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Date: 17 February 2025

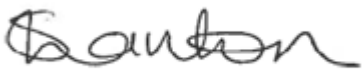
Notice of Meeting

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 **Tuesday 25 February 2025.**

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



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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 6 December 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: Yorkshire Ambulance Service (YAS) NHS Trust 9 - 14

The Committee will receive an update from representatives from the Yorkshire Ambulance Service (YAS) on the delivery of services and

recent developments across the West Yorkshire area.

Contact: Laura Murphy, Democracy Officer – Kirklees Council

6: Non-emergency Patient Transport Services - National Eligibility Criteria

15 - 26

The Committee will receive an update from representatives from the NHS West Yorkshire Integrated Care Board on the approach developed for non-emergency patient transport services and how the national eligibility criteria could be best adopted across the West Yorkshire area.

Contact: Laura Murphy, Democracy Officer – Kirklees Council

7: Memorandum of Understanding

27 - 42

The Committee will consider the adoption of a Memorandum of Understanding between the West Yorkshire Joint Health Overview and Scrutiny Committee and the NHS West Yorkshire Integrated Care Board.

Contact: Laura Murphy, Democracy Officer – Kirklees Council

8: Delegation of Specialised Commissioning Services to NHS West Yorkshire Integrated Care Board

43 - 74

The Committee will receive an update from representatives from the NHS West Yorkshire Integrated Care Board on the process to delegate specialised commissioned services from NHS England to the NHS West Yorkshire Integrated Care Board.

Contact: Laura Murphy, Democracy Officer - Kirklees Council

Contact Officer: Yolande Myers

KIRKLEES COUNCIL

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 6th December 2024

Present: Councillor Elizabeth Smaje (Chair)
Councillor Colin Hutchinson - Calderdale Council
Councillor Jane Rylah – Kirklees Council
Councillor Caroline Anderson – Leeds City Council
Councillor Andrew Scopes – Leeds City Council
Councillor Rizwana Jamil – Bradford Council
Councillor Allison Coates – Bradford Council
Councillor Betty Rhodes – Wakefield Council
Councillor Andy Nicholls – Wakefield Council

Apologies: Councillor Howard Blagbrough – Calderdale Council

1 Membership of the Committee
Apologies were received on behalf of Councillor Howard Blagbrough.

2 Minutes of the Previous Meeting
The minutes of the meeting held on 11 October 2024 were approved as a correct record.

3 Declarations of Interest
No interests were declared.

4 Public Deputations/Petitions
There were no deputations or petitions.

5 Patient transport services: the new national eligibility criteria
Simon Rowe, Assistant Director of Contracting and Ian Holmes, Director of Strategy and Partnerships – West Yorkshire Integrated Care Board (WYICB) were welcomed to the meeting to provide the Committee with an update on the new national eligibility criteria for non-emergency Patient Transport Services (NEPT).

At the October 2024 meeting, the Committee sought further information from the WYICB, including the proposed recommendation to its Transformation Committee in November. The Committee noted that in November 2024 the WYICB's Transformation Committee agreed to support in-principle the implementation of the national eligibility criteria from the 1 April 2025, subject to the completion of a series of recommended actions, and it receiving a progress report prior to April 2025.

The report advised the Committee that the WYICB Transformation Committee's decision was based on key themes which were outlined and detailed within the report: -

- Stakeholder involvement
- Mitigations
- Public awareness and involvement
- Yorkshire Ambulance Service (YAS)
- Individuals and journeys
- Outpatient appointments and Did Not Attends (DNA)
- Managing non-renal SC/W1 journey demand
- Overall demand analysis and benchmarking

The Committee sought clarification that the Transformation Committee accepted the national criteria, rather than rejecting any or part of the proposal, and Mr Rowe confirmed that was the case and that he would be returning to the Transformation Committee in February 2025 to report on progress.

The queried whether when considering the cost of additional call handlers and administration, the potential impact on workflow if there was an increase in non-attendance, the cost effectiveness and whether the savings would outweigh the additional costs had been considered.

Mr Rowe advised that the proposal was not a cost saving exercise in itself, but rather a national review to introduce standardised eligibility criteria across the country. Although the assumption was that additional call handlers would be required, that notion had been actively challenged as evidence that calls would lengthen by ten minutes was not shown. In addition the assumption that YAS would hear any right of appeal was also being challenged, as any appeal made should be independent of the organisation making the decision.

The Committee heard that the proposals would impact around 3,600 individuals which equated to around 12,000 outpatient journeys and have been able to map what this would look like in relation to DNA's.

The Committee noted the variation in mileage payments across the trusts, noting that other community organisations pay around 45p per mile. With the anticipated increase in demand for volunteer drivers, which would add to the community provider costs.

Mr Rowe explained that the administrative costs of the volunteer led schemes, would be less the NHS and partners costs to administer the current scheme, but would take some time and analysis to work through.

The Committee was particularly anxious that if the mileage payment was not sufficient, then the anticipated reliance on volunteer drivers would appear to be an area of concern for the project's success. The Committee also asked what mitigations were in place should a volunteer driver not be available at short notice.

Mr Rowe reiterated that the patients who qualified for patient transport would still get it, and individuals who had their own transport, their rate of mileage was not dependent on which trust their appointment is at. Where appropriate, pre-paid bus tickets would be provided to patients to enable to transport themselves, and this was currently being piloted. As an additional option, the use of volunteer drivers formed part of a suite of options available for an overall approach but would be kept under review.

The Committee was advised that the data showed which communities were not claiming as part of the travel cost schemes, and work would be undertaken to target those communities.

Mr Rowe explained that before February 2025 when he would return to the Transformation Committee, he is hopeful that a consistent mileage allowance would be identified across West Yorkshire. The results of the pre-paid bus ticket pilot would be available for analysis and whether WYICB would be part of a national pathfinder to simplify the travel costs scheme. Alternatively, if it was not part of the pathfinder, then a scheme would be introduced by the ICB.

The national pathfinder was set by NHSE, given the reports that the travel scheme was complex and difficult to manage, where ICB's would bid to be part of the pathfinder to understand and implement the scheme.

Mr Rowe advised that YAS needed to ensure that it could cope well with the demand that it received, particularly in relation to those with the most complex needs. The efficiency and current number of call handlers would be analysed to ensure that their performance would be used to best effect. Broader overall efficiencies were being sought around call handing, including ensuring clinicians could book travel online, rather than having to contact the call centre.

In relation to how the appointment system could be adjusted in relation to DNA, the Committee wanted to understand the discussions with the trust were progressing. The Committee was advised that the reasons for DNA's were multiple and multi-faceted, with rarely one single reason for a patient not attending. Work was also taking place to ensure that patients were only recalled to hospital where absolutely necessary, and for the use of telephone appointment to be used when appropriate.

RESOLVED - The committee noted the information and agreed that:

1) The WYICB be thanked for their report and attendance at the meeting.
2) Further information be provided to the Committee in relation to: -

    (i) the costs in relation to call handing which would ensure a robust system
    (ii) the proposal for an independent right of appeal
    (iii) the business case for payment of volunteer drivers
    (iv) the standardisation of mileage payments,
    (v) the results of the pilot for the pre-paid bus tickets

(vi) the difference in uptake between postcodes for travel claims, and whether these were areas of deprivation or other recordable factors.

3) A further discussion take place with the Chair, Deputy Chair and Ian Holmes relating to the JHOSC's recommendation to the Transformation Committee.

6 Suicide Prevention

Emmaline Irving, Head of Improving Population Health, West Yorkshire Health and Care Partnership attended the meeting to update the Committee on suicide prevention.

The report provided an update on suicide prevention in West Yorkshire in line with the ambition to reduce suicide rates by a minimum of 10% over the next five years. It also reflected the findings of the recent review of the Suicide Prevention Programme and highlighted current trends, prevention funding, key risk groups, risk indicators of suicide, and progress achieved.

The report outlined current suicide rates and trends and provided data in relation to each Local Authority area. Significant progress had been made through system-wide collaboration and targeted initiatives. However, funding challenges and increasing demand underscored the urgency of sustained investment.

In understanding the most 'at risk' groups and to enable a targeted approach, the Committee raised concerns regarding the scarcity of ethnicity data and the merging of ethnic groups within records. The Committee believed a letter to the Chief Coroner to address this issue would be appropriate.

The Committee reiterated their concern around the correlation between unemployment and suicide rates, particularly in some areas for young adult males, and wanted to understand what targeted work in these areas was being undertaken.

Ms Irving advised the Committee that a deep dive had begun to understand who the 'at risk' groups were and to target particularly young at-risk groups. Non-engagement with the education system was a risk factor, and not aspiring to achieve, and so understand how to intervene early was important to ensure engagement with education.

In understanding the importance of employment and health, the Committee was advised that WY was to be an accelerator area for increasing economic activity receiving £20m from the Government to reduce the growth in economic activity and the impact on the prosperity of the region on employment and health and wellbeing.

The Committee noted that each suicide had a financial cost £1.67m, and there was concern about the non-recurrent funding from a national level and questioned what the ICS was doing to ensure funding the prevention strategy. In response, the Committee heard that it was difficult to know whether funding would continue in its current form, particularly when considering the recent change of Government.

The data available to the Committee ended in 2021, which then made it difficult to understand the impact of the strategy which came into force in 2022. The Committee heard that this was due to a delay lag in the data from the Office for National Statistics, although work was being undertaken to use 'real-time' data and looked at how that could be enhanced.

It was also noted that one of the biggest risk factors for suicide was being employed by the NHS, and the Committee asked what was taking place at an employer level to identify the risks.

Ms Irving explained that there was a trauma informed task and finish group set up looking at staff trauma and the reasons behind that, recognising that if the workforce is not cared for, staff cannot care for others.

In relation to the support from Job Centres, the Committee queried whether the workforce would be trained in suicide prevention. Ms Irving responded to say that there was an Adversity Trauma Resilience National Lead within the DWP who have approached the ICB to begin some pilot work within job centres to train the workforce.

In relation to education, the ICB had a task and finish group for the adverse trauma and resilience programme, which had a good cross section of representation from schools, higher education, and universities across West Yorkshire.

RESOLVED - The committee noted the information and agreed that:

1) The committee write to the Chief Coroner to request an improvement the recording of ethnicity data.
2) A further discussion take place at a future meeting of the Committee regarding West Yorkshire being an accelerator area for increasing economic activity.
3) Key Performance Indicators and highlight reports be provided to the Committee where appropriate.

7 Life Expectancy

The Committee welcomed Keir Shillaker, Programme Director for WY Mental Health, Learning Disability and Autism (MHLDA) Collaborative to the meeting.

The report provided to the Committee advised that the programme could 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 had been picked up at a WY level for particular focus.

The Committee noted that Premature mortality for those with poorer mental health, learning disabilities or autism contributed towards significant numbers of

unnecessary deaths every year. Across West Yorkshire, the ICB had committed to narrowing the life expectancy gap between the MHLDA populations and the general population. Whilst work was already underway to achieve the ambition, it was a goal that could only be achieved through concerted partnership working and addressing both healthcare inequalities and the impacts of wider determinants together.

The Committee questioned the way in which care is provided in supported living and residential settings, particularly those with learning disabilities whether the attention is making sure that cultural sensitivities are within the care plans. Those responsible for delivering the care are often transient workers on the minimum wage, and the managers of the establishments often do not appear to have the understanding, training and awareness in the care being delivered to vulnerable people in society.

In response, Mr Shillaker agreed that this was a national problem, but there had been a change in the acceptance that all people delivering care need to understand people who require care who have a learning disability and autism. The Integrated Care System as a whole had been asked to roll out the 'Oliver McGowen Mandatory Training' which was a set of training packages for anyone working in health and care and the ICB was trying to ensure that this training was rolled out to all partners.

Mr Shillaker described the difficulties across MHLDA in relation to recruitment and retention, and whilst some areas of the service were paid better than others, there were still challenges relating to the nature of the job and the emotional toll it took to look after people with MHLDA.

In asking how we know care is successful without objectives to measure it, Mr Shillaker explained this was often down to how well the personalised care had been planned, and what the point of it was, why are the person was in the setting, and what was the benefit. This did work well in pockets, but tracking progress was difficult. The NHS was often measured on access i.e. the number of people seen, but now the focus was partly on access, but was now seeing a shift to a focus on outcomes.

The wider issues around the impact of MHLDA such as employment, housing, and the children currently with and waiting for Special Educational Needs and Disability (SEND) provision were noted.

In relation to healthy life expectancy, rather than just life expectancy and assessments for neurodiversity, and the lengthy waits, and whether these ones would be captured within the data set given and therefore the accuracy of it.

Mr Shillaker explained that a person would need a diagnosis to be included within certain data sets, with the waits for assessment being too high. There is some variation in WY as they are set up differently, which was why the issue of standardisation across the area was being considered. However, regardless of whether a person had a diagnosis, or was waiting for a diagnosis, that person still had needs, and the consideration was around how much resource was put into diagnosis, when the reality was the support such as reasonable adjustments in employment and education was the important aspect.

The Committee questioned whether suitable housing was important and asked whether within the Government targets whether there were targets for people with additional needs and asked for further information regarding this to be provided to them.

The Committee noted the North having problems with housing need in general, with people who require support being place in houses of multiple occupation and then often not getting the care and support they need.

Regarding the data, the Committee asked how the data was prioritised in relation to allocation of funding along with engagement between the ICB, place and partner organisations.

Mr Shillaker explained that the money that comes into MHLDA, conversations take place around what should be given to each place, based on population, but also understanding which areas need the mores support based on other factors such as areas of deprivation. However, it was noted that there was a gap in relation to data and understanding in the system, often due to a lack of experts in analysis employed within the NHS.

The Committee advised that there should be an increased awareness of diversity within the workforce and providing care to the wider community and it asked whether there was any data around barriers and disparities for access to care in minority communities.

In response, Mr Shillaker explained that data was available with examples such as young Black men being more likely to be sectioned, enter the mental health system due contact with the criminal justice system and when as a patient more likely to require seclusion or isolation in some way. For peri-natal mental health for south-east Asian women, the data showed the number of people who you would expect to access this care, were significantly less than their white counterparts.

In addition to training, there was now a focus on inclusive recruitment, as the data showed that a person was likely to receive better care from someone who looked and sounded like them particularly in a mental health setting. Some of the barriers for ethnic minorities workers to enter into a mental health role was often around the application process and particularly reasonable adjustment.

Regarding transitions for young people between primary and secondary and secondary to post-16, the Committee wanted to understand whether there was an understanding of the impact on the mental health of young people when these transitions took place. The Committee was advised that the main focus around transitions was around access to services from childhood to adulthood.

The Committee noted the annul health checks for those with learning disabilities sat at around 79-80% of the population and seemed to indicate reaching the same people each year, and asked what work was being done to ensure all communities were reached.

Mr Shillaker explained that in comparison with other areas of the country, the average of 75% health checks showed good performance, and whilst the number needed to increase it was important to understand what the outcome of the health check was, i.e. was the individual followed up with support to enable them to improve their health.

RESOLVED – The Committee noted the information and agreed that: -

1) The WYICB be thanked for their report and attendance at the meeting.
2) Further information be provided in relation to targets for housing those with MHLDA.

8 Next Steps

The next meetings of the West Yorkshire Joint Health Scrutiny Committee would take place on 25 February 2026 and 30 April 2026.

Yorkshire Ambulance Service NHS Trust

Update from Yorkshire Ambulance Service NHS Trust

Date	25 February 2025
Forum	West Yorkshire Joint Health Overview and Scrutiny Committee

1.0 Purpose

The purpose of this paper is to provide an update for the West Yorkshire Joint Health Overview and Scrutiny Committee on the delivery of services and recent developments from Yorkshire Ambulance Service (YAS) across the West Yorkshire area.

2.0 Demand and performance

2.1 As a key part of the urgent and emergency care system, YAS continues to see high levels of operational demand, with particular pressures during the current winter season. NHS England has reported that 2024 was the busiest year ever for A&E and ambulance services in England, with December recording the highest number of ambulance incidents ever in one month. Response times in A&E Operations (the emergency ambulance service) are seeing some challenges, particularly for category 1 and 2 patients, who are the most seriously ill. The national target for 2024/25 was for all English ambulance services to achieve a category 2 average mean response time of under 30 minutes (although the national response target is usually 18 minutes). Nationally category two ambulance response times have deteriorated during 2024 and for December, the average national response time was an average of 47 minutes 26 seconds (the longest for two years).

2.2 The average category 2 response time for YAS for the year to date (1 April 2024 to 31 January 2025) is 33 minutes and 10 seconds. The response times for West Yorkshire for the year to date are:

- Category 1 – 7 minutes 37 seconds (against a national standard of 7 minutes)
- Category 2 – 31 minutes 34 seconds (against the current national of standard 30 minutes)

Response times vary across the five places within West Yorkshire and in the Harrogate and Craven areas of North Yorkshire.

2.3 Another key measure of performance in urgent and emergency care is the time taken to handover patients at hospital Emergency Departments (ED) from the ambulance service. The national target for patient handovers at Emergency Departments is 15 minutes. Pressures across the health and social care system contribute to the hospital handover delays, and the Trust and its partners remain concerned about the impact of the delays on patients and their care. In particular, YAS is focused on reducing the significant impact these delays can have on the availability of emergency ambulances to respond to patients in the community.

2.4 There are challenges at hospitals across the Yorkshire and Humber region and we are working closely with our system partners to resolve these. The average handover time Trust wide for the year to date (1 April to 31 January 2025) is 30 minutes 18 seconds.

and an average of 363 ambulance hours per day were lost due to delayed ED handovers, which is the equivalent of 30 ambulances on a 12-hour shift per day.

2.5 In West Yorkshire, the average handover time for the year to date is 22 minutes and 44 seconds and an average of 93 ambulance hours per day were lost due to delayed handovers. In West Yorkshire handover times are good compared to other areas within the Trust. However, winter pressures have affected performance and there is variation across hospitals, with some recent challenges with turnaround times at Pinderfields General Infirmary and Airedale General Hospital.

2.6 In our Emergency Operations Centre, (taking emergency 999 calls), YAS took 87,555 calls in January 2025, which was a decrease 4.7% on January 2024. Our 999 call handling remains very good with an average call answer time of 3 seconds during January, the same as January 2024. This is against a national performance target of an average of 10 seconds.

3.0 Improvement initiatives

3.1 There are a number of initiatives to support the improvement of ambulance service performance, including the key measure of the category 2 response target and reducing delays in handing over patients at hospital and ensuring crews are available for the next patient as quickly as possible. In West Yorkshire these include:

- Strategic deployment of Hospital Ambulance Liaison Officers (HALOs) across acute sites, who play a key role in coordinating patient flow, facilitating timely handovers, and ensuring ambulance resources are freed up as quickly as possible. These YAS staff support hospital flow and help to reduce overall turnaround times.
- Expanding the range of alternative clinical pathways, ensuring more patients can access appropriate care without the need for emergency department attendance. This not only improves patient outcomes but also alleviates pressure on hospitals by directing patients to the most suitable service for their needs.
- Enhancing mental health response with the introduction of mental health response vehicles across West Yorkshire in collaboration with partners, providing specialist support to patients experiencing a mental health crisis and investing in specialist paramedics in mental health to enhance care and improve clinical decision-making for patients presenting in a mental health crisis.
- Improving handover and crew clearance processes through involving staff at all levels in using quality improvement methodology to enhance efficiency.
- Increase ‘hear and treat’ rates, (where a clinician is able to provide treatment and advice over the phone and an alternative, more appropriate service is identified). The hear and treat rate has improved from 14.1% in January 2024 to 16% in January 2025.
- Our conveyance rate in West Yorkshire is 52.8% (between1 April 2024 to 31 January 2025) which is an improvement from the same period in 2023/24, reducing from 57.3%, ensuring patient pathways are optimised for patients.
- Increase in staffing from April 2024 to January 2025, with 49 additional paramedics, and 18 additional Ambulance Support Workers/Ambulance Care Assistants in West Yorkshire. YAS works closely with local universities, including Bradford and Huddersfield, where the majority of our paramedics in West Yorkshire are trained.

4.0 Partnership working

4.1 The Trust works in partnership with the wider NHS and social care partners across West Yorkshire to improve patient care. Working with groups such as the West Yorkshire Community Services Provider Collaborative, we support the strengthening

of care coordination and optimising of community pathways. Examples include projects in Bradford (using the pre-dispatch 'push' model) and in Mid-Yorkshire (with the 'call before conveying' for care homes). As part of our work with West Yorkshire Association of Acute Trusts (WYAAT), the Trust is working on handover performance and overall hospital flow, as well as supporting the Right Person, Right Care work with West Yorkshire Police (specifically around missing persons cases).

4.2 Working in partnership, our pathways team has focused on identifying new clinical pathways for our staff to use as alternatives to transporting patients to Emergency Departments. This includes reviewing and improving established pathways and identifying clinical pathways suitable for 'Hear and Treat' by our clinicians within our Emergency Operations Centres (EOCs), where a clinician is able to provide treatment and advice over the phone and an alternative, more appropriate service is identified.

4.3 Optimising alternative pathways improves hospital flow by ensuring only those patients who need hospital care are treated there. Improved flow in turn improves hospital handover times, releasing further ambulances to reach patients in the community. Accessing alternative clinical pathways further improves ambulance availability by ensuring the right community service is sent to patients.

4.4 We are focused on identifying clinical pathways for our crews to utilise as an alternative to transporting patients to Emergency Departments.

Across the area, we have been working on specific initiatives and these include;
Bradford and Craven – working with acute partners to enhance the handover process and support initiatives around single point of access, which involves collaborative work with the community provider, ensuring more efficient patient care pathways.
Wakefield – collaborating with Mid Yorkshire Hospitals Trust to improve utilisation of resource and explore specialist paramedics in urgent care placements to enhance patient care.
Calderdale and Kirklees – supporting the newly implemented clinical reconfiguration, by working closely with partners to review challenges and streamline processes, ensuring smoother access to appropriate care.
Leeds – working to enhance referral rates into key services, (e.g. the Primary Care Access Line, which facilitates referrals to in-hospital services like Same Day Emergency Care) and improving referrals into respiratory pathways, (a priority throughout winter).

5.0 Ambulance Fleet and Estates

5.1 Across Yorkshire Ambulance Service we have invested in our ambulances and increased the number of ambulances in West Yorkshire from 180 to 223. Alongside an increase in clinicians, this enables us to meet the demands of the public as quickly as possible.

5.2 Ambulance stations across West Yorkshire are complemented by a network of strategically placed 'standby points', from which ambulance crews are dispatched, ensuring timely responses to patients. As part of our estates strategy, we are reviewing our facilities to ensure they are fit for purpose and will meet future needs. A number of stations have been identified as priorities for future development, should capital funding become available, including Wakefield.

6.0 Integrated Urgent Care (IUC) service, NHS 111

6.1 Our Integrated Urgent Care (IUC) service, which provides our NHS 111 service, has seen sustained improvements across all the key indicators during 2024/25. In every month from April 2024 to January 2025, we have seen calls answered within two minutes for over 80% of calls and the average speed to answer during that time has been 24 seconds (against a national target of 20 seconds). The busiest day during the recent holiday period was Saturday 28 December, with over 9,900 calls received and on New Year's Day, over 6,000 calls taken and all were answered within 60 seconds. The service experiences increased pressure during public holidays due to limited availability of primary care services.

6.2 Over 64% of our contacts into NHS 111 result in a primary care, self-care or an alternative pathway for our patients; 13.1% of contacts resulted in an ambulance dispatch, and 15.1% resulted in a recommendation to attend an Emergency Department.

6.3 NHS 111 demand patterns continue to be significantly different from previous years despite the end of the COVID-19 pandemic which initially triggered the change, with demand now experienced throughout the day, rather than peaking at key times out of hours (such as evening and weekends). The increases are reflective of challenges in primary care as patients find access to other parts of the health system more difficult and changes have been made to workforce patterns in order to meet this demand.

6.4 In NHS 111, the Trust continues to recruit into our call centres across both clinical and health advisor positions, with a transformation programme in progress to improve working patterns, leadership, education and training opportunities and a clear career structure. This transformation plan includes integration across the 999 and 111 service lines to offer a more coordinated response for our communities.

6.5 In 2024, NHS 111 was extended to provide additional help to those in mental health crisis. This development means that patients are now able to access urgent mental health support directly by contacting NHS 111, and by selecting the mental health option, can be put through to a local mental health crisis line, managed by partners. The extension to the NHS 111 service is for those people who are experiencing a mental health crisis and require urgent medical advice.

7.0 Non-Emergency Patient Transport Service (PTS)

7.1 In our non-emergency patient transport service, (PTS) we continue to see high demand. Our timeliness of response remains good, with 84% of calls answered within 3 minutes, a 7.5% improvement on the same time last year. We provided 74,630 journeys in December, with our busiest period being the run up to Christmas, with over 400 discharges on Christmas Eve, just slightly under last year's figures. In West Yorkshire in December, 32,250 journeys were undertaken, with 2,743 patient discharge journeys from West Yorkshire Healthcare Providers. Pre-planned inwards journeys for arrival before appointment time continue to perform above target.

7.2 Patients using PTS in Leeds have benefitted from improvements in their service, following the introduction of an initiative developed with partners, to ensure every patient is given more information about their journey, advising them on the likely length, the route to be taken and confirming appointment times and any further pick-ups on the way. The improvements for patients and their experience is being rolled out across the rest of the Trust.

7.3 In a further example of partnership working, the Trust is working with West Yorkshire Fire and Rescue Service and Bradford District Care Foundation Trust to enable patients at the end of their life to die at home, surrounded by loved ones, ensuring they receive safe care. With a 'fast track' of risk assessments, where possible, resources needed to move patients are identified on the day. Over the last 12 months, PTS have undertaken 22 end of life bed moves for patients and their families in Bradford, and the approach is being recommended for adoption across the whole of West Yorkshire.

7.4 Following a national review in 2021, NHS England launched the new national framework for non-emergency Patient Transport Services requiring them to become consistently more responsive, fair, and sustainable when providing transport for those with a medical or mobility need but reminded systems that patients should travel independently when able to do so. The three Yorkshire and Humber Integrated Care Boards (ICBs), as commissioners of this service, are leading this implementation, and plans are being put in place for implementation from 1 April 2025. YAS are preparing for implementation of the national criteria, as the provider of this service and the West Yorkshire Joint Health Overview and Scrutiny Committee and being provided with information and updates by the ICB, supported by YAS.

8.0 Recommendation

This paper provides an update for the Scrutiny committee on operational performance and recent developments from Yorkshire Ambulance Service. It is recommended that the update is noted for comment and consideration.

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Meeting name:	Joint Health Overview and Scrutiny Committee
Agenda item no.	
Meeting date:	25th February 2025
Report title:	National eligibility criteria for non-emergency
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:

How the national eligibility criteria could be best adopted across West Yorkshire has been presented to the Joint Health Overview and Scrutiny Committee (JHOSC) on two prior occasions, in October 2024 and in December 2024.

This paper presents an updated approach to any adoption of the national eligibility criteria across West Yorkshire, which has not been previously shared with the JHOSC.

Executive summary and points for discussion:

In this paper to the JHOSC, the NHS West Yorkshire Integrated Care Board (WYICB) would wish to inform members of the progress made in two regards.

1. The updated approach that has been developed, through discussion between the ICB, the Yorkshire Ambulance Service (YAS) and wider stakeholders, for how the national eligibility criteria could be best adopted across West Yorkshire.

This consists of the addition of further detail to ensure that those individuals with a significant physical mobility, or a medical need, that prevents their safe independent travel to/from hospital, are eligible for Non-Emergency Patient Transport Services (NEPTS). In this regard, independent travel is defined as the private arrangements that an individual could make to/from hospital, which may include the support of family/friends.

The key output from this updated approach towards the national criteria is that the adoption of this would reduce the number of differences between it and the current local eligibility criteria to one. This is when an individual, who does not have a significant mobility need, (or is in receipt of renal haemodialysis), says that friends or family are available to enable them to get to/from hospital safely.

This has then informed the scope of the equality/quality impact assessments, in terms of assessing the impact of any change with the adoption of the national eligibility criteria, and what reasonable mitigations there should be.

2. The progress made against each of the points that were agreed at the JHOSC meeting in December 2024. The progression towards each of these points has been shaped by the updated approach to

the adoption of the national eligibility criteria, and what mitigations are required and proportionate to the identified change.

The progress made against each of these points is listed in the below table.

A further key output from the updated approach to the adoption of the national eligibility criteria has been to distinguish between reasonable and proportionate mitigations to the identified change from the current local criteria, and the need for an overall vision/plan for how transport is part of the planning of healthcare services.

In addition to the updates on the points that the JHOSC requested in December 2024, this paper seeks the thoughts on what an overall vision/plan could look like.

Agreed points	**Update**
The costs in relation to call handing which would ensure a robust system.	Prior discussions between the ICB and YAS had concerned whether there was a need for additional call handers with the introduction of the national eligibility criteria. It has been mutually agreed, between the ICB and YAS, for the latter to manage this need, in accordance with the overall financial sum it receives and the planned efficiencies in the use of call handers. This includes further work to maximise clinicians' use of the online booking system, rather than ringing the call centre.
The proposal for an independent right of appeal.	This has been developed by the three ICBs across Yorkshire and the Humber. The independent right of appeal will exist when a matter cannot be resolved directly by the provider of NEPTS.
The business case for payment of volunteer drivers.	Given the singular change, between the current local eligibility criteria and the updated approach to the national criteria, this work has been paused. Attention since the December 2024 meeting of the JHOSC has been to ascertain the use of volunteer drivers, whether through ICB commissioned schemes, or those from partners within the West Yorkshire Integrated Care System.
The standardisation of mileage payments.	This is part of the contract discussions between the ICB and the acute hospital trusts for the 25/26 financial year. NHS England have confirmed that this is a matter for local determination between the ICB and the acute hospital trusts.
The results of the pilot for the pre-paid bus tickets.	This pilot has yet to progress. Discussions with the West Yorkshire Association of Acute Trusts (WYAAT) and he West Yorkshire

	Combined Authority are ongoing to release the pre-paid bus tickets.
The difference in uptake between postcodes for travel claims, and whether these were areas of deprivation or other recordable factors.	Information on who is eligible for the Healthcare Travel Costs Scheme is not held by the ICB, or local partners within the West Yorkshire Integrated Care System. Information is held by various government departments/agencies, dependent on the type of benefit/tax credit Following the December 2024 meeting of the JHOSC, the ICB submitted several Freedom of Information request to these government departments/agencies to identify the difference, by postcode, between the number of individuals eligible for HTCS and those claiming through it.

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. Note the updated approach to how the national eligibility criteria could be best adopted across West Yorkshire.
2. Specifically note that the updated approach would ensure that the capacity of NEPTS would be safeguarded for those individuals where a physical mobility, or medical need, prevents their safe independent travel to/from hospital.
3. Note the distinction made between the reasonable mitigations that are listed within the paper to minimise the impacts from any adoption of the national criteria, and the need for an overall vision for how transport is part of the planning of healthcare services.
4. Provide any specific points of feedback to help develop a draft vision/plan for transport and its role within the planning of healthcare services.
5. Note and support the ‘town hall’ engagement sessions to explain to the public why there is a need for national criteria, how it is considered that the national criteria can be best adopted across West Yorkshire, and what the alternatives are to NEPTS.

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

Not applicable.
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 were previously in receipt of NEPT – are no longer eligible for it.** **The updated approach to the adoption of the criteria has identified that this risk is minimal, and that there are reasonable mitigations in-place.**
Quality and Safety	**There is a risk that individuals no longer eligible for NEPT, and without the means for independent travel, could miss (or face delays) in their secondary care treatment.** **The updated approach to the adoption of the criteria has identified that this risk is minimal, and that there are reasonable mitigations in-place.**
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.** **The updated approach to the adoption of the criteria has identified that this risk is minimal, and that there are reasonable mitigations in-place.**
Finances and Use of Resources	**The approach of the WYICB is one to ensure that the capacity of NEPTS, when faced with increasing demands, is safeguarded for those individuals where safe transportation to/from hospital is unfeasible via independent means.**
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 JHOSC details the further work that has been undertaken to assess how best the national criteria can be adopted across West Yorkshire, and what further actions are planned.**
Citizen and Stakeholder Engagement	**Public engagement is planned for March 2025. This concerns 'town hall' engagement sessions to explain to the public why there is a need for national criteria, how it is considered that the national criteria can be best adopted across West Yorkshire, and what the alternatives are to NEPTS.**

1. Introduction

In this paper to the JHOSC, the NHS West Yorkshire Integrated Care Board (WYICB) would wish to inform members of the progress made in two regards.

Firstly, the updated approach that has been developed, through discussion between the ICB, the Yorkshire Ambulance Service (YAS) and wider stakeholders, for how the national eligibility criteria could be best adopted across West Yorkshire.

Secondly, 2. The progress made against each of the points that were agreed at the JHOSC meeting in December 2024. The progression towards each of these points has been shaped by the updated approach to the adoption of the national eligibility criteria, and what mitigations are required and proportionate to the identified change.

2. The updated approach to the national eligibility criteria

2.1 Background and context

Since the inception of the project group to consider the national eligibility criteria and how it could be adopted across West Yorkshire there has been an ongoing comparison between:

- The content of the current eligibility criteria used across West Yorkshire for Non-Emergency Patient Transport Services (NEPTS). (Across West Yorkshire there are two providers of NEPTS: the Yorkshire Ambulance Service (YAS), who are the principal provider of NEPTS across West Yorkshire, and Lakeside, who are specifically commissioned for Bradford District and Craven.)

  And

- How best to interpret the national eligibility criteria, and how it can be fairly and consistently applied across West Yorkshire.

The previous papers to the JHOSC – in October and December 2024 – raised the possibility that there could be several differences between an adoption of the national eligibility criteria across West Yorkshire and the current criteria used by providers of NEPTS.

2.2 Discussions since December 2024

Since December 2024 (when there was the most recent discussion with the JHOSC) discussions between the WYICB, YAS and wider stakeholders have resulted in an updated approach for any adoption of the national criteria across West Yorkshire. These discussions centred on the two key principles taken from the national eligibility criteria.

- NHS-funded patient transportation is reserved for when it is considered essential to ensuring an individual's safety, safe mobilisation, condition management or recovery.
- When an individual, who does not have a significant mobility need, or require renal haemodialysis, says that friends or family are available to enable them to get to/from hospital safely, then independent travel should be prioritised.

2.2.1 Significant mobility need

As part of the updated approach, and for the purpose of defining a 'significant mobility need', an individual will be eligible, or continue to be eligible for patient transport, if any one of the following apply:

- The individual resides in a care home (residential/nursing).
- The individual receives more than 2 visits from a carer per day.
- The individual receives GP home visits.
- The individual is a wheelchair user, who cannot safely via independent means and needs the support of more than just a driver to be able to safely enter/exit a vehicle.

The above is not less than what is currently within the local eligibility criteria.

2.2.2 Renal haemodialysis

The eligibility of those individuals receiving renal haemodialysis to either choose NEPTS, or the financial reimbursement of their independent travel is because of a specific national policy directive.

This does not represent any change from what is written in the current local eligibility criteria.

2.2.3 Pre-existing condition/impact of a medical intervention

Discussions between the ICB, YAS and wider stakeholders have concerned what is sufficient and clear level of detail about eligibility for NEPTS because of a pre-existing condition/impact of a medical intervention. These would be considered when an individual is not eligible because of a significant mobility need, or because they are not in receipt of renal haemodialysis.

The outputs from these discussions are that:

- The adoption of the national criteria in West Yorkshire must have a specific point regarding when an individual is unable to travel home safely after hospital treatment. An individual, for example, could be assessed to be able to travel safely to hospital, but following medical intervention their independent travel could then be assessed to be unsafe, making them eligible for NEPTS.

- There should be a clear list of the factors that could prevent safe independent travel. The national criteria provide a list in this regard that provides a greater level of detail than the current eligibility criteria,

2.2.4 Conclusion

The key conclusion from this updated approach is that the adoption of this would reduce the number of differences between it and the current local eligibility criteria to one. This is when an individual, who does not have a significant mobility need, (or is in receipt of renal haemodialysis), says that friends or family are available to enable them to get to/from hospital safely.

2.3 Demand trends

This conclusion is of importance to ensure that there is neither no difference between the demand for NEPTS and the available capacity of services, or that this is minimised. The absence of such a difference, or where such a difference is minimised, supports the overall sustainability of NEPTS, and the responsive of it to individuals who cannot travel safely to/from hospital via any other means.

The below table, as an illustrative example for the YAS NEPTS, shows that the yearly demand growth for renal haemodialysis and significant mobility need is 7.5%. A figure of 7.5% for these two areas of demand could then result in a growth for all demand of close to 5% in 25/26. Any mitigation of this, to support the overall sustainability of NEPTS and to ensure it is responsive to those individuals who cannot travel safely to/from hospital via any other means, would concern the impact that the updated approach to the national eligibility criteria could have on total demand.

Given that the updated approach would not impact on all of the in-scope demand, then a just over 14% reduction in it would cancel the close to 5% growth in all demand for 25/26.

Table 1: Analysis of YAS NEPTS demand

Area of NEPTS demand	Within the scope of the eligibility criteria	Percentage of yearly service demand (Average 2022/23 to 2024/25 inclusive)	Average annual growth (2022/23 to 2024/25 inclusive)
Renal	Out-of-scope	65%	7.5%
Significant mobility need			
Other	In-scope	35%	-1%

Includes all journey classifications, types and journeys with escorts.
Forecast outturn for 24/25.

2.4 Groups affected

In the previous papers to the JHOSC it was stated that up to 20% of in-scope journeys with YAS could be impacted with the use of the national eligibility criteria, affecting c.3,600 individuals. These numbers were outputs from a modelling exercise that predates the updated approach to the national eligibility criteria that is described within this paper.

Further to the points raised in the above section on 'demand trends', a 14% reduction in in-scope demand could affect c.2,600 individuals who have been assessed to be able to travel safely to/from hospital without NEPTS.

From the equality impact assessment, it has been identified that such individuals, when considering the overall use of patient transport services, are most likely to:

- To live within an urban area within West Yorkshire, as this applies to nine-tenths of users.
- To be white, as this applies to seven-tenths of users. (Two-tenths of the data did not have an ethnicity recorded.)
- Within the older age cohort aged 66 and above, as this applies to two-thirds of users.
- To live within an area of high deprivation, as this applies to four-tenths of users, noting that this is disproportionate for ethnic minorities, where this applies to two-thirds of users.

It is not possible, however, to directly state who such individuals (within the estimated 2,600) would be.

2.5 Mitigations

For the c.2,600 individuals there would be two principal mitigations, where required.

1. The first of these are community transport schemes. The WYICB shall be presenting to its Transformation Committee in February 2025 a full list of these schemes, including those funded by the Voluntary and Community Sector.
2. The second is the Healthcare Travel Costs Scheme, which is a national means-tested approach to financially reimburse. The WYICB shall also be presenting to it Transformation Committee in February 2025 the latest analysis it has been able to complete to show the current utilisation of this scheme and who could be eligible for it.

The first of these mitigations, in other words, provides an alternative to the use of family and friends, or sole independent travel to hospital; whilst the second does not offer a means of alternative travel, but the financial reimbursement of private travel.

3. Updates on the points requested by the JHOSC in December 2024

The below table provides a summary of the progress made against each of the points requested by the JHOSC.

Agreed points	Update
The costs in relation to call handing which would ensure a robust system.	Prior discussions between the ICB and YAS had concerned whether there was a need for additional call handers with the introduction of the national eligibility criteria. It has been mutually agreed, between the ICB and YAS, for the latter to manage this need, in accordance with the overall financial sum it receives and the planned efficiencies in the use of call handers. This includes further work to maximise clinicians' use of the online booking system, rather than ringing the call centre.
The proposal for an independent right of appeal.	This has been developed by the three ICBs across Yorkshire and the Humber. The independent right of appeal will exist when a matter cannot be resolved directly by the provider of NEPTS.
The business case for payment of volunteer drivers.	Given the singular change, between the current local eligibility criteria and the updated approach to the national criteria, this work has been paused. Attention since the December 2024 meeting of the JHOSC has been to ascertain the use of volunteer drivers, whether through ICB commissioned schemes, or those from partners within the West Yorkshire Integrated Care System.
The standardisation of mileage payments.	This is part of the contract discussions between the ICB and the acute hospital trusts for the 25/26 financial year. NHS England have confirmed that this is a matter for local determination between the ICB and the acute hospital trusts.
The results of the pilot for the pre-paid bus tickets.	This pilot has yet to progress. Discussions with the West Yorkshire Association of Acute Trusts (WYAAT) and he West Yorkshire Combined

	Authority are ongoing to release the pre-paid bus tickets.
The difference in uptake between postcodes for travel claims, and whether these were areas of deprivation or other recordable factors.	Information on who is eligible for the Healthcare Travel Costs Scheme is not held by the ICB, or local partners within the West Yorkshire Integrated Care System. Information is held by various government departments/agencies, dependent on the type of benefit/tax credit Following the December 2024 meeting of the JHOSC, the ICB submitted several Freedom of Information request to these government departments/agencies to identify the difference, by postcode, between the number of individuals eligible for HTCS and those claiming through it.

4. Developing a vision

An output from the discussions on the updated approach to the adoption of the national eligibility criteria has been to distinguish between reasonable and proportionate mitigations to the single, identified change from the current local criteria, and the need for an overall vision/plan for how transport is part of the planning of healthcare services.

In addition to the updates on the points that the JHOSC requested in December 2024, this paper seeks the thoughts on what an overall vision/plan could look like.

5. Next Steps

The next steps concern:

- The preparation of the presentation to the WYICB's Transformation Committee, which is scheduled to meet on the 27th February 2025 to review the proposed adoption of the national eligibility criteria across West Yorkshire. This shall concern the updated approach to the adoption of the national eligibility criteria that has been detailed in the this to the JHOSC.
- The undertaking of the 'town hall' engagement sessions in March 2025 to explain to the public why there is a need for national criteria, how it is considered that the national criteria can be best adopted across West Yorkshire, and what the alternatives are to NEPTS.
- The specific contract discussions with the acute hospital trusts across West Yorkshire regarding the standardisation of mileage payments in 25/26.

6. Recommendations

The JHOSC is asked to:

Note the updated approach to how the national eligibility criteria could be best adopted across West Yorkshire.

Specifically note that the updated approach would ensure that the capacity of NEPTS would be safeguarded for those individuals where a physical mobility, or medical need, prevents their safe independent travel to/from hospital.

Note the distinction made between the reasonable mitigations that are listed within the paper to minimise the impacts from any adoption of the national criteria, and the need for an overall vision for how transport is part of the planning of healthcare services.

Provide any specific points of feedback to help develop a draft vision/plan for transport and its role within the planning of healthcare services.

Note and support the ‘town hall’ engagement sessions to explain to the public why there is a need for national criteria, how it is considered that the national criteria can be best adopted across West Yorkshire, and what the alternatives are to NEPTS.

7. Appendices

Not applicable.

Kirklees COUNCIL

REPORT TITLE: Memorandum of Understanding

Meeting:	**West Yorkshire Joint Health Overview and Scrutiny Committee**
Date:	**25 February 2025**
Cabinet Member (if applicable)	**N/A**
Key Decision **Eligible for Call In**	**Not applicable**

Purpose of Report

To consider the adoption of a Memorandum of Understanding between the West Yorkshire Joint Health Overview and Scrutiny Committee and the NHS West Yorkshire Integrated Care Board.

Recommendations

- The Committee consider the Memorandum of Understanding and determine if any further inclusion or deletion to the document is required and to adopt if appropriate.
- That should the Memorandum of Understanding be adopted, a review of it take place in February 2026.

Reasons for Recommendations

- To continue the close working relationship between the West Yorkshire Joint Health Overview and Scrutiny Committee and the NHS West Yorkshire Integrated Care Board and to ensure that the Committee receives all the relevant information required to scrutinise proposals by the Integrated Care Board.

Resource Implications:

- None Specifically

Date signed off by <u>Executive Director</u> & name	**Give name and date for Cabinet / Scrutiny reports** Not applicable
Is it also signed off by the Service Director for Finance?	**Give name and date for Cabinet reports** Not applicable
Is it also signed off by the Service Director for Legal and Commissioning (Monitoring Officer)?	**Give name and date for Cabinet reports** Not applicable

Electoral wards affected: Not applicable

Ward councillors consulted: Not applicable

Public or private: Public

Has GDPR been considered? Yes. The report does not include any personal data that identifies an individual.

1. Executive Summary

1.1 The West Yorkshire Joint Health Overview and Scrutiny Committee (WYJHOSC) is a collaborative body that brings together representatives from various local authorities within West Yorkshire. As Bradford District and Craven Partnership also covers Craven, which is located within the North Yorkshire Council area, North Yorkshire Council join the WY JHOSC as an interested party.

1.2 Its primary purpose is to provide an overview and undertake scrutiny of the commissioning of services by the West Yorkshire Integrated Care Board (WYICB).

1.3 Meetings of the committee are open to the public and are streamed live (webcast), allowing for transparency and public engagement. The WYJHOSC welcomes members of the public to submit questions, relating to the remit at 1.1 above, in advance of its meetings.

1.4 The MoU, which can be found at Appendix 1, is a formal, but non-legally binding agreement between the WYJHOSC and the WYICB which establishes a clear understanding of the roles of each organisation and highlights the commitment to build strong local relationships.

2. Information required to take a decision

2.1 On 31 January 2024, changes were made to allow the Secretary of State for Health the power to intervene in NHS reconfigurations. These are referred to as the Secretary of State's 'call-in' powers.

2.2 The Government guidance in relation to local authority scrutiny, suggested that local authorities may choose to appoint a discretionary joint health overview and scrutiny committee to carry out all or specified health scrutiny functions - for example, health scrutiny in relation to health issues where local authority and ICB boundaries do not align.

2.3 It is agreed by the WY local authorities, that there are occasions on which a discretionary joint committee is the best way of considering how the needs of a local population, which happens to cross council boundaries, are being met.

2.4 Establishing a joint committee of this kind does not prevent local authorities from separately scrutinising health issues, and these arrangements for informal joint working across boundaries can be stepped up into formal arrangements as required.

2.5 At an informal meeting of the WYJHOSC, Members of the Committee requested that the MoU be considered by each local authorities place scrutiny panel, and to be sent, for approval to the West Yorkshire LA Chief Legal Officers (WYLAW) Board.

2.6 This work has now been completed, and other than one amendment to section 16 of the MoU to provide clarification on the areas involved, no further comments from the place scrutiny panels.

2.7 At its meeting on 29 November 2024, WYLAW Board confirmed it was content with the Joint Arrangement.

3. Implications for the Council

Not applicable.

3.1 Council Plan

Not applicable.

3.2 Financial Implications

Not applicable.

3.3 Legal Implications

Whilst the document is non-legally binding, WYLAW Board met on 29 November 2024 and confirmed that it was content with the MoU joint arrangement.

3.4 Other (e.g. Risk, Integrated Impact Assessment or Human Resources)

Not applicable.

4. Consultation

Not applicable.

5. Engagement

Not applicable.

6. Options

Not applicable.

6.1 Options considered

Not applicable.

6.2 Reasons for recommended option

To continue the close working relationship between the West Yorkshire Joint Health Overview and Scrutiny Committee and the NHS West Yorkshire Integrated Care Board and to ensure that the Committee receives all the relevant information required to scrutinise proposals by the Integrated Care Board.

7. Next steps and timelines

It is recommended that the MoU be reviewed in 12 months' time.

8. Contact officer

Yolande Myers – Principal Governance Officer
Yolande.myers@kirklees.gov.uk

Nic Phillis – Strategy and Transformation, NHS West Yorkshire Integrated Care Board
Nicola.phillis@nhs.net

9. Background Papers and History of Decisions

Not applicable.

10. Appendices

Appendix 1 – Memorandum of Understanding

11. Service Director responsible

Samantha Lawton, Service Director – Legal, Governance and Commissioning (Kirklees Council)

Memorandum of Understanding between West Yorkshire Joint Health Overview and Scrutiny Committee and NHS West Yorkshire Integrated Care Board

Introduction and Scope

1. This Memorandum of Understanding (MoU) provides guidance and a common understanding on how the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC) and the NHS West Yorkshire Integrated Care Board (WY ICB) will work in partnership.

2. WY JHOSC has a legitimate role in proactively seeking information about the performance of local health services and institutions, in challenging the information provided to it by the WY ICB and in testing this information by drawing on different sources of intelligence.

3. As outlined in paragraph 25 of this MoU, the WY JHOSC is a discretionary arrangement, however it is expected that where the WY ICB has under consideration any proposal for a substantial development of the health service across the WY footprint or for a substantial variation in the provision of such service, it will pay due regard to the legislation which may require any member or employee of the WY ICB to attend before the WY JHOSC to answer questions.

4. In recognising the roles of the JHOSC and ICB *(as set out in Statutory guidance: Overview and scrutiny: statutory guidance for councils, combined authorities and combined county authorities* and Local authority health scrutiny - GOV.UK (www.gov.uk) this MoU provides a framework and principles that both parties aim to adhere to. This will ensure that the process followed between WY JHOSC and WY ICB remains positive, collaborative, and ambitious, with the aim of driving the best outcomes for WY residents. In so doing the aim for all parties is to help ensure that the partnership and process followed between the WY JHOSC and WY ICB remains a positive and constructive experience whilst recognising the WY JHOSC's role as a 'critical friend'.

5. The MoU will outline how the WY JHOSC and WY ICB will work together to the strategic planning, provision, and operation of the health service in its area and determine to refer back to its constituent local authority when the matter requires a statutory JHOSC establishing. The WYJHOSC may make reports and recommendations to the WY ICB where appropriate for it to do so and expect a response from the WY ICB within 28 days.

6. This MoU reflects legislative changes effective from 31 January 2024 which include:

    a) The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving

Provisions) Regulations 2024 removes the Committee's power to make referrals to the Secretary of State, when the local NHS is considering a substantial change in service provision.

b) A new Schedule 10A to the National Health Service Act 2006 places a duty on any commissioner of NHS services to notify the Secretary of State when they propose a 'notifiable' reconfiguration of local services and give powers to the Secretary of State to intervene and make decisions on NHS service configurations.

7. Both (a) and (b) above are supported by guidance and statutory guidance, including Reconfiguring NHS Services – Ministerial Intervention Powers, which also came into force on 31 January 2024.

8. This MoU complements each WY local authority area's Health and Scrutiny Committees and does not replace scrutiny undertaken at place level. The WY JHOSC considers and scrutinises the provision and commissioning of health services to ensure they meet the needs of the people of WY. It sits alongside the existing Terms of Reference (ToR) for local Health Overview and Scrutiny Committees (HOSC) and JHOSC's within WY.

9. This MoU does not replace any local statutory arrangements at place.

Leadership

10. Consistent with recently published Overview and scrutiny: statutory guidance for councils, culture and effective leadership are key to the success of the scrutiny function. Both WY JHOSC and WY ICB play a role in creating an environment conducive to effective scrutiny, adding value by improving policy, and delivery of services. The environment is expected to be:

    a) **Ambitious.** Be courageous in our thinking for the people of West Yorkshire. Look at cross-cutting issues alongside solutions.
    b) **With integrity.** Take a neutral and apolitical approach, rather than an organisational or sector approach and act solely in terms of the public interest.
    c) **Respectful and courteous.** All partners have value and are valued, and every effort will be made to avoid defamation of an organisation or person.
    d) **Conducive to effective overview and scrutiny.** It is everyone's responsibility to promote respect, compassion and maintain a culture that is supportive of overview and scrutiny and its reputation.

Principles

11. Both WY JHOSC and WY ICB will ensure that work areas explored through the WY JHOSC are:

a) **Driven by evidence.** Evidence, data, and performance, balanced with views of constituents will be agreed and shared positively and constructively before taking action without discrimination or bias, working within the Equality, Diversity and Inclusion Strategies and Policies of each participant LA and the WY ICB.

b) **Collaborative.** The joint working between the WY JHOSC and WY ICB is crucial to ensure strategic issues of importance are identified and acted on collaboratively, which may include the establishment of a statutory JHOSC, as outlined in paragraph 32 of this MoU or requesting the secretary of state to call in.

c) **Concise and clear.** Understand the purpose and essential role of WY JHOSC to help promote clarity and navigate complex, contentious, or politically challenging changes to services. Guidance is outlined in *Appendix A* to support this.

d) **Proactive**. Take a proactive approach to sharing at an early stage any proposals, reconfigurations and matters of interest. Consider how items are defined and draw a distinction between informal discussions and statutory consultations.

NHS West Yorkshire Integrated Care Board

12. The WY ICB is a statutory body that became legally established when Clinical Commissioning Groups (CCGs) were dissolved through the Health and Care Act 2022. There are two elements, an integrated care partnership (ICP) and integrated care board (ICB) that span five local authority (LA) areas.

13. Governed by partners and focused on collaboration as a means of driving improved outcomes for people in WY, the WY ICB has four aims:

    a) To reduce health inequalities
    b) To manage unwarranted variations in care
    c) Secure the wider benefits of investing in health and care
    d) Use our collective resources wisely.

14. WY ICB delegates match decision making authority and resources to the five places (Bradford District and Craven, Calderdale, Kirklees, Leeds, Wakefield).

15. When there is benefit in working together across a wider footprint, and local plans need to be complemented with a common vision and shared plan for WY, three tests are applied to determine when to work at this level:

    a) To achieve a critical mass beyond local population level to achieve the best outcomes
    b) To share best practice and reduce variation; and
    c) To achieve better outcomes for people and communities overall by tackling ‘wicked issues’ (i.e., complex, intractable problems).

16. A general approach of subsidiarity whereby work is delivered at the lowest level possible, closest to where the impact is felt is also considered.

Health Overview and Scrutiny Committees

17. Local Authorities (LAs) in the WY area include Kirklees Council, Calderdale Council, Leeds City Council, Wakefield Council and Bradford Council (which includes part of Craven District Council). North Yorkshire join the WY JHOSC as an interested party.

18. Health Overview and Scrutiny Committees (HOSC) are fundamental ways for democratically elected local members to voice the views of their constituents and ensure that NHS priorities focus on the greatest local health concerns and challenges on issues that affect the local area. HOSC's review and scrutinise matters relating to the planning, provision and operation of the health service in the area, including the finances of local health services.

19. The primary aim of a HOSC is to strengthen the voice of local people and communities, ensuring that their needs and experiences are considered an integral part of the commissioning and delivery of health services and that those services are effective and safe.

20. HOSCs also have a strategic role in taking an overview of how well integration of health, public health and social care is working and can seek information about the performance of local health services and institutions.

21. HOSCs are part of the accountability of the whole system and may be involved in any part of the health and social care system.

22. Local Healthwatch organisations and their contractors carry out certain statutory activities including that of making reports and recommendations concerning service improvements to scrutiny bodies. This would cover the provision of information and the referral of matters relating to the planning, provision and operation of health services in their area (which could potentially include concerns about local health services or commissioners and providers) to local authority health scrutiny bodies.

West Yorkshire Joint Health Overview and Scrutiny Committee
Discretionary role

23. LAs in the WY area established a discretionary JHOSC to consider health issues with cross boundary implications where the local authority and former CCG areas did not align, and where any specific health issues affected the whole of the WY area.

24. Following the Health and Care Act 2022, the arrangements for the JHOSC remained in WY and it continues to play a vital role as a body overseeing and

scrutinising health services, along with social care services, in order to view the whole system, within the area.

25. Whilst the JHOSC does not fall within the 2013 regulations regarding joint committees, it has worked effectively to date as a discussion mechanism to consider emerging health issues and remains a critical part of the overall governance arrangements for WY ICB; an opportunity to align strategic planning, investment and performance where it makes sense to do so focussing on the key priorities for the ICB. These are determined and set out in a workplan agreed between the chairs of the JHOSC and the ICB Director of Strategy and Partnerships.

26. These discretionary working arrangements can be stepped up into statutory arrangements as required. However, it is intended that the discretionary committee be the first 'port of call' and mechanism to brief all WY LAs regarding proposals when considering any future arrangements. The sections below relate specifically to the formal role of JHOSC.

West Yorkshire Joint Health Overview and Scrutiny Committee discretionary arrangements

Pre decision scrutiny

27. Pre-decision scrutiny refers to when an authority's overview and scrutiny function consider a planned decision before it is made by the executive. In terms of health scrutiny, pre-decision scrutiny is not only important but also a requirement under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Looking at decisions before they are made allows members to both influence and improve those decisions as well as challenge any pre-conceived notions and ideas

Substantial Variation and Substantial Development

28. The WY JHOSC and WY ICB note that the exact meaning of "substantial" has not been defined in legislation or guidance. However, a substantial variation may be one that affects a large number of people in a locality – such as the closure or downgrading of a specialist or community services, or of a general service such as an Emergency Department. It may be one that affects a small number of people, but which is nevertheless substantial because of the impact on a specific group. The key feature of a substantial development or variation is that there is a major impact(s) experienced by service users, carers and/or the public.

29. To consider whether a proposal constitutes a 'substantial' variation or development in the first instance, the WY ICB will meet with the Chair and

Deputy Chair of the WY JHOSC to consider how the proposal is defined to avoid differences of view at a later stage. The Chair and Deputy Chair will report all discussion to the WY JHOSC.

30. When the WY ICB are considering proposals to vary or develop health services, the LAs whose residents are affected must be given the chance to decide whether they consider the proposals to be substantial to local people and their communities. Those authorities that do consider the proposals to be substantial, must be consulted as per legislation and must form a separate JHOSC to respond to the consultation (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 No.218 Part 4, Regulation 30).

31. More information on ministerial intervention powers can be found at Reconfiguring NHS services - ministerial intervention powers - GOV.UK (www.gov.uk).

32. The decision about whether proposals are substantial (and therefore whether to participate in a statutory JHOSC) must be taken by the HOSC of the local authorities that are likely to be affected.

33. The primary focus for identifying whether a change should be considered substantial is the impact upon patients, carers and the public who use or have the potential to use a service. This would include but is not limited to:

a) **Changes in accessibility of services:** any proposal which involves the withdrawal or change of patient or diagnostic facilities for one or more speciality from the same location (other than to any part of the same operational site).
b) **Impact of proposal on the wider community and other services:** including economic impact, transport, regeneration (e.g. where reprovision of a hospital could involve a new road or substantial house building).
c) **People and communities affected:** changes may affect the whole population (such as changes to A&E), or a small group (patients accessing a specialised service). If changes affect a small group, it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example renal services).
d) **Methods of service delivery:** altering the way a service is delivered may be a substantial change, for example moving a particular service into community settings rather than being entirely hospital based.
e) **Issues likely to be considered as controversial to local people:** (e.g. where historically services have been provided in a particular way or at a particular location.)
f) **Changes to governance:** which affect the ICB's relationship with the public or local authority Overview and Scrutiny Committees.

Timeline

34. It is important that early notice is given by the WY ICB to the WY JHOSC of any proposal under consideration so that any initial planning for future statutory consultation can be considered by the WY JHOSC.
35. The term 'under consideration' is not defined, but a development or variation is unlikely to be held to be 'under consideration' until a proposal has been developed, but whilst still at a formative stage.

Collaborative Resolution

36. WY JHOSC may collectively consider whether a specific proposal is only relevant for one authority and therefore should be referred to that authority's HOSC for scrutiny. Two or more LAs may decide that due to the specific impact on their LA areas, and not the full WY footprint, a separate JHOSC should be formed.

37. Alternatively, the WY JHOSC may ask that a matter be considered at place in addition, enabling the place-based Panels to provide a view on a matter.

38. Each participating LA may also wish to consider a discretionary matter itself in addition to it being considered by the WY JHOSC and can give notice to the other participating councils and the joint committee.

39. When consideration is being given by the WY ICB as to whether to notify the Department for Health and Social Care, the WY ICB should consider the individual Local authority and if appropriate, the WY JHOSC's views on the proposal.

40. The WY ICB will make it clear to the Secretary of State for Health and Social Care, the WY JHOSC's view, if one has been taken, on whether they believe the variation or development to be notifiable.

Secretary of State for Health and Social Care

41. Call-in is a safety mechanism to delay and interrogate important decisions made by the WY ICB. It provides a way for councillors to ask that particular decisions are considered by the Secretary of State for Health and Social Care.

42. Anyone locally, including the WY JHOSC may make a request to the Secretary of State for Health and Social Care that a proposal be "called in," whether that proposal is substantial or not. It is envisaged that a proposal will be called in only under "exceptional" circumstances.

43. The Secretary for State for Health and Social Care will use certain criteria to determine whether the proposal will be called in:

    - Attempts have been made to resolve concerns through the local NHS commissioning body, or through raising concerns with their local authority/WY JHOSC.

- Whether WY ICB and local authorities/WY JHOSC has taken steps to resolve issues themselves.
- There are concerns with the process that has been followed by the ICB or the provider (e.g., options appraisal, the consultation process).
- A decision has been made (i.e. a Decision-Making Business Case has been approved) and there are concerns that a proposal is not in the best interests of the health service in the area.

44. The WY JHOSC should not be seen as a gatekeeper to any request for an issue to be called in. Although local attempts at resolution should be attempted, the WY JHOSC's involvement is not a requirement for a successful call-in.

45. The WY JHOSC should be seen as a space for making local attempts at resolution, and that this public forum can be seen as the focus for campaigners and patient advocates.

Summary and review

46. In summary, this MoU serves as a valuable tool for fostering collaboration and cooperation and will be subject to a 12 month review.

Appendix A.

Guidance

In advance of the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC), please consider the following:

- **WY JHOSC meetings are in public.** Meetings will be recorded and published online (previous recordings can be found Browse meetings - WY Joint Health Overview and Scrutiny Committee | Kirklees Council).

- **Meetings can be held on an informal basis if the circumstances are right.** Some agenda items may not be ready for publication however they may require input from members before a consultation is launched. Please speak to the Local Authority Officer in the first instance who will provide guidance and arrange for a briefing with either the Chair and Deputy Chair, or with the full WY JHOSC if appropriate.

- **A statutory HOSC and JHOSC has statutory powers.** Committees have statutory powers to provide overview and scrutinise decisions, plans and implementations and the power to access information. To find out more about the statutory role of committees, please visit Advice to local authorities on scrutinising health services - GOV.UK (www.gov.uk).

- **JHOSC offers the opportunity to highlight issues that matter to local people and the local community.** Members are elected to represent people in a geographical area and have regular contact with the public through ward meetings, telephone calls or surgeries to understand the needs of their community and bring issues that matter to local people into decision making. Engaging early with members may help to anticipate and mitigate any potential issues before the formal meeting.

- **JHOSC is a critical part of governance, the process can add significant value.** JHOSC is beyond transactional governance. It is important to consider the role and purpose of JHOSC and tailor reports, papers, and presentations accordingly. Actively listening to JHOSC members and officers that support them is an important part of this.

The following information may help with the content of the report and usual areas of questioning:

- Try not to use reports that have been considered at other Committees including ICB Board meetings. It can be helpful to link to previous reports or add as an appendix, but the main body of the update needs to focus on the audience of the WY JHOSC.

- Members of the WY JHOSC expect a high level of detail to be included within the report. Links to further information, guidance or background etc is encouraged.

- If you are unsure about the focus of the WY JHOSC and the brief that you have been given, please contact the instructing local authority officer who will be able to provide further guidance.
- Ensure timeframes for each step of service change or consultation are included within the report.
- Avoid ‘jargon’ or too many acronyms. Where it is necessary for acronyms to be used, explain what these stand for in the first instance. Similarly, try not to use ‘shorthand’ to avoid confusion e.g., referring as Calderdale and Huddersfield Foundation Trust simply as Calderdale.
- When referring to different Local Authorities, make sure correct names are used, e.g., Kirklees not Huddersfield, Calderdale not Halifax.
- Previous discussions at the WY JHOSC have highlighted the following areas of interest to Committee Members. We recommend including information of these within the report, or being prepared with answers if questions are raised:
    - Engagement with Ward Councillors – When a proposed service change or reconfiguration will have a particular impact on a specific area or areas, ward Cllrs should be kept informed. All information on who represents each Ward can be found on the relevant Authorities website.
    - Engagement with Place Scrutiny Leads – If one Local Authority is impacted more than another, have you spoken with the lead for the Place-Based Health and Overview Committees?
    - Consultation – Can you include a link to any current consultation so Members can see what has been asked, or if not yet started, can you include in your report what you intend to ask? Are you sure that you have considered the digitally excluded, and other under-represented groups – can you evidence that?
    - Transport/Travel – As more services are centralised, has consideration been given to how patients will travel to receive treatment?
    - National Popular Topics – Consider whether any of the current affairs in health news relate to your item e.g., Physician Associates, GP telephone appointments or ambulance waiting times.
    - Workforce and Recruitment – How would any change impact the ability to recruit? Have you considered the future proofing of services with ongoing training?
    - Data, Target Information – provide information regarding adequate data and targets that the ICB have set, so that the WY JHOSC Members can analyse and monitor.

- Forward Plan of Priorities – show how the proposal links with the forward plan and what the ICB is hoping to achieve.
- Timescales - Constructive dialogue is required when communicating with the WY JHOSC on timescales for comments in relation to substantial developments or variations, as this should help ensure that timescales are realistic and achievable.
- Benchmarking – Consider adding statistical comparisons from neighbouring areas, or in the instance of a specialist service, compare this with a similar service in another area of the country.
- Delivery of Specialist Services – Consider whether WY JHOSC should be briefed on a service that is delivered in one place, but affects patients in the whole or larger part of the WY area.

Centre for Governance and Scrutiny have published a Scrutiny Practitioners Guide. It helpfully sets out an introduction to scrutiny, challenges and solutions and key skills. It is available [online] Scrutineers-guide-final.pdf (cfgs.org.uk) [15.07.2024]

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West Yorkshire Joint Health Overview and Scrutiny Committee

Delegation of Specialised Commissioning Services to the West Yorkshire Integrated Care Board

25th February 2025

1.0. Purpose

1.1. This paper provides an update to members of the West Yorkshire Joint Health and Overview Scrutiny Committee on the process to delegate specialised commissioned services from NHS England to the West Yorkshire Integrated Care Board.

2.0. Summary

2.1. NHS England (NHSE) has set out its intentions to delegate commissioning responsibility for a range of specialised services to Integrated Care Boards (ICBs). Following the delegation of Pharmacy, Optometry and Dental Commissioning in April 2023, it is planned that from 1 April 2025 the identified services will be delegated to all ICBs including the NHS West Yorkshire (WY) ICB.

2.2. There are 84 services to be delegated, with a financial value of £466m for the ICB. We are supportive in principle of receiving the delegation of these services as we believe this gives us the greatest opportunity to join up pathways and make improvements and we are developing a workplan which will set out priority areas for action from April. This direction of travel is also supported by providers of these services in our region.

2.3. We have been working closely with NHSE and neighbouring ICBs since last summer to manage the process of safe delegation. The two ICB Board papers attached as appendices set out the approach. The first, from September 2024 sets the scene, the ICB approach and the 'key tests' to be met before agreeing to delegation; the second, from November 2024 seeks ICB agreement in principle to take on delegation, recognising the progress made to that point and the further work to be completed by the end of the financial year.

2.4. We will be taking a further paper to the Board in March seeking formal approval to delegation and sign off of a range of updated governance documentation that will describe how the function will be discharged in the future.

2.5. The purpose of this item is to share with the Joint Scrutiny Committee the approach we are taking to delegation, and how the commissioning arrangements will function from 2025-26. Update papers taken to the West Yorkshire Integrated Care Board in September and November are attached as appendices for information.

3.0. Recommendations

3.1. Members of the West Yorkshire Joint Health Overview and Scrutiny Committee are asked to note the progress towards delegation of Specialised Commissioning to the West Yorkshire Integrated Care Board.

Meeting name:	NHS West Yorkshire Integrated Care Board
Agenda item no.	11
Meeting date:	24 September 2024
Report title:	Update on the Delegation of Commissioning Responsibility for Specialised Services
Report presented by:	Ian Holmes, Director of Strategy and Partnerships and Deputy CEO, NHS WY ICB
Report approved by:	Ian Holmes, Director of Strategy and Partnerships and Deputy CEO, NHS WY ICB
Report prepared by:	Hayden Ridsdale, Senior Strategy and Transformation Programme Manager, NHS WY ICB Esther Ashman, Deputy Director Strategy and Transformation, NHS WY ICB

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☒
Previous considerations:			
N/A			
Executive summary and points for discussion:			

NHS England (NHSE) have previously set out their intentions to delegate commissioning responsibility for a range of specialised services to Integrated Care Boards (ICBs). It is planned that from 1 April 2025 these services will be delegated to the NHS West Yorkshire (WY) ICB. There are 84 services to be delegated, with a financial value of £466m across WY.

There is broad support for moving towards delegation in principle, and an acknowledgement that it can bring a range of benefits for patients. This includes through improving integration and how we commission services across the pathway, placing a greater emphasis on prevention, and strengthening clinical leadership and provider collaboration. There are also risks around delivery and finance that will need to be managed effectively.

This paper provides the Board with a summary of the context of delegation, outlines the approach being taken to manage the delegation, and sets out the key priorities that will be progressed throughout this year to support a safe delegation and landing from 1 April 2025.

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 NHS WY ICB Board are asked to: • Note and support the approach being taken to manage the safe delegation of specialised commissioning services. • Note current position, including the work currently underway to manage the safe delegation of specialised commissioning, and the risks outlined. • Support the intention to delegate commissioning responsibility, subject to sufficient progress being made as set out in this paper.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
N/A
Appendices
Appendix A – List of Services to be Delegated
Acronyms and Abbreviations explained
1. CEO – Chief Executive Officer 2. ICB – Integrated Care Board 3. MHLDA – Mental Health, Learning Disabilities and Autism 4. NHS – National Health Service 5. NHSE – NHS England 6. OD – Organisational Development 7. PDAF – Pre-delegation Assessment Framework 8. SDC – Safe Delegation Checklist 9. WY – West Yorkshire 10. WYAAT – West Yorkshire Association of Acute Trusts 11. Y&H – Yorkshire and the Humber

What are the implications for?

Residents and Communities	The services being delegated are crucial for patients living with needs that require complex services and support. Through delegation there is an opportunity to improve services across the pathway.
Quality and Safety	There are implications of delegation for quality oversight and management, and an opportunity through improvement to maximise the quality of services delivered to our patients.
Equality, Diversity and Inclusion	There is scope through delegation to improve the focus on health inequalities, and therefore improving and addressing the health needs of our highest need population groups.
Finances and Use of Resources	The services being delegated are high value. There are significant financial challenges, but an opportunity over the long term to improve efficiency through a greater focus on prevention.
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	There is a significant transformation opportunity that will be considered and planned for pre-delegation, but realised in the years post-delegation.
Environmental and Climate Change	There may be opportunities through specific service transformations to support our climate change ambitions.
Future Decisions and Policy Making	The Board will be asked to take a decision on delegation in the future.
Citizen and Stakeholder Engagement	N/A

1.0. Purpose

1.1. There is a national direction of travel from NHS England (NHSE) to delegate their commissioning functions to Integrated Care Boards (ICBs). As part of this there is an intention to delegate a range of specialised services to ICBs from 1 April 2025. This paper provides the NHS West Yorkshire Integrated Care Board (WY ICB) with an update on:

- The status of specialised commissioning delegation as outlined in the Roadmap for integrating specialised services within Integrated Care Systems;
- The approach that is being taken to managing and overseeing the process of delegation;
- The current position on key delegation requirements, including the risks and opportunities; and
- The work that has been delivered on renal, our priority pathway transformation programme.

1.2. The NHS WY ICB Board are asked to:

- Note and support the approach being taken to manage the safe delegation of specialised commissioning services.
- Note current position, including the work currently underway to manage the safe delegation of specialised commissioning, and the risks outlined.
- Support the intention to delegate commissioning responsibility, subject to sufficient progress being made as set out in this paper.

2.0. Background and Context

2.1. NHSE was established as the accountable commissioner for specialised services through the Health and Social Care Act (2012), and is currently responsible for commissioning 154 prescribed specialised services.

2.2. The portfolio of services varies considerably, from low volume services for patients with rare conditions to others, like radiotherapy or neurosurgery that treat tens of thousands each year as part of wider pathways spanning primary, community and other secondary care services commissioned by the ICB.

2.3. NHSE's commissioning of specialised services has brought several benefits. It has standardised and ensured compliance with national services specifications, supported universal access, and implemented a robust policy development process.

2.4. Despite successes there are issues that, by delegating commissioning responsibility from NHSE to ICBs, the Health and Social Care Act (2022) seeks to address. These include:

- A fragmentation of the commissioning pathway between ICBs and NHSE.
- Legislative barriers meaning that risk sharing between commissioners was possible but difficult to achieve in practice.
- As NHSE has provider-based allocations, it was difficult to plan for population health across a geography.

2.5. NHSE are proposing to delegate commissioning responsibility for 84 specialised services to ICBs (or multi-ICB footprints as appropriate). An initial 59 services were already delegated to 9 joint committees covering England, and an additional 25 previously deemed "suitable but not yet ready for ICS leadership" will now be delegated. A full list of services is in appendix A.

2.6. The financial value for the services to be delegated to WY is £466m. There are a range of financial challenges, particularly around budgets and capital investment, and the impact of the move to population-based budgets is as yet unclear.

2.7. The services in scope have been determined nationally, with clinical, financial, legal, and commissioning input. Health and Justice, Operational Delivery Networks, some services, and overall accountability will remain with NHSE.

2.8. NHSE has already transferred some commissioning responsibility for MHLDA services into provider collaboratives. These functions are discharged through lead provider arrangements and delivered via the WY MHLDA Commissioning Hub. They are expected to continue, but in the context of wider ICB responsibilities.

2.9. NHSE initially intended to delegate commissioning responsibility from April 2024. Due to risks highlighted through a pre-delegation assessment framework (PDAF) submission, with NEY ICBs and the NHSE regional team it was agreed that this timeline should be pushed back to April 2025.

2.10. There is substantial work required to ensure sufficient progress in moving towards delegation, that supports Board assurance and the decision to delegate. We are working at pace on this, although work is still underway nationally to set out the operating model for the retained services. Understanding this and the impact is key.

2.11. Delegation will be supported by the current team transferring to South Yorkshire ICB, as the host ICB. The team is substantial, though carrying a number of vacancies, and will continue to deliver the day-to-day functions working as a single team across four ICBs. Some roles within the team will remain within NHSE. South Yorkshire are leading the consultation and TUPE arrangements, with all four ICB directors supporting the team during the transition.

3.0. The Opportunities of Delegation

3.1. As a system, we support the direction of travel to delegate these services to ICBs. Having previously received delegation for Pharmacy Optometry and Dentistry in April 2023, we believe there are similar opportunities. We have already demonstrated across these areas that there is scope to deliver improvements.

3.2. This brings a significant opportunity to align the way a large portfolio of services is commissioned and delivered with other areas of responsibility within our system, to maximise benefits for patients. We have demonstrated this through

our recent pathway transformation work on renal services. We will harness this opportunity by:

- Delivering a more integrated approach to service planning and delivery, with a greater focus on prevention.
- Strengthening clinical engagement and leadership.
- Improving partnership working and collaboration with providers.

4.0. Approach to Managing Delegation

4.1. To support the delegation process and as part of ongoing joint commissioning arrangements, we have been working with the NHSE team and our partner ICBs for a number of years. This ensures that we can influence and effectively manage the process and mitigate risks, for example by delaying the planned delegation date to obtain greater information and assurance.

4.2. We continue to work closely with partners regionally. The following are agreed priorities throughout the transition and delegation process, until April 2025:

- Establishing a process of mutual assurance so that ICBs and NHSE are both assured of the safe transfer of commissioning responsibilities and that service and financial risks are fully understood.
- Understanding the oversight and leadership model for the retained specialised commissioning portfolio to ensure we are clear on the overall operating model of staff involved in commissioning specialised services (delegated and retained).
- Strengthening engagement and relationships with providers through this period of transition and post delegation, to ensure that our approach to delegation is collectively managed and that both current and future transformation opportunities are harnessed.

4.3. Regionally, existing arrangements including a joint committee and partnership and delegation group support this. An overarching delegation sub-group, and several supporting subgroups (finance, quality, and contracting and business intelligence), provide space for detailed discussions, focused on the safe delegation checklist (SDC). All groups include ICB representation.

4.4. A WY Specialised Commissioning Delegation Programme Board has now been jointly established between the ICB, the West Yorkshire Association of Acute Trusts (WYAAT) and the MHLDA Collaborative to oversee the safe delegation on behalf of the WY system. The Board is chaired by Professor Phil Wood (CEO, Leeds Teaching Hospitals NHS Trust) and will report to the System Oversight and Assurance Group. It includes representation from a range of partners, including members of regional groups.

4.5. The programme board will manage and oversee the SDC to support the safe delegation, and has established supporting workstreams reflecting the regional focus and that which is important locally. Broadly, it will consider governance, the operating model for now and future ambitions, transformation, service lines, quality, finance, contracting. The current position is set out in section 5.

4.6. To manage the volume we have sequenced the work required as follows:

- That which must be fully completed pre-delegation, to provide board assurance, enable sign off and ensure safe landing of the delegation.
- That which must be started pre-delegation (for example planning and/or initial delivery) but will continue after.
- That which will only be delivered post-delegation.

5.0. Risks

5.1. The process and approach that we have established, set out in section 4, seeks to ensure a safe delegation and in turn manage the associated risks. The work that will be delivered, as set out in section 6, will either mitigate the risks or set out plans to do so. The Board will be asked to consider this as part of future assurance and sign off.

5.2. Despite the plans in place, there are several overarching risks:

- **Timescales:** The timeline to deliver necessary pre-delegation work is tight. This may have several consequences ranging from insufficient progress and the Board not approving delegation, to inadequate awareness of key issues and accepting delegation without complete knowledge.
- **System risks:** To sign off delegation it will be important that we obtain a system view of all risks associated with specialised services, with a consensus and collective assurance on how this will be owned and managed.
- **Specific service challenges:** There are significant challenges relating to specific service areas which poses a risk to operational delivery and to the ICB, related to the scale of issues that require addressing post-delegation.
- **Financial issues:** There are a range of financial challenges, with a risk that there is an insufficient envelope to deliver safe and high quality services; insufficient capital investment; and work required to fully understand the impact of changes to the financial architecture for specialised services, including moving to population-based budgets.
- **Staffing:** The team will provide functions for both delegated services, working on behalf of four ICBs, and retained services on behalf of NHSE. This presents a capacity risk, exacerbated by current vacancies, and a requirement to support the team to develop.

6.0. Priorities for Delegation

6.1. Most of the work relating delegation falls into the first two categories set out in section 4.6. Prioritising this will enable a safe delegation and landing. A focus on longer-term transformation and improvement will be ongoing post-delegation.

6.2. A detailed breakdown of priorities for each workstream is set out below.

<u>Transition and Delegation</u>

6.3. This workstream focuses on oversight and management of the SDC, and producing the safe delegation governance documentation.

6.4. It is essential that this work is completed prior to delegation.

6.5. We are making good progress on this already, including:

- Agreement of a consistent approach to completing the SDC with our partner ICBs.
- Leadership from experts on areas of the SDC (e.g. finance and quality).

6.6. In order to support the delegation of commissioning responsibility and address the risks set out, the Board will need to be assured that:

- The overall position of the SDC is satisfactory to safely delegate and land specialised commissioning delegation.
- There is a robust suite of delegation governance documents in place.

Governance and Decision-Making

6.7. This workstream focuses on the operational governance structures, systems and processes that will be required to safely deliver our commissioning responsibilities, including how they connect to current WY arrangements.

6.8. It is essential that this work is completed prior to delegation.

6.9. We are making good progress on this already, including:

- Agreement that we will have a joint Y&H decision-making forum with our partner ICBs that considers delegated and retained services.
- Scoping the existing WY governance documents and processes that require amendment or alignment, for example our scheme of reservation and delegation, constitution, and standing financial instructions.
- Understanding the specialised commissioning teams current structures, approach to decision-making and key functions such as managing risk.

6.10. In order to support the delegation of commissioning responsibility and address the risks set out, the Board will need to be assured that:

- Any necessary amendments to the ICBs governance documentation have been/will be made.
- A robust governance and decision-making model will be in place from 1 April 2025, with suitable delegation and empowerment to key forums and individuals to enable efficient operations, but proportionate checks and balances in place.
- Specialised commissioning governance and decision-making is connected with existing WY forums, to ensure that the benefits of delegation and integration are realised, and that decisions are well informed.

Operating Model and Ways of Working

6.11. This workstream focuses on developing the operating model and ways of working that will deliver the benefits of delegation. It will include how the team functions, the approach to transformation, the interface with ICB teams, and working with WYAAT. We will also identify how a future operating model could evolve.

6.12. The work to develop and agree a high-level model must be completed prior to delegation, but will evolve over time.

6.13. We are making good progress on this already, including:

- Understanding the specialised commissioning teams current model.
- Agreement that an OD plan will be developed and in place to support the teams transition toward a new operating model.

6.14. In order to support the delegation of commissioning responsibility and address the risks set out, the Board will need to be assured that:

- The operating model for the teams role over nationally retained functions has been set out, and does not pose significant risk to delivering our responsibilities.
- An operating model has been developed and is in place.
- An OD plan has been developed and will be delivered iteratively.

Services and Pathways

6.15. This workstream focuses on obtaining a complete view of the current position of specific services, in order to provide an accurate assessment of the services that are being delegated to the ICB, including key opportunities, risks and action required. It includes consideration of all services to be delegated, new policies and specifications, clinical networks, high cost drugs and patient flows.

6.16. It is essential that the work to understand the current position is completed prior to delegation as a key component of our due diligence, with further service planning, transformation and improvement being undertaken on an ongoing basis.

6.17. We are making some progress on this already including:

- Obtaining a view of the current risk register.
- Working within WYAAT to understand service pressures.
- Agreement of an approach to prioritise a future Y&H workplan, informed by an overall view of the high risk and high impact service areas.
- Our work on renal services, as a priority service transformation area, which demonstrates our ability to work on a new and highly complex service area. Through a workshop we have codesigned an improvement plan focusing on renal services, kidney health, and a full pathway approach.

6.18. In order to support the delegation of commissioning responsibility and address the risks set out, the Board will need to be assured that:

- A complete view of information, risks and issues with delegated services, has been obtained, with mitigations being developed, that is agreed with both WYAAT and the MHLDA collaborative.
- A prioritised workplan will be in place and delivered from 1 April 2025.
- There is a clear approach to service transformation and improvement that aligns with our system priorities and approach.
- There is a clear approach to service planning across the Y&H footprint, including to optimise patient flows.
- High quality data is available and well utilised to inform service planning and wider work across WY.
- There is a clear approach to working with clinical networks to support our commissioning functions, given the responsibility for the networks will be retained by NHSE.

Quality

6.19. This workstream focuses on processes for service quality monitoring and assurance, strategic quality oversight, and statutory quality duties.

6.20. It is essential that all of this work is completed prior to delegation.

6.21. We are making some progress on this already, including:

- Understanding the current approach, systems and processes for specialised commissioning, and how this aligns with ours.

6.22. In order to support the delegation of commissioning responsibility and address the risks set out, the Board will need to be assured that:

- Robust quality oversight and management arrangements have been developed and will be in place from 1 April 2025.
- Service specific quality concerns are known, with plans in place.
- The quality oversight arrangements from the NHSE region over delegated services are clear and proportionate.

Finance and Contracting

6.23. This workstream focuses on financial governance, allocations, management accounts, financial accounts, the approach to contracting, current financial and contractual positions/risks, and key statutory/regulatory requirements.

6.24. It is essential that all of this work is completed prior to delegation, but work on the financial sustainability of services will be ongoing.

6.25. Work on this area is progressing well through the regional finance and contracting subgroups respectively, with confidence that delegation of the core operational functions is relatively straight forwards.

6.26. In order to support the delegation of commissioning responsibility and address the risks set out, the Board will need to be assured that:

- We have a complete view of the financial and contractual risks specific to services.
- We understand the considerable “distance from target” position, with the acknowledgement that there is no current plan nationally to address this.
- We have an agreed contracting approach in place from 1 April 2025.

7.0. Timescales and Decision-Making

7.1. NHSE will commit to a decision in principle to delegate these services to ICBs at its Board meeting on the 5 December 2024. The WY ICB Board will therefore need to be in a position whereby commitment to an intent to accept the delegation of these services is made in advance of the NHSE Board meeting. It is proposed that an extraordinary meeting of the ICB Board is held in late November 2024 to have further detailed discussions and confirm intent.

7.2. At the extraordinary meeting of the ICB Board in November, it is intended that progress against the areas set out in section 5, as well as assurance that any additional work required is planned, will be provided to the Board to support the

decision to signal intent. It's important to note that the work to support delegation will not have been completed until March 2025, therefore regular updates against risks, mitigations and progress will continue to be provided to the Board.

8.0. Recommendations

8.1. The NHS West Yorkshire Integrated Care Board is asked to:

- Note and support the approach being taken to manage the safe delegation of specialised commissioning services.
- Note current position, including the work currently underway to manage the safe delegation of specialised commissioning, and the risks outlined.
- Support the intention to delegate commissioning responsibility, subject to sufficient progress being made as set out in this paper.

Specialised Commissioning - Service Portfolio Analysis (SPA) Detail

Service Line Code	To Be Delegated to ICBs	Service Line Description	ACUTE/MH	Programme of Care (PoC) Category
NCBPS01C	Yes	CHEMOTHERAPY	ACUTE	B02 - CHEMOTHERAPY
NCBPS01J	Yes	ANAL CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01K	Yes	MALIGNANT MESOTHELIOMA (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01M	Yes	HEAD AND NECK CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01N	Yes	KIDNEY, BLADDER AND PROSTATE CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01Q	Yes	RARE BRAIN AND CNS CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01R	Yes	RADIOTHERAPY SERVICES (ADULTS)	ACUTE	B01 - RADIOTHERAPY
NCBPS01S	Yes	STEREOTACTIC RADIOSURGERY / RADIOTHERAPY	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01T	Yes	TEENAGE AND YOUNG ADULT CANCER	ACUTE	B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES
NCBPS01U	Yes	OESOPHAGEAL AND GASTRIC CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01V	Yes	BILIARY TRACT CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01W	Yes	LIVER CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01X	Yes	PENILE CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01Y	Yes	CANCER OUTPATIENTS (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS01Z	Yes	TESTICULAR CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS02Z	Yes	HAEMATOPOIETIC STEM CELL TRANSPLANTATION SERVICES (ADULTS AND CHILDREN)	ACUTE	F01 - BLOOD AND MARROW TRANSPLANTATION
NCBPS03C	Yes	CASTLEMAN DISEASE	ACUTE	F02 - SPECIALISED BLOOD DISORDERS
NCBPS03X	Yes	SPECIALIST SERVICES FOR HAEMOPHILIA AND OTHER RELATED BLEEDING DISORDERS (ADULTS)	ACUTE	F02 - SPECIALISED BLOOD DISORDERS
NCBPS03Y	Yes	SPECIALIST SERVICES FOR HAEMOPHILIA AND OTHER RELATED BLEEDING DISORDERS (CHILDREN)	ACUTE	F02 - SPECIALISED BLOOD DISORDERS
NCBPS04A	Yes	SEVERE ENDOMETRIOSIS	ACUTE	E09 - SPECIALISED WOMENS SERVICES
NCBPS04C	Yes	FETAL MEDICINE SERVICES (ADULTS AND ADOLESCENTS)	ACUTE	E09 - SPECIALISED WOMENS SERVICES
NCBPS04D	Yes	COMPLEX URINARY INCONTINENCE AND GENITAL PROLAPSE	ACUTE	E09 - SPECIALISED WOMENS SERVICES
NCBPS04F	Yes	GYNAECOLOGICAL CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS04G	Yes	SPECIALIST MATERNITY CARE FOR WOMEN DIAGNOSED WITH ABNORMALLY INVASIVE PLACENTA	ACUTE	E09 - SPECIALISED WOMENS SERVICES
NCBPS04P	Yes	TERMINATION SERVICES FOR PATIENTS WITH MEDICAL COMPLEXITY AND OR SIGNIFICANT CO-MORBIDITIES REQUIRING TREATMENT IN A SPECIALIST HOSPITAL	ACUTE	E09 - SPECIALISED WOMENS SERVICES
NCBPS05C	Yes	SPECIALIST AUGMENTATIVE AND ALTERNATIVE COMMUNICATION AIDS (ADULTS AND CHILDREN)	ACUTE	D01 - REHABILITATION AND DISABILITY
NCBPS05E	Yes	SPECIALIST ENVIRONMENTAL CONTROLS (ADULTS AND CHILDREN)	ACUTE	D01 - REHABILITATION AND DISABILITY
NCBPS05P	Yes	PROSTHETICS (ADULTS AND CHILDREN)	ACUTE	D01 - REHABILITATION AND DISABILITY
NCBPS06Z	Yes	COMPLEX SPINAL SURGERY SERVICES (ADULTS AND CHILDREN)	ACUTE	D03 - SPINAL SERVICES
NCBPS07Y	Yes	PAEDIATRIC NEUROREHABILITATION	ACUTE	E04 - PAEDIATRIC NEUROSCIENCES
NCBPS07Z	Yes	SPECIALIST REHABILITATION SERVICES FOR PATIENTS WITH HIGHLY COMPLEX NEEDS (ADULTS AND CHILDREN)	ACUTE	D01 - REHABILITATION AND DISABILITY
NCBPS08J	Yes	SELECTIVE DORSAL RHIZOTOMY	ACUTE	E04 - PAEDIATRIC NEUROSCIENCES
NCBPS08O	Yes	NEUROLOGY (ADULTS)	ACUTE	D04 - NEUROSCIENCES
NCBPS08P	Yes	NEUROPHYSIOLOGY (ADULTS)	ACUTE	D04 - NEUROSCIENCES
NCBPS08R	Yes	NEURORADIOLOGY (ADULTS)	ACUTE	D04 - NEUROSCIENCES
NCBPS08S	Yes	NEUROSURGERY (ADULTS)	ACUTE	D04 - NEUROSCIENCES
NCBPS08T	Yes	MECHANICAL THROMBECTOMY	ACUTE	D04 - NEUROSCIENCES
NCBPS08Y	Yes	NEUROPSYCHIATRY SERVICES (ADULTS AND CHILDREN)	ACUTE	D04 - NEUROSCIENCES
NCBPS08Z	Yes	COMPLEX NEURO-SPINAL SURGERY SERVICES (ADULTS AND CHILDREN)	ACUTE	D03 - SPINAL SERVICES
NCBPS10Z	Yes	CYSTIC FIBROSIS SERVICES (ADULTS AND CHILDREN)	ACUTE	A01 - SPECIALISED RESPIRATORY
NCBPS11B	Yes	RENAL DIALYSIS	ACUTE	A06 - RENAL SERVICES
NCBPS11C	Yes	ACCESS FOR RENAL DIALYSIS	ACUTE	A06 - RENAL SERVICES
NCBPS11T	Yes	RENAL TRANSPLANTATION	ACUTE	A06 - RENAL SERVICES
NCBPS13A	Yes	COMPLEX DEVICE THERAPY	ACUTE	A05 - CARDIOTHORACIC SERVICES
NCBPS13B	Yes	CARDIAC ELECTROPHYSIOLOGY & ABLATION	ACUTE	A05 - CARDIOTHORACIC SERVICES
NCBPS13C	Yes	INHERITED CARDIAC CONDITIONS	ACUTE	A05 - CARDIOTHORACIC SERVICES
NCBPS13E	Yes	CARDIAC SURGERY (INPATIENT)	ACUTE	A05 - CARDIOTHORACIC SERVICES
NCBPS13F	Yes	PPCI FOR ST- ELEVATION MYOCARDIAL INFARCTION	ACUTE	A05 - CARDIOTHORACIC SERVICES
NCBPS13H	Yes	CARDIAC MAGNETIC RESONANCE IMAGING	ACUTE	A05 - CARDIOTHORACIC SERVICES
NCBPS13T	Yes	COMPLEX INTERVENTIONAL CARDIOLOGY (ADULTS)	ACUTE	A05 - CARDIOTHORACIC SERVICES
NCBPS13X	Yes	ADULT CONGENITAL HEART DISEASE SERVICES (NON-SURGICAL)	ACUTE	E05 - CONGENITAL HEART SERVICES

NCBPS13Y	Yes	ADULT CONGENITAL HEART DISEASE SERVICES (SURGICAL)	ACUTE	E05 - CONGENITAL HEART SERVICES
NCBPS13Z	Yes	CARDIAC SURGERY (OUTPATIENT)	ACUTE	A05 - CARDIOTHORACIC SERVICES
NCBPS14A	Yes	ADULT SPECIALISED SERVICES FOR PEOPLE LIVING WITH HIV	ACUTE	F03 - HIV
NCBPS15Z	Yes	CLEFT LIP AND PALATE SERVICES (ADULTS AND CHILDREN)	ACUTE	E02 - SPECIALISED SURGERY IN CHILDREN
NCBPS16X	Yes	SPECIALIST IMMUNOLOGY SERVICES FOR ADULTS WITH DEFICIENT IMMUNE SYSTEMS	ACUTE	F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES
NCBPS16Y	Yes	SPECIALIST IMMUNOLOGY SERVICES FOR CHILDREN WITH DEFICIENT IMMUNE SYSTEMS	ACUTE	F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES
NCBPS17Z	Yes	SPECIALIST ALLERGY SERVICES (ADULTS AND CHILDREN)	ACUTE	F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE
NCBPS18A	Yes	SPECIALIST SERVICES FOR ADULTS WITH INFECTIOUS DISEASES	ACUTE	F04 - INFECTIOUS DISEASES
NCBPS18C	Yes	SPECIALIST SERVICES FOR CHILDREN WITH INFECTIOUS DISEASES	ACUTE	E03 - PAEDIATRIC MEDICINE
NCBPS18E	Yes	SPECIALIST BONE AND JOINT INFECTION (ADULTS)	ACUTE	F04 - INFECTIOUS DISEASES
NCBPS19B	Yes	SPECIALIST SERVICES FOR COMPLEX BILIARY DISEASES IN ADULTS	ACUTE	A02 - HEPATOBILIARY AND PANCREAS
NCBPS19C	Yes	BILIARY TRACT CANCER SURGERY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS19L	Yes	SPECIALIST SERVICES FOR COMPLEX LIVER DISEASES IN ADULTS	ACUTE	A02 - HEPATOBILIARY AND PANCREAS
NCBPS19M	Yes	LIVER CANCER SURGERY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS19P	Yes	SPECIALIST SERVICES FOR COMPLEX PANCREATIC DISEASES IN ADULTS	ACUTE	A02 - HEPATOBILIARY AND PANCREAS
NCBPS19Q	Yes	PANCREATIC CANCER SURGERY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS19V	Yes	PANCREATIC CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS19Z	Yes	SPECIALIST SERVICES FOR COMPLEX LIVER, BILIARY AND PANCREATIC DISEASES IN ADULTS	ACUTE	A02 - HEPATOBILIARY AND PANCREAS
NCBPS22E	Yes	ADULT SPECIALIST EATING DISORDER SERVICES	MH	C01 - SPECIALISED MENTAL HEALTH
NCBPS22P	Yes	SPECIALIST PERINATAL MENTAL HEALTH SERVICES (ADULTS AND ADOLESCENTS)	MH	C04 - PERINATAL MENTAL HEALTH
NCBPS22S(a)	Yes	SECURE AND SPECIALISED MENTAL HEALTH SERVICES (ADULT) (MEDIUM AND LOW) - EXCLUDING LD / ASD / WEMS / ABI / DEAF	MH	C02 - ADULT SECURE SERVICES
NCBPS22S(c)	Yes	SECURE AND SPECIALISED MENTAL HEALTH SERVICES (ADULT) (MEDIUM AND LOW) - ASD	MH	C02 - ADULT SECURE SERVICES
NCBPS22S(d)	Yes	SECURE AND SPECIALISED MENTAL HEALTH SERVICES (ADULT) (MEDIUM AND LOW) - LD	MH	C02 - ADULT SECURE SERVICES
NCBPS23A	Yes	CHILDREN'S CANCER	ACUTE	B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES
NCBPS23B	Yes	PAEDIATRIC CARDIAC SERVICES	ACUTE	E05 - CONGENITAL HEART SERVICES
NCBPS23D	Yes	SPECIALIST EAR, NOSE AND THROAT SERVICES FOR CHILDREN	ACUTE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES
NCBPS23E	Yes	SPECIALIST ENDOCRINOLOGY AND DIABETES SERVICES FOR CHILDREN	ACUTE	E03 - PAEDIATRIC MEDICINE
NCBPS23F	Yes	SPECIALIST GASTROENTEROLOGY, HEPATOLOGY AND NUTRITIONAL SUPPORT SERVICES FOR CHILDREN	ACUTE	E03 - PAEDIATRIC MEDICINE
NCBPS23H	Yes	SPECIALIST HAEMATOLOGY SERVICES FOR CHILDREN	ACUTE	E03 - PAEDIATRIC MEDICINE
NCBPS23K	Yes	TIER 4 CAMHS (GENERAL ADOLESCENT INC EATING DISORDERS)	MH	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)
NCBPS23L	Yes	TIER 4 CAMHS (LOW SECURE)	MH	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)
NCBPS23M	Yes	SPECIALIST NEUROSCIENCE SERVICES FOR CHILDREN	ACUTE	E04 - PAEDIATRIC NEUROSCIENCES
NCBPS23N	Yes	SPECIALIST OPHTHALMOLOGY SERVICES FOR CHILDREN	ACUTE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES
NCBPS23O	Yes	TIER 4 CAMHS (PICU)	MH	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)
NCBPS23P	Yes	SPECIALIST DENTISTRY SERVICES FOR CHILDREN	ACUTE	E02 - SPECIALISED SURGERY IN CHILDREN
NCBPS23Q	Yes	SPECIALIST ORTHOPAEDIC SERVICES FOR CHILDREN	ACUTE	E02 - SPECIALISED SURGERY IN CHILDREN
NCBPS23R	Yes	SPECIALIST PLASTIC SURGERY SERVICES FOR CHILDREN	ACUTE	E02 - SPECIALISED SURGERY IN CHILDREN
NCBPS23S	Yes	SPECIALIST RENAL SERVICES FOR CHILDREN	ACUTE	E03 - PAEDIATRIC MEDICINE
NCBPS23T	Yes	SPECIALIST RESPIRATORY SERVICES FOR CHILDREN	ACUTE	E03 - PAEDIATRIC MEDICINE
NCBPS23U	Yes	TIER 4 CAMHS (LD)	MH	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)
NCBPS23V	Yes	TIER 4 CAMHS (ASD)	MH	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)
NCBPS23W	Yes	SPECIALIST RHEUMATOLOGY SERVICES FOR CHILDREN	ACUTE	E03 - PAEDIATRIC MEDICINE
NCBPS23X	Yes	SPECIALIST PAEDIATRIC SURGERY SERVICES - GENERAL SURGERY	ACUTE	E02 - SPECIALISED SURGERY IN CHILDREN
NCBPS23Y	Yes	SPECIALIST PAIN MANAGEMENT SERVICES FOR CHILDREN	ACUTE	E02 - SPECIALISED SURGERY IN CHILDREN
NCBPS23Z	Yes	SPECIALIST PAEDIATRIC UROLOGY SERVICES	ACUTE	E02 - SPECIALISED SURGERY IN CHILDREN
NCBPS24C	Yes	FCAMHS	MH	C03 - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)
NCBPS24Y	Yes	SKIN CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS24Z	Yes	SPECIALIST DERMATOLOGY SERVICES (ADULTS AND CHILDREN)	ACUTE	A08 - SPECIALISED DERMATOLOGY
NCBPS26Z	Yes	ADULT SPECIALIST RHEUMATOLOGY SERVICES	ACUTE	A09 - SPECIALISED RHEUMATOLOGY
NCBPS27E	Yes	ADRENAL CANCER (ADULTS)	ACUTE	A03 - SPECIALISED ENDOCRINOLOGY
NCBPS27Z	Yes	ADULT SPECIALIST ENDOCRINOLOGY SERVICES	ACUTE	A03 - SPECIALISED ENDOCRINOLOGY
NCBPS29B	Yes	COMPLEX THORACIC SURGERY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS29E	Yes	MANAGEMENT OF CENTRAL AIRWAY OBSTRUCTION (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS29L	Yes	LUNG VOLUME REDUCTION (ADULTS)	ACUTE	A01 - SPECIALISED RESPIRATORY

NCBPS29M	Yes	INTERSTITIAL LUNG DISEASE (ADULTS)	ACUTE	A01 - SPECIALISED RESPIRATORY
NCBPS29S	Yes	SEVERE ASTHMA (ADULTS)	ACUTE	A01 - SPECIALISED RESPIRATORY
NCBPS29V	Yes	COMPLEX HOME VENTILATION (ADULTS)	ACUTE	A01 - SPECIALISED RESPIRATORY
NCBPS29Z	Yes	ADULT THORACIC SURGERY SERVICES: OUTPATIENTS	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS30Z	Yes	ADULT SPECIALIST VASCULAR SERVICES	ACUTE	A04 - VASCULAR DISEASE
NCBPS31Z	Yes	ADULT SPECIALIST PAIN MANAGEMENT SERVICES	ACUTE	D07 - SPECIALISED PAIN
NCBPS32A	Yes	COCHLEAR IMPLANTATION SERVICES (ADULTS AND CHILDREN)	ACUTE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES
NCBPS32B	Yes	BONE ANCHORED HEARING AIDS SERVICE	ACUTE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES
NCBPS32D	Yes	MIDDLE EAR IMPLANTABLE HEARING AIDS SERVICE	ACUTE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES
NCBPS33A	Yes	COMPLEX SURGERY FOR FAECAL INCONTINENCE (ADULTS)	ACUTE	A07 - SPECIALISED COLORECTAL SERVICES
NCBPS33B	Yes	COMPLEX INFLAMMATORY BOWEL DISEASE (ADULTS)	ACUTE	A07 - SPECIALISED COLORECTAL SERVICES
NCBPS33C	Yes	TRANSANAL ENDOSCOPIC MICROSURGERY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS33D	Yes	DISTAL SACRECTOMY FOR ADVANCED AND RECURRENT RECTAL CANCER (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS34A	Yes	ORTHOPAEDIC SURGERY (ADULTS)	ACUTE	D10 - SPECIALISED ORTHOPAEDIC SERVICES
NCBPS34R	Yes	ORTHOPAEDIC REVISION (ADULTS)	ACUTE	D10 - SPECIALISED ORTHOPAEDIC SERVICES
NCBPS34T	Yes	MAJOR TRAUMA SERVICES (ADULTS AND CHILDREN)	ACUTE	D02 - MAJOR TRAUMA
NCBPS35Z	Yes	SPECIALIST MORBID OBESITY SERVICES FOR CHILDREN	ACUTE	E02 - SPECIALISED SURGERY IN CHILDREN
NCBPS36Z	Yes	SPECIALIST METABOLIC DISORDER SERVICES (ADULTS AND CHILDREN)	ACUTE	E06 - METABOLIC DISORDERS
NCBPS37C	Yes	ARTIFICIAL EYE SERVICE	ACUTE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES
NCBPS37Z	Yes	ADULT SPECIALIST OPHTHALMOLOGY SERVICES	ACUTE	D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES
NCBPS38S	Yes	SICKLE CELL ANAEMIA (ADULTS AND CHILDREN)	ACUTE	F05 - HAEMOGLOBINOPATHIES
NCBPS38T	Yes	THALASSEMIA (ADULTS AND CHILDREN)	ACUTE	F05 - HAEMOGLOBINOPATHIES
NCBPS41P	Yes	PENILE IMPLANTS	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS41S	Yes	SURGICAL SPERM REMOVAL	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS41U	Yes	URETHRAL RECONSTRUCTION	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS51A	Yes	INTERVENTIONAL ONCOLOGY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS51B	Yes	BRACHYTHERAPY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS51C	Yes	MOLECULAR ONCOLOGY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS51R	Yes	RADIOTHERAPY SERVICES (CHILDREN)	ACUTE	B01 - RADIOTHERAPY
NCBPS58A	Yes	NEUROSURGERY LVHC NATIONAL: SURGICAL REMOVAL OF CLIVAL CHORDOMA AND CHONDROSARCOMA	ACUTE	D04 - NEUROSCIENCES
NCBPS58B	Yes	NEUROSURGERY LVHC NATIONAL: EC-IC BYPASS(COMPLEX/HIGH FLOW)	ACUTE	D04 - NEUROSCIENCES
NCBPS58C	Yes	NEUROSURGERY LVHC NATIONAL: TRANSORAL EXCISION OF DENS	ACUTE	D04 - NEUROSCIENCES
NCBPS58D	Yes	NEUROSURGERY LVHC REGIONAL: ANTERIOR SKULL BASED TUMOURS	ACUTE	D04 - NEUROSCIENCES
NCBPS58E	Yes	NEUROSURGERY LVHC REGIONAL: LATERAL SKULL BASED TUMOURS	ACUTE	D04 - NEUROSCIENCES
NCBPS58F	Yes	NEUROSURGERY LVHC REGIONAL: SURGICAL REMOVAL OF BRAINSTEM LESIONS	ACUTE	D04 - NEUROSCIENCES
NCBPS58G	Yes	NEUROSURGERY LVHC REGIONAL: DEEP BRAIN STIMULATION	ACUTE	D04 - NEUROSCIENCES
NCBPS58H	Yes	NEUROSURGERY LVHC REGIONAL: PINEAL TUMOUR SURGERIES - RESECTION	ACUTE	D04 - NEUROSCIENCES
NCBPS58I	Yes	NEUROSURGERY LVHC REGIONAL: REMOVAL OF ARTERIOVENOUS MALFORMATIONS OF THE NERVOUS SYSTEM	ACUTE	D04 - NEUROSCIENCES
NCBPS58J	Yes	NEUROSURGERY LVHC REGIONAL: EPILEPSY	ACUTE	D04 - NEUROSCIENCES
NCBPS58K	Yes	NEUROSURGERY LVHC REGIONAL: INSULA GLIOMA'S/ COMPLEX LOW GRADE GLIOMA'S	ACUTE	D04 - NEUROSCIENCES
NCBPS58L	Yes	NEUROSURGERY LVHC LOCAL: ANTERIOR LUMBAR FUSION	ACUTE	D04 - NEUROSCIENCES
NCBPS58M	Yes	NEUROSURGERY LVHC LOCAL: REMOVAL OF INTRAMEDULLARY SPINAL TUMOURS	ACUTE	D04 - NEUROSCIENCES
NCBPS58N	Yes	NEUROSURGERY LVHC LOCAL: INTRAVENTRICULAR TUMOURS RESECTION	ACUTE	D04 - NEUROSCIENCES
NCBPS58O	Yes	NEUROSURGERY LVHC LOCAL: SURGICAL REPAIR OF ANEURYSMS (SURGICAL CLIPPING)	ACUTE	D04 - NEUROSCIENCES
NCBPS58P	Yes	NEUROSURGERY LVHC LOCAL: THORACIC DISCECTOMY	ACUTE	D04 - NEUROSCIENCES
NCBPS58Q	Yes	NEUROSURGERY LVHC LOCAL: MICROVASCULAR DECOMPRESSION FOR TRIGEMINAL NEURALGIA	ACUTE	D04 - NEUROSCIENCES
NCBPS58R	Yes	NEUROSURGERY LVHC LOCAL: AWAKE SURGERY FOR REMOVAL OF BRAIN TUMOURS	ACUTE	D04 - NEUROSCIENCES
NCBPS58S	Yes	NEUROSURGERY LVHC LOCAL: REMOVAL OF PITUITARY TUMOURS INCLUDING FOR CUSHING'S AND ACROMEGALY	ACUTE	D04 - NEUROSCIENCES
NCBPS61M	Yes	HEAD AND NECK CANCER SURGERY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS61Q	Yes	OPHTHALMIC CANCER SURGERY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS61U	Yes	OESOPHAGEAL AND GASTRIC CANCER SURGERY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS61Z	Yes	TESTICULAR CANCER SURGERY (ADULTS)	ACUTE	B03 - SPECIALISED CANCER SURGERY
NCBPS73X	Yes	SPECIALIST PAEDIATRIC SURGERY SERVICES - GYNAECOLOGY	ACUTE	E02 - SPECIALISED SURGERY IN CHILDREN
NCBPSACC	Yes	ADULT CRITICAL CARE	ACUTE	D05 - ADULT CRITICAL CARE

NCBPSE23	Yes	SPECIALIST PALLIATIVE CARE SERVICES FOR CHILDREN AND YOUNG ADULTS	ACUTE	E03 - PAEDIATRIC MEDICINE
NCBPSECP	Yes	EXTRACORPOREAL PHOTOPHERESIS SERVICE (ADULTS AND CHILDREN)	ACUTE	B99 - CANCER NPOC / CRG TO BE DECIDED
NCBPSNIC	Yes	SPECIALIST NEONATAL CARE SERVICES	ACUTE	E08 - NEONATAL CRITICAL CARE
NCBPSPIC	Yes	SPECIALIST PAEDIATRIC INTENSIVE CARE SERVICES	ACUTE	E07 - PAEDIATRIC INTENSIVE CARE

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Meeting name:	NHS West Yorkshire Integrated Care Board
Agenda item no.	4
Meeting date:	11 November 2024
Report title:	Update on the Delegation of Commissioning Responsibility for Specialised Services
Report presented by:	Ian Holmes, Director of Strategy and Partnerships and Deputy CEO, NHS WY ICB
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Purpose and Action			
Assurance ☒	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☒

Previous considerations:

Specialised commissioning delegation was previously discussed at the 24 September 2024 meeting of the ICB Board and at the 24 July 2024 ICB Board development session.

Executive summary and points for discussion:

NHS England (NHSE) has previously set out its intentions to delegate commissioning responsibility for a range of specialised services to Integrated Care Boards (ICBs). It is planned that from 1 April 2025 the identified services will be delegated to all ICBs including the NHS West Yorkshire (WY) ICB. There are 84 services to be delegated, with a financial value of £466m across WY.

The information provided in this paper builds on the 24 September 2024 paper and discussion, focusing particularly on the progress that has been made since then toward satisfying the “tests” that were set out.

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 NHS WY ICB Board is asked to: • Note the significant work undertaken to support the safe delegation and landing of commissioning responsibility for specialised services. • Note the advice provided by the Hill Dickinson commissioned work, and accept this as additional assurance of the work we are and will continue to do. • Note the new developments since the September discussion which are set out in section 3.2. and 4.2. • Consider the information provided throughout this paper in order to confirm an agreement in principle to receive delegation, subject to no major deviations arising.
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:
A risk will be added to the corporate risk register in the next reporting cycle (17 December 2024) in relation the risk of failing to understand the scope, detail and impact of delegation.
Appendices
N/A
Acronyms and Abbreviations explained
1. ICB – Integrated Care Board 2. MHLDA – Mental Health, Learning Disabilities and Autism 3. NEY – North East and Yorkshire 4. NHSE – NHS England 5. OD – Organisational Development 6. SDC – Safe Delegation Checklist 7. WY – West Yorkshire 8. WYAAT – West Yorkshire Association of Acute Trusts 9. Y&H – Yorkshire and the Humber

What are the implications for?

Residents and Communities	The services being delegated are crucial for patients living with needs that require complex services and support. Through delegation there is an opportunity to improve services across the pathway.
Quality and Safety	There are implications of delegation for quality oversight and management, and an opportunity through improvement to maximise the quality of services delivered to our patients.
Equality, Diversity and Inclusion	There is scope through delegation to improve the focus on health inequalities, and therefore improving and addressing the health needs of our highest need population groups.
Finances and Use of Resources	The services being delegated are high value. There are significant financial challenges, but an opportunity over the long term to improve efficiency through a greater focus on prevention.
Regulation and Legal Requirements	N/A
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	There is a significant transformation opportunity that will be considered and planned for pre-delegation, but realised in the years post-delegation.
Environmental and Climate Change	There may be opportunities through specific service transformations to support our climate change ambitions.
Future Decisions and Policy Making	The Board are being asked to confirm an agreement in principle to receive the delegation of these services.
Citizen and Stakeholder Engagement	N/A

1.0. Purpose

1.1. The NHS West Yorkshire (WY) Integrated Care Board (ICB) Board has previously discussed the delegation of specialised commissioning services from NHS England (NHSE) to the ICB.

1.2. At the Board meeting in September, it was agreed that an extraordinary meeting of the Board would be called in November to receive a further update in order to make a decision in principle to accept the delegation of these services, in advance of the NHSE Board meeting on 5 December 2024.

1.3. This paper provides an update and assurance to the Board on the process and progress being made to support the safe delegation of commissioning responsibility, as well as setting out the next steps that will be taken before 31 March 2025.

1.4. The NHS WY ICB Board is asked to:

- Note the significant work undertaken to support the safe delegation and landing of commissioning responsibility for specialised services.
- Note the advice provided by the Hill Dickinson commissioned work, and accept this as additional assurance of the work we are and will continue to do.
- Note the new developments since the September discussion which are set out in section 3.2. and 4.2.
- Consider the information provided throughout this paper in order to confirm an agreement in principle to receive delegation, subject to no major deviations arising.

2.0. Summary

2.1. The 24 September 2024 board paper sets out the full context relating to the delegation of commissioning responsibility for specialised services. In this paper, several “tests” were outlined that the Board would need to be assured on in order to confirm the intention to accept delegation.

2.2. Work has and continues to happen at pace on those areas identified, as well as identifying the actions required to follow between now and 31 March 2025.

2.3. To support this work, Hill Dickinson LLP were commissioned to undertake a rapid assessment of current position; risks, issues and mitigations; and key legal and governance matters that should be addressed prior to delegation. This was a joint commission with our three partner ICBs in the Yorkshire and Humber (Y&H) region. It is important that the four ICBs in the region arrive at a collective view with regards to the assurance of delegation.

2.4. The Hill Dickinson advice provides additional confidence on our areas of focus, guidance on other actions that we should focus on through our ongoing work until

31 March 2025, and will provide assurance to the Board on both of those things to inform the decision to support delegation.

2.5. In summary, the Hill Dickinson advice sets out:

- Agreement with the assessment of risks and priorities set out in our September Board paper.
- The information that must be included in key governance documents, including the Delegation Agreement, ICB Collaboration Agreement, Commissioning Team Agreement and within existing ICB documents, to preserve organisational safety and integrity.
- The importance of clarifying the NHSE oversight arrangements.
- The importance of undertaking a functions and governance mapping exercise.
- That the safe delegation checklist being used does provide adequate due diligence.
- That good and safe governance, alongside a clear operating model, must be in place from day one of delegation.
- The reputational risk that may arise for the ICB, but that cannot be mitigated through the safe delegation or governance processes.

2.6. On 30 October 2024 the four ICB chairs of Audit Committees convened to discuss the current position, risks and our approach to managing the safe delegation. This provided useful feedback and constructive challenge into the process. It was agreed that we would convene again in the new year to provide greater visibility of plans, and further assurance on risk mitigation.

3.0. Risks

3.1. Throughout the safe delegation processes, identifying and managing the risks associated with the process and specialised services generally is crucial. For the Board to take a decision it is important that there is an understanding of the key risks we will inherit, and how they are being or will be mitigated.

3.2. The Hill Dickinson advice and discussion with audit chairs broadly aligns with and reinforces the risks, issues and mitigations already identified through ongoing work.

3.3. We are managing risk via the WY Specialised Commissioning Delegation Programme Board, which holds a detailed view of the risks and is able to track the changing status of those in line with the ICB policy for risk management.

3.4. The programme board maintains a detailed view of the risks to delegation and live risks, and is able to track the changing status of those risks, in line with the ICB policy for risk management. In summary, the key risks are:

- **Timescales**: The timeline to deliver necessary pre-delegation work is tight. This may have several consequences ranging from insufficient progress and the Board not approving delegation, to inadequate awareness of key issues and accepting delegation without complete knowledge. The work that we continue to deliver, as set out in this paper, mitigates this.
- **People:** The specialised commissioning are undergoing a period of significant change, which could have a negative impact on staff morale and retention. Post-delegation, the team will need to be supported to work in a way that delivers ICB ambitions but does not overwhelm their capacity. The work that we are progressing on the operating model, OD and prioritisation for 2025/26 will mitigate this.
- **Service and quality risks:** There are a range of live service risks, that vary in their exact nature and profile. It's important that we fully understand these prior to delegation, and have the governance structures in place to manage them on an ongoing basis. The work that we have undertaken with the specialised commissioning team, including a deep dive on priority service areas and reviewing their contract risk register, supports our understanding and will be reflected in the 2025/26 priority plan.
- **Governance:** There are a range of governance documents and processes that must be developed and in place for 1 April 2025. This will require establishing new arrangements, and amending our current ICB documents. It's crucial that these documents are consistent across the NEY region, and there is a risk that there are barriers to this. We are mitigating this through joint work with ICB governance leads and with advice from Hill Dickinson.
- **Finance:** There are a range of financial challenges, with a risk that there is an insufficient envelope to deliver safe and high quality services; insufficient capital investment; and uncertainty around the future demand and associated financial impact. Our shared understanding of financial risks, work regionally and nationally (for example on the distance from target position) and plans for post-delegation help us to manage and mitigate this.

3.5. To ensure that the Board is adequately aware of and monitoring the risks, we will set out an organisational level risk on the corporate risk register at the 17 December 2024 ICB Board meeting.

4.0. Safe Delegation Progress

4.1. We have made good progress over recent weeks towards a safe delegation, and are confident that we have a clear collaborative view of the work that is required before 31 March 2025. This is further supported by the Hill Dickinson work.

4.2. There have been three substantive developments, aside from our progress, since the last Board meeting:

- NHSE have confirmed three key criteria for delegation of commissioning specialised services: that no staff employed by another organisation shall have access to the NHSE (or ICB) ledgers; that staff delivering the oversight and assurance role must not also be delivering a commissioning function; and that no decision relating to one organisations specialised commissioning functions shall be made by staff employed by a different organisation.
- It has been confirmed that the staff TUPE transfer will be delayed until July 2025. This means that, for a period of three months the commissioning team will remain to be employed by NHSE. This presents a risk in our ability to manage and direct staff, though it should be noted that this is the model which has been deployed by other ICBs across the country, where delegation took place in April 2024, and it was the same as the TUPE timeline applied to pharmacy, optometry and dentistry delegation.
- The retained model and staffing structure has now been confirmed. Whilst challenges around staff capacity still require mitigating, this provides us with greater clarity to work with in defining our operating model, and to begin OD work across the teams and the ICBs.

4.3. To support our progress, we have taken several crosscutting actions, including:

- Commissioning Hill Dickinson LLP across Y&H, as described in sections 2.3-2.5.
- Convening a meeting of the four Y&H Audit Committee Chairs, as described in section 2.6.
- Agreeing to hold one safe delegation checklist across Y&H, to support a consistent position on safe delegation.
- Held two workshops with more planned in, to work through priorities and significant issues with NHSE and ICBs across NEY collectively.
- Held a “deep dive” session with NHSE colleagues, focusing on priority service lines to better understand service specific risks and issues as well as the overall approach to risk management. It was agreed that these would be now held on a quarterly basis to maintain a focus on service risks.

4.4. Against the tests set out in the September Board paper, our progress is as follows:

Category	Tests	Current Position
	That the overall position of the SDC is satisfactory to safely	This aspect will remain open and only be completed at the end of

Transition and delegation	delegate and land specialised commissioning delegation.	March 2025, with actions to follow as described throughout this table. We have made important steps towards this, including: • Managing the SDC once across Y&H, to ensure consistency in how all ICBs manage and assure themselves. • Established programme board to oversee and support safe delegation for the WY system. • Identified leads for each area to support safe delegation for WY, which link to these workstreams. • Commissioned work from Hill Dickinson to support our due diligence, which mostly validated our initial areas of focus and added greater specificity in parts. • Made progress on all areas, as set out in the following.
	There is a robust suite of delegation governance documents in place.	This remains a priority area of work. Developing the governance documents will take some time, but we have established the means to do this, via a governance leads group, and the work from Hill Dickinson guides our focus. There is an emerging view on the governance options with work planned to progress this, as well as an understanding of the key documents that need to be established or changed, and the timeline for this.
Governance and	Any necessary amendments to the ICBs governance	As above.

decision-making	documentation have been/will be made.	It is worth noting that any changes to the Constitution will require NHSE sign off.
	A robust governance and decision-making model will be in place from 1 April 2025, with suitable delegation and empowerment to key forums and individuals to enable efficient operations, but proportionate checks and balances in place.	This is being developed as a priority, as set out above. Two key points of progress will support our ongoing work: • The Hill Dickinson work offers guidance on governance and function mapping, and specific contents of our governance agreements. • The clarity around the national retained model will be documented in the Commissioning Team Agreement and means that we are able to start to define how the ICB model will operate. This will be set out in a range of documents, that the ICB Board will be required to sign off.
	Specialised commissioning governance and decision-making is connected with existing WY forums, to ensure that the benefits of delegation and integration are realised, and that decisions are well informed.	As set out above, this will progress through the functions mapping and defining the operating model.
Operating model and ways of working	The operating model for the team's role over nationally retained functions has been set out, and does not pose significant risk to	We now have clarity on the national model and the impact for the majority of the team. There are known risks, which it is felt that through appropriate governance

	delivering our responsibilities. AND An operating model has been developed and is in place.	and operating model processes can be mitigated. With the clarity on the national model, we are now prioritising the development of the local operating model which will set out the team structures, ways of working, and connectivity into wider ICB teams and functions.
	An OD plan has been developed and will be delivered iteratively.	There is clear support to focus on OD as part of the team transition. However, in the immediate term other areas have been prioritised, and priority in the coming months will need to be on supporting the team through a transition period, with the staff transfer delay until July 2025.
Services and pathways	A complete view of information, risks and issues with delegated services, has been obtained, with mitigations being developed, that is agreed with both WYAAT and the MHLDA collaborative.	We have obtained a complete list of risks by service line. This was further supported by the “deep dive session”. As part of preparations for safe delegation, we will undertake due diligence activities with our provider collaboratives which will validate (or challenge) this understanding.
	A prioritised workplan will be in place and delivered from 1 April 2025.	We will develop this in line with the planning cycle, ensuring that we use the knowledge of risks, discussion with partners, and other sources of information to shape the plan.
	There is a clear approach to service transformation and improvement that aligns with our system	This will be part of the 2025/26 workplan, and will be reflected in the operating model and OD plan. It is important to note that the service specifications and many

	priorities and approach.	priorities are set nationally, and so local priorities will need to balance this.
	There is a clear approach to service planning across the Y&H footprint, including to optimise patient flows.	There is consensus amongst the lead executive directors that as much planning as possible will be done on a Y&H footprint. The governance arrangements and team will be organised accordingly to support this. Specifically addressing patient flow issues, which are a known and longstanding issue, will happen post-delegation.
	High quality data is available and well utilised to inform service planning and wider work across WY.	There is ongoing work to establish the right data flows. The operating model, to support the team to connect with other WY colleagues, and OD, will also support this.
	There is a clear approach to working with clinical networks to support our commissioning functions, given the responsibility for the networks will be retained by NHSE.	The role of clinical networks will be considered and embedded through the operating model.
Quality	Robust quality oversight and management arrangements have been developed and will be in place from 1 April 2025.	These arrangements will be fully embedded and established throughout the coming months. Work is ongoing between WY and NHSE quality leads to understand current arrangements, with clear plans to align the team into existing WY structures and arrangements. We have established quality and safety oversight processes with the same Trusts. There is an

		opportunity to incorporate specialised commissioning processes into these existing ICB mechanisms delivering a streamlined approach and a better use of resource across both teams.
	Service specific quality concerns are known, with plans in place.	A full service risk profile has been obtained. Further due diligence with provider collaboratives will enhance our understanding. Several quality risks involving specialised services will be already captured through place quality oversight arrangements.
	The quality oversight arrangements from the NHSE region over delegated services are clear and proportionate.	This is currently unknown, but links to section 5.2.
Finance and contracting	We have a complete view of the financial and contractual risks specific to services.	A full service risk profile has been obtained. Further due diligence with provider collaboratives will enhance our understanding. The deep dive session also supported further insight into key service areas, as well as the approach to risk management.
	We understand the considerable “distance from target” position, with the acknowledgement that there is no current plan nationally to address this.	We understand that there is significant distance from target position, which is currently 9.59%. Whilst we know this, there is not currently a clear plan as to how this will be addressed nationally, but it will not be pre-delegation.
	We have an agreed contracting approach	This is crucial to have in place and will be managed over coming

	in place from 1 April 2025.	months by the contracting subgroup.

5.0. Priority Next Steps

5.1. As we move at pace towards delegation, it is crucial that we retain our focus on the areas that must be completed on or before 31 March 2025. As set out above, they broadly are:

- Developing the governance infrastructure, including key forums and documentation, in line with the advice obtained from Hill Dickinson.
- Developing and clearly describing the operating model, in such a way that provides connectivity for the specialised commissioning team across the ICB, enables the team to function efficiently, and ensures visibility of the ways of working and decisions.
- Establishing a complete view and position of consensus on the service risks as part of our due diligence, building on the information obtained to date and the planned due diligence with provider collaboratives.

5.2. In addition to the areas set out, it is important that the Board is aware of the following areas whereby work will need to progress over the coming months:

- The oversight and assurance model that NHSE will implement post-delegation is still in development with no firm model in place. Connecting this in to the existing 4+1 regional assurance model would be optimal and proportionate.
- For a number of service areas there are known risks, shortcomings and pressures. It will be important to understand the scrutiny that will accompany delegation in this regard, and to manage the risk of reputational damage.

6.0. Recommendations

6.1. Whilst there are risks associated with delegation and still significant steps to take prior to March 2025, this paper sets out that work is underway and progressing well to manage this.

6.2. The work planned to be completed by March 2025 will mitigate some of the risks. However, it should be acknowledged that several challenges are longstanding, not immediately resolvable, and may require national input and action. As such, this work cannot be low risk. It requires that we retain a moderate risk appetite, with a clear view of the opportunities associated with delegation. Where delegated services do have associated risks, there is a clear opportunity for the ICB to carry out full pathway transformation which increases our ability to mitigate the risks. This is the approach we have taken on renal services.

6.3. The NHS WY ICB Board is therefore asked to:

- Note the significant work undertaken to support the safe delegation and landing of commissioning responsibility for specialised services.
- Note the advice provided by the Hill Dickinson commissioned work, and accept this as additional assurance of the work we are and will continue to do.
- Note the new developments since the September discussion which are set out in section 3.2. and 4.2.
- Consider the information provided throughout this paper in order to confirm an agreement in principle to receive delegation, subject to no major deviations arising.