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Date: 28 November 2024

Notice of Meeting

Dear Member

West Yorkshire Joint Health Overview and Scrutiny Committee

The **West Yorkshire Joint Health Overview and Scrutiny Committee** will meet in the **Virtual Meeting - online** at **10.00 am** on **Friday 6 December 2024.**

The items which will be discussed are described in the agenda and there are reports attached which give more details.

Samantha Lawton

Service Director – Legal, Governance and Commissioning

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

The West Yorkshire Joint Health Overview and Scrutiny Committee members are:-

Member	Representing
Councillor Elizabeth Smaje (Chair)	Kirklees Council
Councillor Colin Hutchinson (Deputy Chair)	Calderdale Council
Councillor Jane Rylah	Kirklees Council
Councillor Howard Blabgrough	Calderdale Council
Councillor Rizwana Jamil	Bradford Council
Councillor Alison Coates	Bradford Council
Councillor Andrew Scopes	Leeds City Council
Councillor Caroline Anderson	Leeds City Council
Councillor Betty Rhodes	Wakefield Council
Cllr Andy Nicholls	Wakefield Council
Cllr Andy Solloway	North Yorkshire Council
Cllr Andrew Lee	North Yorkshire Council

Agenda
Reports or Explanatory Notes Attached

Pages

1: Membership of the Committee

To receive apologies for absence from those Members who are unable to attend the meeting.

2: Minutes of the Previous Meeting

1 - 8

To approve the minutes of the meeting held on 11 October 2024.

3: Declarations of Interest

Members will be asked to say if there are any items on the Agenda in which they have a disclosable pecuniary interest or any other interest, which may prevent them from participating in any discussion of the items or participating in any vote upon the items.

4: Public Deputations/Petitions

The Committee will receive any petitions and/or deputations from members of the public. A deputation is where up to five people can attend the meeting and make a presentation on some particular issue of concern. A member of the public can also submit a petition at the meeting relating to a matter on which the body has powers and responsibilities.

In accordance with Council Procedure Rule 10, members of the public must submit a deputation in writing, at least three clear working days in advance of the meeting and shall subsequently be notified if the deputation shall be heard. A maximum of four deputations shall be heard at any one meeting.

5: Patient transport services: the new national eligibility criteria

9 - 56

The Committee will receive a further update from representatives

from the NHS West Yorkshire Integrated Care Board on Non-emergency Transport Services.

Contact: Yolande Myers, Principal Governance Officer – Kirklees Council

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6: Suicide Prevention

57 - 64

The Committee will receive an update from representatives from the NHS West Yorkshire Integrated Care Board regarding Suicide Prevention, one of the 10 'Big Ambitions'.

Contact: Yolande Myers, Principal Governance Officer – Kirklees Council

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7: Life Expectancy

65 - 72

The Committee will receive an update from the Integrated Care Board relating to life expectancy, one of the 10 'Big Ambitions'.

Contact: Yolande Myers, Principal Governance Officer – Kirklees Council

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8: Next Steps

The Committee will consider its plans for future meetings and activities.

Contact: Yolande Myers, Principal Governance Officer – Kirklees Council

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Contact Officer: Laura Murphy

KIRKLEES COUNCIL

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 11th October 2024

Present:

Councillor Elizabeth Samji - Kirklees Council
Councillor Colin Hutchinson - Calderdale Council
Councillor Caroline Anderson - Leeds Council
Councillor Andrew Scopes - Leeds Council
Councillor - Rizwana Jamil - Bradford Council
Councillor Allison Coates - Bradford Council
Councillor Howard Blagbrough - Calderdale Council
Councillor Betty Rhodes - Wakefield Council

Apologies: Councillor Andy Nicholls - Wakefield Council
Councillor Jane Rylah – Kirklees Council

1 Appointment of Chair and Deputy Chair

Councillor Elizabeth Smaje was appointed as Chair of the Committee and Councillor Colin Hutchinson was appointed as Deputy Chair of the Committee.

2 Membership of the Committee

Apologies were received from Councillor Andy Nicholls and Councillor Jayne Rylah.

3 Minutes of Previous Meeting

The minutes of the meeting held on 15th March 2024 were agreed as a correct record.

An update was shared in relation to the Committee's recommendations:

- Health Inequalities and Prevention and further information regarding impact and outcomes relating to different key areas of the programme, this information had been received and circulated to the Committee on 11th October 2024.
- West Yorkshire Urgent Care and further discussion and a summary report being shared with the Committee, this was expected within the next few days.
- Workforce Priorities, actions were currently being worked on.

4 Declarations of Interest

Interests were declared from Councillor Howard Blagbrough as an Elected Governor at Calderdale and Huddersfield Foundation Trust (CHFT) and Councillor Alison Coates as an Appointed Governor at Bradford Care Trust.

5 Public Deputations/Petitions

No deputations or petitions were received.

6 Non-emergency Patient Transport Services

Simon Rowe, Assistant Director of Contracting, West Yorkshire Integrated Care Board and Chris Dexter, Managing Director for Non-emergency Transport, Yorkshire Ambulance Service, presented the Committee with information in relation to non-emergency patient transport services, and shared that:

The National criteria was produced to help minimise the variations across local parts of the country and to provide a consistent criterion of eligibility for non-emergency patient transport.

Patients eligible under the national criteria were those with a significant mobility need, those travelling to and from renal haemodialysis and those with a medical need making it unsafe to travel to and from an appointment.

Patients who were not eligible under the national criteria could be considered against a local criteria or for the National Health Care Travel Cost Scheme, which was means tested.

The Committee highlighted issues with overspending and financial difficulties and queried whether this would impact on people being refused transport services.

In response, the Committee was assured that the national criteria would ensure the most vulnerable and in need would be entitled to transport. Investment needed to be in the areas that needed it, and it was important to have a transport offer that worked for communities and was sustainable for five years plus.

The Committee raised concerns in relation to the different travel options available and how people would be supported to access them. The Committee was advised that there was still work to be done with regards to the Heath Care Travel Cost Scheme and its limitations, but there was a clear vision for this.

The Committee highlighted the major concerns relating to the availability of public transport, especially for those in more rural areas, as well as the cost and practicalities of getting to appointments. The Committee felt that attention should be given at an early stage in a patient's care of their ability to attend the required place at the required time, particularly if that meant an early appointment some distance away from where the patient lived. If this issued caused a patient difficulties in attending, it increased the chance of a wasted appointment and in turn ran the risk of serious wastage of clinical resources.

The Committee was advised that some consideration had to be given to public transport, but that it was not the totality in terms of mitigating risks.

The Committee queried the engagement that had taken place and how barriers to engagement would be overcome. The Committee was advised that engagement consisted of a questionnaire and focused groups, and that once the information had been analysed, this would inform whether further engagement was needed. If

further engagement was needed, help from members would be welcomed to ensure the right people were being reached.

The Committee noted that recommendations would be taken to a meeting of the Transformation Committee in November 2024 with implementation proposed for the 1st of April 2025. In response, the Committee was advised that the meeting in November was to provide the Committee with sight of the policy but that it did not rule out further work being completed.

The Committee highlighted the National Eligibility Criteria, noting that over half of people would automatically qualify and half would not, depending on the definitions. In response, the Committee was informed that data identified that patients with a significant mobility need and patients attending for renal haemodialysis was 50% of the demand, but that was not to say that the other 50% would not qualify, this would be subject to the health criteria and any local eligibility criteria that was developed.

The Committee asked if those considered with a medical need included patients with mental health needs and was informed that they were included.

RESOLVED:

- The Committee supported the work being undertaken to simplify the administration of the Healthcare Travel Costs Scheme.
- Further detail be provided to the committee in relation to the proposed recommendations (including those proposed to the West Yorkshire ICB Transformation Committee in November 2024), the local criteria and the impact this has on people.
- Analysis in relation to deprivation and the Business Case be circulated to the Committee.
- Current engagement, and any future engagement plans be shared with the committee to help identify any gaps.
- More advanced discussions be held with the West Yorkshire Combined Authority in relation to concerns regarding the availability and reliability of public transportation.
- Further clarity be provided to the Committee regarding the qualifying measures for people on low income and how they can access help.
- High priority be given in relation to transportation, to ensure equitable access to health care that is not dependent on the future development of a reliable public transport system.
- The appointment system needed to consider transport arrangements and the practical ability of patients to be able attend their appointments including pre-op assessments and ongoing care.

7 Financial Plan 2024-25

Lesley Stokey, Operational Director of Finance at Calderdale shared with the Committee information regarding the ICS Financial Plan for 2024-25 and the latest financial position, and advised that:

NHS funding growth had varied and in 2024-25, growth had been static, and even though there had been a cash increase, inflation had exceeded that considerably.

There were challenges with the allocated budget of 5.7 billion which was split across a number of main areas, with the largest area being acute health care at 2.8 billion, mental health care at 677 million, community over half a billion, continuing health care just short of 300 million and primary care and prescribing at 1.3 billion.
The financial plan for the year was challenging and as of August 2024, the year-to-date deficit was 71 million, however the ICB were still forecasting a 50 million deficit plan to NHSE. The deficit plan was reflective of cost pressures, inflation and lower growth which was comparable to other ICS systems.

A medium-term financial plan was being developed and there were a number of transformation and productivity programmes to ensure best value for money and best outcomes. West Yorkshire Acute Trusts were working with Price Waterhouse Cooper (PWC) to identify specific area to benchmark and deliver more efficiencies cross the Acute footprint.

The Committee queried the 71 million deficit and was advised that four NHS Acute Trusts had submitted deficit plans totalling 71 million. The ICB split the budget across the 5 West Yorkshire places of which two submitted deficit plans that were netted off by the surplus in other areas.

In response to the Committee's question in relation to capital allocation, the Committee was informed that this could not be raided for revenue. There was no capital to revenue transfer within West Yorkshire as the capital allocation was already ring fenced and stretched.

In response to the Committee's question regarding spending on Prevention Services, the Committee was informed that there had been investment in Community Services and Prevention to help reduce hospital admissions. Work was also being done with Public Health colleagues, and the ICS had ring fenced specific investment over the last two years to focus on health inequalities.

In response to the Committee's query regarding the financial planning for services with the longest waiting lists, the Committee was informed that financial planning would incorporate waiting times, capacity and resources and was agreed at place level.

The Committee highlighted the 482 million prescribing costs and was advised that this was the net charge and that there were pressures in relation to high-cost drugs and drug shortages which varied each month.

The Committee acknowledged the shortfall of 14.3 million due to the slippage on delivery of waste reduction and efficiencies. The Committee was advised that part of the financial planning across the eleven organisations was to target where savings could be made in relation to the reduction of waste and delivering services more efficiently.

The Committee highlighted the agency ceiling figure and was advised that this was set by NHSE per organisation. The cap was not specific to posts or specialities but

would ensure appropriate spending on agency. West Yorkshire were spending below the funding cap which indicated good recruitment.

The Committee queried the financial review and were informed that more information should be available in the next few weeks.

The Committee highlighted the high financial risk and were advised that NHSE made the decision based on national specification. West Yorkshire had not been placed under that category but due to adverse variances and deficit plans, the ICS had chosen to put themselves under the regime to ensure the financial position was taken seriously.

In response to a question regarding analysing costs between nonclinical and clinical staff, the Committee was advised that analysis was reported to NHSE monthly, and that other national benchmarking data would help identify if staffing levels were correct and were efficiencies could be made.

RESOLVED:

- Place Committees consider analysing the financial report in more detail in relation to local services.
- Further information be shared with the committee in relation to prevention at a future meeting.
- Further detail be provided to the committee in relation to the financial review, what it encompasses and its recommendations.

8 Maternity and Neonatal System Update

Debi Gibson, Director of Midwifery for West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS) shared with the Committee information regarding the maternity and neonatal system update, and advised that:

A three-year delivery plan had been developed and oversight and assurance had been gained through outcome data, survey data, quality surveillance groups, patient feedback etc.

LMNS supported Trusts by working collectively with them to help improve outcomes and experiences and were able to respond to any early warning signs. Embrace data, as well as local data was also utilised, and in response, further work had been undertaken in relation to neonatal deaths which would be presented at the LMNS Board in November.

A request was being considered to modify the Embrace data, to enable a system wide picture. Data for Leeds was higher when compared to other Trusts locally, but data from similar, unique Trusts, had been obtained, and a group of super centres had been developed that linked together to share learning and peer reviews.

A key intervention to help reduce neonatal mortality and morbidity was the Saving Babies Lives Care Bundle (version 3) which had been implemented across providers and compliance was good. Sometimes compliance fluctuated due to thresholds, but ongoing reviews were in place.

Deprivation within West Yorkshire and Harrogate was one of the highest in the country and further work needed to be done in relation to health inequalities. A Health Inequalities Programme Manager had been appointed to lead on this.

The Committee highlighted the data for Leeds and the varying services offered by different Trusts and suggested the need to see comparable data in relation to mortality rates from similar hospitals, such as Newcastle, Manchester and Liverpool.

In response to the Committee's question regarding maternal mortality and neonatal brain injury rates and the data to monitor progress, the Committee was advised that brain injury data had not been collected for number of years. Different options had been explored to capture this data, but it could not be done at a system level and needed to be undertaken by NHSE.

The Committee acknowledged the risk of Black and Asian women being more likely to have adverse outcomes and asked what was being done to reduce the increase in deaths caused by genital abnormalities.

In response, the Committee was informed that it was the choice of the family, some families chose to continue with their pregnancy and some Trusts had pathways in place to support this. Work was ongoing in areas where there was higher risk of genetic abnormalities, and midwife roles had been created to link with those families, to ensure adequate screening and to support them to make informed choices.

The Committee queried the additional resources that were provided to families who had lost babies prematurely, the Committee was informed that there was a seven-day bereavement service, as well as additional support from specialist trained midwives who followed families through future pregnancies and provided additional care and counselling. Extra funding had also been received to support enhanced continuity of care and Maternity Befriender roles and Support Worker roles had been designed to link with the most deprived families or those needing extra support throughout their pregnancy journey.

In response to the Committees question regarding the Health Review on maternal deaths, the Committee was informed that this was taking place, but no date had been given.

RESOLVED:

- The Committee be provided with an update on the Regional Maternity's plans to start the maternal death review.
- Comparable data be provided to the Committee in relation to mortality, from wider regional areas such as Newcastle, Manchester, Liverpool.

9 Equality, Diversity and Inclusion Strategy

Fatima Khan-Shah, West Yorkshire Inclusivity Champion across the Health and Care Partnership and Combined Authority shared with the Committee information relating to the Equality, Diversity and Inclusion Strategy, and advised that:

An Equality, Diversity and Inclusion Strategy was being developed for the Health and Care Partnership which would link into the ten aspirations, address some of the inequalities and navigate some of the challenging circumstances that both health and care organisations were in.

The Equality, Diversity and Inclusion strategy was a developing process which involved public contributions, data, statutory and legislative requirements, and the aim was for it to be accessible to everyone.

Phase one of the development included targeted events and analysis of data to identify specific groups who had not contributed. Following this, targeted conversations with those individuals would take place to discuss how the priorities could be tangible recommendations and aspirations. Work would also be undertaken with colleagues across the partnership organisations to identify how the priorities would be implemented.

Feedback so far had been that fairness and social justice was everyone's business, but that it was also important to listen to the lived experience of people.

The next steps were to continue the conversations. A live webinar was taking place to discuss key themes and to consider how the Strategy could be a framework that delivered the tangible change people wanted. The transformation would take time, so there needed to be a balance between the short-term goals to build momentum and hope as well as the long-term transformational change.

The Donna Canare review was taking place imminently to see if the progress that was aspired to be achieved had not delivered, but also to explore what more could be done.

The Committee highlighted the disciplinary process within the NHS and the focus being on protecting institutional reputation rather than patient safety. The Committee also acknowledged the likelihood of people from ethnic minorities become the target of disciplinary process, and even though The Department of Health had set out guidance regarding disciplinary processes, many Trusts did not apply it.

The Committee questioned how maintaining high professional standards was being implemented within employer Trusts and whether people had access to speak up guardians.

In response, the Committee was advised that as part of the Workforce Race Equality Standards every Trust had to report on the proportionality of staff who experienced discrimination or who were likely to be escalated to the disciplinary process. The data identified that there was a disproportionate number of individuals from ethnic diverse backgrounds compared to their white counterparts going through the process.

A recommendation for the Dame Donna Canare review was to look at why that was happening and what more could be done to support colleagues going through that process, as well as supporting managers facilitating that process, to make it more inclusive. This would be revisited as part of the Independent Race Review. Organisations had been asked to think creatively about the processes they had in place for the freedom to speak up guardians, such as a network of champions from different sectorial role etc.

The Committee queried the access to health services for migrants and were informed that The Inclusion Health Programme focused on sex workers, prison leavers, refugees and asylum seekers, and assurance was that the lived experience of those individuals was positive. However, it was also important to look proactively at migrants and people with street-based lives.

In response, to the Committee's question regarding how data from Larger Organisation was being used, the Committee was advised that not all large organisations measured the same data, and work was being done to triangulate this.

In response to the Committee's question regarding Community Cohesion, the Committee was informed that not all Local Authorities had a consistent approach or policy in relation to Community Cohesion. Many organisations due to their financial constraints did not have the same infrastructures and staff but the plan was to support the infrastructure behind the scenes to ensure everybody was supporting the same vision.

The Committee highlighted the difficulties around women going through menopause and support within the workplace. The Committee was assured that menopause was a key focus in relation to inclusive workplaces and the Fair Work Charter and would be a topic considered at the Women of the West Yorkshire Network.

RESOLVED:

- The Committee be provided with a draft Equality, Diversity and Inclusion Strategy.
- The Committee receive an update on the Independent Race Review in relation to progress made and any recommendations, and how the strategy and review correlate.

10 Next Steps

The Committee agreed the date of the next meeting would take place on Friday 6th December 2024.

Meeting name:	Joint Health Overview and Scrutiny Committee
Agenda item no:	
Meeting date:	6th December 2024
Report title:	Patient transport services: the new national eligibility criteria
Report presented by:	Ian Holmes, Director of Strategy and Partnerships
Report approved by:	Ian Holmes, Director of Strategy and Partnerships
Report prepared by:	Simon Rowe, Assistant Director of Contracting

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

Previous considerations:

The subject of how best the national eligibility criteria for Non-Emergency Patient Transport (NEPT) can be implemented by the NHS West Yorkshire Integrated Care Board (WYICB) was previously discussed at the October 2024 meeting of the Joint Health Overview and Scrutiny Committee (JHOSC).

At the October 2024 meeting, the JHOSC sought further information from the WYICB, including the proposed paper to its Transformation Committee in November. This paper was circulated to the officers who oversee the JHOSC in October, and the content of it is formally presented to the December 2024 meeting of the JHOSC.

At the October 2024, the JHOSC asked for several actions from the WYICB. These are listed below, along with a summary of the progress made to-date against each. Further detail on each of these can be found within the body of this paper to December's JHOSC meeting and within the provided appendices.

- **The Committee supported the work being undertaken to simplify the administration of the Healthcare Travel Costs Scheme.**

  As an update, the WYICB are working with the other ICBs across Yorkshire and the Humber to assess the potential options to simplify this scheme.

- **Further detail be provided to the committee in relation to the proposed recommendations (including those proposed to the West Yorkshire ICB Transformation Committee in November 2024), the local criteria and the impact this has on people.**

  The WYICB's paper to its Transformation Committee in November 2024 identified that a cohort of c.3,600 individuals across West Yorkshire could be ineligible for NEPT under the

national criteria, and that this would most likely affect their travel to/from their outpatient appointments.

The detail on how this conclusion has been made can be found in the accompanying detail to this paper.

- **Analysis in relation to deprivation and the Business Case be circulated to the Committee.**

  As part of its recommendations to the Transformation Committee in November 2024, the WYICB detailed a series of actions that need to be completed before April 2025. One of these concerns a business case that brings together:

  - Awareness raising of individuals' eligibility to reclaim the costs of their travel to/from hospital.
  - The preferred option to simplify the administration for individuals' seeking to reclaim the costs of their travel.
  - The method of implementing (and monitoring) the preferred option.

  Analysis of the data obtained under a Freedom of Information request to the NHS Business Services Authority, and that from West Yorkshire NHS hospital trusts, shows that the majority of travel reimbursement claims are processed by hospital cashier offices. This finding will inform the engagement plan (with hospital trusts and the public) that is currently being finalised to inform the development of the business case.

- **Current engagement, and any future engagement plans be shared with the committee to help identify any gaps.**

  Two plans for engagement are currently being developed. The first is with the c.3,600 individuals across West Yorkshire who could be impacted by a change to the national eligibility criteria, to understand how any impact could best be mitigated. The second, and as detailed under the previous point, considers the development of a business case for the better administration of individuals' claims for the cost of travel reimbursement.

- **More advanced discussions be held with the West Yorkshire Combined Authority in relation to concerns regarding the availability and reliability of public transportation.**

  This shall be part of the planned engagement work with stakeholders before April 2025, both in terms of the specifics of the business case for travel reimbursement, and to understand the future for the provision of public transport across West Yorkshire.

- **Further clarity be provided to the Committee regarding the qualifying measures for people on low income and how they can access help.**

  The qualifying measures are currently nationally set and are administered by the NHS Business Services Authority. The public-facing website that explains the qualifying measures can be accessed via the below link.

  Healthcare Travel Costs Scheme (HTCS) - NHS

- **High priority be given in relation to transportation, to ensure equitable access to health care that is not dependent on the future development of a reliable public transport system.**

  At October's meeting of the JHOSC, the WYICB informed the Committee that one consideration to mitigate the impact of individuals' ineligibility for patient transport under the national criteria, was to consider the potential for pre-paid bus tickets. This is not the sole consideration of the WYICB to mitigate any impact of ineligibility for patient transport, but one of several, which include the simplification of the process for reclaiming travel costs and the potential for volunteer-led transport services. Each of these is part of the actions that will be undertaken before April 2025.

- **The appointment system needed to take into account transport arrangements and the practical ability of patients to be able attend their appointments including pre-op assessments and ongoing care.**

  This is something that is being considered with the West Yorkshire Association of Acute Trusts, in terms of how best the transport needs of individuals are known and considered before appointments are made. This is part of the planned actions to complete before April 2025.

Executive summary and points for discussion:

This paper seeks to reassure the JHOSC of the approach that has been presented to the WYICB's Transformation Committee in November 2024 to review how the national eligibility criteria for non-emergency patient transport are best implemented.

In November 2024 the WYICB's Transformation Committee agreed to support in-principle the implementation of the national eligibility criteria from the 1st April 2025, subject to the completion of a series of recommended actions between November 2024 and March 2025, and it receiving a progress report prior to April 2025. This includes specific involvement work for those who utilise NEPT for journeys to/from their outpatient appointments and where the previous points raised by the JHOSC, regarding travel and appointment times, will be discussed.

The recommendation for the Transformation Committee to support in principle the implementation of the national criteria, subject to the completion of recommended actions, stems from:

Stakeholder involvement

- The further work that is required with stakeholders, including the Joint Health Overview and Scrutiny Committee, to go through and provide reassurance that the completed analysis (as stated within this paper) shows that nine and out of ten individuals (including renal patients; those requiring assistance from a NEPT driver and crew to enter/exit a vehicle and those requiring supervision from a NEPT crew) will continue to be eligible for NEPT.
- The need to ensure that stakeholders are reassured that the national eligibility criteria would impact on up to one in ten individuals (c. 3,600), and only those that would have previously utilised NEPT (without the need for assistance/supervision from a NEPT crew) to attend an outpatient appointment.

Mitigations

- The further work that is required to prepare how the mitigations for the one in ten individuals who would be ineligible under the national criteria will operate.
- This further work includes the need to address the found variation in mileage reimbursement rates for patients across West Yorkshire; the need to ensure there is public awareness of the Healthcare Travel Costs Scheme (HTCS); the need to gain the conclusions from the West Yorkshire pilot that is trialling the use of pre-paid bus tickets for patient transport, and to work with each place-based Health and Care Partnership to establish the capacity of local volunteer workforces that could support individuals, who do not require assistance to enter/exit a vehicle, to attend their secondary care appointments.

Public awareness and involvement

- The further work – over and above the undertaken public involvement – to specifically prepare the public for the change to the national eligibility criteria.

Yorkshire Ambulance Service

- The further work that is required to understand any additional call handling requirements within YAS to support the implementation of the national eligibility criteria and explore options for how this could be managed - including any additional investment that is required and to assess whether there is a clear return on investment should WYICB, and neighbouring Integrated Care Boards in Yorkshire and Humber support additional investment.
- The call handler performance for when calls should be answered has been variable and the impact of the eligibility criteria on total demand could be marginal.

The WYICB's Transformation Committee were asked to review and consider each of the below points.

Individuals and journeys

- To consider that most individuals will continue to be eligible for NEPT, including renal haemodialysis patients; those with a significant mobility need that require assistance from a NEPT driver and crew to enter/exit a vehicle; and those who are unsafe to travel without a NEPT crew.
- To consider that the subsequent analysis indicates – once the above is considered – that there are only two areas of NEPT demand that remain: non-renal journeys in saloon cars, and non-renal journeys for wheelchair users. Collectively these are termed, 'non-renal SC/W1' journeys.
- To consider – from the commissioned work of the Yorkshire Ambulance Service (YAS) – that the implementation of the national criteria could reduce non-renal SC/W1 journeys by up to 20%. This would subsequently impact on up to one in ten individuals who would be seeking NEPT.

Outpatient appointments and Did Not Attends

- To consider that on average the impact of ineligibility for NEPT on the one in ten individuals (c.3,500) would concern attendance at close to four outpatient appointments per year (c. 13,500).
- To note – from the previous yearly data for non-renal SC/W1 journeys - that half of the 3,500 would have NEPT for a single outpatient appointment per year.
- To consider – in terms of worse-case scenario – that should 13,500 appointments equal 13,500 'Did Not Attends', then this would – for illustrative purposes only - equate to 8% of the

total number of Did Not Attends that West Yorkshire acute hospital trusts experienced in 2023/24 from the West Yorkshire population.

- An additional 13,500 Did Not Attends would increase the 2023/24 total Did Not Attend rate experienced by West Yorkshire acute hospital trusts from the West Yorkshire population by 0.5%. In 2023/24 the total number of DNAs was c.170,000 out of c.2,800,000 appointments.

Managing non-renal SC/W1 journey demand

- To consider – given that the one in ten individuals (c.3,500) would not be requiring NEPT for safety reasons - the suitability of local volunteer workforces paid through mileage reimbursement to transport individuals. This could be individuals self-funding this, where they can and choose to do so, and/or the WYICB paying for such individuals to access this (as an alternative means for those eligible under the HTCS). The latter could be funded through the existing budgets for mileage reimbursement, noting that there is a required action to address the found variation across West Yorkshire.
- To consider – in-terms of non-renal SC/W1 journeys within the YAS NEPT Service – that currently c.40% are undertaken by private taxi firms. The use of local volunteer workforces (paid through mileage reimbursement) would also provide an opportunity, in terms of lower cost and improved quality, to consider how this whole area of demand is delivered.

Overall demand analysis and benchmarking

- To consider – from the overall demand analysis – that a 20% reduction in non-renal SC/W1 journeys does not equate to a 20% forecast reduction in yearly demand. Subject to the demand trends in the areas where individuals would continue to be eligible for NEPT, a 20% reduction in non-renal SC/W1 journeys could reduce total demand by 1.5%.
- To consider – in-light of the above – the requirements for additional call handling capacity, investment required – (including return on investment) – and the options for this.
- To consider – in-terms of benchmarking with the neighbouring South Yorkshire ICB – that the patterns of utilisation of NEPT, and the exhibited trends in demand are similar, and that these offer the basis for collaboration and how NEPT demand is delivered in the future.

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

☐ Improve healthcare outcomes for residents in their system

☐ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

The JHOSC is asked to:

1. Receive the paper that was presented to the WYICB's Transformation Committee in November 2024.
2. Review and provide comment to inform the series of actions that should be undertaken before April 2025.
3. Indicate if it should receive an update on the completion of the action plan prior to April 2025.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
Not applicable.
Appendices
1. Appendix 1: Overview of the 5 work areas. 2. Appendix 2: Summary of the national eligibility criteria and the mobility types within non-emergency patient transport. 3. Appendix 3: Equality and quality impact assessments. 4. Appendix 4: Findings from the public questionnaire. 5. Appendix 5: Financial rates of mileage reimbursement across West Yorkshire, the low-income scheme and travel claims. 6. Appendix 6: Step by step logic to assess the impact of ineligibility on future service demand. 7. Appendix 7: Did not attend analysis. 8. Appendix 8: Demand trends. 9. Appendix 9: Benchmarking with Yorkshire and the Humber ICBs. 10. Appendix 10: Call hander volume and performance.
Acronyms and Abbreviations explained
1. NEPT – Non Emergency Patient Transport 2. HTCS – Healthcare travel costs scheme

What are the implications for?

Residents and Communities	**There is a risk that a change to the national eligibility criteria could mean that some individuals – who do not have the means for independent travel – are no longer eligible for NEPT.**
Quality and Safety	**Individuals no longer eligible for NEPT, and without the means for independent travel, could miss (or face delays) in their secondary care treatment.**
Equality, Diversity and Inclusion	**There is a risk that the impact from a change in the eligibility criteria is disproportionately felt by some, including those in minority and under-represented communities.**
Finances and Use of Resources	**The recommendations from the 2021 national review of NEPT, including that for the national,**

	updated criteria, were each concerned with improving the sustainability of NEPT.
Regulation and Legal Requirements	**The WYICB has a legal duty (within its 'standing rules') to secure the needs of its patients.**
Conflicts of Interest	**Not applicable**
Data Protection	**Not applicable**
Transformation and Innovation	**The new national eligibility criteria follow a national review to improve the sustainability of NEPT services.**
Environmental and Climate Change	**There is a link between the method of transport (whether via NEPTS or independent travel) and carbon emissions, therefore any change in the eligibility criteria could impact on this.**
Future Decisions and Policy Making	**This paper to the Transformation Committee provides recommendations on how best to implement the nationally defined eligibility criteria**
Citizen and Stakeholder Engagement	**This is part of the areas of work, as detailed within the paper.**

1. Introduction

This paper provides to the JHOSC the detail that was presented by the EYOCB to its Transformation Committee in November 2024.

This includes:

- The progress made to-date in the five work areas, including the feedback received from the public involvement work.
- The future required actions – between November 2024 and March 2025 – that are required to be able to implement the national eligibility criteria.
- The feasibility of being able to implement the national eligibility criteria, as planned, from the 1st April 2025.

2. Update on each of the 5 work areas

To recall, the WYICB contracts with two providers of NEPT:

- YAS, which is the largest provider of NEPT and who cover all West Yorkshire; and,
- Lakeside, which is an independent sector provider that cover the areas of Bradford city, Bradford district and Craven.

Appendix 1 provides a diagrammatical overview of the WYICB's approach to assess how best the national eligibility criteria for NEPT services can be implemented. This consists of five work areas.

2.1 Reviewing the national criteria

In the paper to the Transformation Committee in July 2024, a summary was given of the national eligibility criteria, consisting of:

- The circumstances– significant mobility need and transport for renal haemodialysis – where an individual would automatically quality for NEPT.
- The subsequent circumstances – medical/individual safety, should automatic qualification not apply - where an individual would qualify for NEPT.
- The potential use of local discretion – should neither of the above two points apply – to define individuals' eligibility for NEPT.

The summary of the national criteria is included within appendix 2 (for ease of reference), along with the mobility types that are used to categorise NEPT demand. This is both in terms the type of vehicle used and level of assistance that individuals required to enter/exit a vehicle.

Through discussions with YAS (as the principal provider of NEPT to the WYICB), a 'significant mobility need' has been defined as where:

An individual needs (or could need) the support of more than just a driver to be able to safely enter/exit a vehicle used for NEPT.

When this definition is considered against the categories of mobility types, then there are only two that remain.

- 'Saloon car' (SC) transportation, where either an individual requires no assistance, or assistance from the driver to walk to, and enter/exit the vehicle.
- Wheelchair 1' (W1) transportation, where either an individual (as a wheelchair user) requires no assistance, or assistance from the driver to travel to, and enter/exit the vehicle.

It is then possible to state that any potential ineligibility would solely concern individuals seeking NEPT for SC or W1 transportation. Further, as it is possible - within the demand data for NEPT – to separate the journeys for renal haemodialysis, (as this is also an automatic qualification for NEPT), then not all SC/W1 demand could be impacted by the national criteria.

2.1.1 Population groups who will not be affected by a change to the national eligibility criteria

Those who have a significant mobility need, or require transportation to/from renal haemodialysis, will continue to be eligible for NEPT, and will not be affected by a change to the national eligibility criteria.

There are also the subsequent circumstances when an individual could qualify for NEPT under the national criteria. Within the national eligibility criteria these specific circumstances are:

- When it is medically unsafe for an individual to travel independently; and,
- When it is unsafe for an individual (outside of a specific medical reason) to travel independently.

These two circumstances provide an additional assurance that individuals requiring transportation for a mobility type – other than SC/W1 - will continue to be eligible for NEPT and will not be affected by a change to the national eligibility criteria. This is because the mobility types (appendix 2) that fall within the definition of a 'significant mobility need' also cover the potential support from a NEPT driver and crew for the supervision of medical/individual safety.

2.1.2 Population groups who would be affected by a change to the national eligibility criteria

The potential ineligibility for NEPT would concern those individuals who are seeking transportation for non-renal journeys that fall within the SC/W1 mobility types. Collectively these are termed, 'non-renal SC/W1' journeys, throughout this paper.

As it is the SC/W1 mobility types that only require the assistance of a driver, (and without the potential, additional use of a wheelchair), then there is a subsequent point as to whether individuals could quality for NEPT – for the non-renal SC/W1 mobility types – under either medical, or individual safety.

Through discussions with YAS, the subsequent approach has been to consider two factors:

- One, that not all individuals would be ineligible for journeys within the non-renal SC/W1 mobility types, as a driver enables an accompanying escort (friend/family member) to provide direct supervision to maintain an individual's safety.
- Two, to consider the specific journeys within non-renal SC/W1 demand, which do not potentially fall within the above point of supporting individual safety. An example would be the occupancy of NEPT vehicles (without an accompanying escort) to outpatient appointments where the 'outbound' part of the journey – to the appointment - is completed, but the individual aborts the 'inbound' part of the journey. This could suggest – with the assumption of the 'inbound' part of the journey being completed via independent travel – that there was no factor or individual (or medical safety) for the use of NEPT.

In conclusion:

It is those Individuals, seeking the use of NEPT for non-renal SC/W1, and where there is no factor of individual (or medical safety), who would be affected by a change to the national eligibility criteria.

2.2 Equality impact assessment

The WYICB has an established equality impact assessment to identify which individuals/communities across West Yorkshire could be affected by a change in how a service is commissioned.

The latest version of the equality impact assessment is in appendix 3. This version identifies who currently uses NEPT services across West Yorkshire,

so that this can guide which individuals/communities could be most affected by a change to the national eligibility criteria.

- 40% of people accessing NEPT live in the most deprived areas of West Yorkshire. This rises to 47% in Bradford.
- Two thirds of people accessing NEPT are aged 66 and above.
- Almost two thirds of those people aged 66 and above reside in the most deprived areas.
- Although less than 2% of journeys are taken by people under the age of 17, almost two thirds of this group live in the most deprived areas of the region.
- Most people accessing NEPT are White (70%) following by 5% Asian/Asian British and 2% Black/Black British.
- Only 38% of White people accessing NEPT live in the most deprived neighbourhoods compared to 65% of Asian/Asian British people, 66% of Black/Black British people and 50% of other ethnic groups.
- The majority of people accessing NEPT reside in major urban cities and towns (89%), with only 8% residing in rural towns and fringes.

2.3 Quality impact assessment

In addition, the WYICB has an established quality impact assessment to identify how individuals/communities across West Yorkshire could be affected by a change in how a service is commissioned.

The latest version of the quality impact assessment may be found in appendix 3. Within this, the considered impact on individuals being ineligible for NEPT concerns their potential non-attendance at outpatient appointments and the impact this could have on their health.

The further analysis within this area is detailed within sections 3 and 4 of this paper.

2.4 Public involvement

The WYICB commenced its first stage of public involvement on the national eligibility criteria for NEPT in September 2024. This has consisted of the use of a questionnaire, targeted towards the groups identified from the equality impact assessment. Appendix 4

The summary findings (as of the 24th October 2024) are:

- 8% of those surveyed (28 out of a total 351) were in receipt of NEPT.

- Of this, just under half of those in receipt in NEPT, felt – if they were ineligible for NEPT – that they would not attend the appointment.
- A lack of awareness of alternatives to NEPT, including financial reimbursement.

2.5 Mitigations for those who are ineligible for NEPT

In the paper to the Transformation Committee in July 2024, a summary was given of the two potential areas where local eligibility criteria could be used.

- The first concerned the potential local use of eligibility criteria, in addition to that nationally set, to define individuals' eligibility for NEPT. This would therefore concern the potential use of criteria that would determine who would receive non-renal SC/W1 journeys, beyond the factors of individual/medical safety. (All other mobility types would be unaffected by the national eligibility criteria.)
- The second concerned the potential, separate use of eligibility criteria to financially support individuals' independent travel to their secondary care appointments, when ineligible for NEPT.

2.5.1 Local eligibility criteria (medical)

The analysis undertaken to-date has not indicated that there is a need for local eligibility criteria (medical) to supplement that set nationally. Instead, any immediate focus should be on the provision of financial support.

2.5.2 The provision of financial support

Any independent travel - for those individuals ineligible for NEPT – would require either the help of friends/family, or such individuals having the financial resources to pay for this. This would concern individuals:

- Who gain the help of friends/family, or start to self-fund their travel, without knowing that they are eligible under the HTCS.
- Who gain the help of friends/family, or start to self-fund their travel, as they are ineligible for HTCS, without the cost of this being prohibitive, regardless of the required frequency of getting to secondary care appointments.
- Who gain the help of friends/family, or start to self-fund their travel, as they are ineligible for HTCS, but the cost of this becomes prohibitive, because of the required frequency of getting to secondary care appointments.

2.5.3 Healthcare Travel Costs Scheme

For those who are ineligible for NEPT and cannot self-fund their independent travel, then there is the possibility of gaining financial support through the Healthcare Travel Costs Scheme (HTCS). This is nationally, defined scheme, which concerns in terms of its national design:

- Individuals being aware of the HTCS and the evidence that they need to have to gain financial reimbursement for their independent travel. This could be evidence of a qualifying benefit/tax credit, or a certificate of low income.
- Individuals bringing such evidence with them to their secondary care appointments to be able to claim on-day financial reimbursement from a cashier's office, should one be available.
- Individuals being able to wait – should there not be a cashier's office – for their postal claim tor financial reimbursement to be made, which can take several months to process.

Further to this points, specific analysis of financial reimbursement for mileage to patients has found that there is an inconsistent approach across West Yorkshire. Appendix 5 details the different financial rates of mileage reimbursement that currently exist across West Yorkshire. The rate that an individual would currently receive is dependent on:

- Whether it from was a West Yorkshire hospital trust's cashier's office, where the financial rate of mileage reimbursement currently ranges from £0.15 per mile, to £0.25 per mile.
- Whether it is a postal claim that is reimbursed by the WYICB, where the historical rates of reimbursement from the preceding Clinical Commissioning Groups are being used, and range from £0.14 per mile, to £0.20 per mile.

2.5.4 Local eligibility criteria (financial) and schemes

The consideration about the potential use of local eligibility criteria for financial reimbursement of independent travel concerns whether the cost, for example, of self-funding transport to/from several secondary care outpatient appointments could be prohibitive to some and present a potential risk of non-attendance and an impact on their health.

The West Yorkshire Association of Acute Trusts (WYAAT) is currently embarking on a pilot scheme to run up to March 2025 to test how NHS pre-paid bus tickets could be given to individuals to minimise the risk of non-attendance. As this scheme has been designed to cover both those who are eligible for HTCS and those who aren't eligible for it, the findings from it will be important in three regards.

- To test – for those eligible for HTCS – whether this is a better way of administering HTCS, than the use of cashier offices and postal reimbursement forms.
- To inform – for those ineligible for HTCS and where the cost of them self-funding transport was considered prohibitive to their attendance at appointments – what a threshold for local financial eligibility could be.
- To test whether public transport across West Yorkshire supports individuals' timely attendance at their appointment, as feedback from the Joint Health Overview and Scrutiny Committee was that access to healthcare should not be dependent on the future development of a reliable public transport system.

Further to this, there is also the potential to consider the use of volunteer-led travel schemes within each Health and Care Partnership across West Yorkshire. This would be where volunteers are financially reimbursed for the mileage they undertake to transport individuals to their secondary care appointments. This has a link to the need (as stated above) to address the current variation in mileage reimbursement across West Yorkshire, as the basis for such a scheme would be paid volunteers at this rate, plus an additional amount for carrying a passenger. (The HRMC rate for the latter is £0.05 pence per mile.)

The information received from a freedom of information request to the NHS Business Services Authority, concerning the low-income scheme and travel reimbursement is included within appendix 5. This shows for the 23/24 financial year, and by Local Authority area of residence:

- The number of applications made for the low-income scheme ("HC1").
- The number of successful HC1 applications made, resulting in a certificate for full/partial contribution to health costs, including travel. ("HC2"/"HC3").
- The number of unsuccessful HC1 applications.
- The number of unresolved HC1 applications.
- The number of postal travel reimbursement claims made ("HC5").

Subsequent work with WYAAT is now building on this so that it can include those claims made to hospital trust cashier offices.

The intention is that each place-based Health and Care Partnership will be able to see the number of individuals within their area who have claimed through HTCS, and that each will be part of subsequent work between November 2024 and March 2025, to:

- Determine the capacity of volunteers, along with a host Voluntary Community Sector (VCS) organisation, who could administer the scheme, to provide a transport scheme that is both an alternative to the HTCS and to public transport for self-funders that are ineligible for HTCS.
- To generate publicity and awareness of individuals' eligibility for HTCS.
- To receive and review the findings from the WYAAT pilot scheme for the use of pre-paid bus tickets.
- To engage in the work – for those ineligible for NEPT and HTCS and where the cost of them self-funding transport is considered prohibitive to their attendance at appointments – on what a threshold for local financial eligibility could be.

2.5.5 Moving forward

Further to the above, the following are also required:

- To determine and seek approval for a single rate of financial reimbursement for mileage to patients across West Yorkshire.
- To seek approval - (as per the recommendation on the action plan for November 2024 – March 2025) - for a distinction between the role and responsibility of NEPT service providers to adhere to the national eligibility criteria that concern 'medical' need, and the role of responsibility of the WYICB to manage financial eligibility criteria.
- To seek approval – (as per the recommendation on the action plan for November 2024 – March 2025) for the creation of a WYICB policy that covers two areas: the right of individual appeal to it should it be felt that a provider of NEPT has not adhered to the national eligibility criteria, and to set out its approach concerning financial reimbursement/support.

  In terms of the latter point, it is recommended that this consists of:

  - The consistent rate of financial reimbursement for mileage to individual patients across West Yorkshire who are eligible for HTCS.
  - The consistent rate of financial reimbursement for mileage to volunteers providing transport across West Yorkshire, both to those who are eligible for HTCS and those who are ineligible for HTCS and are self-funders.
  - The qualifying criteria for financial support, for those who are ineligible for HTCS, and how individuals can apply for this.
  - An individual's right of appeal to the WYICB, either if it is felt that a provider of NEPT has not followed the national eligibility criteria/addressed their initial appeal, or they wish to appeal a WYICB decision of ineligibility against the qualifying criteria for financial support.

3. Demand analysis: ineligible individuals and journey types

3.1 Assumptions made

Two predominant assumptions have been made.

- The first – which is taken from the analytical work that YAS commissioned from a third-party provider - is to test the feasibility and impact of 20% of non-renal SC/W1 journeys being avoided with the implementation of the national eligibility criteria.
- The further predominant assumption has been to fairly omit the service activity data from Lakeside from this analysis. This is because of the comparatively low level of non-renal SC/W1 activity (c.3%) that Lakeside provide for Bradford city, Bradford district and Craven provide compared to the YAS NEPT service.

The areas of Bradford city, Bradford district and Craven are included in the further analysis (as detailed within this paper), but only for the YAS NEPT service.

3.2 Individual demand

Within appendix 6 there is a series of detailed pieces of analysis that identity:

- That 20% of non-renal SC/W1 journeys constituted c.8% of total YAS NEPT demand for the WYICB in both 22/23 and 23/24.
- That a 20% reduction in non-renal SC/W1 journeys would affect c.10% of the individuals who used the YAS NEPT service commissioned by the WYICB. This equates to c.3,600 individuals across West Yorkshire.
- That the c.3,500 individuals would have a total of c.13,500 episodes (or bookings) with YAS NEPT, when the 22/23 and 23/24 data is considered.
    - (An episode is defined as 1 or more journeys within a single day for each individual patient. This was created as within the YAS NEPTS data some types of service activity equate to two journeys being booked at the same time, and others only equate to a single journey. An example of the former would be the booking of travel for an outpatient appointment, which includes both outward and homebound travel; whilst an example of the latter would be the booking of travel from a hospital discharge to home. Because of these differences the use of journey data may inaccurately represent what the impact to individuals might be when seeking to book transport from YAS, should the national eligibility criteria reduce journeys for non-renal SC/W1 by 20%.)

- That it is a reasonable assumption, as over 95% of non-renal SC/W1 journeys (in both 22/23 and 23/24) were for outpatient appointments, that a reduction of c.13,500 would concern transport to/from these appointments.
- That on average c.3,500 would have just under 4 outpatient appointments that would have previously qualified for NEPT.
- That half of the c.3,500 – from the previous yearly data for non-renal SC/W1 journeys – would have received NEPT for a single outpatient appointment.
- That just half of the journeys (with regard to the 20% reduction) would concern private taxi use, where if the individuals ineligible for NEPT, were actually eligible under HTCS, could self-fund, or meet any financial criteria set by the WYICB, then there could be better ways of meeting this demand.

4. Outpatient Did Not Attend analysis

Within appendix 7 there is data for outpatient Did Not Attends for each acute hospital trust across West Yorkshire. This has been split to show the number of Did Not Attends from each Local Authority area within West Yorkshire and by Index of Multiple Deprivation.

The summary findings are that:

- There is a clear correlation between the greater the Index of Multiple Deprivation and the number of Did Not Attends, although this has not been adjusted for population size.
- In terms of worse-case scenario – that should c.13,500 appointments equal 13,500 ‘Did Not Attends’, then this would equate to 8% of the total number of Did Not Attends that West Yorkshire acute hospital trusts experienced – from the West Yorkshire population - in 2023/24.
- That an additional c.13,500 Did Not Attends would increase the 2023/24 total Did Not Attend rate experienced by West Yorkshire acute hospital trusts from the West Yorkshire population by 0.5%.

5. Demand and cost analysis

5.1 Demand trends

Within appendix 8 there are a series of tables that show the demand trends for the YAS NEPT service. The summary points from these are:

- YAS NEPT service demand for West Yorkshire has fallen for each year between 2016/17 and 2019/20 inclusive. This is also the case for the

demand that is ‘in-scope’ of the eligibility criteria (non-renal SC/W1) and those that is ‘out-of-scope’ of it.

- YAS NEPT service demand for West Yorkshire has increased between 23/24 and 22/23, but both were below the demand in 2019/20.
- YAS NEPT service demand for West Yorkshire in 24/25 (April to August) is greater than in 23/24, with the greatest percentage growth in ‘out-of-scope’ demand.
- That the number of journey aborts, which could be considered an area for improved efficiency, are consistent between 24/25 and 23/24 (April to August) but have growth by 12% in ‘out-of-scope’ demand.

Within appendix 9 there is benchmarking data – in terms of demand trends – with the South Yorkshire ICB, who also contracts with YAS for a NEPT service. The comparison between the data for the WYICB (appendix 9) and that for the South Yorkshire ICB (appendix 10) provides similar themes to each of the four above bullet points.

5.2 Impact of ineligibility on total and future service demand

Within appendix 6 there are a series of detailed pieces of analysis that start with the number of individuals who could be ineligible under the national eligibility criteria, through to the impact that this ineligibility could have on total and future YAS NEPT service demand for West Yorkshire. The summary findings from this work are:

- That it considered the service demand trends from 22/23 (full-year) to 23/24 (full-year and projected these trends to produce a ‘counter factual position’. This was both for demand that is ‘in-scope’ of the eligibility criteria (non-renal SC/W1) and those that is ‘out-of-scope’ of it.
- Based on this, and the assumed 20% reduction in ‘in-scope’ (non-renal SC/W1) demand, then the reduction in total demand, against the ‘counter factual position’, would be 1.5%
- For the reduction in the total demand to be greater than 1.5%, then there would have to be reductions in out-of-scope demand and aborts and escorts.
- The trend positions for 24/25 (April to August) and 23/24 (April to August) – as detailed in appendix 8 – do not show that there have been reductions in these areas.

5.3 Call handlers

As part of the discussions regarding how the national eligibility criteria could be implemented, YAS commissioned a third-party provider, to review the

required approach to call-handling. The work of the third-party provider considered that:

- Call times could increase by up to 10 minutes for ineligible callers.
- And that non-renal SC/W1 journeys could reduce by up to 20% (as already previously outlined).

The third-party provider subsequently concluded that additional call handers were required, which may require an additional investment £600,000 of non-recurrent funding across the ICBs in Y&H to support the additional capacity required.

The central premise, within the report received from the YAS, is that the additional call handers would support a 20% reduction in non-renal SC/W1 journeys, and that the savings from this would be greater than the cost of the call handers and be recurrent in nature.

This analysis, however, did not take into account the demand trends across all areas of NEPT demand (as described in section 5.2 and appendix 6). It therefore assumed that there would be close to an 8% reduction in total service demand, rather than the 1.5% reduction stated in section 5.2.

There is therefore a need to re-visit this work and to better understand what additional call-handling capacity may be required and to identify the options to manage this – whether this be through additional investment or opportunities to manage this within existing resources and what impacts this may have.

The Transformation Committee is therefore not being asked to commit to the non-recurrent investment for additional call-handers, but to note and agree to the further work that is required in this area, as detailed within section 7 – the required actions between November 2024 and March 2025.

Appendix 10 also provides the call handler volumes and performance for April-August 2023 and 2024. This shows that whilst performance has significantly improved - against the contractual standard for response times – in 2024, this can be variable, and should be part of the overall consideration as to whether there is a return on investment for additional call handers, should there be a need for additional funds over and above the current global financial sum with YAS.

6. Monitoring

6.1 YAS report

There is a current draft of a report that has been developed by YAS to monitor the impact of the implementation of the national eligibility criteria.

This includes:

- Monitoring the number of individuals in receipt of non-renal SC/W1 demand.
- Monitoring the volumes of demand by mobility types.
- Monitoring the volumes of aborts and escorts.

6.2 Other commissioned services

The subsequent intention – would be to engage with the other provider of NEPT in West Yorkshire – with the view that this is also adopted by them.

7. Required actions (November 2024 – March 2025)

The required actions – between November and March 2025 – to be able to implement the national eligibility criteria from the 1st April 2025 are provided below. These have been provided to assure the Committee on the work that is planned.

- To undertake further work with stakeholders, including the Joint Health Overview and Scrutiny Committee, to provide assurance that the completed analysis (as stated within this paper) shows that nine and out of ten individuals (including renal patients; those requiring assistance from a NEPT driver and crew to enter/exit a vehicle and those requiring supervision from a NEPT crew) will continue to be eligible for NEPT.
- The need to ensure that stakeholders are reassured that the national eligibility criteria would impact on up to one in ten individuals (c. 3,600), and only those that would have previously utilised NEPT (without the need for assistance/supervision from a NEPT crew) to attend an outpatient appointment.
- To undertake specific public engagement on the likely impact of the national eligibility criteria on non-renal SC/W1 transport, and that this is most likely to concern journeys to/from outpatient appointments.
- To design and implement a campaign to raise awareness of individuals eligibility for HTCS.
- To complete and gain agreement for a business case for a consistent rate of financial reimbursement for mileage.

- To identify, with each Health and Care Partnership across West Yorkshire, the capacity and funding required for a volunteer-led transport scheme in each area.
- To identify, given that 40% of non-renal SC/W1 journeys within the YAS NEPT service are undertaken by private taxi firms, what further opportunities – in terms of lower cost and improved quality – there are to consider how this whole area of demand is delivered.
- To develop and gain agreement for a WYICB policy for financial reimbursement/support.
- To further review, and to come to a collective agreement with the other Yorkshire and Humber ICBs on any investment requirements to support additional call handling requirements for the NEPTS service and how this might be supported (understanding the potential return on any investment) but to also explore alternative options with YAS for managing additional call handling demand.
- To finalise the monitoring report for the YAS NEPT service and to implement his across all providers of NEPT.

8. Sought position (April 2025)

The sought position, by April 2025, and to be able to implement the national eligibility criteria for NEPT, consists of having:

- A clear and agreed position that the responsibility for providers of NEPT services is only to assess individuals against the national eligibility criteria and for this to be consistent across Yorkshire and the Humber - as YAS cover the entirety of this area.
- An agreed position not to implement in West Yorkshire (or across Yorkshire and the Humber) any additional local eligibility criteria (medical) for NEPT. This is because the undertaken analysis hasn't identified a medical need for NEPT over and above those stated in the national eligibility criteria. The need for local eligibility criteria is because of financial need, and to minimise any impact on do not attend rates for outpatient appointments.
- A clear position that the WYICB holds the responsibility for local eligibility criteria for financial need, with an agreed policy to support this.
- A clear and agreed capacity plan (with costs) for the use of a volunteer-led transport scheme in each place-based Health and Care Partnership across West Yorkshire.
- A consistent price for mileage reimbursement across West Yorkshire.
- To have an agreed position across each ICB in Yorkshire and Humber and YAS - using the appropriate governance routes - with regard to the management of any additional call handling capacity required – whether

this will be through additional investment (including agreement on how this will be funded and return on investment this would bring) or opportunities to manage within existing capacity within the NEPT service (with full understanding of any potential impacts on performance).

- A clear vision for the best way to deliver non-renal SC/W1 journey types in future years, in terms of lower cost and improved quality.
- A clear monitoring report that can be shared with the Transformation Committee and other stakeholders.

9. Next Steps

The next steps shall consist of following and completing the actions stated within the provided plan for November 2024 – March 2025, and if supported, to return to the Transformation Committee – prior to April 2025 – for it to review the progress made and to determine if the national eligibility criteria can be implemented from the 1st April 2025.

10. Recommendations

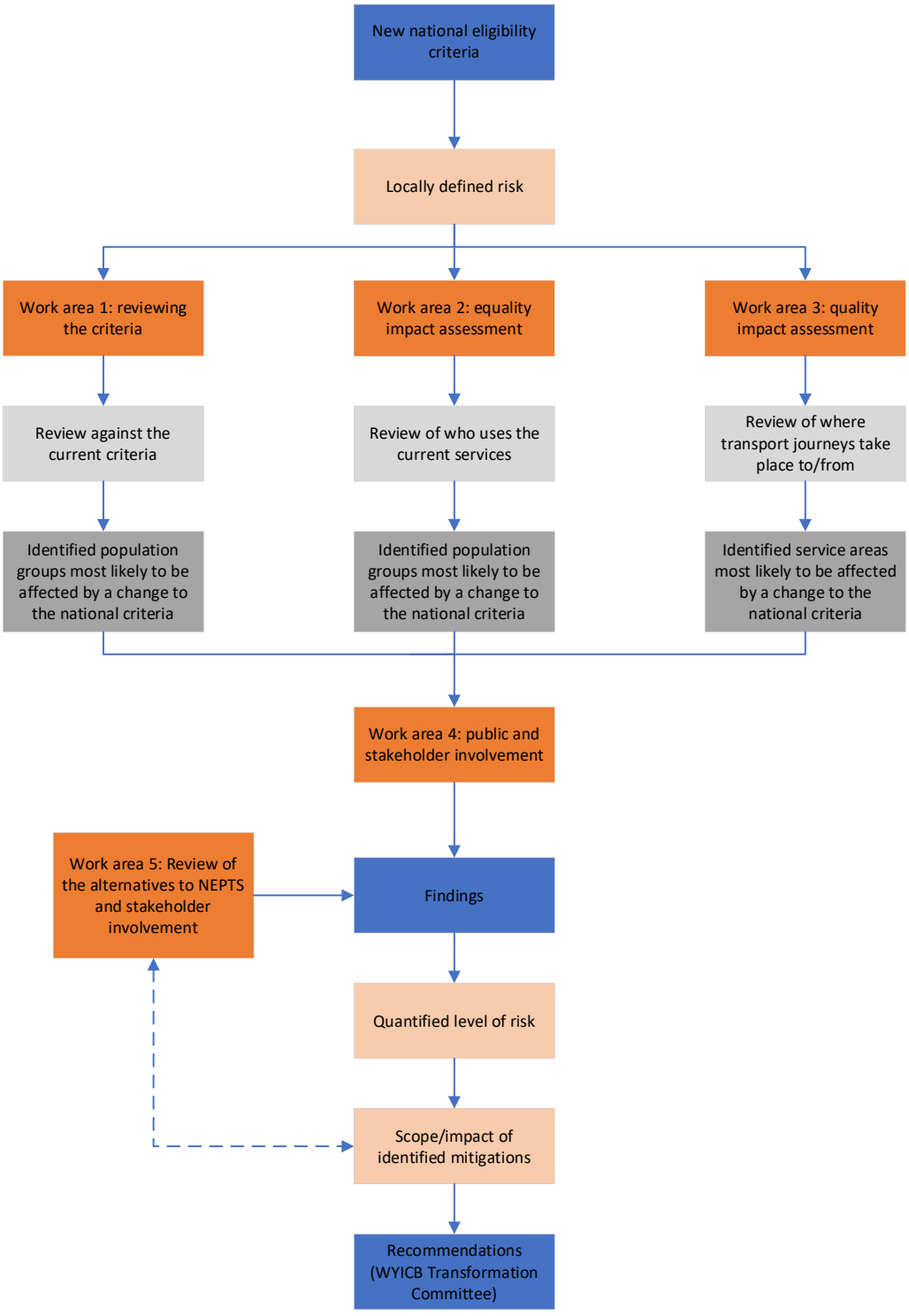
The JHOSC is asked to:

1. Receive the paper that was presented to the WYICB's Transformation Committee in November 2024.
2. Review and provide comment to inform the series of actions that should be undertaken before April 2025.
3. Indicate if it should receive an update on the completion of the action plan prior to April 2025.

11. Appendices

Appendix 1: Overview of the 5 work areas.
Appendix 2: Summary of the national eligibility criteria and the mobility types within non-emergency patient transport.
Appendix 3: Equality and quality impact assessments.
Appendix 4: Findings from the public questionnaire.
Appendix 5: Financial rates of mileage reimbursement across West Yorkshire, the low-income scheme and travel claims.
Appendix 6: Step by step logic to assess the impact of ineligibility on future service demand.
Appendix 7: Did not attend analysis.
Appendix 8: Demand trends.
Appendix 9: Benchmarking with Yorkshire and the Humber ICBs.
Appendix 10: Call hander volume and performance.

Appendix 1: Overview of the 5 work areas



Appendix 2: Summary of the national eligibility criteria and the mobility types within non-emergency patient transport

Summary of the national eligibility criteria:

Local category	Points of the standard eligibility criteria (a to f)	Summary description (eligibility for NEPT)
Automatic qualification for NEPT	Point D	Eligibility for travel to and from in-centre haemodialysis
	Point C	Eligibility because of a significant mobility need that prevents independent travel
Conditional qualification for NEPT	Point A	Eligibility because of a medical need during transportation
	Point B	Eligibility because of individuals (with a cognitive/sensory impairment) only being able to travel safely with the oversight of transport staff
Local discretion	Point E	Eligibility because of a safeguarding concern regarding independent travel
	Point F	Eligibility because of the potential for an individual's discharge or NHS treatment/appointment to be missed or delayed without NEPT

Mobility types within non-emergency patient transport:

Category code	Description
SC	**Driver only** The patient can walk to, and travel in, a saloon car or people carrier unaided or with little assistance from a driver. The patient can manage the steps on the vehicle with steadying assistance only.
T1	**Ambulance with driver plus tail lift** The patient can walk with the assistance of a driver to the vehicle. The patient can manage the step onto the vehicle with steadying assistance only. The patient may require assistance to the vehicle in the provider's wheelchair but they can transfer to the seat of an ambulance and there is easy access at home and destination (no steps) and requires the attention of the driver only.
T2	**Ambulance with driver and attendant plus tail lift** The patient cannot walk, and requires a wheelchair or carry chair supplied by the Provider, with the assistance of two ambulance staff to be transferred to and from the ambulance and/or the patient's

	mental/physical condition requires the attention of two staff and/or the patient requires oxygen whilst travelling.
W1	**Ambulance with driver plus tail lift (patient travelling in own wheelchair)** The patient is required to travel in their own wheelchair and cannot transfer. There is easy access at home and destination (no steps) and requires the attention of a driver only. This mobility can also accommodate wheelchairs with leg extensions.
W2	**Ambulance with driver plus attendant plus tail lift (patient travelling in own wheelchair)** The patient is required to travel in their own wheelchair and cannot transfer. There are steps at home and/or their condition requires a two-person crew. This mobility can also accommodate wheelchairs with leg extensions.
ST	**Stretcher** The patient must lie down for the duration of the journey, and/or has a full leg cast or patient is unable to bend their leg and cannot sit.
CH	**Child requiring child seat or booster seat** Children 12 years or under, or any child under the height of 4ft 5ins, requiring a child or booster seat. All children under 16 years must travel with an escort.
3ML	**Three-man lift** Ambulance with driver and two attendants to convey the patient. 72 hours' notice will be provided to allow a risk assessment to be undertaken prior to the journey.
4ML	**Four-man lift** Ambulance with driver and three attendants to convey the patient. 72 hours' notice will be provided to allow a risk assessment to be undertaken prior to the journey.
5ML+	**Five Plus-man lift** Ambulance with driver and four or more attendants to convey the patient. 72 hours' notice will be provided to allow a risk assessment to be undertaken prior to the journey.
ESC - Escort	A Healthcare professional, relative or carer escort /accompanying Service User.
Escort – Any Support Dog	May accompany a Service User if deaf, blind, or partially sighted. Service Users can only be accompanied by one Support Dog.

Appendix 3: Equality and quality impact assessments

WYICB NEPTS Eligibility EIA Draft v1.

QIA NEPTS Eligibility v19 DRAFT (26.9.24).

Appendix 4: Findings from the public questionnaire

Method and reach

The goal for this involvement work was to understand some of the wider issues and factors relating to travel to medical appointments. This approach was taken due to the complexity of the national eligibility criteria, and the uncertainty as to how the ICB might implement and mitigate the criteria.

People were invited to give their views via a web-based questionnaire. There was the opportunity for people to participate via paper questionnaire that could be returned via freepost envelope.

Key groups highlighted by the equality impact assessment were: those over 65 years old, people from the Asian community, people form the Black community, people living in areas of deprivation (particularly in Bradford), and those from areas of high service use (Wakefield, Calderdale, and Kirklees). These key groups were targeted with the invitation to participate through the questionnaire. People living with and beyond cancer were also targeted through the West Yorkshire and Harrogate Cancer Alliance.

351 people responded to the questionnaire. Demographic analysis showed 61% of respondents were over the age of 60. 4% of respondents were from an Asian background, 1% from a Black Background. 56% response from Leeds, 24% response from Kirklees, 9% from Bradford, 6% from Wakefield. Of those responses from Bradford, Calderdale, Kirklees and Wakefield over half came from the two most deprived quintiles. 94% of participants had recently had a medical appointment.

We also reached out to these groups with the offer of a discussion or focus groups. We attended Wakefield Health and Care Partnership People's Panel to discuss the involvement. A number of groups replied to our invitation highlighting that they had already participated in involvement exercises and highlighted issues with travel to medical appointments, and would send this rather than repeating their views and experiences. A number of involvement findings reports have been received, analysis of these will be included in the full report.

Summary Findings

General Travel

The majority (64%) of people participating in the questionnaire use their own transport day to day, 30% use public transport, 17% rely on relatives friends and carers, 15% using private taxis. 1% using community transport. The majority of individuals use multiple methods of getting around.

Travelling to medical appointments

When people travel to medical appointments there is a change in behaviour, with individuals using a reduced range of methods. 44% use their own transport, 17% rely on relatives friends and carers, 16% use public transport, 12% use private taxi, 8% use transport provided by the NHS (5% Provided by NHS, 3% Non-emergency

ambulance). 4% identified other ways of getting to medical appoints, this predominantly seemed to be made of people walking to appointments.

People who mainly use their own transport day to day, use their own transport or a relative friend or carer to attend medical appointments, only 2% are likely to use travel provided by the NHS. People who mainly get around with support from relatives friends and carers, continue to rely on them to travel to medical appointments (58%), or a private taxi (8%).

Participants who mainly use public transport day-to-day seem to largely maintain this for medical appointments, however any change is likely to be to private taxi or travel provided by the NHS. Based on comments this is likely to be due to the complexity and length of time to travel to some medical venues by public transport; further analysis of this is required.

8% of respondents use travel arranged by the NHS or a non-emergency ambulance to attend medical appointments. The other groups have multiple methods for travelling to medical appointments i.e. they may use their own transport or a private taxi, this group seem to only use travel arranged by the NHS or a non-emergency ambulance to attend medical appointments. If this was not available almost half would not attend the appointment, the primary alternative being private taxi. It should also be noted that a number of free text responses highlighted difficulty using taxis and public transport due to issues with transporting their wheelchair or their mobility. 45% of respondents who use transport provided by the NHS have it arranged by the NHS as well. 65% arrange the transport.

Some respondents who use patient transport used the free text to outline their experience, although this was not disparaging the sentiment suggested that this was not a method of travel that would be chosen above others, as it is time consuming and involves a large amount of waiting. Users of transport provided by the NHS were complimentary of their drivers.

No participants use community transport to attend medical appointments, even those who do use that method to travel day to day. However, 3% of all participants would consider it if their main method of travel to a medical appointment was unavailable.

A small proportion of participants (<5%) do not use the same method to get home from their appointment as they do to travel to their appointment.

Reasons for support

45% of respondents feel they may need support travelling to medical appointments. This relates to a wide range of support needs including; anxiety for those with mental health, neurodiverse needs, and other vulnerabilities. They also include mobility issues, walking to and from drop off and pick up points, as well as difficulty in transporting wheelchairs on public transport and by private taxi. A number of participants also highlighted the availability of informal carers, relatives and friends with many highlighting the need for them to take time off work to support them in attending appointments.

Awareness of support and alternatives

The majority of participants are aware of the bus pass available to older people or disabled people. 52% of participants had heard of non-emergency medical transport, and 32% of community transport. However, only 14% of people had heard of the Healthcare Trave Costs Scheme, and only 2% access it; this appears less than those who are likely to be entitled i.e. less than those responding from areas of deprivation. However, this would require more detailed analysis.

Conclusions

- People's travel behaviour to medical appointments is not the same as their day-to-day travel behaviour.
- If travel arranged by the NHS was not available, about half of those who rely on this service would not attend the appointment. (8% of those surveyed used NHS transport.)
- If a person's main method of travel to medical appointments wasn't available, the majority would find an alternative. However, 13% of participants selected "Other", a high proportion reported that they would not be able to attend the appointment.
- How people choose to travel to medical appointments is complicated and varies and relies on a large number of factors. Choices seem to rely on what happens when they arrive at the medical appointment venue i.e. time of appointment, parking, distance of appointment location from the bus stop. As well as distance to the venue, as well as cost. Inconvenience is more of a factor rather than convenience.
- Although there is a perception that people are abusing the eligibility for transport provided by the NHS, this is not suggested by the findings of this involvement. Those using this support offer seemingly have little option, and this mode appears to be far less convenient than others.

Appendix 5: Financial rates of mileage reimbursement across West Yorkshire, the low-income scheme and travel claims

Financial rates of mileage reimbursement across West Yorkshire:

WY Acute Hospital Trust On-site Cashier Office	HTCS Reimbursement Rate per Mile	Renal In-centre Dialysis Patient Reimbursement Rate per Mile	Out of Area Patient Reimbursement Rate per Mile
Leeds Teaching Hospitals NHS Trust (LTHT)	22p	22p	22p
Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)	17p	No information	17p
Calderdale and Huddersfield NHS Foundation Trust (CHFT)	15p	22p	15p
Mid Yorkshire Hospitals NHS Trust (MYHT)	25p	25p	25p
HC5(T) Postal Claim - Reimbursed by WYICB (pence per mileage rate)	Range from 14p to 20p (previous CCGs arrangements)		

The low-income scheme and travel claims:

		Number made in the 2023/24 financial year (April-March)						
ICB registered General Practice population	**Matched Local Authority area of residence**	**HC1**	**Successful HC1**	**Unsuccessful HC1**	**Unresolved HC1**	**HC2**	**HC3**	**HC5**
NHS West Yorkshire	BARNSLEY METROPOLITAN BOROUGH COUNCIL	16	7	0	9	4	3	
	CALDERDALE METROPOLITAN BOROUGH COUNCIL	1,405	929	57	419	569	360	37
	CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL	4,135	2,720	121	1,294	1,646	1,074	39
	KIRKLEES COUNCIL	3,112	2,025	107	980	1,151	874	42
	LEEDS CITY COUNCIL	6,471	4,268	175	2,028	2,600	1,668	60
	NORTH YORKSHIRE COUNCIL	115	70	8	37	48	22	10
	WAKEFIELD METROPOLITAN DISTRICT COUNCIL	2,339	1,491	83	765	906	585	20
Total		**17,593**	**11,510**	**551**	**5,532**	**6,924**	**4,586**	**208**

*"HC1" is the term for an application to the low-income scheme. "HC2" and "HC3" are the terms given to the subsequent certification for full, or partial financial support (including travel), to those who qualify under the low-income scheme. "HC5" is the

term for the form that can be submitted for travel claims. This is for individuals who qualify under the low income scheme, or are in receipt of a qualifying benefit/tax credit.

Appendix 6: Step by step logic to assess the impact of ineligibility on future service demand

The below points seek to logically structure and explain the potential impacts of moving to the national eligibility criteria for the West Yorkshire NEPT Service provided by YAS. This concerns both the impact of individuals and on service demand.

1. Within the data held by YAS it is possible to define the number of individual patients (registered to a General Practice within the NHS West Yorkshire Integrated Care Board) who have used the NEPT Service. The two below tables show the number of individual patients who used the West Yorkshire NEPT Service provided by YAS within respective time-periods.

	22/23 financial year	23/24 financial year
Total number of individual patients who used the West Yorkshire NEPT Service (YAS)	36,933	37,859

	22/23 (April to August inclusive)	23/24 (April to August inclusive)	24/25 (April to August inclusive)
Total number of individual patients who used the West Yorkshire NEPT Service (YAS)	21,198	20,866	22,447

2. The data held by YAS has numerous fields within it that can be used to focus on specific areas of service demand. This includes, for example, being able to specifically identify the service demand for renal in-centre haemodialysis and the mobility types where a vehicle/additional support is required to be able to safely transport an individual with a significant mobility need.
3. The mobility types are appended to this paper. They range from unaided patients, who only require a driver either in an unmodified saloon car (category ‘SC’), or in a vehicle that has been adapted to carry a wheelchair (category ‘W1’), through to those who require the use of an ambulance and support staff.
4. Through work undertaken by YAS, the mobility types, ‘SC’ and ‘W1’ would be used for individuals who do not have a significant mobility need.
5. The new national eligibility criteria for NEPT services provides automatic eligibility for individuals who require transport for renal in-centre haemodialysis, and those who have a significant mobility need. For these groups of individuals – a move to the new national eligibility change would not affect their eligibility for NEPT services. As this does not equal a change, they can be fairly omitted from any further analysis.

6. By omitting the individuals where there would be no change, the remaining individuals are those who would fall within either the SC/W1 mobility types for non-renal service activity.
7. The tables shown under point (1) can be modified to show the number of individuals who would fall within the SC/W1 mobility types for non-renal service activity.

	22/23 financial year	23/24 financial year
Number of individual patients who used the West Yorkshire NEPT Service (YAS) for non-renal SC/W1 service activity	18,107	18,456
Total number of individual patients who used the West Yorkshire NEPT Service (YAS)	36,933	37,859
Percentage of the total	**49%**	**49%**

	22/23 (April to August inclusive)	23/24 (April to August inclusive)	24/25 (April to August inclusive)
Number of individual patients who used the West Yorkshire NEPT Service (YAS) for non-renal SC/W1 service activity	10,468	10,171	10,696
Total number of individual patients who used the West Yorkshire NEPT Service (YAS)	21,198	20,866	22,447
Percentage of the total	**49%**	**49%**	**48%**

8. Through work undertaken by YAS it is estimated that a change to the national eligibility criteria could reduce journeys within the by SC/W1 mobility types for non-renal service activity by up to 20%. The below table shows the number of journeys a 20% reduction would equate to for full financial years, and what percentage this is of total service demand.

	22/23 financial year	23/24 financial year
Total number of delivered journeys (YAS West Yorkshire NEPT Service)*	310,949	322,526
Number of delivered journeys for non-renal SC/W1 service activity	129,881	125,823
Number of journeys (non-renal SC/W1) that could be reduced	**25,976**	**25,165**
Percentage of the total	**8.4%**	**7.8%**

*Excluding cancelled/aborted journeys and escorts. Includes Core and Extra Contractual Journeys.

9. Within the YAS data some types of service activity equate to two journeys being booked at the same time, and others only equate to a single journey. An example of the former would be the booking of travel for an outpatient appointment, which includes both outward and homebound travel; whilst an example of the latter would be the booking of travel from a hospital discharge to home. Because of these differences the use of journey data may inaccurately represent what the impact to individuals might be when seeking to book transport from YAS, should the national eligibility criteria reduce journeys for non-renal SC/W1 by 20%. As a result of this, a definition of an episode was created with YAS.
10. An episode is defined as 1 or more journeys within a single day for each individual patient. In this manner it is felt to better represent the actual number of bookings that individuals make, i.e. how many times they would be assessed against the national eligibility criteria.
11. The two below tables subsequently show the number of individual patients who used the YAS service for non-renal SC/W1 service activity – within a respective time-period – against the corresponding number of journeys and episodes.

	22/23 financial year	23/24 financial year
Number of individual patients who used the West Yorkshire NEPT Service (YAS) for non-renal SC/W1 service activity	18,107	18,456
Number of delivered journeys for non-renal SC/W1 service activity*	129,881 (Individual average = 7.2 journeys)	125,823 (Individual average = 6.8 journeys)
Number of delivered episodes for non-renal SC/W1 service activity*	68,610 (Individual average = 3.8 episodes)	66,579 (Individual average = 3.6 episodes)

*Excluding cancelled/aborted journeys and escorts. Includes Core and Extra Contractual Journeys.

	22/23 (April to August inclusive)	23/24 (April to August inclusive)	24/25 (April to August inclusive)
Number of individual patients who used the West Yorkshire NEPT Service (YAS) for non-renal SC/W1 service activity	10,468	10,171	10,696
Number of delivered episodes for non-renal SC/W1 service activity*	29,947 (Individual average = 2.9 episodes)	27,505 (Individual average = 2.7 episodes)	28,591 (Individual average = 2.7 episodes)

*Excluding cancelled/aborted journeys and escorts. Includes Core and Extra Contractual Journeys.

12. It is then possible to show the potential impact of a 20% reduction in journeys for non-renal SC/W1 in terms of the number of individuals who could be affected and the potential number of times they would be affected, i.e. being assessed against the national eligibility criteria and potentially having to find alternative means of travel.

	22/23 financial year	23/24 financial year
Number of journeys (non-renal SC/W1) that could be reduced with the national eligibility criteria*	25,976	25,165
Number of corresponding episodes (non-renal SC/W1) that could be reduced with the national eligibility criteria	13,670	13,324
Number of individuals that would be affected by a change to the national eligibility criteria	**3,608**	**3,701**
Percentage of the total number of individuals who used the West Yorkshire NEPT Service (YAS)	**9.8%**	**9.8%**

*Excluding cancelled/aborted journeys and escorts. Includes Core and Extra Contractual Journeys.

13. It can be concluded, when considering that the national eligibility criteria would impact on non-renal SC/W1 journeys only, that up to 10% of the total individuals who use the YAS NEPT service could be affected.
14. Supporting pieces of analysis (as detailed within the detail) highlight both the geographical patterns of YAS NEPT service demand, and that over 95% of non-renal SC/W1 journeys are to/from outpatient appointments. It therefore can be surmised that the journeys for the 10% of affected individuals would concern travel to/from outpatient appointments.
15. It is also possible – separately to the above individual patient level analysis– to consider what impact, if any, a 20% reduction may have on the total demand. As an initial example, the below table demonstrates, if the demand trends from 22/23 to 23/24 continued into 24/25, that a 20% reduction in non-renal SC/W1 activity could lead to a 4% reduction in actual yearly demand. This would, though, be a one-time gain, and does not include cancelled/aborted journeys which are included in the contract sum. (Further data has been requested to compare April-August 2024/25, against the same time-period in both 23/24 and 22/23.)

	22/23 financial year	**23/24 financial year**	**%age change**	**Counter-factual****	**Modelled scenario*****	**%age change from 23/24**
Non-renal SC/W1 journeys*	129,881	125,823	-3%	121,892	96,727	-23%
Renal SC/W1 journeys	75,110	84,764	13%	95,659	95,659	13%
Sub-total – SC/W1 journeys	**204,991**	**210,587**	**3%**	**217,551**	**192,386**	**-9%**
Sub-total - Non SC/W1 journeys	105,958	111,939	6%	118,258	118,258	6%
Grand total	**310,949**	**322,526**	**4%**	**335,809**	**310,644**	**-4%**

* Excluding cancelled/aborted journeys and escorts. Includes Core and Extra Contractual Journeys.

**Counter factual equals the continuation of the demand trends from 22/23 to 23/24.

***Modelled scenario equals the continuation of the demand trends from 22/23 to 23/24, and the additional 20% reduction in non-renal SC/W1 journeys.

16. Further to the above point it is possible to show the demand trends for cancelled/aborted journeys and escorts across the 22/23 and 23/24 financial years.

	22/23 financial year	23/24 financial year	%age change
Aborts/cancelled journeys	24,656	24,216	-2%
Escorts	49,876	55,254	11%
Total	**74,532**	**79,470**	**7%**

17. It is then possible – for cancelled/aborted journeys and escorts – to follow the same method that has been used under point (15), and to add this into the overall total demand analysis. These are shown in the two below tables. If there aren't any mitigations for these two areas, then the demand trends for them would reduce the percentage reduction on total demand.

	23/24 financial year	%age change	Counter-factual	Modelled scenario
Aborts/cancelled journeys	24,216	-2%	24,652	24,652
Escorts	55,254	11%	61,221	61,221
Total	**79,470**	**7%**	**85,873**	**85,873**

	22/23 financial year	23/24 financial year	%age change	Counter-factual	Modelled scenario	%age change from 23/24
Total journeys (excluding aborts/cancelled journeys and escorts)	310,949	322,526	4%	335,809	310,644	-4%
Aborts/cancelled/escorts	74,532	79,470	7%	85,873	85,873	7%
Grand totals	**385,481**	**401,996**	**4.3%**	**421,682**	**396,517**	**-1.4%**

18. Within the global sum payment approach agreed with the YAS since the Covid-19 pandemic there isn't a unit cost for the respective journey types (mobility types) for the YAS NEPT service. Discussions with YAS, however, have noted that the journeys within the non-SC/W1 mobility types attract a higher cost to them, than those within SC/W1 types. There is a subsequent risk – when forecasting a reduction in total demand by reducing lower-cost activity - that not only is it a one-off benefit, but it increases the average cost of journeys.
19. For SC/W1 journey types just under half of the journeys are via private taxi, as part of a sub-contracting arrangements between taxi firms and YAS.

Appendix 7: Did not attend analysis

Number of Did not attends received by West Yorkshire NHS hospital trusts from patients within the registered General Practice population of the NHS WYICB, split by Local Authority area of residence:

	23/24 financial year (April - March)			
Local Authority area of residence	**DNAs**	**Appointments**	**% DNA rate**	**%age change**
BARNSLEY METROPOLITAN BOROUGH COUNCIL	822	14,023	5.9%	
CALDERDALE METROPOLITAN BOROUGH COUNCIL	14,664	285,264	5.1%	
CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL	47,089	772,915	6.1%	
LEEDS CITY COUNCIL	72,101	1,036,207	7.0%	
NORTH YORKSHIRE COUNCIL	6,629	141,934	4.7%	
WAKEFIELD METROPOLITAN DISTRICT COUNCIL	27,426	583,407	4.7%	
Total	**168,731**	**2,833,750**	**6.0%**	
Potential DNAs from a 20% reduction in non-renal SC/W1 NEPT journeys (worse-case scenario)	13,497			
Revised figures	**182,228**	**2,833,750**	**6.4%**	**0.5%**

Number of Did not attends received by West Yorkshire NHS hospital trusts from patients within the registered General Practice population of the NHS WYICB, split by Indices of Multiple Deprivation (IMD) across the Local Authority areas of residence:

	23/24 financial year (April - March)		
IMD_Decile	DNAs	Appointments	% DNA rate
1	60,073	684,595	9%
2	24,405	368,813	7%
3	18,613	301,192	6%
4	10,297	204,265	5%
5	12,448	238,695	5%
6	10,951	238,343	5%
7	11,001	252,181	4%
8	8,924	222,237	4%
9	6,689	174,751	4%
10	5,330	148,678	4%
Grand Total	**168,731**	**2,833,750**	**6%**

1 represents the areas ranked with the highest deprivation. The areas included are the Local Authority areas of residence used in the first table in this appendix.

Appendix 8: Demand trends

1. Up to the Covid-19 pandemic trend

This is for core activity only. Extra contractual responses were not part of the regular contract reporting in this time-period.

Core activity

	Place	2016/17 financial year	2017/18 financial year	2018/19 financial year	2019/20 financial year
In-scope	Bradford	39,633	38,486	35,596	34,645
	Calderdale	28,026	26,612	25,093	22,933
	Kirklees	63,567	55,935	53,245	49,036
	Leeds	96,943	88,103	85,175	81,646
	Wakefield	63,722	61,985	59,501	57,122
In-scope Total		**291,891**	**271,121**	**258,610**	**245,382**
Out-of-scope	Bradford	19,450	17,460	16,070	14,134
	Calderdale	10,292	8,771	8,514	8,184
	Kirklees	23,876	22,978	20,617	20,503
	Leeds	31,283	30,300	27,386	25,632
	Wakefield	19,998	20,050	18,755	19,565
Out-of-scope Total		**104,899**	**99,559**	**91,342**	**88,018**
Sub-total		**396,790**	**370,680**	**349,952**	**333,400**
Aborts		41,004	39,291	36,900	35,328
Escorts		86,829	75,518	70,745	68,095
Total (core activity)		**524,623**	**485,489**	**457,597**	**436,823**

	%age difference between financial years		
	17/18 and 16/17	18/19 and 17/18	19/20 and 18/19
In-scope	-7%	-5%	-5%
Out-of-scope	-5%	-8%	-4%
Total	**-7%**	**-6%**	**-5%**
Aborts	-4%	-6%	-4%
Escorts	-13%	-6%	-4%
Grand total	**-7%**	**-6%**	**-5%**

2. 22/23 and 23/24
Core activity

	Place	2019/20 financial year	2022/23 financial year	2023/24 financial year
In-scope	Bradford	34,645	24,381	25,005
	Calderdale	22,933	18,943	19,631
	Kirklees	49,036	40,936	41,931
	Leeds	81,646	60,766	60,821
	Wakefield	57,122	41,211	42,731
In-scope Total		**245,382**	**186,237**	**190,119**
Out-of-scope	Bradford	14,134	13,526	14,829
	Calderdale	8,184	8,568	9,590
	Kirklees	20,503	23,293	24,483
	Leeds	25,632	29,484	30,862
	Wakefield	19,565	21,740	22,034
Out-of-scope Total		**88,018**	**96,611**	**101,798**
Sub-total		**333,400**	**282,848**	**291,917**
Aborts		35,328	21,520	21,265
Escorts		68,095	44,314	48,583
Total (core activity)		436,823	348,682	361,765
ECRs		Not available	36,692	40,150
Grand total		**436,823**	**385,374**	**401,915**

3. 23/24 and 24/25 (April – August)

	23/24 (April to August inclusive)	24/25 (April to August inclusive)	%age difference
In-scope	77,372	84,012	9%
Out-of-scope	40,734	47,881	18%
Sub-total	118,106	131,893	12%
Aborts	8,961	9,366	5%
Escorts	19,580	21,917	12%
Total (core activity)	**146,647**	**163,176**	**11%**
ECRs	16,868	16,603	-2%
Grand total	**163,515**	**179,779**	**10%**

4. Deeper dive – Aborts

	23/24 (April to August inclusive)	24/25 (April to August inclusive)	%age difference
In-scope aborts (core activity)	5,289	5,255	-0.6%
Out-of-scope aborts (core activity)	3,672	4,111	12.0%
Total aborts (core activity)	**8,961**	**9,366**	**4.5%**
In-scope aborts (ECR activity)	841	551	-34.5%
Out-of-scope aborts (ECR activity)	596	496	-16.8%
Total aborts (ECR activity)	**1,437**	**1,047**	**-27.1%**
Grant total aborts	**10,398**	**10,413**	**0.1%**

Appendix 9: Benchmarking with Yorkshire and the Humber ICBs

YAS South Yorkshire Comparison of Core activity by 2022-23 and 2023-24 Financial Year by Mobility Category and YAS South Yorkshire Comparison of Core activity by Mobility Category showing Previous Year v Current Year activity April to August inclusive:

Mobility Categories	2022-23	2023-24	Total	Mobility Categories	2023 April to August inclusive	2024 April to August inclusive	Total
SC	54,294	51,673	105,967	SC	21,905	20,889	42,794
T1	34,141	35,390	69,531	T1	13,991	16,342	30,333
T2	21,474	21,150	42,624	T2	8,051	9,974	18,025
W1	20,288	23,747	44,035	W1	9,809	10,569	20,378
W2	4,965	6,185	11,150	W2	2,188	3,221	5,409
STR	10,936	12,220	23,156	STR	4,756	5,164	9,920
CH	349	219	568	CH	76	108	184
3ML	591	1,120	1,711	3ML	436	721	1,157
4ML	948	820	1,768	4ML	296	375	671
5ML+	0	0	0	5ML+	0	0	0
Other	0	0	0	Other	0	0	0
Sub Total	147,986	152,524	300,510	Sub Total	61,508	67,363	128,871
Aborts	11,758	10,995	22,753	Aborts	4,532	4,988	9,520
Escorts	27,655	31,645	59,300	Escorts	12,311	15,107	27,418
Total	**187,399**	**195,164**	**382,563**	**Total**	**78,351**	**87,458**	**165,809**

YAS South Yorkshire Comparison of ECR activity by 2022-23 and 2023-24 Financial Year and by Mobility Category and YAS South Yorkshire Comparison of ECR activity by Mobility Category showing Previous Year v Current Year activity April to August inclusive:

Mobility Categories	2022-23	2023-24	Total	Mobility Categories	2023 April to August inclusive	2024 April to August inclusive	Total
SC	2,044	1,904	3,948	SC	858	745	1,603
T1	1,166	1,322	2,488	T1	532	432	964
T2	801	659	1,460	T2	207	254	461
W1	641	922	1,563	W1	330	285	615
W2	154	220	374	W2	102	86	188
STR	798	890	1,688	STR	350	414	764
CH	100	96	196	CH	50	22	72
3ML	35	40	75	3ML	11	18	29
4ML	49	37	86	4ML	17	17	34
5ML+	32	55	87	5ML+	22	16	38
Other	2	4	6	Other	2	0	2
Sub Total	5,822	6,149	11,971	Sub Total	2,481	2,289	4,770
Aborts	521	585	1,106	Aborts	227	191	418
Escorts	1,713	1,850	3,563	Escorts	780	736	1,516
Total	**8,056**	**8,584**	**16,640**	**Total**	**3,488**	**3,216**	**6,704**

Appendix 10: Call hander volume and performance

YAS West Yorkshire NEPT Service Telephony Performance

YAS Telephony Activity Performance April to August 2024 Inclusive

Telephony Performance	Apr-24	May-24	Jun-24	Jul-24	Aug-24	2024 Total KPIs (April to August inclusive)
Calls Offered	44,592	43,601	41,888	45,232	42,861	218,174
Abandoned Calls	2,356	3,347	2,806	2,314	2,092	12,915
Abandoned Calls %	5.3%	7.7%	6.7%	5.1%	4.9%	5.9%
Calls Answered	42,236	40,254	39,082	42,918	40,769	205,259
Calls Answered in 180 seconds	36,902	32,624	33,093	38,169	36,069	176,857
Target Performance %	90%	90%	90%	90%	90%	90%
Actual Performance %	87.4%	81.0%	84.7%	88.9%	88.5%	86.1%
Variance to Target %	-2.6%	-9.0%	-5.3%	-1.1%	-1.5%	-3.8%

Please note, calls Answered in 180 seconds (3 minutes) Target 90%

YAS Telephony Activity Performance April to August 2023 Inclusive

Telephony Performance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	2023 Total KPIs (April to August inclusive)
Calls Offered	35,897	40,525	44,777	40,354	40,007	201,560
Abandoned Calls	6,483	7,813	12,868	9,865	11,629	48,658
Abandoned Calls %	18.1%	19.3%	28.7%	24.4%	29.1%	23.9%
Calls Answered	29,414	32,712	31,909	30,489	28,378	152,902
Calls Answered in 180 seconds	13,275	13,584	7,401	10,389	6,627	51,276
Target Performance %	90%	90%	90%	90%	90%	90%
Actual Performance %	45.1%	41.5%	23.2%	34.1%	23.4%	33.5%
Variance to Target %	-44.9%	-48.5%	-66.8%	-55.9%	-66.6%	-56.5%

Please note, calls Answered in 180 seconds (3 minutes) Target 90%

Telephony Activity and Performance comparison from April to August Inclusive for 2024 and 2023

Telephony Performance	2024 Total KPIs (April to August inclusive)	2023 Total KPIs (April to August inclusive)	2024 v 2023 KPI Comparison	Demand and Performance Change
Calls Offered	218,174	201,560	16,614	↑
Abandoned Calls	12,915	48,658	-35,743	↓
Abandoned Calls %	5.9%	23.9%	-18.0%	↓
Calls Answered	205,259	152,902	52,357	↑
Calls Answered in 180 seconds	176,857	51,276	125,581	↑
Target Performance %	90%	90%	90%	Target
Actual Performance %	86.1%	33.5%	52.6%	↑
Variance to Target %	-3.8%	-56.5%	-52.7%	↑

Please note, calls Answered in 180 seconds (3 minutes) Target 90%

Data taken from Yorkshire Ambulance Service PTS West Yorkshire Consortium Report

West Yorkshire
Health and Care Partnership

West Yorkshire Joint Health Overview and Scrutiny Committee: Suicide Prevention Update
Date: 20 November 2024

This report highlights both the progress and the challenges faced in suicide prevention across West Yorkshire.

Please note the following caveats to the data and information shared:

- Data for population groups (age, gender etc) susceptible to suicide – figures are from 2019 - 2022.
- Each place has data based on population breakdowns and groups of most concern of suspected suicide, however this data fluctuates and varies and would depend on the timeframes of interest.

Introduction

This report provides an update on suicide prevention in West Yorkshire in line with the West Yorkshire Health and Care Partnership's (WYHCP) ambition to reduce suicide rates by a minimum of 10% over the next five years. It reflects the findings of the recent review of the Suicide Prevention Programme and highlights current trends, prevention funding, key risk groups, risk indicators of suicide, and progress achieved. It also incorporates the proposed two-strand approach for programme enhancement and development of the proposed Improving Population Health Academy.

Current Suicide Rates and Trends

The Yorkshire and the Humber region collectively has a suicide rate of 12.3 per 100,000, making it the fourth-highest regional rate in England.

Suicide rates in West Yorkshire have consistently remained higher than the national average since 2015, presenting an ongoing public health challenge. In 2021, 281 lives were tragically lost to suicide across the region.

Nationally, suicide rates among individuals under 30 are increasing, with local authorities identifying incidents involving those aged 17–18 as a concern. The National Real-Time Surveillance System (NRTS) data indicates rising suicide risks among younger adults; however, these trends require confirmation from coroners.

- Wakefield holds the second-highest suicide rate in West Yorkshire, with an upward trend particularly evident among younger populations.

- From the latest Office for National Statistics (ONS) figures (2018–2020), Calderdale's suicide rates were highest among men aged 25–44 (39.8 per 100,000) and 45–64 (32.5 per 100,000). Among women, the highest rates were observed in the 25–44 age group (10.9 per 100,000).
- Leeds data highlights particularly concerning rates for men aged 45–49 and those aged 90 and over, with women aged 50–54 also identified as a high-risk group.
- Bradford's gender-specific data reflects national trends, with 75% of suicides involving males (3 in 4) and 25% involving females (1 in 4).
- Kirklees have identified middle aged men as a key high risk group with high-risk populations including those with a history of self-harm, people in contact with the criminal justice system, individuals with untreated depression, and socially isolated individuals. (Kirklees suicide and self-harm prevention action plan 2020-2023)

Leeds-Specific Observations (2022)

- Leeds has maintained a suicide rate of 10.7 per 100,000 people, consistent with 2021 data. Approximately three-quarters of suicides involved males, equating to a male suicide rate of 16.4 per 100,000. The highest age-specific rates in Leeds were:
- Males: 90 years and over (32.1 per 100,000) and 45–49 (23.0 per 100,000).
- Females: 50–54 (7.8 per 100,000).

Calderdale-Specific Observations

Calderdale is actively revising its Suicide Prevention Strategy for 2025–2027, prioritising three critical areas: Prevention, Intervention, and Postvention. This work has been informed by input from the Suicide Prevention Network and targets high-risk groups, including:

- Younger adults, particularly those with or without neurodiversity.
- Middle-aged men.
- LGBTQ+ individuals.
- People leading complex lives.
- Individuals transitioning out of custody.

Efforts in Calderdale are also focused on improving access to bereavement support, which remains lower than in other areas of West Yorkshire. Additionally, the area is piloting an incident response and learning process to accelerate changes following suicide-related incidents.

Bradford Specific Observations

The most recent suicide audit, (Bradford, Calderdale and Kirklees combined) covering the years 2019–2021, provides a deeper understanding of the circumstances and risks associated with suicides:

- Age specific: Bradford reported a more even age distribution among suicides starting from age 26. Suicide rates among children and young people under 26 were lower (5.1 per 100,000) compared to the overall rate for all ages (10.13 per 100,000).
- Gender Distribution: Bradford's gender-specific data reflects national trends, with 75% of suicides involving males (3 in 4) and 25% involving females (1 in 4).

Kirklees Specific Observations

- Suicide rates in Kirklees (per 100,000) increased from 8.6 in 2011–2013 to 10.8 in 2017–2019. This rise reflects a higher trend compared to England overall.
- Male suicide rates in Kirklees have risen significantly, reaching 17.5 per 100,000 in 2017–2019, compared to 15.5 in England and 18.3 in Yorkshire & Humber.
- Female suicide rates in Kirklees remained relatively stable, but slightly increased from 4.4 in 2016–2018 to 5.9 in 2017–2019.

These findings emphasise the need for tailored prevention strategies that reflect local variations in age, gender, and risk factors. Collaborative efforts across West Yorkshire aim to continue to understand and address these challenges, focusing on real time surveillance data and robust local engagement. Through enhanced strategies and sustained investment, public health initiatives can mitigate risks and support communities in preventing further loss of life.

Efforts continue to strengthen public health interventions and regional support mechanisms across West Yorkshire

Key updates include:

- The development of resources for primary care, such as myth-busting guides and "what to do" guidance for practitioners, aimed at improving understanding and response to suicide risks.
- The widely valued West Yorkshire Suicide Prevention website, which serves as a comprehensive resource for information, help, and sharing best practices.
- Ongoing efforts to improve safety in high-risk public places, ensuring environments are designed to minimise risk and promote community well-being.
- Continue roll out of the West Yorkshire Suicide Prevention Training and campaigns.
- Collaborative Multi-Agency Approach: Continuing to build strong partnership working across sectors to address suicide prevention comprehensively, leveraging local knowledge and resources.
-

Suicide Prevention Champions Initiative

In March 2024, the West Yorkshire Health and Care Partnership launched a campaign to recruit 500 additional Suicide Prevention Champions by the end of the year, equivalent to two Champions for every suicide death registered in 2022.

Champions are trained to challenge the stigma surrounding suicide and promote prevention strategies. They gain access to resources, news, and support services to spread awareness in homes, communities, workplaces, and online.

Becoming a Champion involves a brief online registration, completing a 20-minute suicide awareness video by the Zero Suicide Alliance, and pledging to support suicide prevention. Since March 2024, 225 additional Champions have been recruited, bringing the total closer to the year-end target.

Prevention Funding

- Many initiatives depend on NHS Long Term Plan (LTP) funding for suicide prevention. Securing clarity on funding availability for 2025 and beyond is critical to ensuring continuity of these services.
- The Integrated Care Board (ICB) budget is presumed to be a key source for sustaining prevention funding.

Risk Indicators of Suicide

Understanding the risk indicators of suicide is a crucial aspect of developing effective prevention strategies. It is recommended to use the term “risk indicators” rather than “triggers” when discussing suicide, as the complexity of the issue often involves multiple, interrelated factors rather than a singular cause. These risk indicators highlight the need for a nuanced, trauma-informed approach to suicide prevention.

<u>Complexity and Accumulation of Risk</u>

Suicide is rarely the result of a single event. Instead, it often arises from the accumulation of traumas and difficulties over time. This complexity underscores the importance of understanding the broader context of an individual's life when assessing suicide risks.

<u>Key Risk Indicators</u>

Data from coroner audits and the Real-Time Surveillance System (RTSS) have identified the following key risk indicators:

- **Mental Health:** Conditions such as depression, anxiety, and bipolar disorder are strongly associated with an increased risk of suicide.
- **Physical Health Problems**: Chronic illnesses, disabilities, or terminal conditions can contribute significantly to suicidal ideation, particularly when they lead to a diminished quality of life or increased isolation.
- **Problematic Drug and Alcohol Use**: Substance misuse is both a risk factor and a coping mechanism for many individuals at risk of suicide, often exacerbating underlying issues.

- **Contact with the Criminal Justice System**: Individuals involved in the criminal justice system, whether as perpetrators or victims of crime, face elevated risks. Specific examples include those leaving custody, especially for offences involving children or domestic violence.
- **Social Isolation and relational risks**: A lack of meaningful social connections can lead to feelings of hopelessness and despair, increasing the risk of suicide.
- **Adverse Life Experiences**: Difficulties such as childhood trauma, abuse, or neglect contribute to long-term physical and mental health issues and increase vulnerability to suicide.
- **Situational and Environmental Risks**: work related stress, burnout, unemployment

Life Events and Timing

Certain life events have been identified as significant risk factors, though their impact often depends on individual circumstances and timing. Examples include:

- **End of a Relationship**: Events such as bereavement by suicide or the loss of custody of children can be devastating and are frequently cited as contributing factors in suicides.
- **Delays in Response**: The time gap between a adverse event and suicide complicates the identification of causation, further highlighting the importance of considering a range of contributing factors.

Access to the means for suicide

- **Access to Lethal Methods:** Ready availability of means, such as medication, high-risk locations, or ligatures, heightens the risk of suicide.
- **Catalyst Factors:** Impulsivity under the influence of drugs or alcohol can act as a catalyst in individuals at risk.

System level risk

- Toxic and traumatised culture in organisations
- Leaving mental health services
- Leaving custody
- Social media and online harms
- stigma

The risk indicators of suicide reflect a complex interplay of individual, societal, and environmental factors. Addressing these risks requires a collaborative, data-driven approach that incorporates both national strategies and local insights. By recognising and responding to these indicators, public health programmes can better support at-risk individuals and work towards reducing suicide rates across the region.

National and Local Patterns: These findings align with national evidence-based risk factors outlined in the national suicide prevention strategy. They are not unique to Bradford, Calderdale, or Kirklees, indicating the universal nature of these challenges across diverse populations.

Piloting New Approaches: To enhance understanding and responsiveness, Calderdale is piloting an incident response and learning process. This initiative aims to rapidly identify areas for change following suicide-related incidents, providing valuable insights into risk indicators and how they evolve.

Recommendations

1. Sustain and Strengthen Proven Initiatives

- Bereavement Services: Approve continued support for bereavement services, ensuring alignment with local needs and informed by regular data reviews.
- Campaigns and Communications: Refine and amplify initiatives such as *"Check in with Your Mate"* with trauma-informed messaging. Develop a structured communications strategy to promote awareness and reduce stigma.
- Place-Based Interventions: Tailor bespoke interventions to address specific community needs, especially in disadvantaged areas.

2. Build System-Wide Capabilities

- **Workforce Development**: Prioritise training in trauma-informed care, equipping professionals to address suicide risks effectively.
- **Collaborative Practice:** Expand forums like SPAN to share best practices and align suicide prevention efforts across sectors.

3. Support the ambition of reducing suicides and enhancing mental health support,

- Prioritise the development of a trauma-informed and responsive system across West Yorkshire by 2030.
- Embedding trauma-informed principles into all services and interventions, to address the underlying causes of distress and vulnerability, including adverse childhood experiences, trauma, and social inequalities. This approach will ensure that individuals at risk of suicide receive compassionate, tailored support that fosters resilience, reduces stigma, and promotes recovery, ultimately strengthening our collective ability to prevent suicides and improve mental health outcomes

4. Emerging Conversations: Improving Population Health Academy

Early discussions are underway to explore the potential expansion of the existing Health Inequalities and Adversity Trauma and Resilience Academies into a broader Improving Population Health Academy. These initial conversations aim to consider the inclusion of Suicide Prevention and Serious Violence, creating a unified framework to address interconnected public health challenges. It is

important to note that this approach is still in development and has not yet been fully consulted on or approved.

Centralised Support

The proposed academy would aim to consolidate resources and expertise, bringing together workstreams such as health inequalities, trauma-informed care, suicide prevention, and serious violence. This integration seeks to enable a more coordinated approach, providing a central hub for training, resources, and shared learning.

Benefits of Integration

By integrating these focus areas under one academy, the approach could:

- Reduce Duplication: Streamline efforts and resources to avoid overlap across separate programmes.
- Improve Innovation: Foster collaboration across interconnected areas, encouraging creative and effective solutions.
- Provide Holistic Training: Address cross-cutting issues with comprehensive training programmes tailored to the needs of various sectors and roles.

Tailored Interventions

While centralising support, the model would prioritise bespoke interventions to meet the unique needs of individual programmes and local contexts. The aim is to maintain flexibility while leveraging the benefits of a unified, system-wide approach.

Securing Sustainable Funding

These emerging plans would require sustainable funding to ensure programme continuity and success. Conversations are focusing on:

- Advocating for increased investment at both local and national levels.
- Exploring diverse funding streams, including grants, partnerships, and innovative financing models.

Monitoring, Evaluation, and Innovation

To guide and refine the academy's work, early proposals emphasise the importance of robust monitoring and evaluation. Key priorities could include:

- Strengthening tools like the Suspected Suicide Surveillance System to enable timely, data-driven responses.
- Regularly assessing the impact of initiatives to inform adjustments and allocate resources effectively.

Next Steps

These early discussions represent an opportunity to develop a unified framework that aligns with the West Yorkshire's wider strategic ambitions. Ongoing consultation and co-production with

stakeholders across sectors will be critical to shaping and refining this approach, ensuring it meets the diverse needs of communities and organisations across West Yorkshire.

Conclusion

The West Yorkshire Suicide Prevention Programme has made significant progress through system-wide collaboration and targeted initiatives. However, funding challenges and increasing demand underscore the urgency of sustained investment. By integrating the proposed enhancements, the programme can better address the wider determinants of suicide risk and move closer to a zero-suicide future.

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We will reduce the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population

WYJHOSC UPDATE PROVIDED BY THE WY MHLDA PROGRAMME

1.0 BACKGROUND

The following provides a broad summary of the action going on across the partnership to support this ambition. This has been put together through the WY Mental Health, Learning Disability, and Autism (MHLDA) programme, but it should be acknowledged that the work of the MHLDA programme represents only a small proportion of the work going on across the system addressing this partnership ambition.

*A more **detailed summary** of the **background to this ambition** and **progress towards understanding and reducing gaps in life expectancy**, including **data around progress and partnership KPIs**, is available in the paper shared recently with the **West Yorkshire Partnership Board here**.*

2.0 FRAMING WORK AROUND THIS ACTION

Broadly, this can be considered in terms of **primary** (addressing the wider determinants of health), **secondary** (early diagnosis and treatment), and **tertiary** prevention (preventing further deterioration of health). Although the exact details differ for different mental health conditions, for autism and ADHD, and for learning disabilities, the following broader areas of focus have been picked up at a WY level for particular focus.

2.1 PRIMARY PREVENTION

Promoting positive mental wellbeing and preventing the development of mental health conditions, with examples of ongoing MHLDA programme work including:

- Completion of a **MHLDA housing needs assessment**, highlighting gaps in current provision, and shared with partners to support us in addressing housing as both a determinant of poorer mental health, a barrier to discharge from inpatient settings, and a catalyst in generating physical health inequalities for MHLDA populations.
- Continued provision of our **WY Staff Mental Health and Wellbeing Hub** to support the mental health and wellbeing of our workforce, with additional wider system working co-ordinated by the WY MHLDA programme ongoing to support the resilience of the health and care workforce, acknowledging their roles as anchor institutions.
- Work around **anti-racism**, **cultural competency**, and **smoking cessation** as described in 2.2 and 2.3 that has cross-cutting impacts around primary prevention.

Outside of the MHLDA programme, this is an area in which the **VCSE sector**, **Local Authorities**, **WYCA**, **anchor institutions**, **place-based partnerships**, the West Yorkshire

ICB's **Improving Population Health Programme** and others also have significant influence, and their own widely varied programmes of work.

2.2 SECONDARY PREVENTION

Early and equitable recognition of deteriorating mental health, and early and equitable access to the right support, treatment, and services, with examples of ongoing MHLDA programme work including:

- A dedicated programme of work around **neurodiversity**, which recently hosted two **West Yorkshire neurodiversity summits**. The outputs of which are informing ongoing work with the ICB around the **strategic approach** to better understanding and meeting need for autistic people and people with ADHD in view of the current challenges around waiting times for diagnostics and treatment.
- Those providing mental health services are currently developing statutory plans around the "**Patient and Carer Race Equality Framework**" (PCREF), put together by NHSE to bring together preexisting legislation and additional regulation to mandate providers in becoming anti-racist. The WY MHLDA programme are supporting this work through a **WY racial equity steering group**, which is about to deliver the second **of three WY events** aimed at maximising the impact PCREF has across WY on racial inequity.
- Delivery of bespoke **Cultural Competency and Humility** training linked to community health transformation work, and supporting staff to better engage with racialised communities, positively evaluated in partnership with the University of Leeds.
- CAHMS offering risk assessments to children and young people on **national gender identity waiting lists**, in recognition of their long waiting times and the fact that they may not have any additional support offer whist waiting.
- Work supporting **access to crisis services**, especially in light of recent changes to **111 provisions**.
- Work around eating disorders, including:
    - A focus on **all age eating disorder care** across the whole pathway, with a particular focus on early intervention using the **THRIVE model**.
    - Acknowledging the potential for **BMI-based referral criteria to cause iatrogenic harm** through incentivising further weight loss to access services, with a pilot of the **CONNECT service** trialling an adjustment of the referral criteria in line with expected changes to the ICD11 diagnostic criteria to address these concerns.
- Partnership working around the **mental health/physical health interface**, **secondary prevention of physical health conditions** for MHLDA populations, and **access to smoking cession support,** some of which impacts secondary mental health prevention, as described in section 2.3.

Again, a wide variety of additional work is ongoing across the wider system, in particular with our **mental health**, **primary care**, and **wider community providers**, especially those organisations providing specialist **inclusion health** provision, support by West Yorkshire

inclusion health and health inequalities workstreams through the WY **Improving Population Health Programme**.

Additional work is going on around the implementation **Right Care Right Person**, facilitated through the **Criminal Justice and Mental Health Forum**.

2.3 TERTIARY PREVENTION

Preventing those with Mental Health Conditions, Learning Disabilities, Autism and ADHD from experiencing further inequity around their physical and mental health, with examples of ongoing MHLDA programme work including:

- The MHLDA programme is working with a range of partners working to promote the uptake, accessibility, and acceptability of **health checks and health action plans around serious mental illness and learning disability** including through the expansion and integration of interventional research.
- Linking insights from MHLDA programmes and services with ICB and **CORE20+5** ambitions around "**Secondary Prevention" of physical health conditions** to ensure people with MHLDA have their physical healthcare needs met.
    - Providing MHLDA input to **ICB "secondary prevention" transformation priorities** focussing on early recognition and management of physical health, ensuring that we have a focus on addressing the inequalities faced by MHLDA population in diagnosing and managing the key long-term conditions that contribute towards early mortality.
    - The MHLDA programme has linked data from programmes such as **LeDeR,** ensuring learning from deaths informs this process, and worked with a range of partners, including those in the **Health Innovation Network** and **Long Term Conditions** workstreams of the ICB's **Improving Population Health Programme** to support widespread uptake of evidence based and well evaluated solutions, including innovations such as the award winning "**Keeping My Chest Healthy**" in Bradford.
- The MHLDA programme has worked with the **West Yorkshire Association of Acute Trusts** (WYATT) through a **joint forum**, the governance of which is currently being re-visited to ensure we're adding the most value to the existing work across the physical/mental health interface going on across the system.
- Specific pieces of work being carried out by partners/places, and supported through the MHLDA programme, around the physical/mental health interface, including:
    - A project around **complex needs in gastroenterology**.
    - Developing and taking forward a training SOP around **nasogastric feeding,** supported by nasogastric feeding governance structures.
- **WY commissioners hub** collated information relating to inpatient access to physical healthcare and national screening programmes, highlighting variance in provision, with subsequent work in place to develop **standards to meet the physical healthcare needs of those in hospital**.

- Joint working with the **maternity system** around addressing inequalities in the perinatal period, recognising the impact that birth trauma/loss has on our population and the support we are offering around this, supported through **learning from incidents across Trusts**. Specific work carried out to address known inequalities in outcomes for **gypsy and traveller populations.**
- Close working with the **West Yorkshire Suicide Prevention Programme**, in recognition of the disproportionate impact suicide has on the mortality of people with mental health conditions, learning disabilities, and autism.
- **Reducing smoking** amongst people with mental illness, a key determinant of the gaps in life expectancy due to the disproportionately high smoking rates associated with a range of mental health conditions. Supported by work being led through the **Improving Population Health Programme** and **WY Tobacco Alliance,** there have also been specific projects carried out through the MHLDA programme, including work with **community pharmacy teams** around the provision of tobacco dependency services around mental illness and learning disability.

Once again, extensive work is going on around West Yorkshire aiming to address these inequalities. Including physical health optimisation work within our **mental health provider organisations**, work to address MHLDA inequalities by our **acute Trusts** (including trailblazing work around the employment of population health management approaches to support people with learning disability accessing physical health care), and examples of holistic multidisciplinary approaches to providing care across the physical and mental health interface.

3.0 SYSTEMS WORKING AND THE MHLDA PROGRAMME

However, people do not exist neatly in these boxes, and a key role for the MHLDA Programme is to work across the whole system to address complex and multicomponent inequity.

- **Consultant in Public Health** employed within the WY MHLDA programme to support system working, and linking existing programmes of work around health inequalities and prevention within the ICB's **Improving Population Health Programme (IPHP)**, and with a range of external partners, including the **West Yorkshire Combined Authority (WYCA).**
- **Data and Intelligence**:
    - A business case taken forward for WY-level sub-licencing ICB-held data across the health and care system to facilitate **data sharing** to support joint system working around health inequalities across whole pathways, aligned to recommendations made through the **Strathdee Report**.
    - Deep dives into specific areas with the aim of informing improvement around known challenges, with specific projects having been conducted around **Neurodiversity data** and **Learning Disabilities data**, and about to commence around **VCSE data**.

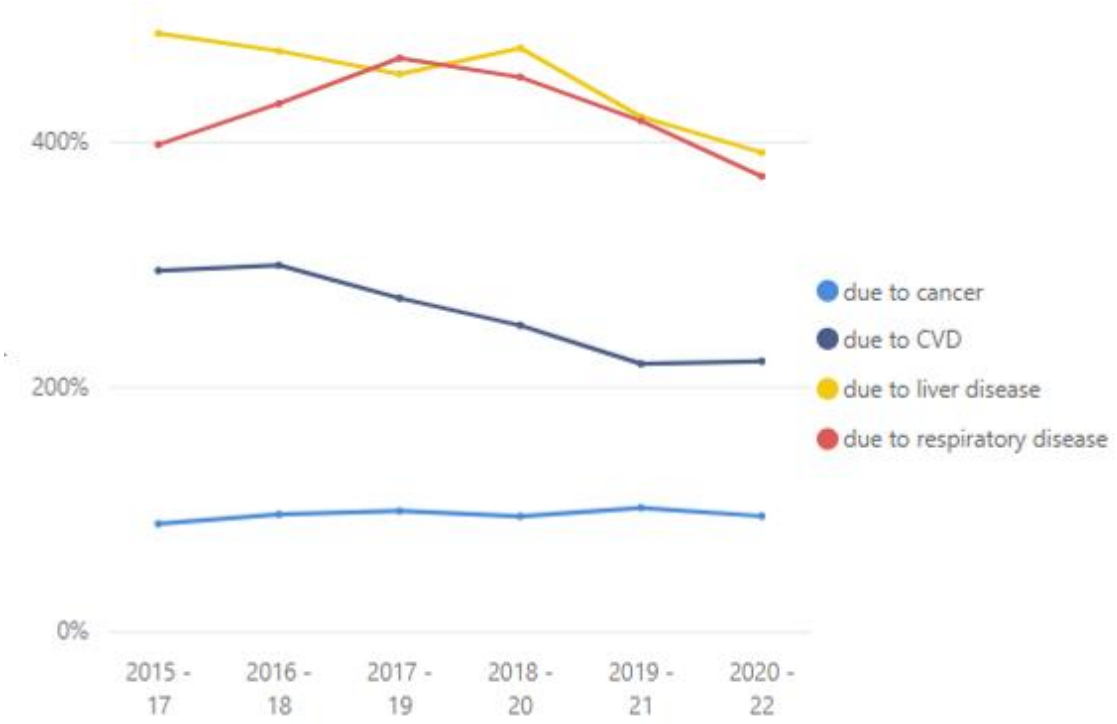
- Communication and joint working across West Yorkshire through regular data and **intelligence networks,** with the consultant in public health chairing a **regional data collaborative** to support escalation of key challenges.

- Working with the **Integrated Care Board** to support systems action around this ambition, including through support of recent board focuses on **health inequalities across the life-course**.

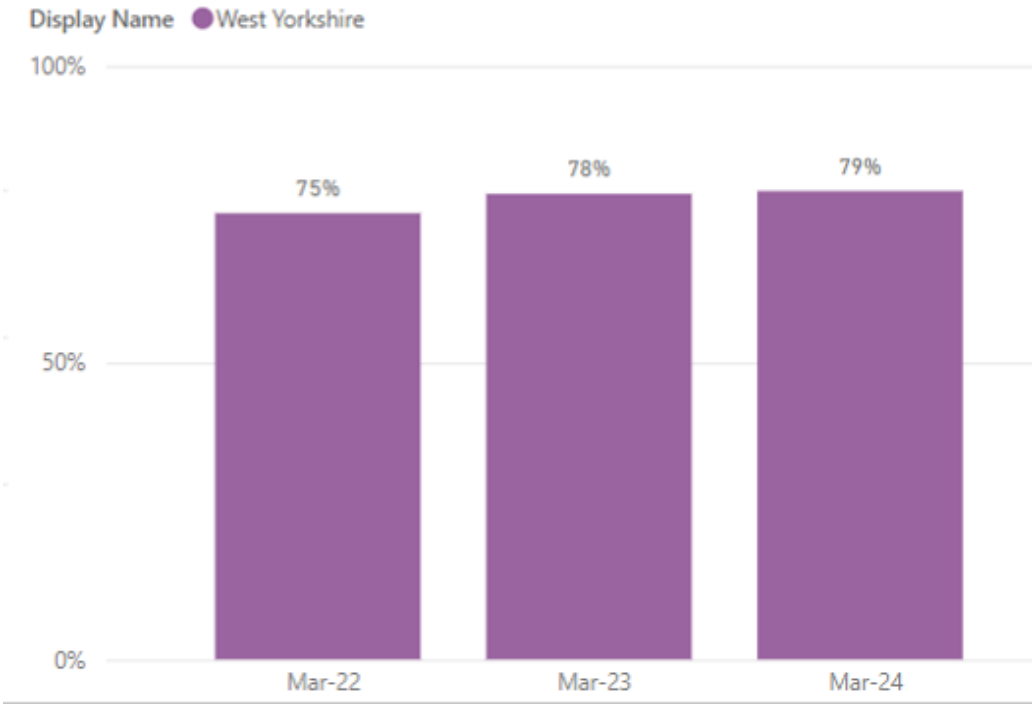
4.0 PERFOMANCE AGAINST THE AMBITION

The following metrics are compiled by the ICB to give an idea of high-level progress towards the ambition. Metrics around race equality measures are currently being worked up to align with metrics around PCREF. Whilst metrics are broadly trending in the direction we would like, measuring performance against a complex and multifaceted ambition such as this requires equally nuanced and detailed evaluation to fully understand, as is highlighted by the prioritisation in section 3.0 around the need to improve data and intelligence systems across WY.

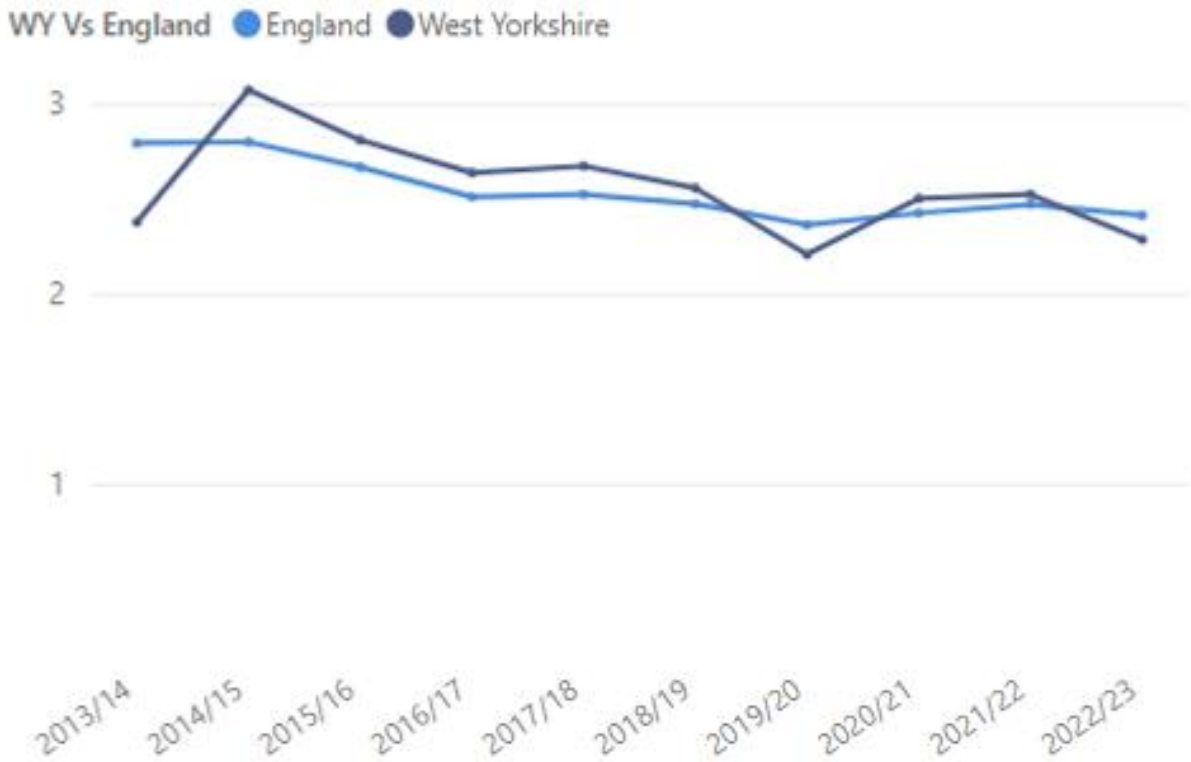
WY ICB Excess Mortality for People with SMI (Average for WY Places)



Percentage of people with a Learning Disability offered annual health checks



Odds of current smoking (self-reported) among adults aged 18 and over diagnosed with a long term mental health condition



4.0 SUMMARY

Premature mortality for those with poorer mental health, learning disabilities or autism contributes towards significant numbers of unnecessary deaths every year. Across West Yorkshire, we have committed to narrowing the life expectancy gap between the above populations and the general population. Whilst a large body of work is already underway to achieve this ambition, this is a goal that can only be achieved through concerted partnership working and addressing both healthcare inequalities and the impacts of wider determinants together.

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