaged via Heads of Commissioning. Final plan to be agreed by the system.
- Co-production of Aligned Incentive Contract with LHHT reflects provider support to new approaches to contracting as part of wider commissioning strategy.
- We have supported the development of the GP Confederation to ensure the voice of primary care as a provider is clear in strategic discussions, and to identify and delivery economies of scale in order to maximise clinical time where appropriate.
- The Clinical Commissioning Forum in January 2020 is being used to bring together PCN Clinical Directors with CCG Clinical Leads, CCG and Confederation officers to explore how the CCG supports and works with the emerging PCNs to take on a more strategic and integrated role in delivering healthcare and improving outcomes for patients in the context of the ‘Shaping Our Future’ programme.

Mitigating actions (what more should we be doing?):

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Due by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leeds Plan to be refreshed in line with ambitions of NHS Long Term Plan / CCG Strategic Plan and to be fully owned by the system.</td>
<td>Katherine Sheerin</td>
<td>Complete</td>
</tr>
<tr>
<td>Development of agreed clinical model (based on population health analysis) for the city. This is now known as the ‘left shift blue print’ and will involve clinicians across the system.</td>
<td>Katherine Sheerin</td>
<td>Apr 2020</td>
</tr>
<tr>
<td>Assurances (how do we know if the things we are doing are having an impact?):</td>
<td>Gaps in assurances (what additional assurances should we seek):</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
</tbody>
</table>
| **Internal Assurance**  
- Providers collectively choose to prioritise and focus on work that supports delivery of CCG Strategic Plan e.g. working collectively to deliver system outcomes  
- Increasing levels of trust between leaders of commissioning and provider organisations in Leeds. Commissioning and Provider leaders proactively engage with each other to inform decision making that will have a system impact.  
- Clinical and financial risks are shared and managed differently between the CCG and providers and also between providers, with resources shifting to enable improved health outcomes and inequalities to be addressed.  
- The Provider CIC (LPICC) work-plan aligning with the CCG Strategic Plan and Delivery Framework priorities.  
- PCNs starting to operate successfully, offering services beyond the contract. |  
- Internal measures and milestones to measure the assurances described. |

| **Independent Assurance**  
- 360 survey |  

**Additional Comments:**

Very good progress on reducing the risk with considerable controls in place. Still require a period of time to ensure new arrangements are being fully embedded and that system relationships strengthen further before risk within risk appetite.

The Internal Audit plan for 2019/20 includes the following audit designed to provide assurance against this risk:

- Development and Delivery of the Commissioning Strategy and Plan

<table>
<thead>
<tr>
<th>Risk register:</th>
</tr>
</thead>
</table>
| 655 – Member Engagement (9)  
707 – System flow (12) |
**Risk 5: Resources are not targeted effectively to areas of most need, leading to failure to improve health in the poorest areas**

**Risk Appetite:** The CCG has an *averse* risk appetite for health inequalities; this means that the CCG is not prepared to take risks in this area.

**Relevant commitments:**
- Deliver better outcomes for people’s health and well-being
- Reduce health inequalities across our city

**Risk Rating**

<table>
<thead>
<tr>
<th>(consequence x likelihood)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 x 5 = 20</td>
<td>20</td>
</tr>
<tr>
<td>Current score: 4 x 4 = 16</td>
<td>16</td>
</tr>
<tr>
<td>Target score: 3 x 2 = 6</td>
<td>6</td>
</tr>
</tbody>
</table>

**Rationale for current risk score:** Commissioned services and programmes may not be designed in a way which meets the needs of groups who have poorer access to services, particularly preventive, proactive and primary care services. This could result in an increase in health inequalities with some patients receiving sub-optimal care and potentially poor patient experience outcomes.

Most recent Public Health Annual Report has identified increased inequalities across the city, with more people living in the 10% most deprived wards.

**Rationale for target score:**

The CCG has a legal duty to reduce inequalities in the population in terms of both access to services and health outcomes. This is a key strategic aim the CCG’s Strategic Plan in line with the Health and Wellbeing ambition that the Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. This is a significant challenge, particularly given reductions in funding across the public sector and the changing nature of the communities we serve. And it is recognised that inequalities in the city have actually widened over the past decade. As such, we need to work with partners to endeavour to make the difference, and to ensure that CCG resources are targeted to best effect.

**Controls (what are we currently doing about the risk?):**

- CCG Strategic plan is grounded in the Health and Wellbeing Strategy and reflects the city Joint Strategic Needs Assessment (JSNA) & local health needs with a clear focus on reducing health inequalities.
- CCG is an active member of the Health and Wellbeing Board and other partnership arrangements, e.g. Partnership Executive Group, Leeds Health and Care Plan
- CCG Health Inequalities Framework – the CCG Governing Body has recently endorsed an Interim Health Inequalities Framework for Action. This describes how the CCG will use its £1.3bn resource to drive the changes needed to realise the aim of reducing health inequalities. It is also sets out how the CCG will use its position as a major statutory body to influence the wider determinants of health and our partners in ways which more positively impact on the inequalities faced by the poorest people in the city.
- Action at programme/project level – there is already significant work underway which is targeted at reducing health inequalities, including:
  - Services for marginalised groups including sex workers, homeless people, gypsies and travellers, ex-offenders, etc.
  - ‘Equalised’ weighted funding for General Practice and greater focus on health inequalities
  - New IAPT service has targets built in which direct the providers to ensure effective access for people from BAME communities and people living in deprived Leeds
  - Community midwifery teams aligned to areas of greater deprivation, working closely with children’s centres and health visiting teams
- Long Term Plan response – the CCG is currently confirming its response to the Long Term Plan. This will require delivery of key initiatives and targets, many of which will then impact on health inequalities. In addition to schemes which are required of all parts of England, there are significant resources for schemes which are more targeted in terms of needs (for example health of homeless people) and resources to test pilot schemes. The CCG is ensuring that it is well placed to access these resources where appropriate.

**Mitigating actions (what more should we be doing?):**

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Due by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop clear approach for CCG to take to address health inequalities, signed off by the Governing Body and supported by partners. Workshop held in December 2019 – investment principles debated. Output from the workshop to be built into revised Health Inequalities framework, with formal sign off by Governing Body planned for March 2020 (revised dates agreed by Governing Body at workshop).</td>
<td>Katherine Sheerin</td>
<td>January 2020</td>
</tr>
<tr>
<td>Once agreed, performance framework for priorities contained with the Health Inequalities Framework to be developed.</td>
<td>John Tatton</td>
<td>April 2020</td>
</tr>
<tr>
<td>Redesign approach to health inequalities impact assessment</td>
<td>Becky Barwick</td>
<td>December 2019</td>
</tr>
<tr>
<td>Develop process for differential investments across the city to more effectively meet needs</td>
<td>Becky Barwick / Matt Turner</td>
<td>December 2019</td>
</tr>
<tr>
<td>Refresh the Public Health Memorandum of Understanding between the CCG and the LA to ensure appropriate support for intelligence on actions to address health inequalities.</td>
<td>John Tatton</td>
<td>January 2020</td>
</tr>
</tbody>
</table>
- Memorandum of Understanding in place between Leeds CCGs and Leeds City Council to deliver Public Health Healthcare Advisory Service (PHHCAS) with action plan.
- CCG commitment to Population Health Management approach will enable providers to work together at very local levels (through LCPs) to shape services around needs.
- Commissioning for value programme now established to understand how commissioning investments impact on finance, quality and health outcomes.
- Joint data analysis team in place across Local Authority and CCG.

<table>
<thead>
<tr>
<th>Assurances (how do we know if the things we are doing are having an impact?):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Assurance</strong></td>
</tr>
<tr>
<td>The CCG does not have a comprehensive report which draws together progress in addressing health inequalities. However, there are some indicators in the current IQPR, Primary Care IQPR and General Practice Quality Improvement Scheme.</td>
</tr>
<tr>
<td><strong>External Assurances</strong></td>
</tr>
<tr>
<td>There are a number of external reporting mechanisms which will be used to build the CCG’s reporting framework, including:</td>
</tr>
<tr>
<td>Public Health England Local Authority Health Profiles</td>
</tr>
<tr>
<td>Public Health Annual Report</td>
</tr>
<tr>
<td>Local Authority Quarterly Report</td>
</tr>
<tr>
<td><strong>Independent Assurance:</strong></td>
</tr>
<tr>
<td>Internal audits of Business Case Procedures and Performance Management during 2018/19 provided Significant assurance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gaps in assurances (what additional assurances should we seek): - Update Oct 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>As part of finalising the Health Inequalities Framework for Action, performance measures will need to be developed. These will be driven by the priority areas confirmed by the Governing Body, and will need to provide the CCG with clear information on whether resources are being targeted effectively.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk register:</th>
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</thead>
<tbody>
<tr>
<td>305 – Compliance with the Equality Act 2010 Public Sector Equality Duty (6)</td>
</tr>
<tr>
<td>688 – Utilising patient experience data to inform commissioning decisions (6)</td>
</tr>
<tr>
<td>695 – Learning Disabilities Mortality Review Programme (LeDeR) (12)</td>
</tr>
</tbody>
</table>
Risk 6: Insufficient primary care workforce capacity, capability and adaptability to deliver the ambitions

Risk Appetite: The CCG has a medium risk appetite for the transformation of the CCG function and purpose; this means the CCG will accept a medium level of risk in this area.

Relevant commitments:
We will work with our partners and the people of Leeds to -
- Achieve better integrated care for the population of Leeds
- Create the conditions for health and care needs to be addressed around local neighbourhoods.

Risk Rating (consequence x likelihood)

<table>
<thead>
<tr>
<th>Score</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>10</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>20</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

Initial score: 4 x 4 = 16
Current score: 4 x 3 = 12
Target score: 4 x 2 = 8

Rationale for current risk score:
Despite the actions taken, the availability of a current and future workforce supply within primary care remains a national issue.

Rationale for target score:
This reflects that there is a requirement to significantly increase the primary care workforce within 5 nationally mandated roles. At this point it is likely that Primary Care Networks will be unable to recruit to 100% of the required additional capacity within the national timescales.

Controls (what are we currently doing about the risk?):

Governance
- City wide approach to strategic workforce development has recently been refreshed and agreed, with 7 priorities.
- City-wide Board being renewed: CCG Executive Nurse to be a member, with remit to ensure CCG commissioning priorities are reflected in workforce developments.
- Health and Social Care Academy (funded by all partners in the city) established to deliver this programme of work.
- Primary care workforce sub-group in place – TOR of reference and membership has been reviewed to ensure alignment with PCN workforce challenges and links to the wider system.
- The role of the Leeds GP Confederation in relation to workforce planning and workforce development is reflected in the CCG/Confederation Partnership Agreement. A formal workforce subcommittee of the Confederation Board has been established chaired by the shared (with LCH) Workforce Director.
- The CCG actively participates in the West Yorkshire and Harrogate ICS Primary and Community Care Workforce Group

Planning
- Primary Care Workforce action plan in place.
- Baseline assessment of current gaps in workforce undertaken (Dec 2018).
- Workforce action plans being developed at PCN level.
- PCN workforce data packs have been produced and shared with PCNs to enable workforce planning.
- General Practice Nurse Strategy developed and launched.

Delivery
- Locality leadership teams are in place across 18 agreed LCP footprints, supported by the investment to release the leaders from clinical practice with good alignment to PCNs.
- The investment to support leadership has been made recurrent via the new GP contract linked to the development of PCNs.
- Investment linked to workforce planning and workforce development into general practice has been made through the Quality Improvement Scheme (QIS); national initiatives e.g. Time to Care; GP Access Fund; and transformation monies.
- The primary care development team has restructured and aligned to 18 LCP footprints and are actively supporting locality leaders.
- New roles developing within general practice e.g. care navigation; Rotational Paramedic; role of occupational therapists in primary care pilot; shared roles across a number of practices. The new GP contract sets out 5 mandated roles and the funding to support them over the next 5 years through a national directed enhanced scheme.
- PCN DES workforce in year 1 focussed on additional clinical pharmacists and social prescribing link worker – 15.5wte social prescribers and 18.75wte pharmacists appointed to date.
- Generation X scheme launched (initiative between Leeds LMC/ GP Confederation and CCG) to support retention of mid-career GPs.
- Practice Nurse Preceptorship programme in place – successfully recruiting new PNs into the workforce.
- The Confederation has developed an offer to primary care networks that includes options in recruiting and employing the additional roles described in the GP contract.
- Implementation and reporting against GP Forward View (GPFV) workforce trajectories.
- The CCG is leading a programme of international GP recruitment on behalf of the ICS.

Actions | Owner | Due by
--- | --- | ---
Consider the challenge and opportunity set out in the NHS Long Term Plan and 19/20 planning guidance, including aligning potential additional investment. | Katherine Sheerin | 2019/20
Support Primary Care Networks in understanding their responsibilities for the 5 national mandated roles in primary care and the funding streams associated as 4 of the roles are funded at 70% cost only. | Katherine Sheerin | 2019/20
Clarify governance arrangements in relation to strategic primary care workforce planning. The ToR and membership of the Primary Care Workforce Group have been reviewed. The group will be chaired by the Director of Workforce for the GP Confederation. The Associate Director of Primary Care for the CCG will be a member as will the Chair of the CCG Primary Care Commissioning Committee. | Katherine Sheerin | Complete

The Health and Care Workforce Academy CEO role is being recruited to on a permanent basis.

The new One Workforce Board met for its initial meeting in 13 November 2019, chaired by Dr Sara Munro, CEO of LYPFT
<table>
<thead>
<tr>
<th>Assurances (how do we know if the things we are doing are having an impact?):</th>
</tr>
</thead>
</table>
| **Internal Assurance**  
  Primary Care workforce: |
| - Monitoring of the completion of workforce tool  
- Reporting against GPFV trajectories to NHS England  
- Primary Care Workforce Steering Group meets bi-monthly chaired by CEO of GP Confederation with membership from all stakeholders  
- A report provided to the January 2019 CCG Primary Care Commissioning Committee which set out the work programme for the Primary Care Workforce group and how it links into programmes at West Yorkshire and Harrogate ICS and Leeds health and Care Plan workforce structures ensuring priorities are aligned. |
| Local Care Partnerships and Primary Care Networks: |
| - Evidence of wider partners coming together in LCP meetings across the city.  
- General Practice locality leaders describing their involvement with wider partners in LCPs at the Leeds GP Confederation Strategic Board.  
- Strategic support for the LCP vision evident from PEG.  
- System wide stakeholder group meets bi-monthly to track progress  
- LCP development programme reported via LPICC  
- New GP contract and process to sign up the Network DES |
| **Gaps in assurances (what additional assurances should we seek):** |
| Independent assurance – consider requesting a review by internal audit |

<table>
<thead>
<tr>
<th>Additional Comments</th>
</tr>
</thead>
</table>
| Ensuring we have the workforce to deliver a sustainable primary care today and a workforce to deliver a transformed primary care for tomorrow is hugely complex. The CCG needs to ensure that this is being addressed at city-wide levels within the context of workforce challenges across the system.  
The establishment of the Leeds GP Confederation brings new opportunity to engage with primary care ‘at scale’ and develop workforce initiatives for general practice across the city e.g. a local ‘bank’ for locum GPs; employment contracts that allow working across a locality; development and support programmes for newly qualified GPs. This is yet to be realised.  
Developing Local Care Partnerships as the way of delivering integrated local services as described in the Leeds Health and Care Plan is a massive transformational programme for the whole system. |

<table>
<thead>
<tr>
<th>Risk register:</th>
</tr>
</thead>
</table>
| 651 – General Practice Workforce (12)  
703 – WYUC Service (12)  
672 – Delivery of Online Consultations (9) |
**Risk 7: Failure to enable partners to work together to deliver the CCG commitments**

**Lead Director/risk owner:** Tim Ryley, Chief Executive

**Date last review:** January 2020

**Risk Appetite:** The CCG has an open risk appetite for partnership working; this means the CCG is willing to consider a higher level of risk in this area.

**Relevant commitments:** All

### Risk Rating (consequence x likelihood)

<table>
<thead>
<tr>
<th>Risk</th>
<th>Initial score</th>
<th>Current score</th>
<th>Target score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 x 3 = 9</td>
<td>3 x 3 = 9</td>
<td>3 x 3 = 9</td>
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</table>

**Rationale for current risk score:**
Changing Governance arrangements across the health and social care economy both within Leeds and West Yorkshire may lead to failure to coordinate actions around shared priorities which could lead to omission or duplication of actions. Recent national guidance on the role of CCGs within the ICS will lead to a need to further consider joint commissioning arrangements at West Yorkshire and Harrogate. Similarly the CCGs further development of NHS plans and as an organisation including a review of its role within the system may cause some testing of Leeds systems. There remain risks around competing priorities between need for placed based services and support to local providers, and the requirement to work at Integrated Care System (ICS)/ West Yorkshire Sustainability and Transformation Partnership (STP) level. Therefore risk has been increased to target level.

**Rationale for target score:**
The appetite for this type of risk is open; a target score of 9 has allowed the CCG to take greater risk than it is currently taking, should an opportunity arise to progress / develop partnership working.

### Controls (what are we currently doing about the risk?):

- Integrated Commissioning Executive (ICE) meetings and Partnership Executive Group meet on a monthly basis.
- A new provider Committee in Common meets quarterly with representation from the Local Authority and 3rd sector. Memorandum of Understanding (MOU) for West Yorkshire signed and in place.
- Aligned incentives contract in place across providers which facilitates alignment of priorities.
- Representatives from the GP Confederation attend the Leeds Health and Care Partnership Executive Board. Representation from the Local Authority invited to the planning meeting in the CCG.
- Partnership framework developed.

### Mitigating actions (what more should we be doing?):

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Due by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Team put in place stakeholder management plan around NHS planning and Organisational Transformation and actively manage</td>
<td>Tim Ryley</td>
<td>October 19 to January 20</td>
</tr>
<tr>
<td>Ensure CCG Governing Body are kept fully sighted on emerging West Yorkshire and Harrogate proposals</td>
<td>Tim Ryley</td>
<td>January 2020</td>
</tr>
<tr>
<td>CCG to support a Leeds system governance review on the back of Internal Audit work and outputs of Leeds plan and keep Governing Body sighted.</td>
<td>Tim Ryley</td>
<td>November to January 2020</td>
</tr>
</tbody>
</table>

### Assurances (how do we know if the things we are doing are having an impact?):

#### Internal Assurance

West Yorkshire minutes and issues are included in the CEO report to the Governing Body, Integrated Commissioning Executive (ICE), Provider Committee in Common and Leeds Health and Care Partnership Executive Board. Issues are reported via the CEO to the Governing Body. The Health and Well Being Board reviews our collective progress every quarter.

#### Independent Assurance

The Internal Audit plan for 2019/20 includes the following audits designed to provide assurance against this risk:
- Partnership Governance – final report provides Significant assurance
- Partnerships

### Gaps in assurances (what additional assurances should we seek):

**Additional Comments:**

N/A

**Risk register:**

N/A
### Risk 8: Failure of system to be adaptable and resilient in the event of a significant event.

**Risk Appetite:** The CCG has an **averse** risk appetite for service quality and performance; this means that the CCG is not prepared to take risks in this area.

**Lead Director/risk owner:** Helen Lewis, Interim Director of Operational Delivery

**Date last review:** January 2020

#### Risk Rating

- **Initial score:** 5 x 4 = 20
- **Current score:** 3 x 4 = 12
- **Target score:** 2 x 4 = 8

#### Rationale for current risk score:

This risk relates to the CCG working with partners to mitigate the impact and to support recovery of the delivery of healthcare services to the Leeds population as a result of a significant event. A significant event can be a ‘rising tide’ or a one off event e.g. epidemic, adverse weather therefore the mitigations and plans are wide ranging across all organisations across the Leeds Health and Care system. Our current score with regards to a significant one off event remains high due to national threat levels being severe (government).

#### Rationale for target score:

The target score has been increased from 6 to 8, the CCG aims to minimise the impact of a significant event on healthcare services but has limited influence on the likelihood of the risk occurring and the likelihood score has been aligned with the national threat level. No system can plan for every eventuality, so residual risk will remain. This reflects an averse risk appetite in relation to impact.

#### Controls (what are we currently doing about the risk?):

**CCG Controls**
- Engagement at West Yorkshire level with local resilience forum and West Yorkshire urgent care meetings
- Training for key senior managers JESIP Training, On call training
- Counter Terrorism and Organisational Security Awareness delivered to all staff
- CCG Business Continuity Plan
- CCG Incident Response Plan with Action Cards
- On call systems in all providers plus the CCG, linking to NHS England (NHSE) and region at times of pressure
- EPRR Compliance and Action Plan
- Winter plans in place, includes primary care and public health / Comms actions

**System Controls**
- System wide Surge and escalation plans in place and tested through exercises,
- Business continuity plans in place for providers as part of NHS contract, including General practices,
- Emergency Preparedness Resilience and Response (EPRR) Compliance and Action Plan for NHS organisations
- Operational delivery meetings at LTHT and weekly Operational Winter Group
- Leeds resilience plan and Forums in place
- Leeds Safety Advisory Group (SAG) to discuss the Health and Safety issues relating to an event and offer professional guidance
- System Resilience Assurance Board
- System and regional meetings. Local Health Resilience Partnership (LHRP), Health and Social Care Resilience Group.
- Health Protection Board
- EPRR framework for NHS organisations includes clear roles and responsibilities for system wide response
- Clear roles and responsibilities for outbreak planning (NHSE, CCG. LA)
- Leeds Outbreak Plan and Outbreak Roles and Responsibilities.

#### Assurances (how do we know if the things we are doing are having an impact?):

**Internal Assurance**
- Assurance from providers on EPRR compliance, and business continuity plans.
- Leeds resilience plan has agreed x12 performance indictors to demonstrate impact from transformation activity.

#### Mitigating actions (what more should we be doing?):

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Due by</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU Exit preparedness: Steering group, self-assessment, action plan, and liaison across system and with NHS as directed</td>
<td>Debra Taylor Tate</td>
<td>Jan 2020</td>
</tr>
<tr>
<td>Implement the EPRR Action Plan</td>
<td>Debra Taylor Tate</td>
<td>Mar 2020</td>
</tr>
<tr>
<td>On-call training (aligned to NHS England reporting requirement) – ongoing following on call list review</td>
<td>Debra Taylor Tate</td>
<td>March 2020</td>
</tr>
</tbody>
</table>
- Regular testing of the CCG Business Continuity Plan
- Annual self-assessment against EPRR – goes to Governing Body
- Outputs from real or tested scenarios and learning – reports and action plans produced e.g. winter reviews.

**Independent Assurance**
- NHSE complete an annual CCG assurance assessment through quarterly reviews.

**Additional Comments:**
The Internal Audit plan for 2019/20 includes the following audit designed to provide assurance against this risk: Emergency planning and Business Continuity Arrangements

<table>
<thead>
<tr>
<th>Risk register:</th>
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</thead>
<tbody>
<tr>
<td>650 – CCG Business Continuity (6)</td>
</tr>
<tr>
<td>706 – Emergency Preparedness Resilience and Response (8)</td>
</tr>
<tr>
<td>690 - Great Britain's EU Exit (12)</td>
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</tbody>
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NHS Leeds CCG Governing Body Meeting

Date of meeting: 29 January 2020

Title: Leeds Mental Health Strategy 2020 - 25

Lead Governing Body Member: Helen Lewis, Interim Director of Acute & Specialised Commissioning

<table>
<thead>
<tr>
<th>Category of Paper</th>
<th>Tick as appropriate (✓)</th>
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</thead>
<tbody>
<tr>
<td>Decision</td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td>✓</td>
</tr>
<tr>
<td>Information</td>
<td>✓</td>
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</table>

Report Author: Caroline Baria, Deputy Director, Integrated Commissioning, Leeds City Council

Review by EMT/Date: 8 January 2020

Review by Committee/Date: N/A

Check by Finance (Y/N/N/A - Date): N/A

Approved by Lead Governing Body member (Y/N): Y

Leeds Health & Wellbeing Strategy Outcomes – that this report relates to:

1. People will live longer and have healthier lives ✓
2. People will live full, active and independent lives ✓
3. People’s quality of life will be improved by access to quality services ✓
4. People will be actively involved in their health and their care ✓
5. People will live in healthy, safe and sustainable communities ✓

NHS Leeds CCG Strategic Commitments

We will focus resources to:

1. Deliver better outcomes for people’s health and wellbeing ✓
2. Reduce health inequalities across our city ✓

We will work with our partners and the people of Leeds to:

3. Support a greater focus on the wider determinants of health ✓
4. Increase their confidence to manage their own health and wellbeing ✓
5. Achieve better integrated care for the population of Leeds ✓
6. Create the conditions for health and care needs to be addressed around local neighbourhoods ✓

Assurance Framework – which risks on the GBAF does this report relate to:

1. Inadequate patient and public engagement results in ineffective decisions and challenge ✓
2. Failure to assure the delivery of high quality services, leading to commissioned services not reflecting best practice and improving care ✓
3. Failure to achieve financial stability and sustainability ✓
4. Lack of provider and clinical support for change will impact on the development and implementation of the CCG strategy ✓
5. Resources are not targeted effectively to areas of most need, leading to failure to improve health in the poorest areas ✓
6. Insufficient workforce capacity, capability and adaptability to deliver the ambitions ✓
7. Failure to enable partners to work together to deliver the CCG commitments ✓
8. Failure of system to be adaptable and resilient in the event of a significant event
**EXECUTIVE SUMMARY:**

The Leeds Health and Wellbeing Strategy provides a framework for improving health and for making Leeds the best city for health and wellbeing. In response, the Leeds Mental Health Strategy sets out how we will achieve this vision for mental health.

This is an all-age strategy which covers how we plan to improve mental health and wellbeing from conception through to end of life. The focus in the strategy is about promoting good mental health, preventing mental illness, and supporting recovery through treatment, care and support services.

The purpose of the strategy is to:

- Drive forward the vision that “Leeds will be a Mentally Healthy City for everyone”, show how we can all play a part in achieving this, and how we will know we are achieving this
- Set out the delivery plan - three key areas, and eight priorities that will help achieve the vision and ambition
- Provide a framework within which to develop a shared culture across diverse services
- Help inform future investment decisions for mental health in the city.

The Governing Body is asked to endorse the vision and ambitions set out in the strategy and the priorities contained within it. The strategy will then be presented to the Health and Wellbeing Board in February 2020 for final sign-off.

**NEXT STEPS:**

The Mental Health Strategy 2020 - 25 is due to go to the Health and Wellbeing Board in February for final sign-off.

Work is underway to complete the Delivery Plan which sets out the actions that are underway, or are required, to deliver the priorities, who will be leading each of the work streams, and the timelines for delivery. The delivery plan will also help inform or steer future investment decisions.

Key performance measures are also being identified which will help track progress on delivery of the outcomes.

Progress on implementation of the delivery plan will be overseen by the Mental Health Partnership Board and will be reported to the Integrated Commissioning Executive (ICE) and ultimately to the Health and Wellbeing Board.

**RECOMMENDATION:**

The Governing Body is asked to:

(a) **RECEIVE** and **ENDORSE** the new Mental Health Strategy for Leeds.
DRAFT
Leeds Mental Health Strategy
2020 - 2025
Foreword

Leeds has all the attributes of a great northern city, with plenty to offer to those of us who live, learn and work here. Whether it’s by birth or by choice, there’s something about our city that makes us proud to call it home.

It may well be because of our growing economy and population, diverse and vibrant communities, our unparalleled Third Sector, green spaces, high quality services, an exceptional educational offer, the breadth of culture and art.

More likely it’s because of our people. Our greatest strength and most important asset is us: the people of Leeds. Our connections with family, friends and colleagues, the behaviour, care and compassion we show one another, the environment we create to live together, the way services work together to get the best results or the thousands of people offering care and support for someone they love.

All of these things contribute to our quality of life and our mental wellbeing. However, there remains enduring inequality in the city - some of us experience worse mental wellbeing because of where we live, how much we earn, the physical health conditions we have, the air we breathe or the pressure we face day to day. The cost is too great to our people, to our economy and to the way we and others view our city. This is unacceptable and must end.

That’s why Leeds has a new Mental Health Strategy. It’s for everyone, of all ages, wherever you live, study, or work in Leeds, for however long you call Leeds home.

The strategy seeks to tackle head on some of the greatest challenges we face as a city, ensuring that mental health underpins everything we do, whilst targeting efforts where they are most needed so that the health of the poorest improves the fastest.

It covers how we plan to strengthen our efforts to keep people in Leeds mentally healthy, whilst addressing the fact that we need to do more to support people with mental health problems, including those that live with severe and enduring mental illness.

We all have a part to play in Leeds being a mentally healthy city, a compassionate place where our default is to listen to others, where everyone feels able to talk freely about their feelings and emotions and where families are supported to ensure good mental health now and for future generations.

The Leeds Mental Health Strategy makes sure we have the conditions and culture in which we can all flourish in our diverse communities. This means we can enjoy the things that help us feel good and get access to high quality support and compassionate services when we need them.

New money coming into Leeds as part of the NHS Long Term Plan gives us the opportunity to shape and grow services for children, young people and adults, rooted in a Think Family approach that supports parents.

In Leeds, we have the conditions and power within our communities and organisations to promote good mental health and turn the tide on poor mental health, so that everyone in our city can thrive.
Introduction

The Leeds Health and Wellbeing Strategy provides a framework for improving health and for making Leeds the best city for health and wellbeing.

In response, the Leeds Mental Health Strategy sets out how we will achieve this vision for mental health, so that ‘Leeds will be a Mentally Healthy City for everyone’.

Being a mentally healthy city means that it will feel normal to talk about mental health and that everyone, whoever they are and wherever they live, will be able to access good quality mental health services, if and when, they need them. It also means that Leeds will be a place where the conditions in which people are born, grow up, and grow older, support good mental health and wellbeing. This includes acting to reduce poverty and the impact of poverty.

This strategy sets out ‘the story’ of mental health in Leeds – what is important and why. It is also a bold call to action. Mental health and wellbeing is everyone’s business. Only by coming together to address the wider factors that affect mental health, improving services and, by truly focussing on prevention, will Leeds achieve the vision of being a mentally healthy city for everyone.

Our vision: Leeds will be a mentally healthy city for everyone
Scope and Purpose

The Leeds Mental Health Strategy adopts the World Health Organisation (WHO) positive definition of mental health, which is broader than just mental illness.

“A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (World Health Organisation, 2013).

The strategy is all age: it covers how we plan to improve mental health and wellbeing from conception through to end of life. It also makes clear the contribution that other policy areas, such as housing or community safety, make towards people having good mental health.

Building on the Leeds Mental Health Framework 2014 - 2017 this strategy includes a focus on improving services. There are other strategies in Leeds that address the mental health of children and young people and the mental health of older people. There are also city-wide plans for improving adult mental health services over the next five years and for suicide prevention.

The Leeds’ Mental Health Strategy does not replace these existing strategies and work programmes, but it does provide a unified vision for mental health in the city. This means that activity across children and adult services, across both prevention and treatment, and in community settings and hospitals, can be better aligned and therefore have the greatest impact on people’s lives.

The purpose of the strategy is to:

- Drive forward the vision that “Leeds will be a Mentally Healthy City for everyone”, show how we can all play a part in achieving this, and how we will know when we’ve achieved it
- Set out the delivery plan - three key areas, and eight priorities that will help achieve the vision
- Provide a framework within which to develop a shared culture across diverse services
Summary

Infographic to show/detail relationship between key aspects of strategy
To be used as Plan on Page

Leeds is a Mentally Healthy City

5 outcomes  3 passions  8 priorities
Guiding Principles

When working together to develop and implement this strategy, partners in Leeds have agreed to:

- Ensure that services and new work are co-produced with people at the centre
- Recognise the impact of trauma and adversity on people’s mental health
- Take a person and family-centred, strengths-based approach
- Have a strong focus on the wider determinants of mental health and illness
- Ensure that mental health and physical health are treated equally
- Challenge stigma and prejudice
- Make sure that any action is based on the best possible evidence.
- Adopt a recovery focus wherever possible
- Address issues of inclusion and diversity

These commitments align with the three agreed principles that guide the way health and social care organisations in Leeds work together.

<table>
<thead>
<tr>
<th>Principles of our approach</th>
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<tbody>
<tr>
<td><strong>We put people first:</strong> We work with people, instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds citizens and our workforce.</td>
</tr>
<tr>
<td><strong>We deliver:</strong> We prioritise actions over words to further enhance Leeds’ track record of delivering positive innovation in local public services. Every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds £.</td>
</tr>
<tr>
<td><strong>We are team Leeds:</strong> We work as if we are one organisation, taking collective responsibility for and never undermining what is agreed. Difficult issues are put on the table, with a high support, high challenge attitude to personal and organisational relationships.</td>
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How this strategy has been developed

The Leeds Mental Health Strategy has been developed by a small sub-group of the Leeds Mental Health Partnership Board. Members of this group reviewed all the information that has been gathered about mental health in the city during the last five years. From this, three passions and a number of priorities were chosen. These were discussed at a series of engagement events with service users, carers and wider stakeholders. What people said at these events, and their thoughts on the passions and priorities, have informed the structure and content of the strategy.
Our Strengths

Mental Health is connected to everything: it’s where we live, how we learn, work and play. It’s our physical health, the environments we are surrounded by, the relationships we have and importantly, the experiences we go through. It all has an impact on how we think and feel. This means that there are many opportunities for improving mental health. It can also make knowing where to start feel difficult.

The good news is we are already doing many things in Leeds that contribute towards being a mentally healthy city.

Leeds is a vibrant city with many individual and community assets to build upon. This includes our lively arts and cultural scene which has a central role in celebrating the diversity of the city, growing the economy, reducing unemployment, connecting communities and reducing poverty. Programmes such as Leeds Pride and Carnival, alongside the work of theatres, dance programmes, sports clubs and faith groups, all support good mental health and wellbeing. Such activities enable people of all ages and backgrounds to build connections with others, to feel like they belong and to build shared sources of identity.

Leeds is a compassionate city, committed to an approach that focuses on the strengths of people and communities. Asset Based Community Development is about nurturing communities and connections between people that live in local areas. For everyone in Leeds, including those with mental health needs, to have the opportunity to contribute to, be valued by, and be involved with where they live has enormous potential for building resilience and supporting good mental health.

Leeds is a thriving city with an economy worth an estimated £21.3bn. A significant number of large organisations call Leeds home and these organisations have enormous potential to contribute towards Leeds being a mentally healthy city. The decisions they take in terms of how they decide to support their workforce, providing jobs and training for local communities, and reducing carbon emissions and greenhouse gases, all impact on the people of Leeds and their mental health.

Leeds also delivers innovative and award winning mental health services, including the Yorkshire Centre for Eating Disorders, the regional Personality Disorder Service and digital resources for both children and young people (Mindmate) and adults (Mindwell). Underpinning this is the significant contribution of the Third Sector, along with widespread commitment to recovery-based approaches, and service user involvement - including the development of ‘I statements’ and ‘we statements’, which set out how people want to be treated when they access services (See Appendix 1)
Finally, Leeds is a pioneering place. The city develops and sustains prevention approaches over time. This includes: delivering a comprehensive suicide prevention programme and being an early signatory to the Public Health England Prevention Concordat, as well as establishing the Leeds Best Start strategy which supports parents’ wellbeing, and therefore protects the future mental health of babies and children. Leeds also provides many opportunities for people to be physically active – and therefore mentally healthy - through programmes like Leeds Girls Can and through supporting access to green spaces and active travel.

The Leeds approach to mental health and wellbeing
The Challenges

Despite Leeds’ diverse culture, thriving economy and excellent services, not everyone is benefitting from what the city has to offer. Estimates suggest that mental ill-health costs Leeds over £500 million every year through lost economic output, benefits payments and its effects on the health and social care system.

Within the city, there remains an unacceptable health inequality gap, with 10 years difference in life expectancy between those with the best and worst health. This inequality is related to both mental and physical health and has a relationship to where people live. Simultaneously, the population of Leeds is changing and this means that we are likely to face new and greater challenges in the coming years.

The number of people living in poor neighbourhoods and the proportion of children and young people within this, has significant consequences for the future mental health of our city. This is because we know that what happens in childhood has long term implications for people’s mental health.

The population of children and young people is growing at a faster rate than the population of the city as a whole, and this is particularly acute in our communities that experience the greatest inequality.

The ageing population also provides Leeds with significant challenges in terms of how to support older people, many of whom live alone, to maintain connections with other people and to access support that meets their needs.

The impact of austerity and new economic models are putting pressure on some of the poorest communities in the city. In-work poverty has increased in the city as it has elsewhere in England in Wales. Financial insecurity has huge implications for people’s mental health and has been estimated by the World Health Organisation to be the largest single reason that maintains mental health inequality.

There has been a recent growth of in-work poverty, with an estimated 70,000+ working age adults from

Over 170,000 people in Leeds live in areas ranked amongst the most deprived 10% nationally.

In 2016 over 17% of children (under 16s) were estimated to live in poverty

The population of the city continues to age. This has a range of implications for services not least as a result of a far more ethnically diverse older population, with a greater concentration in the city’s inner areas.

National research suggests that the mental health of girls and young women appears to be worsening. This has particular resonance for our city which hosts over 60,000 young people every year, many of whom fall in to this age bracket. Feedback from Higher Education institutions in the city is that students of all genders are arriving in the city with increasing levels of emotional distress.
It is vital that health and social care systems scale-up prevention if the pressure on mental health services is to be reduced. But current funding for mental health services, including supported accommodation, does not meet demand.

National funding for mental health has never equalled that of physical health. Even large flagship services like IAPT (Improving Access to Psychological Treatment) have only ever been resourced to meet a small proportion of mental health need (currently around 20%). Recent announcements made as part of the NHS 10 year plan suggest that funding will be increasing across both adult and children and young people’s mental health services but this comes within a broader context of significant under-investment, particularly in relation to children and young people.
Mental Health in Leeds

People’s mental health and wellbeing changes from moment to moment and anyone can develop a mental health problem. But the factors that increase the risk of poor mental health or promote good mental health, are not distributed equally across the city. This means that certain communities or groups are more likely to have poor mental health and to face more barriers when accessing treatment. Ultimately, this leads to avoidable or unfair outcomes called health inequities or health inequalities.

The World Health Organisation (WHO) has identified five key factors that contribute to health inequity:

- Health services
- Income security and social protection
- Living conditions: including housing deprivation, unsafe neighbourhoods and lack of green spaces
- Social and human capital: incorporating education, trust and political voice
- Employment and working conditions.


Risk and Protective Factors

There are specific factors, that fall under the headings identified by the WHO, that are known to either increase the risk of someone having poor mental health or to protect it. These are important at the time, but they also have significance in the future.

For example, we know that children who live in an environment where their emotional needs are not met are more likely to have mental health problems as an adult. This is because of the way in which early childhood experiences, particularly those that are ‘adverse’, affect brain development and future emotional and social functioning.

Risk and protective factors in Leeds
A sensitive understanding of how mental ill health occurs helps to ensure that efforts to prevent it are focused in the best possible way. Recent local studies which summarise the mental health inequalities experienced by different groups in the city, can be found on the Leeds Observatory: https://observatory.leeds.gov.uk/health-and-wellbeing/needs-assessments/

Across the course of people’s lives there are also points of change that often have an impact on mental health and wellbeing. In most cases, these transitions do not lead to mental health problems. However, it is often during major life changes that people benefit from extra support to stay mentally healthy. These transitions include: becoming a parent for the first time, starting high school or university, the menopause, retirement or experiencing a bereavement.

What we know about mental health in Leeds – some key facts
A Mentally Healthy City for everyone

Leeds has laid the foundations to become a Mentally Healthy City for everyone. The five outcomes that make up the vision reflect different areas of work that have already begun. Bringing them together provides the city with a unique opportunity to maximise the work that is happening but to also make important connections outside of mental health.

It will take determination from strategic partners, businesses and communities in order to achieve the vision. Reducing stigma, developing trust within and between communities, improving services, and working across organisational boundaries to meet people’s physical and mental health needs, is dependent upon changing how we think and feel about mental health and relies upon organisations and systems working together in new ways.

But Leeds already has the building blocks, the assets and the commitment in place to enable the vision to become a reality.

Five Outcomes – starting with people

1. People of all ages and communities will be comfortable talking about their mental health and wellbeing

2. People will be part of mentally healthy, safe and supportive families, workplaces and communities

3. People’s quality of life will be improved by timely access to appropriate mental health information, support and services

4. People will be actively involved in their mental health and their care

5. People with long term mental health conditions will live longer and lead fulfilling, healthy lives
What will a Mentally Healthy Leeds feel like in 5 years?

A mentally healthy Leeds is a city where...

People flourish within diverse families and communities of all shapes, sizes, geographic and non-geographic groupings. The relationships and resources in communities, alongside our thriving Third Sector, commerce, and public spaces are building blocks for a good quality of life. We use cultural activity to both celebrate and reaffirm who we are, helping us strive for inclusion and challenge that which seeks to divide us. We seek greater social equality and mobility and stand against inequity, inequality and injustice so that everyone can benefit from what our city has to offer.

The places we live, work and play in are safe, improve our wellbeing and keep us mentally and physically healthier for longer. Leeds is a city where our default is to listen and understand people’s experiences, meaning we create spaces for people to feel safe, supported and comfortable to talk about feelings of stress, worry or upset. We do whatever we can to care for ourselves and do the best for one another.

People’s mental and physical health are equally understood and equally valued. In times of need, we find information that helps us explore what we might be feeling, give it a name and quickly get to the best care possible. We have control over the care we receive and are equal partners with health and care professionals. If we have a long term mental health disorder, we can access the healthy living services we want and our physical health doesn’t suffer as a result of mental ill health.

We have diverse and responsive mental health services but one shared, compassionate culture. Mental health services we access feel joined up and they all take a ‘Think Family’ approach that supports mental health and wellbeing within the context of family relationships. This helps tackle poor outcomes for families now and breaks the cycle of poor mental health for future generations.
What needs to improve?

Service reviews, need assessments and public engagement projects carried out in Leeds in recent years show that, despite excellent work in the city, improvements need to be made in three big areas: mental health inequalities, children and young people’s mental health and in how mental health services are delivered.

These three passions provide the city with a clear framework for driving forward positive change over the coming five years.

Three passions – areas for improvement

1. Reduce mental health inequalities
2. Improve children and young people’s mental health
3. Improve flexibility, integration and compassionate response of services

Developing priority actions

There are already established programmes of work that fall under each passion: these will not stop as Leeds continues to strive for better mental health for everyone. However, to bring about lasting change, partners in Leeds need to focus attention on the areas that will have the greatest impact.

Service users, carers, families, communities, clinicians and commissioners have been asked what these areas should be. This feedback has been combined with existing knowledge about the city to develop eight priorities which address a problem, reduce an enduring and unacceptable inequality or meet a current unmet need.

Reduce mental health inequalities

There are clear mental health inequalities in Leeds, both in terms of who experiences the greatest risk of poor mental health and in terms of unequal access to treatment. These inequalities are complicated. However, through looking at data and through engagement with people in Leeds, three distinct priorities for the next five years have emerged.

People living in poorer parts of Leeds are more than twice as likely to experience anxiety and depression but are least likely to complete treatment for these types of conditions. Rates of both suicide and self-harm admission (being cared for in hospital) are also higher in poorer areas of the city. Whilst they affect people of all ages and all genders, highest rates of suicide are found in middle aged men and girls and young women have the highest rates of being admitted into hospital because of self-harm.
Secondly, Black, Asian and minority ethnic communities (BAME) in Leeds report that discrimination increases people’s risk of poor mental health but that mental health services do not always meet the needs of BAME groups. This complex inequality can be seen to culminate in the fact that people from BAME communities in the city are more likely than White people to be admitted in to a mental health setting in crisis.

Finally, employment is a protective factor for good mental health but people with ongoing mental health problems often struggle to find and then maintain work that supports their wellbeing. This then puts people at risk of financial problems, perhaps worsening their mental health further. In particular, women and carers in Leeds report that having stable employment and a supportive employer is vital to their mental wellbeing.

**Improve children and young people’s mental health**

The Leeds Future in Mind strategy and action plan co-ordinates work to promote emotional wellbeing, and to prevent and treat mental health problems in children and young people.

This all-age strategy provides opportunities to further the aims of Future in Mind.

People working with children in Leeds report that ‘Think Family’ does not always translate into ‘Work Family’ and that adult and children’s services could be better integrated.

Supporting the mental health of parents and carers and taking a ‘whole family’ approach to mental health, is seen by practitioners as a vital area to focus on. This is because infants and children who do not receive consistent emotional help with managing their feelings are more likely to struggle in later life. Those that experience neglect or abuse (often called adverse childhood experiences) are significantly more at risk of mental health problems. Because of a combination of factors - including early life experiences that are often traumatic - children who grow up in care need additional support.

For those young people needing ongoing mental health treatment, practitioners continue to find that the transition between children and young people’s mental health services and adult mental health services remains a significant challenge.

Young people in the city who took part in engagement on this strategy also report that mental health support across Leeds schools is not consistent.
Improve flexibility, integration and compassionate response of services

When people seek help for a mental health problem, they want to access support quickly – not be kept on a waiting list. There are current issues with waiting times and availability of some services. People report that they feel ‘bounced around’, unable to find the service that meets their need. Major pressures in the system include long waiting lists for IAPT (Improving Access for Psychological Therapies), and a lack of appropriate housing and supported living services. This latter issue has a ‘knock on’ effect in that it prevents people being discharged from mental health wards, which means new people being admitted may need to be treated in settings outside Leeds. These ‘delayed transfers of care’ and ‘out of area placements’ often affect people with the most serious and enduring mental health problems.

A recent survey by Healthwatch Leeds highlights the need for better mental health crisis services. The key message from this report is that, in the first instance, people need better and earlier support to help avert the crisis. However, when people are experiencing a mental health crisis they need a kind and compassionate response.

Experiencing trauma, including sexual, emotional and physical abuse, increases the risk mental health problems – from anxiety to psychosis. As part of a programme of work in the city addressing ‘trauma-informed’ practice, people have told services and commissioners that they want to be asked about what has happened to them and they want to be supported to access compassionate support that meet their needs.

Specific feedback about services, collected as part of developing the strategy, includes:

- Mental health services need to be able to meet the needs of everyone, whilst providing responsive, personalised care to whoever ‘walks through the door’. This is a significant challenge.
- ‘Marginalised groups’ such as street sex workers, Gypsy and Traveller communities and asylum seekers, continue to experience significant barriers to accessing mental health treatment.
- Older people are at risk of not having their mental ill health recognised or supported by mental health services. In Leeds, older people do not access Improving Access to Psychological Therapies services to the same level as working age adults and their mental health is often overshadowed by physical ill health.
- People who have physical disabilities, are deaf and/or have a long term condition are at an increased risk of poor mental health but report experiencing barriers in accessing mental health treatment. Conversely, people with Serious Mental Illnesses experience significant challenges in achieving good physical health.
- People who have mental health problems alongside other conditions like Learning Disabilities, Autism or Attention Deficit Hyperactivity Disorder have particular needs. Practitioners report that these groups need accessible information about mental health services and improved transition support.
- Finally, those people who have criminal justice involvement and mental health problems are a particularly disadvantaged group.
Eight priorities – focusing our attention

1. Target mental health promotion and prevention within communities most at risk of poor mental health, suicide and self-harm
2. Reduce over representation of people from Black, Asian and minority ethnic communities admitted in crisis
3. Ensure education, training and employment is more accessible to people with mental health problems
4. Improve transition support and develop new mental health services for 14-25 year olds
5. Ensure all services recognise the impact that trauma or psychological and social adversity has on mental health. This includes an understanding of how to respond to adverse childhood experiences and embedding a ‘Think Family’ approach in all service models
6. Improve timely access to mental health crisis services and support and ensure that people receive a compassionate response
7. Ensure older people are able to access information, support and appropriate treatment that meet their needs
8. Improve the physical health of people with serious mental illness.
How Leeds will deliver the vision

Achieving the vision is dependent upon a strong partnership approach that takes positive action across the areas shown in the circles below (Appendix 2 details activity under each heading).

This will ensure that people in Leeds stay mentally (and physically) healthy for longer.

A conceptual model derived from the World Health Organisation Public Mental Health Framework (2013)

The term ‘Left Shift’ is sometimes used in Leeds to refer to the idea of balancing across a system – in this case, across the three circles of Mental health promotion, Mental illness prevention and Improving lives, supporting recovery and inclusion.

Moving 'left' means moving resources (time, money, activities) further upstream along an imagined river. This ‘river’ begins with the broad factors that influence mental health (on the left) and ends with inpatient mental health care (on the right). The movement towards the left, does not always mean doing less in terms of delivering services, but rather it can mean doing more further ‘upstream’.
Success Indicators

The success indicators included in the delivery plan at the end of this document will enable the Leeds Mental Health Partnership Board to monitor progress towards achieving the strategy’s vision.

The indicators are a deliberate mix of how people feel (about living in Leeds and their experience of mental health support and treatment), service data (numbers of people accessing the right support for them) and broader population measures (such as rates of suicide and self-harm).

Cross-Cutting Themes

Two cross cutting themes have emerged from the engagement carried out as part of developing the strategy. These will inform how the actions, aligned to each priority, will be developed and put in to action.

Workforce

Having a mentally healthy and well-trained workforce is central to being able to achieve the vision of Leeds being a Mentally Healthy City for everyone.

The Health and Social Care workforce - GPs, social workers, third sector workers and teachers, are often the first practitioners that people approach when they have a mental health problem. These groups need to be supported to maintain their own mental health and wellbeing, particularly given limited resources and increasing levels of need.

If Leeds is truly to be a city where people feel comfortable talking about their feelings, this means that people working in services, including those outside of mental health, must also feel supported and enabled to have conversations about mental health.

Information

People in Leeds report that despite significant work, including the MindMate and Mindwell websites, it remains difficult to find information about how to access mental health support and the mental health system is still difficult to navigate.
Leeds Mental Health Strategy Delivery Plan 2020 - 2025

Overview

The vision set out in this strategy cannot be delivered in isolation. The delivery plan has important interfaces at a city-wide and regional level.

These include: Include links here
- The Leeds Best Council Plan
- The Leeds Health and Wellbeing Strategy
- The Leeds Inclusive Growth Strategy
- Leeds Future in Mind Strategy and Action Plan
- Leeds Clinical Commissioning Group Mental Health Commissioning Framework
- The West Yorkshire and Harrogate Health and Care Partnership Mental Health, Learning Disability and Autism Strategy

There are opportunities for improving outcomes through the new commissioning arrangements established by the Leeds Integrated Commissioning Framework, and through the transformational actions set out in the Leeds Health and Care plan. Local Care Partnerships also have a significant role to play in supporting the delivery plan. Bringing together general practice networks with wider organisations ensures that intelligence about mental health needs is combined with local assets - meaning that services are better able to meet people’s needs holistically.

Delivering this ambitious plan and driving improvements across the eight priorities is dependent upon organisations working together in new ways, sharing approaches and putting people at the heart of what we do as a city.
Process

- Each priority in the delivery plan has a named strategic lead and an associated multi-agency group. These groups have refreshed or developed actions in order to address the priorities.
- Each priority has at least one associated indicator. The indicators will be reviewed quarterly by the Leeds Mental Health Partnership Board, which in turn will report regularly on progress to the Leeds Health and Wellbeing Board.

<table>
<thead>
<tr>
<th>Passions</th>
<th>Priorities</th>
<th>Delivered through...</th>
<th>Success indicators (Draft)</th>
<th>[Mentally Healthy City Outcomes]</th>
</tr>
</thead>
</table>
| Reduce mental health inequalities | Target mental health promotion and prevention within communities most at risk of poor mental health, suicide and self-harm, | Leeds Strategic Suicide Prevention Group  
Leeds Prevention concordat | Deprivation/place based measure of social connectedness/wellbeing  
Suicide rates  
Self-harm admission rates | People of all ages and communities will be comfortable talking about their mental health and wellbeing, free from stigma |
|                                 | Reduce over representation of people from Black, Asian and minority ethnic communities admitted in crisis | Synergi Steering Group (TBC)  
Over-representation of BAME groups MH Act | | People will be part of mentally healthy, safe and supportive families, workplaces and communities |
<p>|                                 | Ensure education, training and employment is more accessible to people with mental health problems | TBC | TBC | People will be actively involved in their mental health and their care |
| Improve children &amp; young people’s mental health | Improve transition support and develop new mental health services for 14-25 year olds | Future In Mind | TBC | |</p>
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<tr>
<td>Improve the flexibility, integration and compassionate response of services</td>
<td>Ensure all services recognise the impact that trauma or psychological and social adversity has on mental health. This includes an understanding of how to respond to adverse childhood experiences and embedding a ‘Think Family’ approach in all service models.</td>
<td>MH Collaborative Think Family</td>
<td>TBC</td>
<td>People’s quality of life will be improved by timely, access to appropriate mental health information, support and services</td>
</tr>
<tr>
<td>Improve timely access to mental health crisis services and support and ensure that people receive a compassionate response</td>
<td>Leeds CCG Commissioning</td>
<td>People using crisis services report receiving a kind and compassionate response.</td>
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<tr>
<td>Ensure older people are able to access information, support and mental health treatment that meets their needs</td>
<td>TBC</td>
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<tr>
<td>Improve the physical health of people with serious mental illness</td>
<td>SMI and Physical health strategic group</td>
<td>Increase the proportion of people with SMI accessing NHS check and Healthy Living services</td>
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Appendices:

1. Key principles of mental health service delivery in Leeds

Service User Involvement

During the last three years, mental health services (both adults’ and children’s) have developed a series of statements that set out what’s important to them when they access mental health support. These principles are now embedded in service specifications and in practice across the city.

Adult Mental Health: ‘I Statements’
- I am more than a mental health diagnosis. Treat me like an individual human being.
- I may rely on family and friends to stay well. Give them support, information and respect.
- I want to be heard and included, regardless if my identity. Offer me accessible and culturally competent support.
- I may be facing more than just a mental health challenge (e.g. substances including alcohol or a physical condition). Respond to these creatively and without judgement.
- I will know the name of the person responsible for my support. Show me that you are a human being too.
- I have a story to tell. Share information effectively, with my permission, so I don’t have to repeat myself.

Children and Young People ‘We Statements’
- I may be facing more than just a mental health challenge (e.g. substances including alcohol or a physical condition). Respond to these creatively and without judgement.
- I will know the name of the person responsible for my support. Show me that you are a human being too.
- I have a story to tell. Share information effectively, with my permission, so I don’t have to repeat myself.
- Those of us who are most vulnerable and have the most complex needs should get extra help and support early enough to make a difference.
- We want to be able to get help quickly and easily when we ask for it, especially when we are in crisis.
- When get older and if we need to move into adult support services, we want to feel supported and not abandoned.

Recovery Based Approaches

In Leeds, we believe that it is possible to recover from many mental health illnesses or problems and that people can go on to live enjoyable lives even after experiencing or whilst living with a serious mental illness. One example of putting recovery based approaches and co-design principles into practice is Leeds Recovery College hosted by Leeds and York Partnership Foundation Trust, the largest provider of mental health services in the city. The college provides training courses that focus on developing the knowledge and strength to overcome life’s challenges and live mentally and physically well. People with lived experience of mental health challenges have helped to design and deliver these courses in partnership with health professionals, education providers and trainers.
2. Delivering activity across the mental health system

**Mental health promotion:** *Increasing protective factors for good mental health across the whole of the Leeds population.* These approaches target action on the factors that promote good mental health including supporting people into employment, education, and training, reducing stigma and supporting healthy relationships between children and their care-givers.

**Mental illness prevention and suicide prevention:** *Reducing risk factors for mental ill health, particularly for groups most at risk of mental health problems.* This means using evidence and what people tell us to think carefully about groups of people who may be more at risk of experiencing poor mental health and actively co-creating solutions with them that support their mental health.

**Improving lives, supporting recovery and inclusion:** *Ensuring people receive the best possible mental health support and treatment.* Providing compassionate mental health services and support that meets people’s individual needs in both hospital and community base settings. This includes ensuring that services are culturally competent to meet the needs of people from Black and other minority ethnic backgrounds, recognising the impact of trauma and supporting people’s physical health needs.
<table>
<thead>
<tr>
<th>Agenda Item: GB 19/103</th>
<th>FOI Exempt: N</th>
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</table>

**NHS Leeds CCG Governing Body Meeting**

**Date of meeting: 29 January 2020**

**Title:** Living well with dementia in Leeds – our local strategy

**Lead Governing Body Member:** Helen Lewis, Interim Director of Acute & Specialised Commissioning

**Report Author:** Tim Sanders, Commissioning Manager, Dementia - NHS Leeds CCG and Leeds City Council

**Category of Paper**
- Decision

**Reviewed by EMT/Date:** 8th January 2020

**Reviewed by Committee/Date:** N/A

**Checked by Finance - N/A**

**Approved by Lead Governing Body member (Y/N):** Y

**Leeds Health & Wellbeing Strategy Outcomes – that this report relates to:**

<table>
<thead>
<tr>
<th>Number</th>
<th>Outcome Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>People will live longer and have healthier lives</td>
<td>✓</td>
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<tr>
<td>2.</td>
<td>People will live full, active and independent lives</td>
<td>✓</td>
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<tr>
<td>3.</td>
<td>People’s quality of life will be improved by access to quality services</td>
<td>✓</td>
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<tr>
<td>4.</td>
<td>People will be actively involved in their health and their care</td>
<td>✓</td>
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<tr>
<td>5.</td>
<td>People will live in healthy, safe and sustainable communities</td>
<td>✓</td>
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**NHS Leeds CCG Strategic Commitments**

**We will focus resources to:**

<table>
<thead>
<tr>
<th>Number</th>
<th>Outcome Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Deliver better outcomes for people’s health and wellbeing</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>Reduce health inequalities across our city</td>
<td>✓</td>
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**We will work with our partners and the people of Leeds to:**

<table>
<thead>
<tr>
<th>Number</th>
<th>Outcome Description</th>
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<tbody>
<tr>
<td>3.</td>
<td>Support a greater focus on the wider determinants of health</td>
<td>✓</td>
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<tr>
<td>4.</td>
<td>Increase their confidence to manage their own health and wellbeing</td>
<td>✓</td>
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<tr>
<td>5.</td>
<td>Achieve better integrated care for the population of Leeds</td>
<td>✓</td>
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<tr>
<td>6.</td>
<td>Create the conditions for health and care needs to be addressed around local neighbourhoods</td>
<td>✓</td>
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**Assurance Framework – which risks on the GBAF does this report relate to:**

<table>
<thead>
<tr>
<th>Number</th>
<th>Outcome Description</th>
<th>Tick</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Inadequate patient and public engagement results in ineffective decisions and challenge</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>Failure to assure the delivery of high quality services, leading to commissioned services not reflecting best practice and improving care</td>
<td>✓</td>
</tr>
<tr>
<td>3.</td>
<td>Failure to achieve financial stability and sustainability</td>
<td>✓</td>
</tr>
<tr>
<td>4.</td>
<td>Lack of provider and clinical support for change will impact on the development and implementation of the CCG strategy</td>
<td>✓</td>
</tr>
<tr>
<td>5.</td>
<td>Resources are not targeted effectively to areas of most need, leading to failure to improve health in the poorest areas</td>
<td>✓</td>
</tr>
<tr>
<td>6.</td>
<td>Insufficient workforce capacity, capability and adaptability to deliver the ambitions</td>
<td>✓</td>
</tr>
<tr>
<td>7.</td>
<td>Failure to enable partners to work together to deliver the CCG commitments</td>
<td>✓</td>
</tr>
<tr>
<td>8.</td>
<td>Failure of system to be adaptable and resilient in the event of a significant event</td>
<td>✓</td>
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</table>
EXECUTIVE SUMMARY:

The draft Leeds Dementia Strategy covers thirteen themes which span from reducing the risk of developing dementia, through diagnosis and support, through to the later stages of the condition and end of life care. It covers important aspects such as diversity, housing options, and strengths-based approaches. It aims for an integrated approach covering NHS, social care, and community support, and has been developed by the Leeds Dementia Partnership.

This draft follows a consultation process involving people living with dementia, carers and professionals.

It reports and celebrates improvements made since the previous strategy in 2013, particularly the significant increase in diagnosis rate, waiting times for diagnosis, and post-diagnosis support. It acknowledges where there are still gaps in services e.g. for people with more complex needs and at risk of being delayed in hospital. It seeks to join up with Leeds-wide developments, e.g. Population Health Management – people with a dementia diagnosis make up about 12% of the frailty and end of life ‘cohort’.

The draft strategy is presented to Governing Body for any further comment on the approach and content. These comments together with feedback from NHS Leeds CCG EMT (8th January), and Leeds City Council Adults & Health Leadership team (15th January) will then be used to inform the final version which will be presented to the Health & Wellbeing Board in April 2020.

NEXT STEPS:

The next draft of the strategy to be developed, to include:
- improved focus on outcomes and measurable objectives in a separate section, which can be regularly updated to show progress;
- clear statement of priorities: primary care & frailty; carer support; social care quality & timely transfers of care from hospital; BME diversity; end of life care.
- recognising achievements regarding appropriate prescribing and reduced use of anti-psychotic medication for behavioral & psychological needs.

The final version will then be presented to Leeds Health and Wellbeing Board in April 2020.

RECOMMENDATION:

The Governing Body is asked to:

(a) CONSIDER and COMMENT upon the draft Leeds Dementia Strategy.
Our vision

For Leeds to be the best city to live with dementia, where people and carers are included in social, community and economic life; and supported by services which work well together.

Introduction

There are an estimated 8,700 people living with dementia in Leeds. To give an idea of what this means in our local neighbourhoods, there are about 9,500 streets in the Leeds City Council area; so the ‘average street’ is much more likely than not to have a person living there with dementia. There are approximately 6,500 with a recorded diagnosis, i.e. 75% of the total. Of the other 25%, some are in the earliest stages of experiencing symptoms, and some will be going through the diagnosis process. Others might be reluctant to acknowledge the concerns of others, reluctant to seek a diagnosis, or not know what to do next. Each person and family will experience the condition in individual and diverse ways.

This strategy aims to offer hope, and to identify opportunities to improve the quality of life and support to live well with dementia. However, it is important to recognise that dementia can be extremely tough and challenging, affecting family and social life, plans for retirement and much else besides. We all have our strengths and abilities, within ourselves and through our families, friends and support networks. A ‘strengths-based’ perspective is important for people with dementia to live as well as possible. At the same time, it is the case that dementia, as a progressive condition affecting the brain, causes loss and impairment of abilities which can, at times, feel overwhelming.

This document looks forward, to describe the challenges and priorities for improving services. It is also an opportunity to show what has been achieved in the seven years since “Living Well With Dementia in Leeds – our strategy 2013-16” was published. There has been excellent progress in Leeds to improve the diagnosis of dementia, and support to help more people and carers to live with the condition. Our ‘dementia-friendly’ social movement has grown, to make people more aware, reduce the sense of stigma around the condition, and sign up local business
and community groups. Thousands of local NHS staff have been trained, and specialist support for community services and care homes has been enhanced.

However, significant challenges remain. The capacity and quality of services, particularly for people with more complex needs, is inconsistent. There are still people and families who miss out on the support available and feel isolated. The population living with dementia will increase, and become more diverse.

Contrary to widespread belief, the number of people with dementia in the UK population has probably stayed roughly the same over recent decades. The evidence for this is a comparison of population samples twenty years apart, by the Cognitive Function in Ageing Study. This is a positive public health story, often overlooked in reporting about dementia. However, as the generation born in the years after 1945 approaches age 75 and beyond, it is likely that there will be demographic growth during the 2020s. Health inequalities are important, with increased risk of dementia linked to higher prevalence of heart disease, type 2 diabetes and high blood pressure. This makes it important to find ways in which we all can reduce the risk of developing dementia - “what’s good for the heart, is good for the brain”.

The level of dementia-related disability is anticipated to increase, according to research which models population ageing and health. People are living longer with dementia, alongside other long-term health conditions and frailty. Hospitals and care services report that there are more people needing help with more complex needs. It can then be difficult to identify long-term care, and people then experience delays leaving hospital.

Therefore this document sets the course in Leeds for the next five years, to achieve the goals of the “Prime Minister’s Challenge On Dementia 2020”, to “transform care, support and research”, and “build social action by individuals, businesses and communities”. The NHS has set out its long-term plan, including “supporting the Alzheimer’s Society to extend its Dementia Connect programme”; “supporting people to age well”; “fully integrated community-based care”, and “improved support to care homes”.

In Leeds we have real strengths in the sense of partnership and commitment, involving people with dementia, families and carers, community groups, care providers, and many organisations beyond social care. This strategy describes how that shared commitment will be put to work to better support people living with dementia in Leeds.
1. **Dementia-Friendly Leeds**  
   People and places in Leeds are ‘dementia-friendly’; we promote inclusion & understanding, and reduce stigma.

2. **Timely diagnosis and support**  
   Timely diagnosis leads to support to live with the condition, and community capacity keeps pace with emerging needs.

3. **Dementia, healthy ageing and frailty**  
   People with dementia benefit from initiatives to promote well-being in later life, and care co-ordination for people living with frailty.

4. **Caring for a person with dementia**  
   Carers are treated as partners in care, and benefit from information, support, and breaks.

5. **Younger people with dementia**  
   People with younger onset of dementia benefit from specialist support, which recognises people’s specific social, economic and clinical needs.

6. **Diversity, inclusion and rights**  
   People’s voices are heard, and rights are upheld when decisions are made. Services recognise and respond well to diverse needs.

7. **Strengths, support networks and positive risk management**  
   People with dementia and carers benefit from person-centred understanding, good conversations and choices about needs & risks.

8. **At home - housing options, design and technology**  
   People live well at home supported by dementia-friendly environments, choices about housing and care, and innovative solutions.

9. **Arts and creativity**  
   People thrive on meaningful activity and occupation, and opportunities for self-expression and communication when life is difficult.

10. **Research - making a difference for the future**  
    Leeds is ambitious to create opportunities for people living with dementia to take part in research to improve treatment and care.

11. **Good quality care & timely transfers of care**  
    Leeds has good quality & availability of health & care provision to support people living with dementia, including people with more complex needs.

12. **Specialist services & partnership working**  
    All NHS, care and support services are skilled at meeting dementia care needs, and have timely access to specialist clinical support.

13. **Care at the end of life**  
    There is honesty about dementia as a progressive neurological condition, and opportunities to plan ahead to make the most of life.
## Achievements 2013-19

- A worker to co-ordinate the campaign is established with Leeds Older People’s Forum.
- ‘Up and Go’ involvement group established in 2016, for people living with dementia.
- **Leeds Dementia Action Alliance** now has over 200 organisations signed up, including the emergency services, sport, culture, leisure and transport.
- Leeds has achieved recognition as a dementia-friendly community, from the Alzheimers Society and British Standards Institute. Local initiatives at Horsforth and Morley have achieved recognition.
- Dementia-Friendly Rothwell established with eg. local shops, pubs, and the first dementia-friendly garden in a public park.
- Dementia-Friendly community initiatives at Chapel Allerton, Otley, Roundhay, Wetherby, and the Elmet and Rothwell parliamentary constituency.
- Over 30,000 **Dementia Friends** in Leeds. Over 130 Leeds residents are Dementia Friends Champions and have run almost 2,000 awareness sessions.
- West Yorkshire Playhouse awarded “Best Dementia-Friendly Project” at the 2015 Alzheimers Society Awards.
- Sporting reminiscence activities hosted monthly at Leeds United FC, Leeds Rugby, and Yorkshire County Cricket Club.
- Leeds City Council support from colleagues in Museums and Galleries, Libraries, Parks and Gardens.
- Opera North presenting a dementia-friendly performance of *La Bohème* in October 2019.
- Ten successful ‘Dementia Information Roadshows’ in 2018-19 at community venues in each Community Committee area.

## Challenges and actions 2020-24

- People living with dementia have chosen priorities for the dementia-friendly Leeds campaign: transport, shops and businesses, and arts & recreation.
- Growing the Leeds Dementia Action Alliance and reaching a wider range of businesses and partners; seek opportunities to improve life for working carers.
- Seeking more opportunities to work with schools and reach children and young people.
- Gathering evidence of how dementia-friendly actions have made a difference.
- More dementia-friendly initiatives in local communities, linked to age-friendly and other campaigns for inclusion.
- Leeds City Council colleagues in Revenues & Benefits to improve access to Council Tax discount.
- Further public information initiatives, working with community partners, including: an event with a BME focus and an event for people who are Deaf or hearing impaired.
More about Dementia-Friendly Leeds:

Leeds was one of six places to commit to the campaign for dementia-friendly communities at its launch in 2012, by the Prime Minister of the day at the Alzheimers Society conference. The campaign seeks to sign up organisations to local ‘Dementia Action Alliances’, and create individual ‘Dementia Friends’ via awareness sessions and online. The national total of Dementia Friends passed 3 million during 2019.

Dementia-friendly communities are at the heart of improving lives, letting people know that they’re not alone, are still welcome, and will be understood. They and the people who are active in local initiatives are true strengths and assets, making it easier to talk about dementia, to live life as fully as possible, and reduce the sense of stigma.
2. **Timely diagnosis and support**

*Timely diagnosis leads to support to live with the condition, and community capacity keeps pace with emerging needs.*

<table>
<thead>
<tr>
<th>Achievements 2013-19</th>
<th>Challenges and actions 2020-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Leeds achieved the national ambition for a 66.7% diagnosis rate at March 2015, and has gone on from there to get to 75.4% at September 2019. There are now more than 6,400 people on GP dementia registers.</td>
<td>➢ Review and update the Leeds diagnosis and support pathway.</td>
</tr>
<tr>
<td>✓ Leeds Memory Service sees more than 90% of people within 8 weeks of referral; more than 65% have a diagnosis within 12 weeks of referral.</td>
<td>➢ Ensure that less common diagnosis routes (eg. acute hospital) lead to recording on GP register and to post-diagnosis support.</td>
</tr>
<tr>
<td>✓ Leeds Memory Service has retained its accreditation by the Royal College of Psychiatrists’ Memory Services National Accreditation Programme (MSNAP).</td>
<td>➢ Set out an accessible local offer for people with a dementia diagnosis, both in leaflet and online form.</td>
</tr>
<tr>
<td>✓ The Memory Support Worker service started in October 2015, which supports 1,500 people per year.</td>
<td>➢ Develop the ‘Side By Side’ service model for Leeds, matching people with volunteers to stay active and access the community.</td>
</tr>
<tr>
<td>✓ Information and leaflets about services available at <a href="http://www.leeds.gov.uk/dementia">www.leeds.gov.uk/dementia</a>.</td>
<td>➢ As people born in the years after 1945 reach the age of 75 and beyond, ensure capacity keeps pace with demand.</td>
</tr>
<tr>
<td>✓ 47 Memory Cafes and 13 singing groups, supporting all communities in Leeds.</td>
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More about timely diagnosis and support:

For people living with dementia, it is a significant and often difficult decision to explore the possibility that something might be wrong. Dementia-friendly communities and better public awareness will help, but will never entirely take the worry and fear associated with the condition. Reactions to diagnosis vary between individuals and can be a complicated mix of feelings. Sometimes there is relief that there is an explanation for what has been happening; for many it is a very low point.

Diagnosis rates will never reach 100% of estimated prevalence. This is because people must be supported to seek diagnosis in a timely way, but not ‘ambushed’ with it; and because for some frail older people approaching the end of life with other health conditions, it could be ‘overdiagnosis’ to explore mild symptoms of possible dementia – ie. there may be no benefit to going through the process.
Most importantly, diagnosis is a gateway to support and an opportunity to offer people, families and carers a way ahead and come to terms with living with dementia. Although ‘diagnosis rate’ is still the thing that NHS England use to measure local services, diagnosis is not by itself an achievement. It must connect to meaningful support to live with dementia.

The approach in Leeds since 2013 has been to create a support offer to everyone living with dementia through investment in Memory Support Workers and continuing to build community capacity. The level of post-diagnosis support is no longer dependent upon whether a person is prescribed medication, and will usually come from a non-clinical support worker. This has enabled clinical staff to be available in a more timely way, eg. to reduce waiting times for diagnosis.

Leeds is fortunate to have many dementia-friendly organisations and volunteers who have set up and run groups such as Memory Cafés. This has contributed to a significant increase in services and activities, which has been needed as Leeds has become better at diagnosing dementia, and connecting people to support.

![Graph showing people with a dementia diagnosis in Leeds 2011-19](image)

**Objectives:**

a. The dementia diagnosis rate for Leeds continues its steady improvement, and seek to achieve 80% during 2023 and thereafter.

b. The dementia diagnosis and support pathway is reviewed and the updated version is published on Leeds Health Pathways by September 2020, and its effectiveness is evaluated during 2021-22.

c. Review & update the ‘Living with dementia in Leeds’ leaflet by September 2020, and ensure everyone with a diagnosis receives it.

d. Improve the online information offer (timescale to be decided), connected to other online initiatives such as improvements to the Leeds Directory.
### 3. Dementia, healthy ageing and frailty

People with dementia benefit from initiatives to promote well-being in later life, and care co-ordination for people living with frailty.

#### Achievements 2013-19

- Identifying health inequalities as an important influence on dementia risk, and starting to engage with local communities.
- Memory Support Workers have been established as part of Leeds Neighbourhood Teams, older people’s mental health services, and linked to GP practices.
- Leeds Community Healthcare development of “Dementia, Depression & Delirium” pathway.

#### Challenges and actions 2020-24

- Increasing awareness of dementia and risk reduction via eg. Public Health campaigns, improved take-up of the NHS Healthcheck; diabetes prevention programme.
- Improving quality and consistency of the annual dementia review, using the Leeds approach to ‘Collaborative Care and Support Planning’.
- Explore innovative approaches eg. using community venues for review; a six-month review after diagnosis.
- Ensure there is access to support in the months / years after diagnosis, for people who don’t take up services immediately post-diagnosis.
- More opportunities and support to plan ahead for the later stages of dementia.
- Taking the opportunities offered by the further development of social prescribing, and introduction of care-co-ordinator roles; particularly for partnership working alongside Memory Support Workers.

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**More about Dementia, Healthy Ageing and Frailty:**

Traditionally, dementia has been ‘badged’ as a mental health condition, affecting cognition, mood and behaviour; specialist services and professional expertise has developed within old-age psychiatry and specialist clinical roles. The NHS Long-Term Plan shifts the focus to seeing dementia as a long-term condition linked to frailty and often occurring with other long-term conditions more prevalent in later life. This approach is consistent with Leeds dementia strategy since 2013. The focus of support to live well with dementia is primary care (GP practices) and community services (NHS, social care and community groups). The Memory Support Workers are there to help people navigate the system and join up services. Specialist NHS services able to offer advice and referral in a timely way when required.

Leeds City Council and local NHS organisations have adopted the approach of ‘Population Health Management’. This recognises that health and wellbeing is more
than just being without disease, and that it can be helpful to consider ‘cohorts’ of people who may live with multiple conditions and life challenges. Local NHS data indicates that there are some 32,000 people who live with moderate to severe frailty, and/or are near to the end of life; of whom more than 4,000 have a diagnosis of dementia.

GP practices are funded to do annual reviews with people living with dementia, and with a range of long-term conditions. This is an important opportunity to ‘check in’ with people who might not have any support or attend any groups, to see if a person’s dementia has progressed, whether carers are struggling, and whether more is needed. Improving the quality and consistency of reviewing is a high priority for this strategy, and NHS investment in healthy ageing and frailty is a real opportunity to achieve this.

Public Health in Leeds has worked with GP practices to develop ‘Collaborative Care and Support Planning’ (CCSP) with people with long-term conditions, to change conversations towards living well, goals that people would like to achieve, and actions to achieve them. Dementia is included in this approach; we know that 2,800 people with a dementia diagnosis had a CCSP review in the 12 months to September 2019. Work is in progress to understand to what extent the reviews recorded goals related to dementia.

The NHS Long-Term Plan envisages that “Expanded neighbourhood teams will comprise a range of staff such as GPs..., pharmacists, district nurses, community geriatricians, dementia workers....”. In Leeds, we can claim to have already achieved the integration of Memory Support Workers into neighbourhood teams alongside clinical staff.

The clinical concept of ‘frailty’ helps to understand how episodes of crisis can develop for people living with dementia, and how crisis can be prevented and managed. Frailty refers to a reduction in our resilience and ability to cope with illness and adverse events; and consequent vulnerability to sudden changes. People with dementia are particularly susceptible to episodes of acute delirium, which may be perceived as ‘dementia getting worse’, and it is important to prevent when possible, and offer opportunities for recovery.

Objectives:

a. For everyone with a dementia diagnosis to have a care plan, which is held and understood by the individual and/or carer. Timescale to be decided, aligned to Leeds work with people living with long-term conditions and frailty.

b. By 2021-22, 90% of annual dementia reviews in primary care are carried out using the Leeds Collaborative Care and Support Planning (CCSP) approach.

c. To achieve clarity of how Memory Support Worker and new Care Co-ordinator roles will work together and complement each other, as Local Care Partnerships introduce the new roles.

d. Review local initiatives on preventing, assessing and managing delirium during 2020-21, and appraise options for developing a shared, Leeds-wide approach.
4. **Caring for a person with dementia**

Carers are treated as partners in care, and benefit from information, support, and breaks.

**Achievements 2013-19**

- A ‘Dementia Carer Hub’ at Carers Leeds, with over 1,000 carers supported per year. Services include:
  - 1:1 support offer for carers
  - Hospital-based support at St James.
  - Information and education sessions for carers
  - Carers’ support groups.
- ‘Working carers’ initiative with large local employers.
- Leeds hospitals signed up to “John’s Campaign”, so carers can support people with dementia beyond usual visiting hours.
- Recruiting carers to join Leeds Dementia Partnership

**Challenges and actions 2020-24**

- Reach more carers of people with dementia with a positive offer of support, and reduce the isolation experienced by carers.
- Improving capacity and choice for carer breaks.
- More residential short-stays bookable in advance, so carers can plan holidays.
- Cultural competence and language skills as more carers from BME origins seek to use carer break services.
- Offer support and substitute care which enables carers to prioritise their own health and well-being.
- Strengthening and listening to the voice of carers.

**More about caring for a person with dementia:**

A local carer, speaking at a Dementia Information Roadshow event in 2019, used a revealing phrase when telling her and her husband’s story:

“When we got our diagnosis...”

‘Living with dementia’ applies to families, friends and carers as well as the person experiencing the condition itself. Research\(^1\) indicates that:

- 85% of people with dementia are supported by an unpaid carer; for Leeds this is an estimated 7,400 carers.
- 34% of carers of people with dementia are ‘economically active’; so Leeds has c. 2,500 carers of people with dementia who combine unpaid caring with paid work.

Most people with dementia live at home (c. 25-35% live in care homes), and even when dementia becomes “severe”, an estimated 50% of people live at home\(^2\). Perhaps 1,000 carers in Leeds are supporting people with the effects of the later stages of the condition: eg. psychological distress, disturbed sleep pattern, continence care, support to stay safe. As well as the physical demands of caring, there is the emotional impact of

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seeing someone close to you change as the condition progresses, and perhaps the gradual sense of loss.

Carers may struggle to put their own needs first, and even to articulate one’s own needs when in the habit of speaking for the person with the condition. Carers want to know that other care arrangements are available, whether in an emergency, or for a planned appointment, for holidays, for a hospital stay and, as carers said in the course of consultation on this strategy, “what if I die first?”. This latter point is followed up in the “At Home – Housing Options... section).

When carers are able to stay positive about life with dementia, it is often because there are opportunities to do things together, and to feel that the original relationship with the person is still there; when their expertise and views are respected by professionals; when there are opportunities to learn about dementia and share experiences with others; and/or opportunities to take a break and have even a couple of hours a week to choose how to spend their time.

**Objectives:**

a. To develop specific plans including costings during 2020-21 to:

- improve access to a range of planned carer breaks;
- increase hospital-based dementia carer support
- offer planned follow-up / ‘keep in touch’ calls to carers.
- extend the offer of training for carers, particularly to run courses in more neighbourhood locations.
5. Younger people with dementia

People with younger onset of dementia benefit from specialist support, which recognises people’s specific social, economic and clinical needs.

<table>
<thead>
<tr>
<th>Achievements 2013-19</th>
<th>Challenges and actions 2020-24</th>
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<tbody>
<tr>
<td>✓ Day services for younger people with dementia have moved to new premises with a new provider (Community Links), and are offering more choices of activity, working with partners to offer eg. creative arts and cookery, and have developed a Memory Café.</td>
<td>➢ For people with a learning disability who develop dementia, to improve access to diagnosis and understand specific support needs, eg. for older parent carers.</td>
</tr>
<tr>
<td>✓ The service now works with Carers Leeds to offer dedicated younger dementia carer support, accessible to carers of people who don’t use the day service.</td>
<td>➢ Seek opportunities to enable people who develop dementia whilst in paid employment to have reasonable adjustments to stay in work.</td>
</tr>
</tbody>
</table>

More about younger people living with dementia:

There are c. 200 people in Leeds who are aged under 65 with a dementia diagnosis[^3]. The overall prevalence of younger-onset dementia is hard to estimate, but there may be a further 100-200 people without a diagnosis. Younger people with dementia have specific needs which reflect the medical and social circumstances of developing the condition at this time of life. The provision of specialist services is supported by the National Institute for Health and Clinical Excellence (NICE) guideline on dementia. The need for such services requires a holistic view of family, social and clinical aspects, rather than whether a person has reached the age of 65.

Amongst younger people, is a higher prevalence of rarer types of dementia, eg. frontal-temporal dementia and post-cortical atrophy. There is generally a wider range of symptoms such as behavioural disinhibition and personality changes. The diagnosis of dementia can be more complex at a younger age, with a combination of factors – eg. stigma, medical complexity – leading to longer diagnosis processes and a lower ‘diagnosis rate’ for this population. Very rare types of dementia may occur when brain cells are affected by neurological conditions such as Huntington’s Disease.

Socially, people may be at a particular stage of family life and career / employment, and there may be particular impact on social networks. Younger-onset dementia can have

[^3]: NHS Digital, monthly data publication.
catastrophic consequences, arising from eg: loss of employment and income (for the carer as well as the person with dementia) and complete change in plans for retirement. People may have young grandchildren and important family roles with childcare; or their own children may still be financially dependent, eg. in higher education or even younger (Office of National Statistics data shows that the average age of parents is increasing). People with younger-onset dementia often have parents who are ageing, perhaps with care and support needs of their own.

The onset of dementia tends to be younger for people with a learning disability, particularly Downs Syndrome, in which the risk of developing with dementia at any given age is approximately the same as for a person thirty years older without the syndrome. In Leeds, NHS community learning disability services manage a specialist diagnosis pathway. The culture and practice of person-centred care is of long standing in services for people with learning disability, and may help providers of care and support to adapt to dementia care. However, when a person with a learning disability has lived into adulthood with parents in the caring role, Carers Leeds report that the development of dementia can present new difficulties, and sometimes affect both generations in the family.

Residential services for younger people with dementia are required for both carer breaks and longer-term care, and there is potential for providers to meet demand more locally, with carers reporting that this would be preferable to placements outside Leeds.

Objectives:

a. In 2020, bring together carers of younger people with dementia and interested local care home providers, to co-design new care home services.

b. Work with younger people and carers locally in 2020-21 to agree further priorities.

c. Work with Carers Leeds and colleagues in learning disability services to understand emerging needs of parent carers.
### 6. Diversity, inclusion and rights

People’s voices are heard, and rights are upheld when decisions are made. Services recognise and respond well to diverse needs.

<table>
<thead>
<tr>
<th>Achievements 2013-19</th>
<th>Challenges and actions 2020-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Memory cafes and groups supporting local Caribbean, Irish, Jewish, south Asian people with dementia and carers.</td>
<td>➢ A rights-based approach, to complement dementia-friendly initiatives and person-centred care; ensuring rights are upheld at key decision when decisions are made.</td>
</tr>
<tr>
<td>✓ BME dementia worker funded at Touchstone Leeds.</td>
<td>➢ Obtain funding and commission research into the experience of people with dementia and carers of BME origins in Leeds.</td>
</tr>
<tr>
<td>✓ Establishment of BME Dementia Forum.</td>
<td>➢ Improve access to Memory Cafés and other groups in rural areas.</td>
</tr>
<tr>
<td>✓ Dementia awareness promoted via Dementia Friends Champions in community organisations.</td>
<td>➢ Dementia awareness and addressing barriers to seeking support with older LGBT people.</td>
</tr>
<tr>
<td>✓ A BME dementia event in 2015, leading to a grants process and new service developments.</td>
<td>➢ Develop care and support services with language and cultural competence for carer breaks and longer-term care; keep pace with emerging needs.</td>
</tr>
<tr>
<td>✓ Memory Clinics established in 7 GP practices to reduce travelling distances. People in the Wetherby area can attend Memory Clinic hosted at Crossley Street Surgery, rather than travel to Knaresborough.</td>
<td></td>
</tr>
</tbody>
</table>

### More about diversity, inclusion and rights:

‘Diversity’ has many aspects, and for people living with dementia it is important that person-centred care is informed by an understanding of social and cultural factors, alongside personal history.

Most people with dementia are aged 80+, and the condition is more common in affluent areas where people live longer. These tend to be more rural areas, where than can be difficulties accessing services. Some villages have well-established Memory Cafés, whereas people in some places have to travel to access services. However, the age-related risk of developing dementia is higher for people at a disadvantage from health and social inequalities. This means that the geographical spread of people living with dementia is more even - between inner city, suburban and rural areas - than might be expected from the age profile alone.

There are people from diverse BME communities who have experienced old age and increasing risk of dementia for several decades (eg. Irish, Jewish and eastern European older people) and the past one or two decades (south Asian and Caribbean older people). South Asian and Caribbean populations in particular have a 4-5 times higher
risk of developing Type 2 diabetes, which in turn is linked to increased risk of dementia. Dementia can take away the ability to speak English for people who learned it as a second language. Reported experience is that people from south Asian communities are looking to use eg. residential short stays for carer breaks and the language capability of services is a difficulty. Local BME services have worked with GP practices to support assessment of memory and cognition in the diagnosis process.

More women have dementia than men, because women are more likely to live beyond age 80; men are marginally more likely to have younger-onset dementia. There is evidence that unpaid caring is more likely to affect women, in the caring tasks carried out, and at a younger age⁴.

Lesbian, gay, bisexual and transgender older people have grown into adulthood and later life at a time of changing social attitudes and inclusiveness, and both developing dementia and coming into contact with care services can lead to difficulties and uncertainties. Alzheimers Disease in particular can take away recent memories and lead to a sense of the past being the current reality, which can be distressing for the person and loved ones to eg. be back in a time when sexuality or gender identity was more often concealed.

Generally, people wish for mainstream services to work well and be competent with diverse needs – eg. Memory Services, hospital care. However, specific services are often valued, such as a memory café where mother tongue language is used and understood; or groups for older LGBT people.

Dementia is itself a disabling condition and important rights are conferred under equalities legislation and the legal framework for mental capacity. These cover access to services, social inclusion, and decision-making. ‘Dementia-friendly’ approaches have had considerable success to improve understanding of the condition and acceptance of people living with dementia. A rights-based approach will complement and strengthen inclusion and quality of services.

**Objectives:**

a. In 2020-21, explore the option to design and offer of a two-hour briefing on “dementia and diversity” to enable staff to apply relevant knowledge to the practice of person-centred care.

b. In 2020-21, seek funding to co-design and commission an evaluation of experience of diagnosis and support of people from BME communities.

c. Include language- and culturally-competent services in work to develop carer support, education and breaks (see Carers section).

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This considers unpaid caring as a whole, it is not a dementia-specific study.
### 7. Strengths, support networks and positive risk management

People with dementia and carers benefit from person-centred understanding, good conversations and choices about needs & risks.

<table>
<thead>
<tr>
<th>Achievements 2013-19</th>
<th>Challenges and actions 2020-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ A team of three “Dementia and Mental Health Liaison Practitioners” has been</td>
<td>➢ Develop training for social workers for better conversations and support planning with people with dementia.</td>
</tr>
<tr>
<td>established, offering specialist support and co-working with NHS colleagues and</td>
<td>➢ Explore and take opportunities to include dementia in work on better conversations, strengths-based social work and asset-based community development.</td>
</tr>
<tr>
<td>social workers in Neighbourhood Teams.</td>
<td>➢ Develop our shared understanding of how strengths-based practice works with people in the later stages of dementia, and with more complex needs.</td>
</tr>
<tr>
<td>➢ Recovery approaches have been promoted in contracts for Community Care Beds, and</td>
<td></td>
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<tr>
<td>introduction of short-term additional funding for people to leave hospital or</td>
<td></td>
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<tr>
<td>avoid admission.</td>
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<tr>
<td>➢ Dementia-friendly approaches have strengthened community networks and assets.</td>
<td></td>
</tr>
<tr>
<td>➢ Memory Support Workers and Dementia Carer Support Workers offer conversations</td>
<td></td>
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<tr>
<td>which listen to people’s concerns and connect people to community groups and</td>
<td></td>
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<tr>
<td>activities.</td>
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</table>

**[discussion at Adults & Health DLT may develop this section further]**

**More about strengths, support networks and positive risk management:**

A strengths-based approach to social care offers supportive conversations to connect people to a range of resources and groups; respond effectively at times of crisis; and plan for the longer term. It seeks to avoid the often undignified and diminishing experience of the ‘gift and entitlement’ model, of being assessed to see if eligibility criteria are met. Hand-in-hand with this approach is ‘asset-based community development’, building on the strengths of communities to offer opportunities for people to live well and to be active and involved.

The ambition for people in Leeds to live well with dementia, and to benefit from person-centred care, fits very well with these approaches. However, it can be difficult to identify strengths as dementia progresses to its later stages, and more difficult for community assets to support people with needs related to eg. psychological distress, continence care, or impaired awareness of personal safety. Family carers are a huge resource for many people in the later stages of dementia, but are likely to need support from services, timely response to crisis, and a break from caring.
‘Positive risk management’ means taking a person-centred approach to why a person might be behaving in certain ways and presenting risks, and looking at creative ways to reduce and monitor risks; and balance different risks, preferences and rights. Interventions such as residential care resolve many concerns, but can create other risks related to eg. the loss of a sense of belonging, or understanding why strangers are in one’s living space.

The care of older people has traditionally focussed more on personal care, meals and routine daily living, and less so on social activity and access to the community. For people with dementia, involvement and meaningful occupation are beneficial and can be crucial to maximise brain function and individual ability.

Direct Payments and other kinds of personal budget can offer person-centred solutions, acknowledging that people and carers living with dementia nearly always need additional support to co-design and manage the care arrangements.

[insert 1 or 2 individual narratives showing successful outcomes]

Objectives:

a. During 2020-21, develop a short training session (c. 2 hours) for social workers to focus on person-centred, strengths-based management of risk.
8. ‘At home’ - housing options, design and technology

People live well at home supported by dementia-friendly environments, choices about housing and care, and innovative solutions.

### Achievements 2013-19
- Dementia-friendly design has been implemented as wards have been redecorated at Leeds Teaching Hospitals.
- Dementia specialist wards at The Mount have had environmental improvements.
- Successful bid for ‘Widening Digital Participation’ funding to improve understanding of how digital developments can support living with dementia.
- ‘Smart House’ at Assisted Living Leeds includes options to enable people to live at home with dementia.
- Accommodation for people with dementia included in extra-care housing developments.

### Challenges and actions 2020-24
- Applying best design principles to dementia care environments – housing, care homes and hospitals.
- Improving choices and outcomes for housing with care for people with dementia.
- Co-design: so that digital solutions are informed by real-life experiences, and investment is directed by what people need.

More about ‘At home’ - housing options, design and technology

Good design can involve small things that make a big difference to the ability of people to live well and independently – for example, signage which reminds a person where the toilet is. Technology has huge potential for everything from peer support, monitoring for personal safety, reminders and prompts, meaningful activity and even care & companionship. It is important that digital technology is used in an enabling way that offers less restrictive options to support living well and personal safety. Bringing together the expertise of people with dementia and carers, with design and technical expertise will co-produce useful innovation. It is likely that the most useful solutions will be those adaptable for each individual.

A recent conversation at Leeds “Up and Go” group for people living with dementia suggested that people are ready to consider moving in the earlier stages of dementia and that extra care housing is seen as a positive option. Spouses / partners in the caring
role do worry about what would happen if they were to need to go into hospital, or were to ‘be the first to go’. Extra care housing offers that reassurance. People value connections with where they live, and this supports the Leeds approach of planning extra-care development to local footprints. Concern was expressed that, as dementia progresses, extra-care housing should continue to support people as a ‘home for life’, and that further moves to care homes are kept to an absolute minimum.

The independent sector tends to use standard designs for care homes, and recent experience suggest that opportunities have been missed to apply best practice to new developments. One option, suggested by developments in Liverpool, is that the local authority can design and build new specialist accommodation, even if it does not directly provide the care.

The specialist inpatient accommodation at The Mount has been improved as far as possible with redecoration and improved lighting, but there are limitations arising from adapting traditional mental health wards for dementia care. Longer-term, Leeds has the ambition to offer purpose-built accommodation using best-practice dementia care design.

Objectives:

a. *(insert extra-care development plans here)*

b. use contract monitoring to understand the frequency of moves from extra-care schemes to care homes, and the reasons.

c. Consider follow-up of service improvement project offering bright red walking frames for people with dementia on medicine for older people wards. Consider potential for a research study.
## Arts and creativity

People thrive on meaningful activity and occupation, and opportunities for self-expression and communication when life is difficult.

### Achievements 2013-19

- A range of creative opportunities established by the Leeds Living With Dementia Peer Support Service working with Leeds Playhouse, Leeds Museums and Galleries, and other partners.
- Many one-off creative projects carried out by third sector partners with local artists – eg. Mosaic project as Leeds City Museum; Pavilion Arts work with Touchstone and Leeds Irish Health and Homes.
- Fifteen singing groups for people with dementia in Leeds.
- People in two local groups have produced banners, working with artist Ian Beesley and poet Ian McMillan, as part of a national project.
- Leeds Playhouse staged the “Every Third Minute” festival, co-curated by people living with dementia.
- Dementia-friendly performances established at Leeds Playhouse, and introduced by Opera North.
- Leeds Playhouse has produced a “Guide To Dementia Friendly Performances” to provide best practice advice based on its award-winning performance model.

### Challenges and actions 2020-24

- Creative arts for living well - explore and take opportunities offered by developments in social prescribing.
- To offer music, art and creativity for people experiencing psychological distress in the more advanced stages of dementia, to improve well-being and enable less restrictive care.
- Work with universities to evaluate creative initiatives and develop evidence for investment.

### More about arts and creativity:

Good things come from taking part in creative activity – feeling calm, making connections, opportunities to take the lead, self-expression, lifting the mood. Some people with dementia report that they feel less inhibited at trying new and different things than they might have before developing the condition. There are excellent local

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examples of arts organisations, creative artists and community groups working together, and the challenge for Leeds is to extend these opportunities to more people, especially people in the later stages of dementia, and move from successful ‘one-offs’ to sustain provision.

The two Leeds banners

Leeds City Museum - mosaic

each group which took part now has its own section of the mosaic.

Objectives:

a. In 2020-21, agree a plan and seek funding for a partnership project to link creative artists to people with complex needs including psychological distress.

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7 https://phm.org.uk/exhibitions/the-unfurlings-a-banner-display/
8 www.leedsinspired.co.uk/projects/mosaic-leeds-paul-digby
10. Research - making a difference for the future
Leeds is ambitious to create opportunities for people living with dementia to take part in research to improve treatment and care.

<table>
<thead>
<tr>
<th>Achievements 2013-19</th>
<th>Challenges and actions 2020-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ When diagnosed, people are offered information about ‘Join Dementia Research’.</td>
<td>➢ Increase the numbers of people, with and without dementia, in Leeds who are signed up to ‘Join Dementia Research’.</td>
</tr>
<tr>
<td>➢ Leeds Beckett University has opened its Centre for Dementia Research, and has a lead role in important research areas such as the effectiveness of training.</td>
<td>➢ Increase opportunities to participate in research studies on treatment and care.</td>
</tr>
</tbody>
</table>
| ➢ University of Leeds has developed ‘SIDECAR’ tool for measuring well-being of carers of people with dementia. | |}

More about ‘Research - making a difference for the future’:
Alzheimers Research UK has identified two important barriers to participation in dementia research: Firstly, general awareness of opportunities and how to get involved; secondly, the cognitive and other impairments which affect informed consent, and the practicalities of taking part.

Involvement in research not only contributes to progress in treatment and care, it enables people to feel more hopeful and useful. Leeds has real opportunities to increase involvement, with three universities, three NHS Trusts and a GP Federation.

Objectives:

a. During 2020, a main agenda item at Leeds Dementia Partnership to review current research and participation, and co-design an approach to involvement of people and carers living with dementia.

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### Achievements 2013-19
- LYPFT service redesign has introduced specialist older people’s teams (March 2019), to work more closely with Neighbourhood Teams to support the older population living with dementia and frailty.
- Over 6,000 staff trained in dementia care by Leeds Teaching Hospitals, including ward clerks, housekeepers and porters as well as nursing staff; improvements to ward environments, introduction of ‘Know Who I Am’ document, dementia-friendly food choices and menus.
- 370 Leeds Community Healthcare clinical staff ‘Tier 2’ trained; 1,200 staff trained at ‘Tier 1’ (March 2019 data)
- An improved training offer for care homes, domiciliary care providers and social work staff, including leadership in dementia care.
- Leeds City Council has established a Care Quality Team which is prioritising work with care homes to better support people with dementia.

### Challenges and actions 2020-24
- Increasing the number of dementia care services rated ‘Good’ or better;
- An ambition to provide purpose-built specialist inpatient environment (subject to feasibility and funding)

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**More about good quality care, skilled staff and partnership working:**

The Alzheimer’s Society’s ‘Fix Dementia Care’ campaign shares examples of poor experiences of care services, and identifies national concerns including the expense to families of self-funding and ‘topping up’ care; shortage of government funding, variable care quality and lack of staff training.

Good quality dementia care depends upon recruiting, training and retaining the right staff in sufficient numbers. This is especially a challenge in the social care sector, where pay is low, there are limited opportunities for promotion and career development, and high staff turnover. The relative success of the Leeds economy in retail and other areas...
means that there are alternatives on offer which can seem more attractive than working in social care.

There is a particular connection to the Leeds ‘Inclusive Growth Strategy’ and its ambition to create better jobs and tackle low pay. Initiatives are in place to attract and support both young people, and middle-aged workers who may not have considered a social care career, into the workforce.

Boosting the pay and conditions of a largely private sector workforce will require increased funding via contracts. This must be seen as an investment in the Leeds economy, with beneficial consequences both for the spending power of low-paid workers, and to improve support for ‘working carers’ – ie. to unpaid carers who wish to continue in their paid jobs. However, in the context of local government funding, the investment still has to be identified.

Access to specialist NHS services is an important aspect of good quality care. People with dementia who receive social care need a multi-disciplinary approach with good working relationships, and timely access to expert colleagues who can advise and co-work when required. The reintroduction of specialist older people’s services, from March 2019, by Leeds and York Partnership NHS Foundation Trust (LYPFT) was a significant step forward. People living at home, and in care homes, can benefit from both care co-ordination and intensive interventions.

Objectives:

a. An event with care providers in 2020, to promote the improved training offer.

b. During 2020-21, Leeds City Council’s work on domiciliary care procurement, to include specific plans to improve services and choices for people with dementia.

(LTHT and LCH objectives to add here).
12. People with complex needs & timely transfers of care

Leeds has good quality & availability of health & care provision to support people living with dementia, including people with more complex needs.

**Achievements 2013-19**

- Leeds City Council has increased fees for dementia specialist care home placements.
- Pilot scheme to fund additional care needs to support transition from hospital / prevent readmission.
- LYPFT Intensive Care Homes Treatment Team piloted from July 2018 and established long-term from April 2019.
- Hospital bed-days lost to delayed transfers of care reduced by c. 50% in winter 2018-19 compared to previous winter.

**Challenges and actions 2020-24**

- Build further on success to achieve timely transfers of care for everyone with dementia in hospital;
- Focus on timely support to avoid hospital admission where appropriate;
- Identify the best funding and procurement option for care services, to ensure the right supply and quality.
- Develop medium-to-longer-term care options for people with enduring and complex care needs.
- 1:1 care and overnight options for people and carers living at home with more complex needs.

**More about people with complex needs and timely transfers of care:**

Care homes are understandably more reluctant to take people whose needs are more complex, unless they are satisfied that funding of the care will enable sufficient staffing, and that specialist support will be available when necessary. This can lead to people waiting in hospital for a suitable placement to be identified, sometimes being assessed and turned down by many care homes.

During 2017-18, a range of initiatives started to address these concerns, and the chart below shows how delayed transfers of care have started to be addressed. However, there is still progress to be made, and small numbers of people with very individual, more complex needs, which remain unmet.

Reduction in % of beds at The Mount occupied by people delayed following treatment.
Objectives:

a. Early in 2020, appraise options for developing very specialist dementia care in Leeds, which offers a recovery approach combined with longer-term care.

b. Develop an interim ten-bed unit, opening in spring 2020 to support people with very complex needs.

c. For 2020-21, identify sustained funding for short-term additional staffing in care homes (‘Dementia Transition Fund’).

d. During 2020, LYPFT to review the capacity and skill mix in the Intensive Care Homes Treatment Team.
13. Care at the end of life
There is honesty about dementia as a progressive neurological condition, and opportunities to plan ahead & make the most of life.

<table>
<thead>
<tr>
<th>Achievements 2013-18</th>
<th>Challenges and actions 2019-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ø Dementia included alongside other long-term conditions in electronic Palliative Care Co-ordination System (ePaCCs)</td>
<td>Ø Enhance hospice &amp; palliative care teams with specialist dementia nursing capacity;</td>
</tr>
<tr>
<td>Ø Leeds guidance produced on recognition and management of end-stage symptoms in dementia.</td>
<td>Ø More &amp; better conversations about advance care planning, to avoid unnecessary A&amp;E attendances, admissions and medical treatments towards the end of life.</td>
</tr>
<tr>
<td>Ø Dementia training for 142 staff at Leeds hospices.</td>
<td>Ø To improve symptom recognition and pain relief, by establishing a consistent approach to assessing pain, discomfort and other symptoms.</td>
</tr>
<tr>
<td>Ø A recognised pain assessment tool for people with dementia is available on Leeds Community Healthcare patient record.</td>
<td>Ø To ensure that all directly-delivered or commissioned health and care services which support people with dementia meet the NICE Quality Standards on end-of-life care.</td>
</tr>
</tbody>
</table>

[https://www.nice.org.uk/guidance/qs13](https://www.nice.org.uk/guidance/qs13)

More about care at the end of life:
People with a dementia diagnosis make up approximately 15% of the people who die each year in Leeds; and approximately 15% of people with a dementia diagnosis die each year. These numbers indicate how significant dementia is in developing and improving end of life care.

The Leeds Palliative and End-of-Life Care Strategy has developed seven outcome statements, for people to -

1. Be seen as an individual who is able to influence their care in a way that matters to them
2. Be recognised and have fair access to services
3. Be supported to live well as long as possible, maximising comfort and wellbeing
4. Have their care well-coordinated
5. Have care provided by people well equipped to do so
6. Be supported by communities that are ready, willing and able
7. Be assured that their family carers, relatives and others are well supported during and after their care

For people with dementia, the opportunity to influence care may come at an earlier stage of the condition, whilst the capacity to think through and decide what we want is relatively intact. This is not easy to do in the face of a progressive condition; people often manage dementia ‘one day at a time’ rather than looking too far ahead. NHS England colleagues supporting the West Yorkshire and Harrogate Integrated Care Partnership have supported a training programme to facilitate advance care planning.
(ACP), and Leeds now has NHS and third sector staff equipped to train colleagues as ACP facilitators. The idea is that anyone who is known and trusted by a person can have the important conversations about wishes and preferences.

End-of-life care and dementia benefits from the perspective of dementia as a life-limiting neurological condition, ultimately affecting a range of physical functioning alongside cognitive abilities; and one which impairs the ability of a person to communicate symptoms such as pain and discomfort. Indeed, the frustrations associated with not being able to explain symptoms may manifest as agitated behaviour, and be misinterpreted.

**Objectives:**
a. Seek investment in dementia specialist roles to work with palliative care teams and support the development of advance care planning.
NHS Leeds CCG Governing Body Meeting

**Date of meeting:** 29 January 2020

**Title:** Position Statement: People and Organisational Development Strategy

<table>
<thead>
<tr>
<th>Lead Governing Body Member: Sabrina Armstrong, Director of Organisational Effectiveness</th>
<th>Category of Paper</th>
<th>Tick as appropriate (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Authors: David Hornsby, Organisational Development Manager; John Scott, Head of People &amp; OD</td>
<td>Decision</td>
<td></td>
</tr>
<tr>
<td>Reviewed by EMT/Date: October 2019, and January 2020 by correspondence</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>Reviewed by Committee/Date: Workforce &amp; Diversity Group (22 October and 28 January 2020)</td>
<td>Information</td>
<td></td>
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<tr>
<td>Checked by Finance (Y/N/N/A - Date): N/A</td>
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<tr>
<td>Approved by Lead Governing Body member (Y/N): Y</td>
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</table>

**Leeds Health & Wellbeing Strategy Outcomes – that this report relates to:**

1. People will live longer and have healthier lives ✓
2. People will live full, active and independent lives ✓
3. People’s quality of life will be improved by access to quality services ✓
4. People will be actively involved in their health and their care ✓
5. People will live in healthy, safe and sustainable communities ✓

**NHS Leeds CCG Strategic Commitments**

We will focus resources to:

1. Deliver better outcomes for people’s health and wellbeing ✓
2. Reduce health inequalities across our city ✓

We will work with our partners and the people of Leeds to:

3. Support a greater focus on the wider determinants of health ✓
4. Increase their confidence to manage their own health and wellbeing ✓
5. Achieve better integrated care for the population of Leeds ✓
6. Create the conditions for health and care needs to be addressed around local neighbourhoods ✓

**Assurance Framework – which risks on the GBAF does this report relate to:**

1. Inadequate patient and public engagement results in ineffective decisions and challenge ✓
2. Failure to assure the delivery of high quality services, leading to commissioned services not reflecting best practice and improving care ✓
3. Failure to achieve financial stability and sustainability ✓
4. Lack of provider and clinical support for change will impact on the development and implementation of the CCG strategy ✓
5. Resources are not targeted effectively to areas of most need, leading to failure to improve health in the poorest areas ✓
6. Insufficient workforce capacity, capability and adaptability to deliver the ambitions ✓
7. Failure to enable partners to work together to deliver the CCG commitments ✓
8. Failure of system to be adaptable and resilient in the event of a significant event
EXECUTIVE SUMMARY:

NHS Leeds CCG’s People and Organisational Development (P&OD) Strategy 2018-21 was endorsed by the Governing Body in October 2018 and has been publicly available since that time. Fifteen months on, and despite a changing environment, the Strategy remains broadly fit for purpose.

Drafted alongside the Leeds CCG Strategic Plan, it benefitted from insights into planned changes in approach to commissioning and the way the organisation interacts with, and influences, the wider system in which it operates.

The P&OD Strategy, through its six Ambitions and eight Themes, set out how the organisation should focus its People and OD activities in anticipation of changes in the wider system. Those changes have continued at pace in the intervening period so this report seeks to:

- Identify which key developments since the Strategy’s publication have been the most significant for the P&OD function
- Describe the function’s response, and plans, around the impact of these developments
- Provide an opportunity for the Governing Body to note these developments and consider ways in which the CCG can further capitalise on the opportunities they present
- Provide assurance to the Governing Body that the steps being taken now and over the next 12 months will increase the organisation’s resilience and capacity for delivery and, where appropriate, development and transformation.

NEXT STEPS:

Publication of the update and associated communication and engagement with staff and partners.

RECOMMENDATION:

The Governing Body is asked to:

(a) **Note** the progress made in the first fifteen months of the Strategy and Plan,
(b) **Comment** on the content of this report, and
(c) **Endorse** and **support** the plans described.
1. **SUMMARY**

1.1 This paper summarises progress since the publication of the P&OD Strategy, developments since publication and planned activity to ensure the Strategy remains current and relevant.

2. **BACKGROUND**

2.1 The P&OD Strategy was developed in response to the merger of the three Leeds CCGs and relocation of staff. It drew from the events that preceded the merger and reflected the pervading culture and position as a newly constituted organisation.

2.2 The Strategy was written alongside the Leeds CCG Strategic Plan and so adopted the ambition of the Strategic Plan and echoed a Workforce Ambition to: ‘…attract and develop a flexible, dynamic and responsive group who can lead and support the health and care system to achieve this ambition.’

2.3 An Action Plan listed tasks and initiatives that support the eight themes which contextualise the response. These are summarised at Annex A. The RAG rating suggests that we have established a strong basis but that we now need to place greater emphasis on wider leadership development and the broader talent agenda.

2.4 **Further developments that impact on the Strategy**

2.4.1 The CCG merger influenced the paper to focus on consolidating this significant change for our staff. But, reflecting the dynamic health and care environment, we need to respond to developments, including:

- In January 2019, NHS England published its Long Term Plan, followed by the Interim NHS People Plan. Both these documents describe a future health and care system based on a ‘left-shift’ of services and increasing fluidity of staff across organisational boundaries. It describes a system in which all contributors work together to deliver a seamless and efficient service for patients and citizens. The People Plan also indicates a shift towards compassionate and inclusive leadership.

- In March we terminated our contract with eMBED for the provision of core HR and Learning and Development services (and several other services were brought in-house).

- In May, the CCG appointed a new Chief Executive which prompted changes to Director Portfolios and a review of Executive members’ level of involvement in operational management issues. That, in turn, has prompted a greater involvement and delegated responsibility to other parts of the Senior Leadership Tier (SLT). This group comprises both the Executive members and those colleagues who report directly to them (typically Deputy and Associate Directors, Heads of Service and equivalents.)

2.4.2 In response to these and other changes and developments, we have reviewed and changed a number of our P&OD services. These include:
• **Contracting with Leeds Teaching Hospitals NHS Trust for the provision of core HR and Learning and Development services.** This has included aligning some services including recruitment and on boarding and strengthening the in-house HR capability, developing a set of ‘gatekeeper’ arrangements for the CCG. Taken together, this has produced a more streamlined and specific service for our Executive, line managers and staff;

• **Launching a new on-line appraisal system** that places a strong focus on behaviours as well as performance, identifying learning and development requirements and opportunities and also positions the organisation to respond to the next phase of the NHS pay and reward agenda;

• **Embedding some 60 CCG staff into the GP Confederation.** This utilised a Memorandum of Understanding (MOU) to help support and underpin arrangements to improve primary care across Leeds. This represents more than 20% of the CCG workforce and clearly reflects the Strategy’s key message that “Increasingly, organisational boundaries will become blurred in response to integrated care initiatives;”

• **Launching a programme of activity around coaching.** This includes the offer of targeted personal coaching for the SLT, continuing development for our trained coaches, and an offer to all line managers to attend a Manager as Coach event to underpin conversations around appraisal and development and support the CCG’s journey towards a coaching culture;

• **Building support around Health and Wellbeing.** The CCG has committed to be a Mindful Employer and also trained a number of Mental Health First Aiders. A Health and Wellbeing Group has enthusiastically engaged in the issues and has instigated action. However, much of the ensuing activity has been self-started by staff including lunchtime walks, yoga, Pilates and mindfulness sessions.

• **Adding capacity and capability to the OD team.** Building on shared working across the system we have used secondments and recruitment to bring in expertise to enhance and strengthen our OD support to the organisation.

• **Beginning to refresh our diversity and inclusion offer.** Initiatives include a BAME (Black, Asian and Minority Ethnic) network and further support to staff facing particular challenges (like premature birth, caring responsibilities and historical abuse).

3. **PROPOSAL**

3.1 **What is planned to prepare the CCG for future developments?**
3.1.1 The recent history of the CCG has been characterised by change and, whilst the People & OD function has adapted, it will need further significant development to respond to and drive internal developments as well as acting as an enabler for system-wide change.

3.1.2 Improvements continue to be made to our core activities and the foundations of an effective and resilient organisation, such as appraisal, learning and involvement. Our focus must now address broader and impactful interventions reflecting the wider context of national plans, regional partnerships and the ambitions of our system partners.

3.1.3 In particular, the NHS Long Term Plan Implementation Framework set out that the characteristics of a mature ICS should include ‘An integrated local system, with population health management capabilities which support the design of new integrated care models for different patient groups, with strong PCNs and integrated teams and clear plans to deliver the service changes set out in the Long Term Plan; improving patient experience, outcomes and addressing health inequalities.’

3.1.4 To this end, our plans include:

- **Shaping Our Future.** From November 2019, we are devoting considerable resource to working on a programme of review and service improvement. This is supported by a consortium of Deloittes and NHS AGEM (NHS Arden & Greater East Midlands Commissioning Support Unit) to enable us to develop this work over the next 9 to 12 months. The scope includes:
  
a. Clearly articulating the future medium and longer term operating model for the CCG.

b. Clarifying ambition, ‘red lines’ and pace of change at place and system level.

c. Undertaking, and progressing actions associated with infrastructure needs-assessment and analysis of capabilities required to achieve the defined operating models

d. Providing Organisational Development Expertise to support the transformation

- **Skills Audit** to determine existing capabilities, and an assessment of the further skills required as the CCG evolves. The ensuing Gap Analysis will help to ensure that individual development plans align with emerging organisational needs. This was planned for 2019-20 but has been deferred pending the outcomes of Shaping Our Future;

- **Senior Leadership Tier Development** including workshops, secondment and shadowing opportunities and the offer of Executive Coaching;

- **Engagement with Culture Change initiatives at national, place and local levels.** Ensuring we remain fully informed and involved in developments around Inclusive and Compassionate Leadership and embedding those principles into all our activities, processes and practices.
• **Talent Management.** Full adoption of the NHS Leadership Academy’s **Talent Management Framework** to inform development pathways and targeted activities. As well as increasing capabilities, it will help to retain and provide continuity for key staff during times of change. A Talent Management Strategy is planned before the end of this financial year;

• **Engagement** through the CCG’s first full participation in the annual **NHS Staff Survey** which will deliver a comprehensive report on how people feel about working at the CCG, and how that experience compares with other NHS organisations, locally and nationally;

• **Inclusion.** Throughout these activities, a key priority must be to ensure that our people feel fully informed and involved from an early stage;

4. **NEXT STEPS**

4.1 Although the Strategy reflected the events immediately post-merger, it also pre-empted and accurately anticipated the focus of the NHS Long Term Plan in terms of greater collaboration and partnership working across the system. This remains our direction of travel and so we see no reason for any significant reorientation of the Strategy.

4.2 Further change is inevitable. Shaping Our Future will prompt significant action for and from management and staff across the CCG and beyond. Our plans and priorities will change and the P&OD offer will need to flex, develop greater agility, resilience and insights to manage these demands. That will help us support managers and staff in what will certainly be a challenging period.

5. **STATUTORY/LEGAL/REGULATORY/CONTRACTUAL**

5.1 The CCG has existing contractual relationships with providers of professional People and OD services that are necessary for the realisation of its strategic plans.

5.2 This report does not seek to change these so there are no additional statutory, legal, regulatory or contractual implications.

6. **FINANCIAL IMPLICATIONS AND RISK**

6.1 Shaping Our Future has a limited timescale and the costs were agreed as part of a rigorous tender process that met all necessary procurement and governance requirements. The additional in-house OD capacity set out in this report is provided through either secondment or temporary arrangements within existing budgets. Service arrangements, such as those via LTHT, give improved value for money through partnership working that enables the CCGs to shape those services within existing budgets.

6.2 The CCG has to be both resilient and agile in order to respond to the dynamic environment in which it operates, which in turn, requires responsivity and agility from our P&OD function.
If that cannot deliver effective support, the risk is that it will fail to create the right conditions to enable the CCG to achieve its ambitions.

7. **COMMUNICATIONS AND INVOLVEMENT**

7.1 The original P&OD Strategy covered the period 2018 – 21. The communication and involvement activities around its review include:

7.1.1 September 2019 - A thorough desktop review against organisational and national developments, including the publication of the NHS Interim People Plan, concluded that it remained fit for purpose, so it will remain publicly available on the CCG’s website.

7.1.2 October - Draft content was presented to the Workforce and Diversity Group and supported with minor amendments.

7.1.3 October - Draft content was presented to the Executive Management Team and supported with minor amendments.

7.1.4 December – Report to Governing Body meeting deferred due to General Election purdah.


7.1.6 February - The report and supporting communications will then be published on the CCG website, Extranet and shared with staff through Team Brief and the weekly staff bulletin. The timing will also allow for the Strategy to inform the action planning in response to the outcomes of the 2019 NHS Staff Survey, which will be published in late February.

8. **WORKFORCE**

8.1 The plans set out in this report are designed to build the CCG’s capacity through, amongst other things, employee and leadership development. This will increase awareness of, and competence in ‘soft skills’ such as Coaching, which will support people to operate more confidently and effectively across a broader range of scenarios.

8.2 Better engagement through the staff survey, involvement, inclusion and development through appraisal, health and wellbeing through staff-led groups and collaborative working through active pursuit of partnership, will all work together to produce a workforce that is more motivated, capable and engaged.

8.3 No negative workforce implications are anticipated.
9. **EQUALITY IMPACT ASSESSMENT**

9.1 The staff survey response rate of 80% is encouraging, and in line with the national average completion rate for CCGs. This gives confidence that the results will provide a reliable representation of staff opinions.

9.2 Similarly the introduction of an improved and consistent appraisal system, and the encouragement for staff-led communications and groups, deliver tangible benefits for involvement, equality and staff voice.

9.3 An Equality Impact Assessment is not required at this stage for Shaping Our Future. However, should the Review recommend changes to the way in which the CCG’s activities are resourced, an Equality Impact Assessment will be carried out to enable us to identify any positive impacts; disproportionate negative impacts; and to develop appropriate mitigating actions.

10. **ENVIRONMENTAL**

10.1 There are no anticipated environmental issues.

11. **RECOMMENDATION**

The Governing Body is asked to:

(a) **Note** the progress made in the first fifteen months of the Strategy and Plan,

(b) **Comment** on the content of this report, and

(c) **Endorse** and **support** the plans described.
ANNEX A: PEOPLE & OD STRATEGY. ACTION PLAN SUMMARY STOCKTAKE

The diagram below describes the actions completed in the first year of the strategy (in green) and indicates key activity for the coming 12 months (in red). The table that follows lists the activities as described in the Action Plan and uses a RAG rating to assess progress in each workstrand.
<table>
<thead>
<tr>
<th>THEME</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>Engagement 1</td>
<td>Revisit previous communications survey outcomes, temperature check, engagement thermometer and take appropriate action (e.g. refresh team brief, workplace launch etc)</td>
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<tr>
<td>Engagement 2</td>
<td>Development a schedule of Staff Away Days inform content and implement</td>
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<td>Engagement 3</td>
<td>Evaluation and Review the Building Champions network</td>
</tr>
<tr>
<td>Engagement 4</td>
<td>Increase the Champions cohort</td>
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<tr>
<td>Engagement 5</td>
<td>Suggestions Box and Bright Ideas, you said we did model</td>
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<tr>
<td>Engagement 6</td>
<td>Conduct Staff Survey</td>
</tr>
<tr>
<td>Health &amp; WB 1</td>
<td>Clarify the accountability of the H&amp;WB Group and publicise the role of the group and it’s outcomes</td>
</tr>
<tr>
<td>H&amp;WB 2</td>
<td>Director level responsibility for H&amp;WB and H&amp;WB Champions</td>
</tr>
<tr>
<td>H&amp;WB 3</td>
<td>Learning from other organisations where we can share good practice and shared arrangements i.e. WIRA Business Park, city-wide organisations, LCC, LTHT, etc.</td>
</tr>
<tr>
<td>H&amp;WB 4</td>
<td>Extranet page specific to H&amp;WB</td>
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<tr>
<td>H&amp;WB 5</td>
<td>Re-procurement of OH and counselling services (widening the offer/scope of services i.e. MSK)</td>
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<tr>
<td>H&amp;WB 6</td>
<td>Promotion of H&amp;WB at induction, manager training and as part of organisational value</td>
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<tr>
<td>H&amp;WB 7</td>
<td>Link flexible work arrangements (and it’s support) to induction and appraisal conversations. Explore extension to current flexible work patterns and examples of best practice.</td>
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<tr>
<td>H&amp;WB 8</td>
<td>Revise Special Leave Policy to include provision for voluntary work/time out to improve H&amp;WB and support corporate social responsibility</td>
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<tr>
<td>THEME</td>
<td>ACTION</td>
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<tr>
<td>Inclusion 1</td>
<td>WRES action plan actions published and reviewed annually</td>
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<tr>
<td>Inclusion 2</td>
<td>Review membership of all CCG formal meetings, to ensure protective characteristics are considered (board diversity)</td>
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<tr>
<td>Inclusion 3</td>
<td>Update self-assessment for disability confident standard for the single CCG</td>
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<tr>
<td>Inclusion 4</td>
<td>Research development opportunities which target under-represented groups and share</td>
</tr>
<tr>
<td>Inclusion 5</td>
<td>Review protected characteristic data that is available as a check and balance for all people related processes</td>
</tr>
<tr>
<td>Inclusion 6</td>
<td>Developing Managers awareness of their responsibility to support any reasonable adjustments for new starters and current employees</td>
</tr>
<tr>
<td>Learning &amp; Development 1</td>
<td>Review appraisal process, train people appropriately in the appraisal process</td>
</tr>
<tr>
<td>L&amp;D 2</td>
<td>Capture individual development needs from appraisal discussions and inform learning &amp; development needs for the organisation</td>
</tr>
<tr>
<td>L&amp;D 3</td>
<td>Capture organisational wide development need from directorates and inform the learning &amp; development needs</td>
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<tr>
<td>L&amp;D 4</td>
<td>Statutory/Mandatory compliance, ongoing monitoring and maintenance of the provision, transition from current arrangements i.e. impact of eMBED contract end</td>
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<tr>
<td>L&amp;D 5</td>
<td>Link into wider Leeds resources i.e. training programmes, coaching etc., Influencing and developing a portfolio</td>
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<tr>
<td>L&amp;D 6</td>
<td>Support for existing coaches</td>
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<td>THEME</td>
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<tr>
<td>L&amp;D 7</td>
<td>Address the need for clear management of Learning and Development applications - consider broader approaches for CPD across the city</td>
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<tr>
<td>L&amp;D 8</td>
<td>Develop and implement a Management skills programme</td>
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<tr>
<td>Resourcing 1</td>
<td>Apprenticeship Guidance, including a city-wide approach</td>
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<tr>
<td>Resourcing 2</td>
<td>Review the promotion of alternative channels of recruitment i.e. LinkedIn, local communities, primary care, Leeds employers city-wide</td>
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<tr>
<td>Resourcing 3</td>
<td>Alternative method of recruitment i.e. alternative to NHS Jobs and internal administration (E-track)</td>
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<tr>
<td>Resourcing 4</td>
<td>Offer broader induction including an understanding of commissioning process, teams and impacts on each other. Including Biographies, structure charts and extranet information</td>
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<tr>
<td>Resourcing 5</td>
<td>Standardised approach to recruitment</td>
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<tr>
<td>Resourcing 6</td>
<td>Recruitment toolkit for managers, including a suite of values based interview questions for recruitment</td>
</tr>
<tr>
<td>Resourcing 7</td>
<td>Understanding and collating internal pools of resources, skills and capabilities internally</td>
</tr>
<tr>
<td>Talent 1</td>
<td>Review appraisal process, including a talent matrix approach, train people appropriately in the appraisal process</td>
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<tr>
<td>Talent 2</td>
<td>Scope the meaning of the skills gap analysis and agree approach/timeframe</td>
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<tr>
<td>Talent 3</td>
<td>Formalising the CCG's approach for access to mentoring,</td>
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<tr>
<td>Talent 4</td>
<td>Consider adopting the Citywide network approach, that is used for coaching to support mentoring</td>
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<tr>
<td>THEME</td>
<td>ACTION</td>
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<tr>
<td>Talent 5</td>
<td>Using data from workforce planning, identify 'at risk' roles and agree a succession planning approach to address the gap (including Clinical Leadership)</td>
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<tr>
<td>Talent 6</td>
<td>Review previous approaches to Governing Body development and work with Corporate Governance team to identify future approach</td>
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<tr>
<td>Workforce Planning &amp; Transition 1</td>
<td>Consider the validity of the development of a long term workforce plan that includes information about future alignment of work streams to other organisations</td>
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<tr>
<td>W P &amp; T 2</td>
<td>Audit of current New Ways of Working arrangements, following its implementation in April 2018</td>
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<tr>
<td>W P &amp; T 3</td>
<td>Agree an approach of aligning resources to support the work of the Academy</td>
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<tr>
<td>W P &amp; T 4</td>
<td>Scoping the approach to matrix management for discussion with EMT</td>
</tr>
<tr>
<td>W P &amp; T 5</td>
<td>Flexible deployment toolkit for managers including an examplar way of working document</td>
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</tbody>
</table>