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Date: 22 April 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 **10.30 am** on **Wednesday 30 April 2025.**

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

Samantha Lawton

Service Director – Legal, Governance and Commissioning

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

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

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

Agenda
Reports or Explanatory Notes Attached

Pages

1: Membership of the Committee

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

2: Minutes of the Previous Meeting

1 - 8

To approve the Minutes of the Meeting held on 25 February 2025.

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 of 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: Cancer Early Diagnosis

9 - 30

Representatives from the West Yorkshire Integrated Care Board will attend the meeting to proivde an update on Cancer and Early Diagnosis.

Contact: Yolande Myers, Principal Governance Officer

6: Work and Health Plan and Programmes

31 - 52

Representatives of the West Yorkshire Integrated Care Board will attend the meeting to provide an update on its Work and Health Plan and Programmes.

Contact: Yolande Myers, Principal Governance Officer

7: Amendment to Memorandum of Understanding

53 - 68

To consider an amendment to the Memorandum of Understanding.

Contact: Yolande Myers, Principal Governance Officer

Contact Officer: Yolande Myers

KIRKLEES COUNCIL

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday 25th February 2025

Present: Councillor Elizabeth Smaje (Chair)
Councillor Colin Hutchinson - Calderdale Council
Councillor Andrew Scopes - Leeds Council
Councillor - Rizwana Jamil - Bradford Council
Councillor Howard Blagbrough - Calderdale Council
Councillor Andy Solloway - North Yorkshire County Council
Councillor Andy Nicholls - Wakefield Council

Apologies: Councillor Allison Coates - Bradford Council
Councillor Betty Rhodes - Wakefield Council

1 Membership of the Committee

Apologies were received on behalf of Councillors Alison Coates and Betty Rhodes.

2 Minutes of the Previous Meeting

The Committee queried if acknowledgement had been received following a letter sent to the Chief Coroner in December 2024. The Committee was advised that no response had been received to date. The Committee agreed to send further communication to the Chief Coroner in respect of the letter sent on the 17 December 2024 requesting a reply.

The Committee highlighted the NHS England Operational information for 2025/26, and the reduction in national priorities, particularly in relation to health checks for people with mental health, learning disabilities and Autism. The Committee questioned the Integrated Care Boards (ICB's) response in ensuring that important work continued.

Ian Holmes, Director of the ICB, responded and advised the Committee that a number of national targets had reduced by 50% to allow greater flexibility within the ICB and local organisations to respond to local needs. Health checks for Mental Health and Learning Disability remained important and would continue. Further information was requested regarding the reduction in national targets.

RESOLVED- That the minutes of the meeting held on 6th December 2024 were approved as a correct record.

3 Declarations of Interest

Councillor Smaje and Councillor Hutchinson declared an 'other interest' in their role as Co-Chairs of the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee.

4 Public Deputations/Petitions

No deputations or petitions were received.

5 Yorkshire Ambulance Service (YAS) NHS Trust

Nick Smith, Chief Operating Officer for Yorkshire, attended the meeting to provide the Committee with an update on current work being undertaken by YAS.

Mr Smith gave an update on response times, and advised the Committee that 999 calls were answered by a non-clinical call taker (Emergency medical dispatcher) who asked a number of set questions (via an algorithm) which enabled them to identify a patient's needs and appropriate category. Categories ranged from one to five, one being life threatening and five being the least serious. Categories two, three, four and five were assessed by a clinician within the contact centre who could identify the most appropriate treatment and this led to around 15 to 18% of 999 calls not needing an ambulance to respond.

The Committee was advised that there was a team of dispatchers who were able to identify the nearest, most appropriate resource to send out to patients requiring an ambulance. Calls were dispatched in priority order and ambulances usually responded from hospitals. A clinical handover was required at the Emergency Department and then once ambulance crews were released, the vehicle had to be cleaned, prepared and ready for the next call.

Mr Smith also highlighted (i) the response expectation times for each category and the increased pressures (ii) the positive partnership working with Acute providers and the ICB to improve options for patients (iii) changes to ambulance stations due to increased demand (iv) the investment of pre-dispatch and the number of clinicians within contact centres (v) the integration of 111 and 999 systems so that patients could be directed to the most appropriate care and (vi) Patient Transport Services and the added value this brought to the most vulnerable patients accessing care.

The Committee queried the issues around patient handovers and turnaround times. Mr Smith advised that this was a national challenge and varied across the different ICB areas.

Rachel Gillott, Director of Partnership and Operations, West Yorkshire, further advised that the handover position in West Yorkshire was good. The average handover was 22 minutes compared to the national standard of 15 minutes, and that the aim for a complete turnaround was 30 minutes but averaged at around 48 minutes. A number of quality improvement initiatives were in place to understand the barriers / complications and the Committee was advised that some issues were related to Wi-Fi connectivity outside A&E departments.

The Committee acknowledged the hard work of the Ambulance services throughout the winter period but queried whether performance targets obscured the patient's

experience, and whether alternative data forms could be provided to give a more accurate picture. Mr Smith advised that, measurements were based on percentile which helped to identify additional risk to patients, the impact and alternatives.

Julia Nixon, Associate Chief Operating Officer, Remote Care, continued and advised that further work was being done around excessive delays and that a joint working group with clinical / operational colleagues, informatics' and stakeholders had been established to look at the data. This was broken down per area (CBU level) to fully understand what the numbers, patient feedback and adverse events documentation was highlighting, and presented a more holistic view. A quarterly report would be submitted to governance processes, the quality committee and board.

In response to the Committee's query regarding the pre-dispatch push model in Bradford and the call before conveying scheme in Mid-Yorks, Ms Gillott shared that the two pilots were linked to the national directive around single points of access and supporting patients to be navigated and referred into the right service.

The work in Bradford was to enhance the national directive and enabled specialist paramedics in urgent care to respond to patients with lower acuity needs but who still had an urgent care need. This involved direct conversations with clinicians who were able to identify the suitability of patients. There was lots of learning to be taken away to refine processes and procedures, and to cut out any inefficiencies.

The Conveying Scheme in Mid Yorks focused on patients within care homes. Ambulance crews were able to attend and have a direct conversation with a senior clinician to identify if there was an alternative pathway to avoid an unnecessary trip to the Emergency Department. The Scheme had only been running a few weeks and numbers had been low.

Ms Nixon added that a lot of work had been done around directing patients into alternative services, however services had to be available for crews to refer into. There were over 100 alternative services across Yorkshire, but it was noted that there were still some gaps and variances.

In response to the Committee's query regarding the variances in clinical pathways and the long-term plan, Ms Gillott, responded and advised that paramedics worked from a system where clinical pathways were uploaded to a system to ensure they were able to see what services were available and where services were located, to identify the most appropriate one.

The West Yorkshire Community Services Provider Collaborative was addressing the variation across the different areas and levelling up, so that all areas had a similar level of provision. Acute hospital also had a similar provider collaborative.

Mr Smith, further advised that three Directors of Operations had been appointed across West Yorkshire to fill the gap on engagement with local providers.
The Committee queried the newly implemented clinical re-configuration and was advised that this was the ongoing reconfiguration work at Calderdale and Huddersfield Trust.

The Committee highlighted the integration of the 111 service and Primary Care, Ms Nixon, responded and shared that a review from NHS England regarding 111 was expected and would provide some national steer around how NHS 111 and Primary Care services aligned.

Mr Holmes, added that as part of the 10 year plan, there was a significant focus on integrated neighbourhood health care, which focused on moving away from being a reactive service to a more proactive service. Urgent Care services also fitted within this work and were being discussed at the West Yorkshire Urgent Care Board.

Ms Gillott, highlighted to the Committee the work in relation to the dedicated mental health response. The were four dedicated response vehicles within West Yorkshire, as well as a developing team of specialist paramedics. The work undertaken had enabled access into more mental health services and provided a much more positive patient experience.

In response to the Committees query regarding the work of the West Yorkshire Fire and Rescue Service and Bradford District Partnership in relation to end of life care, Chris Dexter, Managing Director for Patient Transport Services, advised that Patient Transport Services had carried out some work specifically in the Bradford area, and although there had not been huge numbers, feedback had been positive, and it was work that could be broadened out.

RESOLVED –

1) That YAS continued to make improvements to WIFI networks across West Yorkshire, particularly within Acute Trusts to ensure better connectivity for ambulance crews.
2) That the Committee be provided with further information in relation to the planning guidance on integrated care across 111 and primary care systems.

6 Non-emergency Patient Transport Services - National Eligibility Criteria

The Committee welcomed Simon Rowe, Assistant Director of Contracting to the meeting to give it a further update on Non-Emergency Patient Transport Services.

Mr Holmes reminded the Committee of the scope of the work and that the aim was to implement criteria to ensure that transport was provide for patients who needed it the most. It was noted that demand for this service had increased dramatically over recent years.

Mr Rowe advised the Committee that not all mitigations were within the gift of the ICB to change or implement, such as lack of public transport, socioeconomic factors, and tailored appointment times, but with the proposed travel cost scheme reasonable and proportionate mitigations would be in place.

The Committee queried the community transport schemes, as this was one of the mitigations, whether the schemes would cover the whole of the West Yorkshire area, and whether they had the capacity to take on the increased workload. Mr Rowe advised that work had been undertaken to try and understand what was

available throughout the area, as well as how they were funded. He explained that there was still a piece of work to be undertaken to understand how the voluntary and community available transport was funded and supported.

The Committee was informed that there remained a number of aborted transport journeys, where patients made their way home following their outpatient appointment. The question was therefore around whether these patients needed transport arranging, if they then subsequently could manage without it to get home. The Committee commented that the patients in question may well have been able to make their way home but would be unable to make their way to the appointment due to the timing of the appointment.

The Committee asked how risks were assessed for patients to ensure that they remained safe on the journey home from hospital. Mr Rowe explained that if a patient had a medical need that prevented them from travelling to or from hospital by any other means, then they would be entitled to transport. The national review of patient transport found that those without a clear medical need were obtaining transport, often at the expense of those who did have.

The Committee noted that there still did not appear to be an independent right of appeal to the refusal of patient transport. Despite assurances that officers of the ICB would undertake the review, the Committee felt that any appeal should be independent of both the commissioners and the providers.

The Committee understood that transport services needed to be aimed at those who needed it the most, but with frequent changes to services and pathways, instigated by the NHS, it meant patients having to travel further to attend their appointments. The Committee felt that there was a need for an overall plan in relation to planning of specialist commissioning. Mr Rowe advised that every time a change was made, then transport should be considered, but that the cost of private taxi transport was the primary concern. The Committee queried whether the cost of private taxis was smaller compared to the cost of patients not attending their appointments on time and getting the treatment they needed.

RESOLVED –

1) That consideration be given in ensuring that any community transport scheme, be it commissioned by the ICB or commissioned via alternative means, be available across all local authority areas.
2) That details of the communication plan be considered and further assurances should be sought regarding the Town Hall engagement events in relation to the target group of patients whose views are required, given that these are the patients who may find it difficult to attend in person.
3) That the concerns of the Committee in relation to the risk of patients being left without a safe transport service be noted, particularly if this followed outpatient day procedures or in-patient care.
4) That, in recognising comparable processes exist within the ICB, the lack of independent representation in the proposed appeal process be

noted, and that consideration be given to ensuring an independent clinical perspective is sought as part of any appeals process.

5) That the ICB considers a future overall approach and plan in relation to transport for any change or reconfiguration to a service.
6) That the ICB considers a future overall approach and plan in relation to appropriate appointment times, the availability of public transport, particularly in rural areas, along with the socio-economic needs of the local population.
7) That assurances should be sought regarding the pre-paid bus ticket pilot scheme, given that information was not available to the Committee.

7 Memorandum of Understanding

The Chair of the Committee advised that the Memorandum of Understanding was a joint understanding between the West Yorkshire Joint Health Overview and Scrutiny Committee and the West Yorkshire Integrated Care Board. The Memorandum of Understanding had been considered at place scrutiny committees and at the West Yorkshire Legal Officers meeting.

The Committee highlighted a slight amendment to page 41, in relation to the delivery of specialist services.

Mr Holmes advised that the partnership agreement was a mature way of working that had been formalised through a Memorandum of Understanding and he would now seek executive support from within the ICB.

RESOLVED –

- That the Memorandum of Understanding be approved and implemented.
- That the West Yorkshire ICB seek executive support of the MOU and confirmation of their support be shared with the Committee.
- That the Memorandum of Understanding be reviewed in 12 months time.

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

Mr Holmes advised the Committee of a national direction to delegate commissioning responsibilities from NHS England to ICB's.

The majority of specialised services (84) would become the responsibility of the ICB and had a total value of approximately £460 million. The ICB were supportive of the delegation to ensure joined up and improved services but needed to ensure due diligence with regards to discharging the commissioning function efficiently.

Esther Ashman, Deputy Director of Strategy and Transformation, ICB, added that positive work had taken place with NHS England colleagues along with colleagues across the Yorkshire region. Staff who currently commissioned the services would move over to the ICB and continue to commission those services as a hub. A strong operating model was in place to show how collective working would be implemented.

Hayden Ridsdale, Senior Strategy and Transformation Manager, ICB, advised that there was a roadmap for integrated specialised services and that there were benefits to having pathway integration, planning of services, as well as some benefits retained from the current model. Independent legal advice had been sought throughout, and feedback was challenging but re-affirming, and ensured that processes and documents were robust.

A new Board had been set up to manage the safe delegation which consisted of commissioners and providers to ensure the right level of input, oversight and challenge. Work with the Chairs of the ICB's Audit Committees was also undertaken.

The Committee questioned the proposed governance system and agreement for a joint Yorkshire and Humber decision making forum. Ms Ashman, advised that, a paper to the ICB Board in March would provide a suite of documents that supported the delegation and the governance processes, as well as the Terms of Reference for a joint committee across Yorkshire and Humber.

In response to the Committee's query regarding retained services and mitigations locally, Ms Ashman offered to share a link with the committee which detailed the retained service and the delegated services. Staff would commission both retained and delegated services and would work with both NHS England and the ICB. A process had been agreed in relation to the transparency of retained services and would enable the ICB to have more oversight of those services.

The Committee acknowledged the transfer of commissioning responsibility for Mental Health, Learning Disability and Autism services into provider collaboratives, but queried the governance arrangements.

Mr Ridsdale responded and advised that the benefit of this was that the service was more integrated. Money and responsibility were delegated to the lead host then detailed and robust oversight assurance and reporting mechanisms were in place between the lead host and NHS England.

In response to the Committee's query regarding the Board being assured that clear approaches to service planning were in place, Ms Ashman advised that the commissioning team would move over to the ICB and continue to commission services across the Yorkshire and Humber footprint. Services would connect much better into the ICB than they had done previously. A work plan and focus for the coming year would be developed collectively, and a Programme Board would oversee this along with the delegation, to ensure it reflected the roadmap.

RESOLVED -

- That the proposed governance process be shared with the Committee following the ICB Board meeting in March.
- That further information be provided to the Committee with regards to clinical networks and the link to those networks.

- That the Operating Model and Work Plan be shared with the Committee to enable them to better understand those services identified as a priority for improvement and how changes to services will be implemented.

West Yorkshire and Harrogate Cancer Alliance

NHS West Yorkshire Integrated Care Board

Meeting: West Yorkshire Joint Health Overview and Scrutiny Committee.

Date and Time: Wednesday 30th April 2025, 10am to 12noon.

Report Title: Cancer and Early Diagnosis (Update).

Report Author: Jason Pawluk, ICB Associate Director for Cancer and Managing Director, West Yorkshire and Harrogate Cancer Alliance.

Recommendation: The Joint Health Overview and Scrutiny Committee is asked to **RECEIVE** the update and consider the suggestions made in section 4.

Executive Summary:

NHS West Yorkshire Integrated Care Board (WY ICB) has identified ten key population health priorities, referred to as big ambitions. Big ambition number 2 is to increase early diagnosis rates for cancer.

WY ICB committed to 1,000 more people having the opportunity for curative cancer treatment by 2024 then was the case in 2018/19. Progress against this goal was reported in the Joint Forward Plan and its annual refresh, which is published in the public domain and is available from the ICB website.

Using the Rapid Cancer Registration Dataset (RCRD), our analysis showed that 1,382 more people in West Yorkshire have been diagnosed at early cancer stages one and two, which make curative treatment more possible.

This meant that the WY ICB Joint Forward Plan now looks to go further, showing how we can progress towards three in four people being diagnosed with cancer at an early stage, as described in the NHS Long Term Plan, with an initial goal of 62%. Current rates of early diagnosis are 56%. This figure was used by reviewing the total number of diagnoses at cancer stages one and two at the end of each year with a cumulative figure created. Rates of early diagnosis decreased during the Covid-19 pandemic but recovered to this number.

The paper describes progress on existing initiatives which have supported improvements in early diagnosis rates and the appendix gives details of operational strategies being developed to support additional improvement. These include the fields of screening; population awareness raising activities; innovation; living with and beyond cancer; and improvement in pathways, so that the best treatment is

provided sooner. These efforts will continue to be supported by West Yorkshire and Harrogate Cancer Alliance, working with all its partners.

1.0 Introduction

NHS West Yorkshire Integrated Care Board (WY ICB) has identified ten key population health priorities, referred to as big ambitions. Big ambition number 2 is to increase early diagnosis rates for cancer.

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1.1 How are the efforts of the ICB to improve early diagnosis for cancer overseen?

The West Yorkshire and Harrogate Cancer Alliance is a hosted, non-statutory body which sets system-level strategy and oversees transformation work in this area towards achieving this vision, reflecting both national priorities and responding to local need.

As a body, its purpose is to bring partners together to transform outcomes, with specific areas of work focussing on improving patient and carer experience of cancer care improving patient and carer experience; reducing health inequalities; harnessing networks for better treatment outcomes; adopting innovation and new models of care; and developing our people.

1.2 Why continuing to focus on early diagnosis is important in West Yorkshire?

Cancer continues to be a major population health priority for the ICB because 1 in 2 people are expected to have cancer at some stage of their lifetimes, with outcomes continuing to be worse than international comparisons and strongly affected by health inequalities. Almost every family locally will have been touched by this condition.

For an increasing number of people affected by cancer, the disease will become a chronic condition, which will significantly affect the type, range, and duration of support they will need to care for them as individuals. It is vital that our focus as an

ICB reflects the ongoing needs of people affected by cancer as new, innovative, and more personalised, forms of care and treatment increasingly become available.

1.3 What are we aiming to achieve?

As described in the Joint Forward Plan and via our website, our vision for cancer care in West Yorkshire is that we transform services so that cancer care, treatment and support is wrapped around each individual patient throughout their entire care journey – from awaiting diagnosis, to treatment options, to discharge where appropriate, end of life care where needed, including living with and beyond cancer. We listen to our patients as part of this, a good example recently being through our non-surgical oncology work.

By the end of the 2027/28 financial year (year 5) and the end point of the Joint Forward Plan, the Cancer Alliance will have:

- Supported the West Yorkshire Integrated Care Board, and its constituent members and partners, to have achieved improvements for people affected by cancer in West Yorkshire both in terms of them being diagnosed earlier.
- Having a better experience of cancer pathways when they need them.
- Worked with partners to increase early diagnosis rates further.

2.0 Headline progress on early diagnosis of cancer - 2019-24

In 2019, the West Yorkshire early-stage cancer diagnosis rate, expressed as a twelve-month moving average, was 52%. By 2024, this same figure was 56%, with a range of 53.7-57.4%. An improving trend rate was demonstrated across four of the five Places in West Yorkshire, with Bradford and Leeds both seeing a 3.6% uplift; Kirklees and Wakefield a 6.3 and 6.4% uplift respectively; and Calderdale a balanced position. The Calderdale data partly impacted by completeness but with shows a high point of 58.3% being achieved in 2023.

Trend rates of early cancer diagnosis have overall increased at a faster rate in West Yorkshire than the underlying England average (3.5% uplift locally, versus 3.1% nationally) across the review period. These improvements have helped to support both the initial delivery of the ambition for cancer for the ICB and have kept the system on track to deliver the goal set out in the Joint Forward Plan, whilst recognising that more work needs to be done.

2.1 Interpreting early diagnosis data

Some additional contexts may be helpful to interpret and understand small deviations in these data.

- Cancers are staged at the point of diagnosis at four grades - one, two, three and four. The higher the stage the more advanced is the disease present in the patient and the greater its spread into other organs or body systems (metastasis).

- **Cancers staged at one and two are considered "early" whereas cancers which have either locally metastasised (three) or developed into wider organs or body systems (four) are referred to as "late."** Late-stage cancers are more challenging to treat and are typically associated with worsened prognosis and treatment outcome.
- Therefore, **cancers stages at one and two are generally accepted as a measure of better prognosis and treatment outcomes**, including treatment given with curative intent. Cancers detected via elective routes of presentation, such as GP referrals and screening detected cases also typically have better outcomes than cases detected via emergency admission as the initial route of presentation.

- **Data completeness refers to the staging completeness rate**. When a cancer is diagnosed, via any route of presentation, then there is an opportunity to determine the stage via discussion and agreement at a multidisciplinary team meeting including the clinicians responsible for the care of the patient.

- Within the period **January to March 2021 to April to June 2024,** the staging completeness rate increased across West Yorkshire from **61.4% to 72.6%** and improvements have been seen in all Places. This rate of improvement reflected national trends, where similar improvements were seen across England, based on concerted and continuing efforts to improve data quality.

- However, on some occasions, it is not possible to stage a cancer until either further surgical intervention, imaging, or pathology, is available which is then able to fully determine the extent and location/s of the tumour. On other occasions, staging of tumours is subject to retrospective review, and is also required to be assessed if there is a recurrence of a cancer in a previously treated patient. This also includes scenarios whereby post-intervention testing on the tumour is required to determine if it is either a malignant (harmful) or benign tumour or lesion.

- These clinical situations impact on the **overall cancer staging rate.** The overall cancer staging rate is a comparison between the total number of cancers recorded and the proportion of those which are staged, taking in to account the above clinical scenarios.

- Stage reported outcome metrics derived can also be influenced by the **case-mix** of cancers which are staged via these processes, particularly where differences are small. For example, the early-stage distribution rate for some common cancers tends to be both higher and associated with higher staging completeness than for some rarer tumours, or haematological (blood cancer) malignancies.

A rapid cancer registration dataset offers a reliable interpretation of tumours staged around six months following the cancers treated and is accepted for reporting purposes and a moving average is used to help reflect trends arising. The higher the underlying staging completeness rate, the more reliable are analyses from the data arising. Cancer registries, also retrospectively analyse and interpret all national data, report around two to three years in arrears.

It follows that whilst we can say that movement in cancer stage is statistically significant, caution should be applied to statements which rank Places based on relatively small variations in early-stage rates.

3.0 Ongoing work and activity to further improve early diagnosis of cancer

For clarity, each of the following priorities in this update section have been adopted into the five West Yorkshire Place based strategies for cancer and the Joint Forward Plan. We are continuing to seek to deliver initiatives which encourage patients to both be diagnosed earlier with cancer (through new services and innovation); support their awareness of cancer symptoms and participation in proactive measures (such as lifestyle adjustments and cancer screening programmes); and have better experiences of cancer pathways when they need them.

The implementation timeline for each goal, in each Place, commenced in either year 1 (2023/24) or year 2 (2024/25) of the plan – details of which are covered in the Delivery Plan for the Cancer Alliance. For signposting purposes, this is shown further in the paper headings below. Additionally, the Cancer Alliance is also developing a more comprehensive early diagnosis strategy, focussing on other elements, which will be published in the Summer. More details of this are provided in the Appendix and depict new or continuing actions from year three (2025/26) onwards.

3.1 Improving rates of cancer screening participation - progress:

3.11 Lung

All residents in West Yorkshire and Harrogate who have either ever smoked, or smoke currently, will have been invited to undertake a lung health check if aged between 55 and 74. For clarity, this will be achieved by 2028/29. Existing schemes preceded year 1 of the Joint Forward Plan commitment, a new scheme (Bradford District and Craven, Phase 2) commenced year 2.

Linked to the above, the Yorkshire Lung Screening Trial (YLST) has completed in Leeds and the system will re-invite the “aged-in” and “control group,” populations from later in 2025, subject to the finalisation of procurement processes. Bradford District and Craven (Phase 1) has been completed, with eligible patients undergoing surveillance and monitoring, and Bradford District and Craven (Phase 2) commenced in January 2025. North Kirklees has been completed with the same surveillance and monitoring processes as in Bradford District and Craven (Phase 1), building on a smaller pilot in Wakefield prior to the national lung cancer screening programme.

3.12 Lung (new schemes and next steps)

Evidence from each of these programmes show statistically significant increases in early diagnosis rates from cancer, with disproportionate benefit to lower socio-economic demographic populations. For clarity, our recorded coverage rates include all these populations and are based on the eligible population, as per the start of the lung cancer screening programme. However, via subsequent national agreement, we have also secured this programme incorporating those groups who have either "aged in" to eligibility or have moved into the West Yorkshire area since the start of the programme. This increases the eligible denominator population significantly, and the potential benefit, as does the decision to re-invite parts of the City of Leeds based on the initial success achieved by YLST. In this context, coverage and programme mobilisation rates are on track with the trajectories set by the Cancer Alliance, agreed with the ICB, and advised to NHS England respectively.

Additionally, procurement processes to develop the services in Wakefield, Calderdale, and Harrogate are also on track to commence invitation and community engagement activity prior to the end of the 2025/26 financial year (year three). This should mean that a lung cancer screening programme has commenced in all West Yorkshire districts by 2026/27 (year four). The Cancer Alliance and ICB are successfully managing reductions in 2025/26 lung cancer screening funding provided by NHS England (and lack of inflation-indexing) to ensure that eligible populations receive access to screening services in accordance with the national objectives set out.

Local management processes and the phasing of programme activity and population coverage has supported the system to manage the impact on thoracic surgery and other primary and secondary care support services, along with ensuring that the overall envelope of funding can support the wider range of activities which support earlier diagnosis of cancer cases. It is anticipated that linked to the advice of the National Screening Committee that there will be a transition to a national screening programme for lung cancer thereafter, in the same way as one exists for breast, bowel, and cervical cancers.

3.2 Bowel, Breast, Cervical, and Liver screening

Work continues to support increases in participation rates in the national cancer screening programmes (breast, bowel and cervical) and we have commissioned research, promotional, and awareness raising activity particularly amongst seldom heard, marginalised, and vulnerable population groups.

Age eligibility for faecal immunochemical testing (FIT, year one) has been extended for the bowel cancer screening programme and is progressing towards coverage from age 50 (continuing from year one in phases), based on evidence around age-based incidence of the condition.

West Yorkshire is also supporting initiatives to reduce positivity thresholds for FIT from 120ug/ml to 80 ug/ml by working with endoscopy hubs to generate the

additional capacity and workforce needed to expand asymptomatic surveillance amongst these cohorts (year three to four).

Nationally, tens of thousands have accessed NHS advice on attending mammograms since the launch of the first-ever NHS breast cancer screening campaign in February (year two). There were 32,432 visits to NHS breast screening advice pages last week from 17 February to 24 February – an increase of 145% in just a week. Locally, the "Don't let it be you" campaign in Kirklees has delivered success in supporting people to come forward (year two).

Notable success has been achieved with award-winning campaigns seeking to reduce barriers to access to cervical screening amongst the transgender population, which is now being extended to include men who have sex with men (years one and two, continuing to three).

The operational delivery network for hepatitis C has also achieved significant success in terms of signposting persons at elevated risk of liver cancer on to ultrasound and screening assessment services, using health awareness and treatment busses in community-locations (years one and two, continuing).

3.3 Smoking cessation - progress:

We aim to achieve and sustain the position adult smoking rate in West Yorkshire and Harrogate will be 13% or less. We continue to specifically support this goal through incorporating this focus into lung cancer screening and secondary influencing opportunities; supporting all tobacco control boards locally; encouraging local teams to invest in this area via Core20Plus5 recurrent funding and other commissioning opportunities; and by undertaking specific promotional campaigns highlighting the benefits of smoking cessation (all continuing from year one).

We work closely as a system with Improving Population Health colleagues in this regard. This includes via the lung cancer screening programme discussed.

Rates of cigarette smoking amongst adults has seen a percentage decline of 42% from 2011 to 2023 and across Yorkshire and Humber, prevalence was 12.7% in 2023. Prevalence is lower amongst younger populations who will also affected by legislative control measures.

3.4 Earlier presentation - progress:

We will continue to ensure that more patients to have access to curative treatment; improve population awareness of cancer signs and symptoms; and continue to close the health inequalities gaps in our system. This is reflected across the portfolio of work delivered by the Cancer Alliance, working with all of our partners (continuing).

3.41 Earlier presentation – supporting faster diagnosis

We continue to pursue our goal that at least 4 in 5 people receiving either a diagnosis of cancer, or an exclusion of cancer, within one month of being referred with cancer symptoms. Currently, across West Yorkshire and Harrogate, 82.5% of patients either received a diagnosis of cancer, or were excluded from the cancer pathway within one month of referral in February 2025 (year two), which is the most recent data available. The rolling quarterly performance was 80.5%. The headline national ambition was that 77% of patients would be managed in this way by the end of the 2024/25 financial year. In January 2025, faster diagnosis rates were the highest in West Yorkshire and Harrogate than in any of the other nineteen Cancer Alliances in England.

3.42 Earlier presentation – supporting best treatment, sooner

We also continue to pursue our goal that at least 95% of people receive cancer treatment within one month of a decision to treat being made. Currently, across West Yorkshire and Harrogate, 91.7% of patients received treatment within one month of a decision to treat being made in February 2025 (year two), which is the most recent data available. The rolling quarterly performance was 90.6%. The NHS Constitution measure is that 96% of patients receive treatment within this timeframe, but no specific improvement goal has been set nationally. This standard is met in five of the six hospital Trusts in West Yorkshire and Harrogate, the exception being Leeds Cancer Centre.

The standard is met for most enabling treatments and chemotherapy but is not currently met for radiotherapy provision and some specialist surgery, where an improvement plan is in place and performance is improving. Delivery rates compare favourably between West Yorkshire and Harrogate and other Cancer Alliances on a regional and national level, although more work is needed in this area linked to the Joint Forward Plan goals.

Nationally, the entire pathway length (of 62 days) is reviewed from the point of initial referral or escalation on to an urgent suspected cancer pathway through to the point of a first definitive treatment being delivered. Rates of referral on this pathway have doubled over the last ten years.

New diagnoses and new treatment courses have increased also significantly, but at a lower underlying rate in most scenarios. Currently, across West Yorkshire and Harrogate, 73.1% of patients received treatment within one month of a decision to treat being made in February 2025 (year two), which is the most recent data available. The rolling quarterly performance was 73%. The NHS Constitution measure is that 85% of patients receive treatment within this timeframe. The specific improvement goal has been set nationally for delivery by the end of 2024/25 (year two) is that 70% shall be achieved. Five providers have rolling quarterly performance more than this figure, the exception being Leeds Cancer Centre, where

adjustments for case-mix and complexity need to be made to render a fair comparison. Three providers (Calderdale, Harrogate, and Airedale) deliver significantly greater performance than national expectations and the system exceeds regional and national benchmarks for performance.

3.5 Personalised care – supporting best treatment, sooner

We continue to make progress towards a fully embedded system for genomics testing in West Yorkshire and Harrogate, reflecting national strategy aims. We are also supporting initiative to ensure all suitable patients have a personalised care support plan (PCSP) and benefit fully from the living with and beyond cancer programme, linked to a community model of support (year one onwards). Good work in this area has occurred with BRCA gene mutation testing for hereditary breast and ovarian cancer risk (year one onward); incorporation of local studies for EUROPAC (familial link of pancreatic cancer) (year two onwards); the Cancer Vaccine Launch Pad (year two onwards); and testing for lynch syndrome (year one) which has been effectively incorporated in to local cancer pathways.

3.6 Innovation – supporting best treatment sooner:

Alongside an enabling innovation pipeline, we continue to support transformation of cancer diagnostic management by introducing asymptomatic and symptomatic blood test screening for the local population, based on service evaluation and clinical trial evidence. We have also supported other innovations via the Small Business Research Initiative Route (SBRI), as part of a pipeline of around 45 projects currently in progress and being supported (year one onwards).

Linked to all the above, we continue to bring patient experience to the heart of what we do by developing and extending our partnership working. We continue to expand our reach and connection across the Health and Care Partnership, further expanding opportunities to work with primary care, research and the VCSE sectors as priorities. A good example of this work is our collaboration with Yorkshire Cancer Community and their highly successful Cancer SMART programme, linked to our Patient VIEW panel (year one onwards).

4.0 Conclusions and next steps

Overall, whilst recognising that more and accelerated efforts are needed to challenge health inequalities and how they interact with early stage of diagnosis rates for cancer, good progress is being made across the West Yorkshire system. Rates of early diagnosis have increased faster locally, than is the case nationally, pointing to the strong culture of collaboration and integrated working across the Health and Care Partnership. The Cancer Alliance will continue to support annual refreshes of the Joint Forward Plan and will pursue the areas shown the Appendix as new and continuing priorities respectively.

The Joint Health Overview and Scrutiny Committee is asked to receive the paper and indicate how it would prefer to retain information and updates about the progress being achieved by the health system in this area.

At a working partnership level, the Cancer Alliance was pleased to work with the Committee in relation to its work on improving non-surgical oncology services. Building on this, the Cancer Alliance would also be pleased to share details of its public awareness and campaign work with the Committee for early diagnosis of cancer, so that Members may be able to consider distributing information via their own networks to develop greater awareness and traction to the activities described for the benefits of people affected by cancer in West Yorkshire and Harrogate.

Additionally, we would also welcome the opportunity for further discussion, including developing the lung cancer screening programme into a national scheme at the end of population rollout.

Appendix:

West Yorkshire and Harrogate Cancer Alliance early diagnosis strategy – extract (year three onwards).

Introduction:

To comply with NHS England planning guidance directions, the strategy intents are reviewed annually and approved centrally, however we would envisage these steps to be multi-year focusses, aligning with the period both before and following the new 10-year NHS plan and refresh of the 10-year cancer plan in England. Funding and resource profiling is provided from a subset of the service development funding provided to Cancer Alliances annually, which is reserved for use on the improvement of cancer services.

Governance operates both via ICB approval mechanisms described in the Joint Forward Plan and via the Board of the Cancer Alliance. The Cancer Alliance continues to work with partner agencies across the Health and Care Partnership and others to maximise the activity it can undertake in this area. Operational delivery of programme areas is achieved through alignment to the strategic objectives of the Cancer Alliance and our programme management office functions. The plan both considers those areas where scale of impact warrants an approach of delivery once in West Yorkshire versus others whereby local intelligence and delivery will optimise population benefit.

Improving rates of early diagnosis of cancer

At a system level, we recognise that the causes of later stage presentation and diagnosis are highly complex. In some respects, and as is widely acknowledged in the literature, causes of later stage presentation may be outside of both the direct agency of Cancer Alliances, and in some respects, the population health systems which they reside within. This is particularly true in so far as causative factors relate to social inequality and spend distribution patterns; measures of social deprivation; and the associated measures of inequity which stem from poverty driven factors. Some of this can be seen within international benchmarking efforts, including the International Cancer Benchmarking Partnership. This is considered in the strategy and approach, whilst acknowledging that local health systems have significant opportunities to make a positive difference for the people they serve.

In forming priorities, we have also sought to consider both variations within the Cancer Alliance geography itself and how our performance compares with peer group health economies. By peer group health economies, we have selected the North East and Yorkshire Region and its four constituent areas of South Yorkshire

and Bassetlaw, Humber and North Yorkshire and the Northern Cancer Alliances. This is because we recognise that underlying social deprivation factors significantly influence stage of presentation. The evidence used to develop this plan was as follows:

- Consideration of research outcomes from Cancer Research UK and conference material in 2024 around early diagnosis pipeline initiatives.
- Review of outcomes and logic models from existing developments in the National Cancer Programme.
- Discussions with Cancer Alliance research partners, such as Yorkshire Cancer Research, with whom we are aiming to develop a wider Yorkshire Cancer Early Diagnosis strategy.
- Internal strategy engagement; discussions with clinical leads; interdependent ICB functions and Board-level dialogue.
- Review of Primary Care Network, Place and Alliance-level data from Cancer Stats and more granular database representations of referral, early diagnosis, and survival rates split by determining population characteristics such as age, gender, social deprivation quintiles, and ethnicity.

Annualised Target

In 25/26, West Yorkshire and Harrogate Cancer Alliance is aiming to improve stage one and stage two cancer diagnosis on the rapid cancer registration data calculations to 58.5% working with NHS West Yorkshire ICB principally, which represents a rate of improvement more than the underlying trend growth and improvement rate. This rate of achievement is targeted by March 2026. It also supports progress towards 62% as described in the Joint Forward Plan.

This aligns with the strategic goals and delivery trajectory in the ICB Joint Forward Plan; the wider achievement of the “top 10” ambitions for population health improvement in the local system; and data-driven approaches. The ICB Joint Forward Plan and associated “top 10” ambitions set an initial delivery trajectory of 2028 and this is the overall lifecycle of the Cancer Alliance strategy. Initiatives referred to in this submission will continue to mature and have impact across the remaining interval of the strategy (2028).

Stage baseline and completeness

Across West Yorkshire, staged cancers (1-4) in the RDRD represent 67.8% of the total Rapid Cancer Registration Dataset volumes. There has been a 6% increase in the percentage of staged cancers since 2019 and all remarks in the strategy and actions referred to staged volumes only.

A 12-month trend line of 8,874 cancers has been established with an equitably distributed trend line across all five Places in West Yorkshire; Leeds, Bradford, Calderdale, Kirklees, and Wakefield. Prostate, lung, colorectal and breast cancers accounted for 72.5% of all staged cancers in 2023, reflecting a distribution pattern as the most common cancers of incidence across all five Places, with some variation in order of prevalence by Place.

Our data shows that 4,976 of the 8,874 stageable cancers (56.1%) diagnosed in 2023 were identified at an early stage – an improvement of 2.7 percentage points on pre-pandemic levels, with a rising trend line across all Places. The start point value for 25/26 focus is 56.4% and a Place-Based range of 53-57% respectively.

Early detection rates by tumour

Early-stage detection rates for common cancers were 86.7% breast cancer; 51.3% prostate cancer; 50.3% colorectal cancer; and 34.4% lung cancer. Variation in early-stage diagnosis rates with comparator benchmarks is exhibited in prostate, lung, colorectal, and oesophageal cancers.

There are a high proportion of stage three diagnoses for prostate and colorectal cancer, and to a lesser extent in lung and oesophageal cancers, providing a high-volume opportunity for a stage-shift to stage two. 75.3% of the late-stage cancer diagnoses are found in prostate, lung, colorectal and oesophageal. Lung cancer accounts for 27.4% of all late-stage cancers (n=1067).

Over 50% of all staged cancers were diagnosed via an urgent suspected cancer (USC) route, ~15% were diagnosed via an emergency presentation (EP). In terms of late-stage diagnoses, 44.6% were from an urgent suspected cancer route, and 23.9% via emergency presentation. Late-stage cancers are over-represented when the route to diagnosis is either via emergency presentation or other non-elective routes.

The table below shows influenceable volumes on pathways affected by weaker performance in the Cancer Alliance boundaries. +10% ES volume goals align with the interval objectives set out in the ICB Joint Forward Plan for West Yorkshire.

Figure 1

Tumour Site	**Current Early Stage %**	**+2.5% ES (Volume)**	**+5% ES (Volume)**	**+7.5% ES (Volume)**	**+10% ES (Volume)**
Lung	34.4%	36.9% (41)	39.4% (81)	41.9% (122)	44.4% (163)
Prostate	51.3%	53.8% (48)	56.3% (97)	58.8% (145)	61.3% (194)
Colorectal	50.3%	52.8% (32)	55.3% (65)	57.8% (97)	60.3% (130)
OG	27.5%	30.0% (10)	32.5% (19)	35.0% (29)	37.5% (39)
All Cancer	56.1%	57.6% (131)	59.0% (263)	60.5% (394)	62.0% (525)

Approach to improving early-stage cancer detection

The Cancer Alliance early diagnosis strategy can be summarised as follows:

- Primary Consideration: Volume and performance gap

We will focus efforts on tumour groups where there is both a sizeable denominator of stage three diagnosed cancers, as we consider these to be most susceptible to stage-shift activity, whilst also recognising that the quality imperative for latest stage cancers (4) must also be a driver of our wider work and activity, considering the impact that late diagnosis has on all patients and their families.

- Secondary Consideration: Excess emergency presentation and below benchmark screen detection rates

Within this volume and performance adjusted profile, we will initially focus on non-clinical variation in emergency presentation routes at comparator PCN level, towards other elective routes of diagnosis.

We will maintain a specific focus on trying to support screen detected cancers closer to recognised international benchmarks where these possibilities happen to exist from our consideration of volume and performance gap.

- Tertiary Consideration – Stimulating innovation:

We will support stage-shift opportunities where there are "gaps in the field," in existing national programmes, avoiding duplication with Core20Plus5 where added value is achieved through intentional action led by the Alliance with its partners. This will include supporting research opportunity where possible, and channelling focus into health inclusion groups. Health inclusion groups will include socio-economic deprivation profiling, but will also include relevant other considerations, to achieve harmonisation of approach with local population health and inequalities strategies. Primary, secondary, and tertiary considerations operate together, but are prioritised accordingly.

Priorities by tumour group

- **Priority 1: Lung cancer**

The lung cancer early diagnosis rate is 34%, which is significantly below the national average. However, this has recovered to this figure from a nadir of 29% during the pandemic. The national average is 39.6%. The 75-89 age group has the highest number and proportion of diagnoses (45%). There is a disproportionate bias towards most deprived quintile 1 having the highest proportion of diagnoses (37%) whilst quintile 5 (least deprived) having the lowest (9%). 1627 cancers were diagnosed with this ICD10 classification in 2023, resulting in an influenceable denominator.

Emergency presentation routes have the highest proportion of diagnoses (30.7%), which also disproportionately affect lower decile groups and the 75-89 age group, with an equal distribution profile between male and female. 22.7% of cancers are at stage three, representing 370 patients in the Cancer Alliance in 2023, with higher proportion presenting as emergencies affecting Bradford, Kirklees, Wakefield, and

Leeds in particular. Delivery of a 10% (n=163) uplift in lung cancer earlier stage rates, along with the same uplift in prostate, colorectal and oesophago-gastric cancers, would contribute to a system position of 62%. Implemented over multiple years, this would provide a substantial contribution to the goals set out in the Joint Forward Plan.

Our approach for this priority is to:

- **Lung cancer screening**:

  Focus on scaling of the lung cancer screening scheme, achieving observational assessment in the upper age threshold for eligibility (up to 74) and in lower decile groups, which should translate to improved surveillance and risk assessment once these populations move into the highest risk-adjusted age bracket (75-89). This will also include re-invitation processes and enhanced surveillance of populations diagnosed with pre-cancerous nodules.

- **Symptom awareness campaigns**:

  Develop wider symptom awareness and call to action activity focussing on populations with low reading age, who are less digitally enabled, focussing on geographies targeted for rollout of lung cancer screening for aligned effort. This will include non-responders. We also plan to examine existing activity via pharmacy-based referral routes, including chest X-Ray access. We will also explore successful concepts around surveillance vans from neighbouring Alliances but will not be able to make a financial commitment or plan due to funding constraint, however other financing routes may be explored.

- **Referral optimisation**

  There are ten PCNs which are in the higher risk profile, based on significant numerators of lung cancer diagnoses, matched with later stage diagnosis rates of greater than 65%. Where these are not captured in lung cancer screening efforts then targeted awareness raising campaigns will be a focus.

- **Priority 2: Colorectal cancers**

The colorectal cancer early diagnosis rate is 50.3%, which is 1.2% above the national average, but 5.8% below the all cancer average in West Yorkshire. By age, the 75-89 age group has the highest number of diagnoses at stage three (n=136), followed by the 50-64 (n=134) and 65-74 (n=108) age groups. As a proportion, this distribution is split evenly by ethnicity, although White ethnicity males are typically over-represented in terms of volume. 1,297 cancers were diagnosed with this ICD10 classification in 2023, resulting in an influenceable denominator. 32.3% of cancers are at stage three, representing 418 patients in the Cancer Alliance in 2023,

Emergency presentation routes have the highest proportion of late-stage diagnoses for colorectal cancer compared to all other routes to diagnosis. More than 60% of

colorectal cancers are diagnosed at a late stage via this method of presentation in Wakefield, Kirklees and Leeds. A lower numerator but worsened position exists in Calderdale. There is disproportionate association between lower decile groups and emergency presentations. More than 120 cases of colorectal cancer are diagnosed via an emergency presentation per annum across the Alliance geography.

More widely, stage at diagnosis is disproportionately biased towards stages three and four in all socio-economic decile groups except for least deprived 5. Twelve PCNs have high volumes of late staged colorectal cancers, beyond the median, including one PCN with more than 70 cases last year. Delivery of a 10% (n=130) uplift in colorectal cancer earlier stage rates, along with the same uplift in prostate, lung and oesophago-gastric cancers, would contribute to a system position of 62%. Implemented over multiple years, this would provide a substantial contribution to the goals set out in the Joint Forward Plan.

Our approach for this priority is to:

- **Bowel cancer screening**:

  Focus on improving bowel cancer screening rates and accommodating the FIT threshold reduction to 80 ug/ml as a first step is a key part of the Cancer Alliance strategy, working with partners - and enabled by Public Health commissioner funding. Endoscopy units have planned for the proposed 30% increase in surveillance directed colonoscopies. Addressing barriers to participation in bowel cancer screening will be delivered via normalising educational resources focussed on groups with a low reading age and undertaking focus group/engagement activities on barriers to screening amongst the targeted demographics (PCN, age, gender, and deprivation quintile).

- **Symptom awareness campaigns**:

  Develop wider symptom awareness and call to action activity focussing on populations with low reading age, who are less digitally enabled, focussing on geographies targeted for bowel cancer symptom awareness raising programmes for aligned effort. This will include non-responders and issues. We also plan to examine existing activity via pharmacy-based referral routes. We will also explore successful concepts around surveillance vans from neighbouring Alliances but will not be able to make a financial commitment or plan due to funding constraint, however other financing routes may be explored.

- **Referral optimisation**

  There are twelve PCNs which are in the higher risk profile, based on significant numerators of colorectal cancer diagnoses, matched with later stage diagnosis rates of greater than 60%. Existing service structures for frailty assessment will also be considered in these settings.

- **Priority 3: Prostate cancers**

The prostate cancer early diagnosis rate is 51.3%, which is below the national average (53.9%). More than 75% of emergency detection cases were at stages three and four, which represents a similar position to the national average. On stage distribution, 30% of all prostate cancer diagnoses were at stage three (n=582), with 1,938 cases detected in total, the largest tumour group in the Alliance.

Emergency detection cases were disproportionate biased towards Leeds Health and Care Partnership within the NHS West Yorkshire ICB boundaries. According to area profile and census data, within Leeds, 26% of the population (an estimated 226,000 people) live within the 10% most deprived areas nationally (or IMD1). 63% of Black (denominator 43,576, 5.6% total population, 48% male), 40% of Mixed and 36% of Asian background people living in Leeds live within IMD1 areas. This makes IMD1 more ethnically diverse than the Leeds average and English is either not a first, or confidently spoken language for 10% of the population. There has been an increase of 15.7% in people aged 65 years and over in Leeds, with all age demographics above the age of 50 seeing a rise between 2011 and 2021. This leads to an operating context of an ageing, more ethnically diverse population where prevailing risk factors from prostate cancer are higher.

Prostate cancer is the most common cancer in men in the UK. Although it affects all men, Black men are two to three times more likely to develop this cancer than their white counterparts, including additional risk factors such as familial history. The mortality rate is twice as high, although early staged prostate cancers have one of the highest five-year survival rates of all cancers. Furthermore, Black men are more likely to develop prostate cancer at a younger age. It is established national policy that every Black man over the age of 45 years is eligible to have the blood test, called PSA (prostate specific antigen) from their GP. Our approach aims to build on successful campaign work in Kirklees working within the principles of the NHS Prostate Cancer Risk Reduction programme.

Ten PCNs have high volumes of late staged prostate cancers, beyond the median, including two PCNs with more than 80 cases last year. Several of the PCNs are in Leeds ICB boundaries. Delivery of a 10% (n=194) uplift in prostate cancer earlier stage rates, along with the same uplift in colorectal, lung and oesophago-gastric cancers, would contribute to a system position of 62%. Implemented over multiple years, this would provide a substantial contribution to the goals set out in the Joint Forward Plan.

<u>Our approach for this priority is to</u>:

- **PSA testing – promote access**:

PSA testing is known to have significant false-positive and less regular but still observable false-negative readings, so advances in multi-cancer blood testing amongst asymptomatic groups are likely to be a better intervention in time. GPs have access to the Prostate Cancer Risk Management Programme, which says that men, even with no urinary symptoms, can have a PSA on request.

Deprivation distribution data shows that more Black men live in higher socio-economically deprived groups than the population. However, specific data on PSA uptake and participation amongst this sub-group is challenging to identify. The intervention will focus on data collection, community advocacy, and local initiatives to expand knowledge and awareness of PSA testing amongst this group, learning from the pilot in Kirklees – seeking to mature in priority PCNs. The principles of the Prostate Cancer Risk Reduction programme are incorporated in to this work and effort. Workstreams are also in an earlier stage of development for achieving earlier stage of diagnosis for bladder cancer, including the prospective use of AI as a diagnostic aid and tool. A similar logic model exists in terms of population selection criteria and approach.

- **Symptom awareness campaigns**:

Develop wider symptom awareness and call to action activity focussing on populations with low reading age, who are less digitally enabled, focussing on geographies targeted for prostate cancer symptom awareness raising programmes for aligned effort. This will include bladder cancer. We will also explore successful concepts around surveillance vans from neighbouring Alliances but will not be able to make a financial commitment or plan due to funding constraint, however other financing routes may be explored.

- **Referral optimisation**

Ten PCNs have high volumes of late staged prostate cancers, beyond the median, including two PCNs with more than 80 cases last year. Several of the PCNs are in Leeds ICB boundaries. Existing service structures for frailty assessment will also be considered in these settings due to age profile distributions of later staged cancers.

- **Priority 4: Oesophageal (OG) cancers**

The OG cancer early diagnosis rate is 27%, which is below the national average (31.2%). 389 ICD10 classified OG cancers were detected overall with area distribution profiles for OG cancer detections are balanced on population size. Male detections of OG cancer were significantly higher than female detections. 132 male stage four and 57 male stage three detected cancers in 2023. 88 cancers overall were detected at stage three, representing an influenceable denominator.

Age range distribution of OG cancers was over-represented in 50-64, 65-74, and 75-89 age groups; in White ethnicity groups; across socio-economic deciles 1-4 (IMD1= 60/28 stage 4/3; IMD2 = 33/15 stage 4/3; IMD3 = 45/21 stage 4/3; IMD4 = 37/14 stage 4/3); and into non-elective and emergency presentation routes. Compared to the national average, when broken down by patient factors, our position is typically worse, and agnostic to place-based variation in this tumour site.

Nine PCNs have high volume late-stage cancers, significantly more than the median and worse than 75% overall. Delivery of a 10% uplift in prostate cancer earlier

stage rates would contribute to a system position of 62% delivery over multiple years which achieves the initial goals set out in the Joint Forward Plan (n=27).

Our approach for this priority is to:

- **Capsule sponge**

Support existing services to make use of capsule sponge as a diagnostic investigation and ensure that business as usual service evaluations are shared amongst the optimal pathway group to sustain services on the grounds of quality, addressing health inequality, and contributing to stage shift.

- **Symptom awareness campaigns**

Develop wider symptom awareness and call to action activity focussing on populations with low reading age, who are less digitally enabled, focussing on geographies targeted for OG cancer symptom awareness raising programmes for aligned effort, with any relevant national or regional programme. We will also explore successful concepts around surveillance vans from neighbouring Alliances but will not be able to make a financial commitment or plan due to funding constraint, however other financing routes may be explored.

- **Referral optimisation**

Nine PCNs have high volumes of late staged OG cancers, beyond the median, including two PCNs with more than 15 cases last year. Existing service structures for frailty assessment and diagnostic window availability will also be considered in these settings due to age profile distributions of later staged cancers.

- **Priority 5: Targeted action for health inclusion groups**

Kidney cancer

Kidney cancers account for 2-3% of all adult malignancies in the UK. Men are mostly affected by renal cancer with an average age at diagnosis of 64 years. Renal (or clear) cell carcinoma (RCC) accounts for 90% of kidney cancers. Early diagnosis improves survival with five-year survival rates for renal cancer of 70-94% for localised tumours in the UK. No national screening programme for kidney cancer exists, however results from the Yorkshire Kidney Screening Trial in Leeds were promising. WY&H will therefore support TACTICAL to work towards RCT by supporting this Yorkshire Cancer Research study by using the LCS eligibility cohort and inclusion criteria in either Bradford or Wakefield (depending on funding for LCS). However, no specific stage shift opportunity is profiled.

Liver cancer

Around 6,100 people are diagnosed with liver cancer each year. However, instances of liver cancer have increased by 50% over the past decade and are expected to continue to rise. Incidence of liver cancer in West Yorkshire is higher than the

national average. Existing evidence suggests only a third to a half of liver cancers are currently diagnosed at an early stage, either stage one or two.

The Community Liver Health Check aim to support early detection and diagnosis of liver cancer by identifying and referring those at high risk onto liver surveillance pathways, operated via the HPB Operational Delivery Network. People diagnosed with significant fibrosis or scarring of the liver are referred directly to liver cancer surveillance pathways, which aims to detect the commonest form of primary liver cancer (hepatocellular cancer) at a curable or treatable stage. Support work will continue, however, no specific stage shift opportunity is profiled.

Deprivation and Minority Group access to established national cancer screening programmes:

The Cancer Alliance has had considerable success in targeted screening awareness raising and accessibility campaigns focussing on minority populations such as people affected by a learning disability; people affected by a severe mental illness (SMI); transgender communities; men who have sex with men; and traveller populations.

These programmes will continue, as will research and interventions focussing on barriers amongst other known low-uptake groups, such as women from the South Asian community (all programmes) and younger women with respect to the cervical screening programme. Locally developed, co-produced assets with campaign groups and representatives from these communities, alongside the Cancer SMART initiative have proven to be more effective than more generalised campaign collateral, due to specific asset generation and evaluation-led call to action. These have been well received, working in partnership with NHSE Regional Public Health and Screening teams.

Routes to diagnosis data shows that UK screening diagnoses range between 1 in 16 and 1 in 14 of all cancers diagnosed. From Darzi, one can see that an achievable range is closer to 1 in 12 (reference Denmark). Danish early diagnosis and survival data is significantly better than the UK (and West Yorkshire) in each of the coverage areas. The intention is to expand and continue to these programmes by also reviewing barriers to access from a pan-geographic deprivation lens (quintile distribution); use of easy read materials; delivering targeted social media campaigns; and following community-based advocacy and influencing routes. Interventions will be targeted by a review of PCN data where a combination of routes to diagnosis, early-stage diagnosis and screening participation rates compare in an adverse manner with peer group average over a five-year period.

Along with priorities 1-4, this assessment will occur via dedicated GP clinical leadership in the Cancer Alliance, critically examining the range of contributory factors which could be contributing to a correlation – such as access to diagnostics; NG12 knowledge and education processes; workforce strengths and access barriers in primary care or lack of community engagement and activation.

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West Yorkshire Health and Care Partnership

West Yorkshire Health and Care Joint Health Overview and Scrutiny Committee

30 April 2025

Summary report	
Item No:	*TO BE COMPLETED BY SECRETARIAT*
Item:	**Work and Health Plan and programmes**
Report author:	Jennifer Connolly, Associate Director Population Health, West Yorkshire Integrated Care Board and West Yorkshire Combined Authority
Presenter:	Jennifer Connolly, Associate Director Population Health, West Yorkshire Integrated Care Board and West Yorkshire Combined Authority

Executive summary

West Yorkshire Work and Health Plan was launched by the Mayor Tracy Brabin, and Chair of the ICB, Cathy Elliot, last Monday 10th March.

The West Yorkshire Work & Health Partnership commissioned the co-production of a Work, Health and Skills Plan in 2024. The Partnership convenes partners and stakeholders from the Combined Authority, the West Yorkshire ICB, Jobcentre Plus and the five local authorities, along with partners from the wider health, employment and skills system and the Voluntary, Community and Social Enterprise (VCSE) sector.

Key points in the Plan:

- The **vision** for the Work, Health, and Skills Plan is **for West Yorkshire to have the healthiest residents and workforce in England by 2040**.
- We will do this by **creating a work, health, and skills system which provides person – centred support to individuals and helps employers fill vacancies and create a diverse, skilled workforce.**
- We will know we have succeeded when we see **more people, especially those with health conditions and disabilities, enter, remain, and progress in good quality work**.

Within this vision, the Plan has a **clear objective**:

- To reduce economic inactivity and health and socio-economic inequalities by supporting more residents with health conditions and disabilities to access or keep good quality work

The Government White Paper published on the 26th November 2024 – Getting Britain Working - announced eight trailblazer locations in England and Wales which would accelerate a more locally led and joined-up approach to tackling economic inactivity. Three of these eight would also receive funding for Integrated Care Systems to address the health drivers of economic inactivity.

West Yorkshire has been nominated as a trailblazer and an accelerator location and is set to receive £37m in total for related programmes, West Yorkshire Combined Authority accountable

for the trailblazer (£10m) and the Connect to Work programme (£16m), with NHS West Yorkshire ICB accountable for the Accelerator programme (£11m).

The £11m for the West Yorkshire ICB is to support 1,300 people who are at risk of being (or who are) economically inactive due to ill health to stay economically active (or return).

A Joint Programme Board has been created. It has representatives from across the ICB, Combined Authority, Local Authorities, DWP, DHSC, NHSE, Skills and VCSE partners. This Board will oversee and ensure decisions from the Work, Health, & Wellbeing Strategic Board are enacted, advise and make recommendations on operational decisions and, more generally, maintain a sharp focus on reducing on economic inactivity across West Yorkshire.

Recommendations and next steps

- The Integrated Care Partnership Board agreed at its meeting on 1st April 2025 to endorse the collaborative approach to planning and programme governance for delivery of the accelerator and trailblazer programmes, and to support these programmes over 25/26 to ensure their success and delivery of our shared outcome target of 1,300 people prevented from becoming economically inactive, or returned to work from economic inactivity.
- Commissioning of the planned interventions in each place is underway as agreed in the detailed delivery plans, and governance at each place level has been established to bring together the different aspects of the overall programme, at a place level.
- The West Yorkshire Joint Programme Board meets regularly to share learning, address challenges collectively and review the progress, now moving from planning to implementation phase.

Work and Health Plan for West Yorkshire and Joint Delivery Plan

1 Purpose

This paper summarises the West Yorkshire Joint Delivery Plan of the NHS England Health and Growth Accelerator (Integrated Care Board-led) and the Economic Inactivity Trailblazer (Combined Authority-led).

The objective is to ensure that there is a coordinated, joined up approach that enables the development of a coherent plan with partners across the region. This includes collaboration on programme development and performance, delivery and evaluation as part of a long-term commitment to work in partnership on work, health, and skills as a shared priority.

1.1 Accelerator and Trailblazer

1.1.1 The Work and Health Plan for West Yorkshire sets out an ambition and roadmap to tackle health related economic activity, building on the strength of partnerships and the system leadership role of strategic authorities.

1.1.2 Aligned to the strategic approach within this plan, officers within the Combined Authority and West Yorkshire Integrated Care Board (ICB) have developed delivery plans for two schemes of work: the Economic Inactivity Trailblazer (trailblazer) and the NHS England Health and Growth Accelerator (accelerator).

1.1.3 A joint delivery plan aims to bring these schemes of work into alignment, reiterating the strategic and economic case for both, and highlighting opportunities for partnership working.

1.1.4 This work supports a Joint Programme Board to ensure coherence across the two grant funded programmes and demonstrate alignment with wider Work and Health activity. The Joint Delivery Plan also aims to ensure coordinated delivery across the region and consistency of evaluation to inform our approach from 2025 onwards.

1.1.5 To further integrate the region's work, health, and skills provision, work is underway to ensure that the accelerator and trailblazer are aligned with (CA - led) Connect to Work, which is focused on using supported employment models to support people with health conditions, disabilities and complex barriers to work.

2 Context

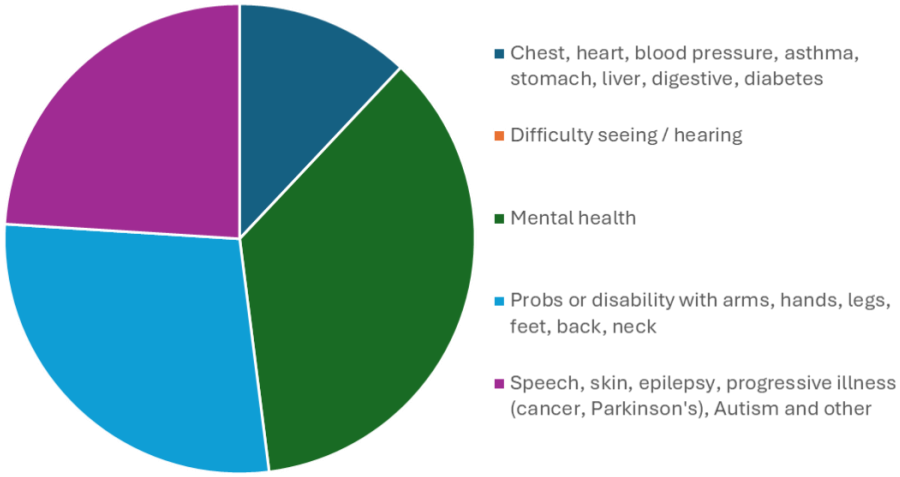
2.1 Labour market context

2.1.1 West Yorkshire's working age population is approximately 1.5m. The employment rate is 73% (vs national average of 76%). Employment rates have been below the national average since 2008, with local areas experiencing significant inequality of outcomes within this.

2.1.2 Economic inactivity rates are rising, with 26.3% of the working age population (399,944 residents) classed as economically inactive, compared with a national average of 21.6%.

2.1.3 The opportunity to build on our existing strengths and test new approaches to address economic inactivity is timely.

2.1.4 Rising incidences of ill health and disability - particularly post-pandemic - are a key contributing factor, with around 101,400 of those economically inactive and of working age reported to be inactive due to long-term sickness.



Employment status by health condition across Integrated Care Boards, England: April 2019 to March 2024 - Office for National Statistics

2.1.5 National data shows that, for those economically inactive due to long term sickness, 38% of people reported having five or more conditions. This suggests that those who are inactive because of long-term sickness have increasingly complex health issues.

2.1.6 The West Yorkshire Work and Health Plan (available under item 9: https://westyorkshire.moderngov.co.uk/ieListDocuments.aspx?CId=133&MId=1402) deepens our understanding of the labour market context and the impact of economic activity on individuals, through the data gathering and insights of around 500 stakeholders including people with lived experience, key experts and local people via public consultation.

2.2 **Work and Health in West Yorkshire**

2.2.1 The West Yorkshire Work & Health Partnership was formed in late 2023, convening key partners and stakeholders from the Combined Authority, the West Yorkshire ICB, Jobcentre Plus and the five local authorities, along with partners from the wider health, employment and skills system and the Voluntary, Community and Social Enterprise (VCSE) sector.

2.2.2 The Partnership seeks to provide a forum within which strategy amongst partners can be aligned toward the goal of a healthy West Yorkshire where residents are able to find good jobs.

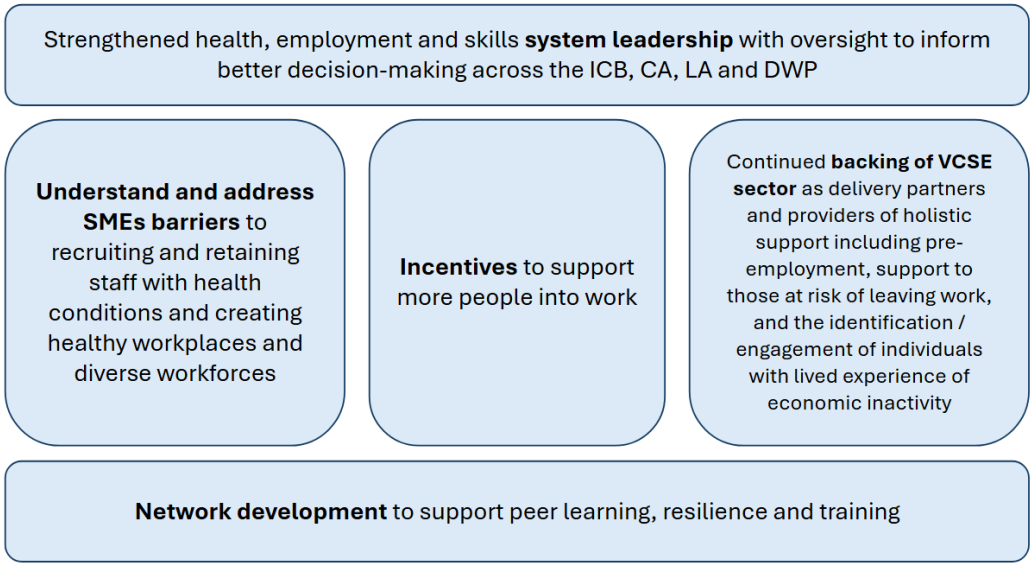
2.2.3 Accelerator and trailblazer interventions provide an opportunity to build on this partnership working, to scale and spread the areas of good practice already showing success within the region, and test and pilot innovative approaches to support those at risk of becoming economically inactive to stay in work and move economically inactive individuals towards and into good work.

2.2.4 A key aspect of this work is ensuring knowledge and best practice is shared amongst partners, to eliminate potential gaps or duplication of commissioned interventions and to ensure activities achieve the objectives set out in the Work, Health and Skills Plan for the region.

2.3 **Work and Health Plan**

2.3.1 The West Yorkshire Work & Health Partnership commissioned the co-production of a Work, Health and Skills Plan in 2024.

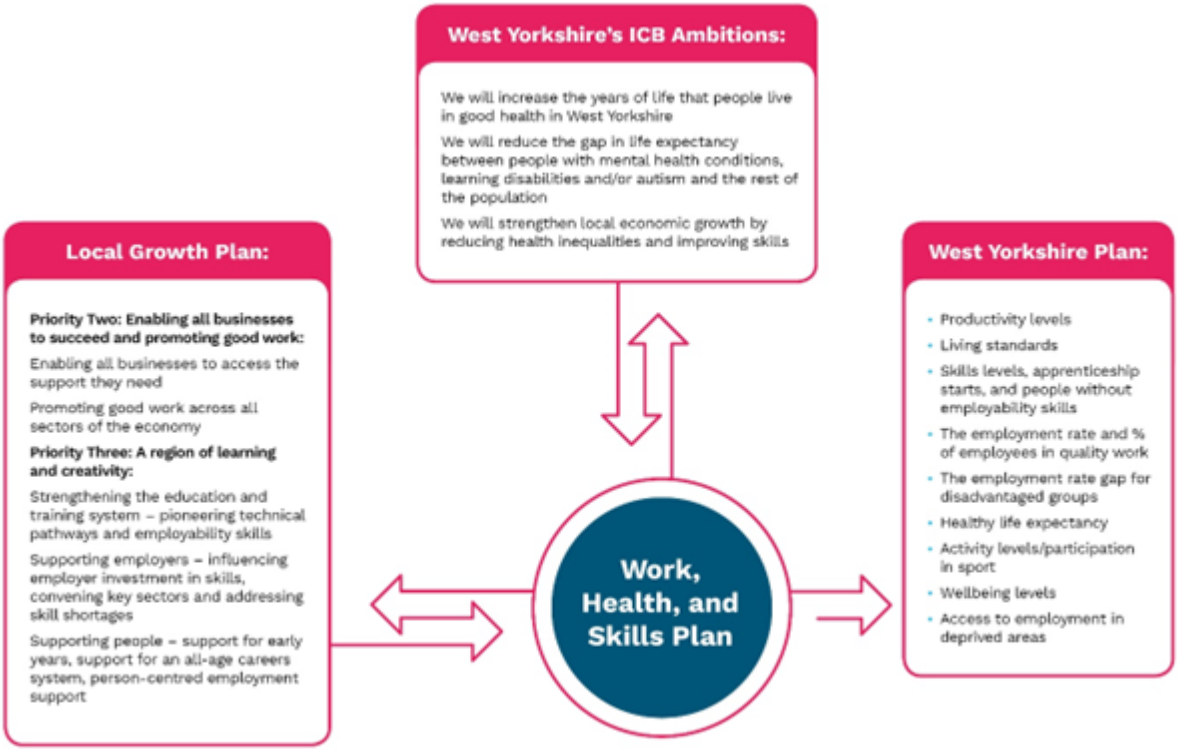
2.3.2 Five priority areas of focus emerged from the plan, responding to the needs articulated by residents, employers and other key stakeholders:



2.3.3 Successful implementation of the plan will be measured through improved population health and well-being, and the improved labour market status of individuals.

2.4 **Alignment with organisational, local and regional priorities**

2.4.1 The Work and Health plan intersects key strategic priorities across West Yorkshire, including the West Yorkshire Plan, West Yorkshire's ICB Ambitions and the region's Local Growth Plan, illustrated by the diagram below.



2.4.2 It is also recognised that it is important to align this work with other priorities and strategies of the ICB, and an update is provided below on how this is being taken forward.

ICB priority / strategy	Connections with Work and Health Accelerator
Integrated neighbourhood health	Presentation to Fuller Board 13/01/25 Place level governance to ensure connections in developing plans
Independent Race Review refresh / Equity and Fairness Strategy	Recommendation included on Work and Health plans to focus on equitable access by ethnicity – to be addressed in planning and evaluation planning

People Strategy and refresh	Regular attendance at People Board to ensure alignment and engagement in strategy development
Digital Strategy	Opportunity to strengthen through digital therapeutics funding (see section 6)
Creative Health System	Alignment through Work, Health and Skills plan – update to Creative Health Board 24/02/25 Creative Health interventions supported at place

3 Case for change

3.1 Existing provision and gaps

3.1.1 Interventions within the accelerator and trailblazer will build on the reach, effectiveness and impact of existing provision, innovation and collaboration within West Yorkshire, informed by the co-designed Work and Health Plan that guides the region's approach.

3.1.2 The integration of Employment West Yorkshire as a key element of the employment and skills system infrastructure across the region is particularly important.

3.1.3 Employment West Yorkshire is a careers / employment programme service for residents of West Yorkshire, regionally co-ordinated by the Combined Authority and delivered by local authorities.

3.1.4 Other existing interventions related to work, health and skills include West Yorkshire's Fair Work Charter, employer networks, VCSE activity at neighbourhood-level, and some supported employment activity.

3.1.5 This existing provision provides infrastructure within which newly proposed interventions can be embedded, establishing them as part of wider referral pathways for those seeking employment support.

3.1.6 Despite this existing provision, rates of economic inactivity in West Yorkshire are rising. Whilst health is a key factor, significant numbers of people are economically inactive due to caring responsibilities and/or not having the skills they need to participate in the labour market.

3.1.7 The Work and Health Plan sets out the gaps in provision across West Yorkshire, where we can go further through these programme interventions for residents, businesses and the region.

3.1.8 For example, employers across multiple sectors report hard-to-fill vacancies and skills shortages, constraining business growth. However, raising employment to the national rate would bring over 60,000 more people into work.

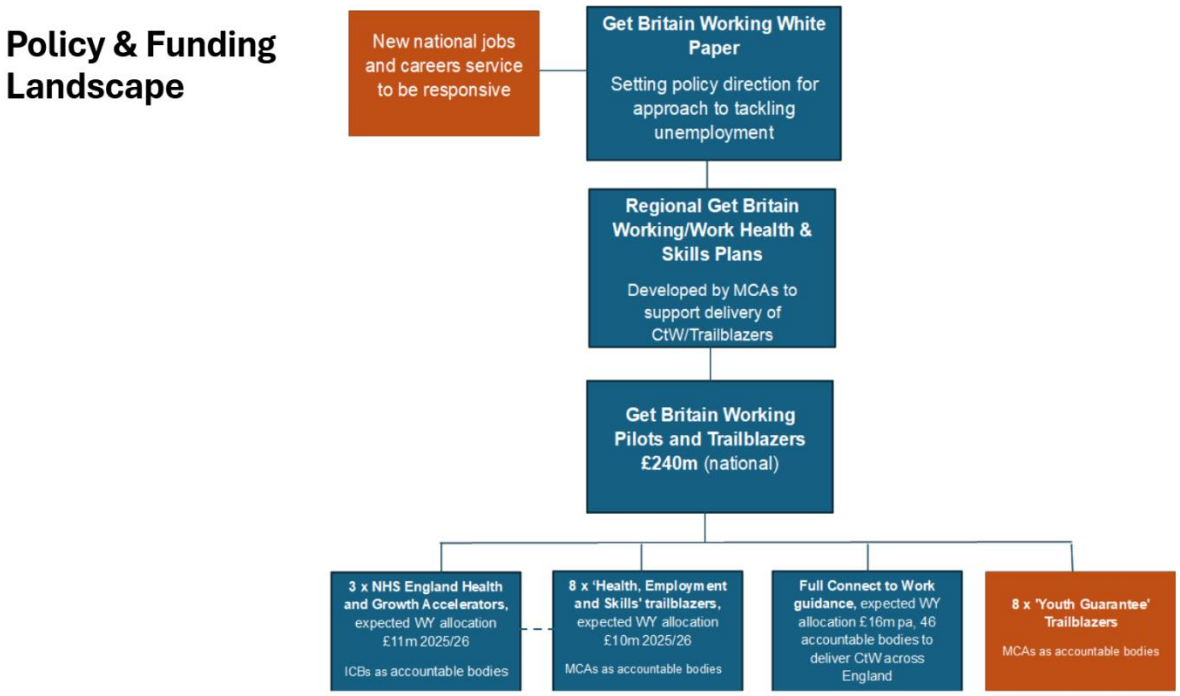
3.1.9 Interventions delivered as part of this programme have the potential to bridge the gap between individuals and businesses, supporting inclusive growth across the region and moving those who are economically inactive into good work.

3.2 **Programme objectives**

3.2.1 The vision of the Work and Health Plan is that West Yorkshire will have the healthiest residents and workforce in England by 2040. This will be achieved through:

- Reducing the number of people becoming economically inactive through prevention and early intervention for those at risk
- Supporting residents with health barriers towards and into good quality paid work

3.2.2 Accelerator and trailblazer interventions, alongside Connect to Work, work towards these objectives and feed into the broader policy and funding landscape for Work and Health nationally.



3.2.3 The principal objective of the Accelerator and the Trailblazer is for the Combined Authority, ICB and partners to identify, engage and support 1,300 more people to be economically active through health-orientated interventions, compared to a do-nothing scenario.

3.2.4 Trailblazer anticipated outputs also include:

- Supporting 1000 economically inactive individuals and those in work with (a) health condition/s through Employment West Yorkshire
- Work with 100 businesses
- Support 1000 economically inactive people through the VCSE intervention

3.2.5 A further objective of this programme is to take a new system-wide approach to this challenge and to learn and test to scale activity – whether linked to the accelerator or trailblazer or Connect to Work. This is to shape a strong, joined-up local work, health and skills offer.

3.3 Vision for testing and piloting new interventions

3.3.1 Accelerator and trailblazer interventions both seek to test approaches to achieving the objectives set out above.

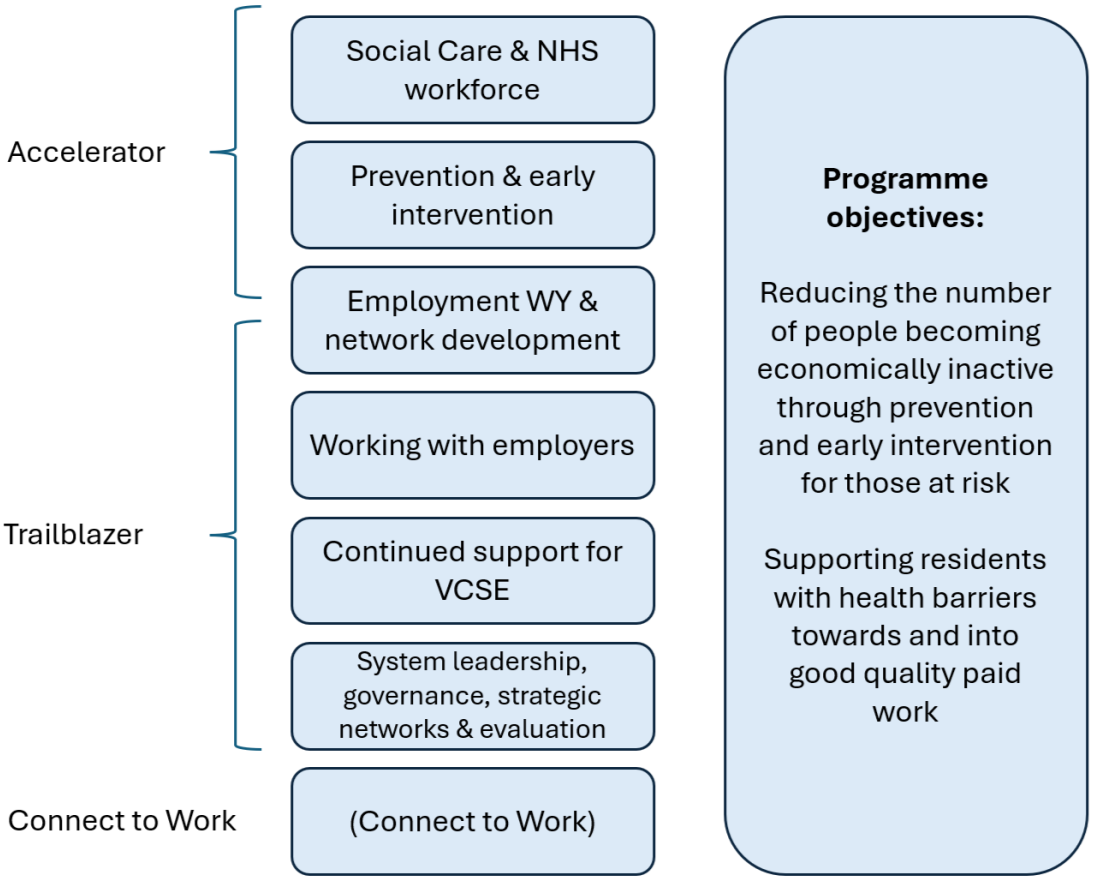
3.3.2 This will require strong programme, risk and change management as well as a flexible but thorough approach to monitoring and evaluation, so we can learn from pilots and share best practice across the region.

3.3.3 A successful approach to piloting interventions will enable West Yorkshire to improve outcomes and see the impact of Work and Health activity at pace, benefitting individuals, employers, and the region.

4 Programme scope

4.1 Summary of planned interventions

4.1.1 There are six interventions proposed across the accelerator and trailblazer delivery plans.



4.2 **Connect to Work**

4.2.1 Connect to Work is a supported-employment programme, grant-funded to Accountable Bodies (of which the Combined Authority is one) by the DWP.

4.2.2 The programme will utilise the Individual Placement Support (IPS) model and the Supported Employment Quality Framework (SEQF) to support residents in work and those at risk of falling out of labour market.

4.2.3 The ambition is to align oversight and further development of Connect to Work through the Joint Programme Board.

4.2.4 Employment West Yorkshire is a key element to ensuring the capacity and capability to deliver Connect to Work in West Yorkshire, acting as a front-door triage service for those seeking to improve their labour market status.

4.3 **Targeted cohorts and accelerator interventions**

4.3.1 The interventions outlined above target particular cohorts of economically inactive individuals.

4.3.2 The diagram below illustrates the expected targeted cohorts by intervention, to demonstrate potential intervention overlap and referral routes.

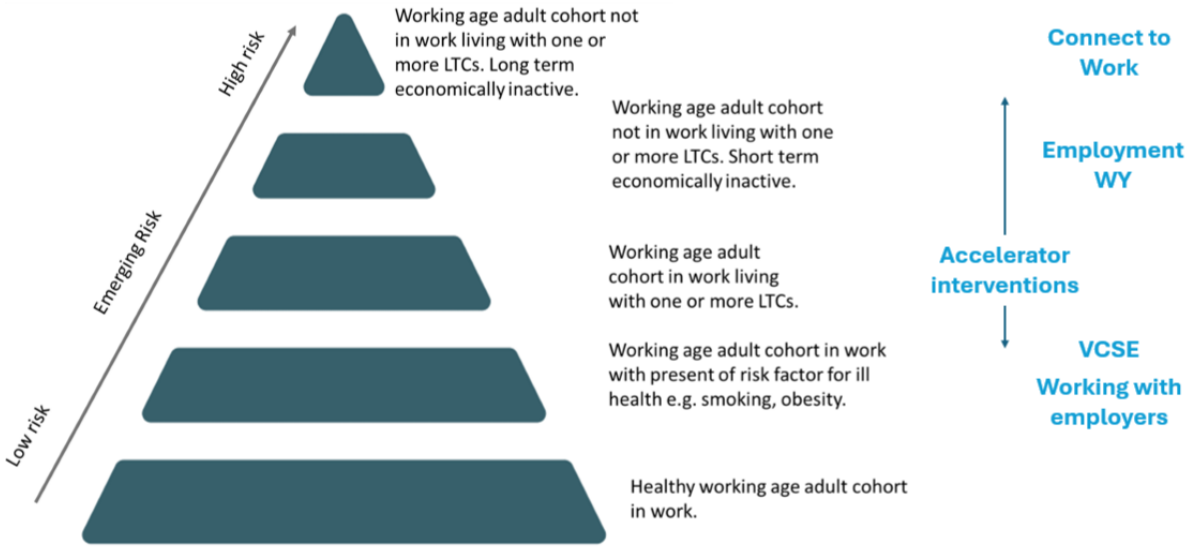


Diagram source: Accelerator update to Joint Programme Board 10.02.25

5 Accelerator Delivery Plans

5.1 Social and NHS Workforce Intervention

5.1.1 This pillar effectively enables us to undertake targeted work within our West Yorkshire health and social care sector. The pillar will use the core principles, data and priorities of the Prevention and Early Intervention Pillar in conjunction with sector specific workforce data, insights and opportunities, including any identified needs particular to this workforce.

5.1.2 Aligned around shared workforce objectives, built on collective insights and evidence, and enabled by collaborative working across West Yorkshire, this pillar will predominantly be designed at Place and connected clearly into the other two Pillars at Place to ensure coherence, recognise local contexts, and optimise impact for local populations and workforce.

5.1.3 Based on available population and sector workforce insights, the interventions for this Pillar will focus on the following targeted health conditions: Mental health, MSK and cardio-metabolic conditions, but will also pay specific attention to neurodiversity and disability and ethnicity where there is also an impact on health in the workplace.

5.1.4 Across each of the Places, the agreed shared objectives for this pillar are to:

- Prevent people leaving work due to ill health.
- Support quicker returns to work through early interventions for those absent from work due to ill health.
- Support alternative employment opportunities for people leaving work due to ill health.

5.1.5 These objectives help identify the people in our workforce who are most likely to benefit from this programme of work, specifically people in work with one of the targeted health conditions, people currently off sick with one of the targeted health conditions, and people who are leaving their current employment due to ill-health.

5.1.6 In order to optimise impact, there are a number of design principles specific to the Workforce Pillar:

- Deliver a small number of targeted, well-evidenced interventions.
- Focus on both pre-determined programme targets, and wider impact for individuals, families and communities.
- Narrowing inequalities will be core to our approach.
- Rigorous evaluation will be designed into every intervention.
- Places will prioritise and design local interventions within the agreed framework, but opportunities for joint delivery, shared learning and collective impact will enhance efficiency and effectiveness.
- 80-90% of interventions will be adapting and scaling-up existing models and services that demonstrate progress toward these objectives, and 10-20% will be innovation.
- The programme will be iterative, with an agile delivery plan which embeds learning throughout the delivery phase, as informed by new information and evidence that will enable increased impact.
- All decisions will have due regard for sustainability and long-term progress, whilst ensuring that short term impact is achieved.

5.1.7 £2m of the accelerator funding will be allocated to the Workforce pillar and managed through 90% being allocated to places based on health and social care workforce headcount as a proportion of West Yorkshire total, with an indicative target of 237 fewer economically inactive people from the health and social care sector, contributing to the overall target of 1,300.

5.1.8 This pillar agreed a set of principles for action as set out in the interim delivery plan, and a framework for interventions has been developed, prioritising the following intervention types:

- Increase capacity and improve connections across health coaching, work coaching and social prescribing. Building on Neighbourhood Health concept to improve access to resources and support networks for H&SC staff.
- Increase fast-track access to sector-specific services for guided self-management, professional assessments and first stage therapies for

targeted conditions (MSK, CMD - may include wider pain management, long term waits, and neurodiversity).

- Mental health interventions including fast-track services where these align appropriately with place plans.
- Develop the Workplace Promise – changing employer policy, culture, manager & HR training, access to health and work support services in work AND supporting people who are leaving employment due to health, to secure positive next steps.

5.2 Prevention and Early Intervention

5.2.1 The principles for this pillar are as follows:

- We recognise these interventions are only effective with the right support structure, taking account the wider circumstances surrounding a person. As such the healthcare interventions need to interface with wider employment support and related offers.
- The approach we take is grounded in the recognition that people are often living with multiple long-term conditions and may be living with multiple symptoms that impact their ability to work.
- We will focus our efforts and limited resource on the population groups with the highest levels of need who can benefit in the intervention period of April 2025 to March 2026.
- We recognise that mental health/musculoskeletal conditions/cardio-metabolic conditions as they are the biggest drivers of ill-health related economic inactivity.
- Whilst the outcome target is 1,300 fewer people becoming economically inactive due to their health, the number needed to treat for different interventions will vary, so numbers needing to be supported will be multiple times higher than the outcome numbers. The evaluation will help assess NNT (number needed to treat) of different interventions.
- We will tailor our approach based on the needs of local communities and population groups.
- We will remember that the six principles of ‘Keep it Local’ are a key contributor to achieving the strategic ambitions of the West Yorkshire Health and Care Partnership.
- We will work with the VCSE and community champions to support mobilisation and bridge the gap between “service” and “community”.
- We will support the collective system outcome and may agree collective interventions, but the how these interventions are delivered will be up to local determination.
- We will take a person-centred and trauma-informed approach to understand why the person is economically inactive.
- We will focus on scaling existing innovative interventions that are well evaluated and demonstrate outcomes relevant to our target, to enable us to move at pace.

- We will accept that the interventions may not be perfect, to allow space for reflection, adaption and change with the expectation we will learn over time and improve along the way.
- We will acknowledge the funding is non-recurrent and as such build in - sustainability and exit strategies.
- We will consider evaluation from the outset recognising the opportunity we have to build the evidence base in this area and influence future strategy.

5.2.2 £8million of the accelerator funding is allocated to this pillar of activity, and then further allocated to place using the relative proportion of people who are economically inactive due to poor health between each of our five places follows:

	% of all WY economically inactive LT sickness
Bradford	22.7%
Calderdale	14.8%
Kirklees	18.2%
Leeds	31.8%
Wakefield	12.5%
West Yorkshire	100%

5.2.3 This approach sets out 10% of the resource to be used across West Yorkshire to add value to place interventions and it is proposed this resource is used to support:

- Rehabilitation services – tailoring services to increase access to stroke, cardiac and pulmonary rehabilitation for working age adults and incorporating vocational support into existing rehabilitation programmes.
- Employment support for Unpaid Carers.
- Work and Health Accelerator Programme and Evaluation support.

5.2.4 **Rehabilitation services**. We will enhance the WY Rehabilitation offer. Pulmonary, Cardiac and Stroke rehab were highlighted as key areas to focus. Through scoping and stakeholder engagement we have highlighted the variations in rehabilitation provision that exist across the 5 places. Whilst differences also exist between the three patient cohorts, there is an

opportunity to grow and scale up areas of good practice with a needs-based approach whilst maintaining aspects of condition specific focus.

5.2.5 Key areas of focus with the potential to scale are:

- Providing a Vocational Rehabilitation offer using expertise from the Bradford Districts and Craven Long Covid pathway and the Airedale Stroke Vocational Rehabilitation Pathway – In year 1 this would provide Level 3: Advice and signposting on return-to-work plan (in line with the NHSE Stroke Vocational Rehabilitation Toolkit) alongside training to upskill the workforce
- Providing a psychologically informed offer across all 5 places – for further consideration
- Continuing areas of good practice within the VCSE, in particular Aphasia Support
- Consider emerging evidence around digital solutions in rehabilitation, such as KiActiv for patients with Heart Failure, Welsh Respiratory offer, local digital solution to patient reported outcome measures and patient support system

5.2.6 **Support for unpaid carers**. The 2021 census estimates 193,885 unpaid carers in West Yorkshire. We believe this figure to be much higher, General Practice Patient Survey suggests as many as 1 in 5 patients are unpaid carers, the NHS Staff Survey shows 1 in 3 NHS staff are unpaid carers. This equates to approximately 48,471 working carers with West Yorkshire. A commitment to our unpaid carers is in line with our West Yorkshire Health and Care Strategy.

5.2.7 The plans to support our unpaid carers include scaling our VCSE initiatives across West Yorkshire, to offer:

- Awareness training to employers
- Manager training
- Support for employer forums
- Individual discovery and action planning
- Organisational review and gap analysis

5.2.8 **Place plans**. As agreed, 90% of the funding will be allocated to our five local places on a weighted basis based as above. Based on the principles detailed above and the specification agreed, places have determined which interventions to implement based on local need. The need is related to the leading causes of economic inactivity due to ill health.

5.2.9 The impact on inequalities has been considered and referenced for each of the proposed interventions.

5.2.10 Following submission of draft plans in mid-late February, a rapid peer-review of plans was undertaken with written feedback provided to places. Places have reviewed and updated plans in line with this feedback. A further

workshop session was also held with all place representatives, where it was agreed that continual learning and sharing of plans and progress would be maintain. Regular weekly catch ups, and the programme board, will provide ongoing opportunities for this continuous learning/peer review.

5.2.11 The planned interventions include:

- Rehabilitation – embedding vocational support and expanding symptom-based approaches.
- Expanding Individual Placement support.
- Targeted secondary prevention for working age adults – exercise referral, hypertension case finding, diabetes footcare, expanding health check offers.
- Working with primary care to identify and offer referral routes.
- Support for people managing pain.
- Mental health support including improved access to NHS Talking Therapies.
- Waiting well support for ADHD and for planned care.
- VCSE employee support.
- Creative health support.
- Targeted employment support for people who use illegal substances.

5.2.12 In addition, places have built in capacity for programme and evaluation support and we have reviewed collectively the opportunities to align these resources (and processes), which has informed revised plans.

5.2.13 The proposals demonstrate commitment to working with VSCE organisations to support the delivery of Work and Health Accelerator interventions.

5.2.14 The submissions from places identify exit strategies to minimise financial risk to the organisation. It has been acknowledged due to timescales for procurement and recruitment that the timescales for the delivery of the intervention will vary over the 12-month period in 25/26. As such the spend over the period will be required to flex to support this. Most interventions will have a step up and potentially a step-down period and this is being incorporated in the planning.

6 Risks and dependencies

6.1 Key risks and mitigations

6.1.1 Individual interventions hold their own risks. However, there are some risks that are shared across the programme of work, as outlined below.

Risk	Mitigation
There is a risk that the recently announced cuts to ICB and NHSE	Reaffirmed as a government priority. Rapid review of impact to take place in late March/early April.

staffing and resources will leave insufficient capacity to deliver the plan.	
Tension between delivering at pace to achieve targets and the need to work equitably to address health inequalities.	This will be continually reviewed as the programme develops, with a commitment to working equitably from the outset. Weighted allocations to place based on need. Impact on inequalities monitoring through intervention design and evaluation.
Lack of assurance from government on the funding following the announcement of investment linked to the Get Britain Working White Paper and the risk that this poses for delivery and the reputation of the Combined Authority and West Yorkshire ICB and other partners.	Highlighting the risk through our relationships with DWP at all appropriate levels. In the meantime, being clear in delivery plans that 'all proposals are subject to funding terms, and are null and void if these funding terms change'.
Inability to 'course correct' at pace, due to lengthy assurance processes.	Establishing Joint Strategic Board with a view to providing delegated authority for system-wide, joined-up, and at pace decision making.
There is a risk that there will be some duplication of activity across all related work, health and skills programmes.	Established a Joint Programme Board to align the related programmes. Development of Joint Delivery Plan to highlight shared risks and opportunities for partnership working.
There is a risk that with the necessary planning, commissioning and recruitment timescales, service delivery will not commence on 01/04/25, and delivery may reduce towards 31/03/26 due to single year funding.	Raised with NHSE – can we carry over activity as a system if commencement is delayed. Bids made to multi-year Spending Review which may increase number of years of activity. Further review of activity and planning will be required once spending review outcome known.
There is a risk that co-design of interventions will be limited, due to the short timescales for funding.	Insight gathered through the Work, Health and Skills plan, which considers the perspectives of a broad range of stakeholders, will guide the design and delivery of interventions. Further development at place will support co-design and delivery.

6.2 **Equality impact assessment**

6.2.1 An Equality Impact Assessment was completed as part of the development of the Region's Work and Health Plan.

6.2.2 This will be built upon during the development of the Work and Health programme, to reflect emerging detail and plans for interventions.

6.3 **Capacity and capability within the system**

6.3.1 Capacity and capability within the system will need to increase to align with programme interventions.

6.3.2 For example, delivery of trailblazer and accelerator interventions rely on the VCSE sector across West Yorkshire as a key delivery partner, to enable early engagement and intervention within communities for individuals who are, or are at risk of becoming, economically inactive.

6.3.3 It is also recognised that employers play an important role in supporting employees to remain in work by adopting inclusive practices. Businesses can also support those who are economically inactive through interventions such as Employment West Yorkshire and Connect to Work, providing opportunities for individuals to move into good work.

6.3.4 The development of VCSE, employer, and lived experience networks as part of the Employment West Yorkshire intervention will build capability within those spaces and encourage sharing of learning and best practice.

7 Programme management and governance

7.1 Governance including key roles and responsibilities

7.1.1 To build on partnership working across accelerator and trailblazer delivery, and to develop strengthened governance of this agenda, a Joint Strategic Board is being explored and will be Chaired by the Mayor of West Yorkshire.

7.1.2 Options are being actively considered on how this body can operate with the intention to delegate authority from the Combined Authority and the ICB. Membership would include the ICB, CA, LAs, DWP, DHSC, VCSE and wider partners, with the intention to:

- Make strategic decisions to deliver shared outcomes
- Maintain a shared and sharp focus on reducing economic inactivity
- Collaborate on recommendations to the respective accountable body / decision
- Recommend action within respective organisations to support delivery of overall outcomes in West Yorkshire
- Create a strategic forum to share and test what is working well across the region and recommend a steer for change / adaptation on programmes

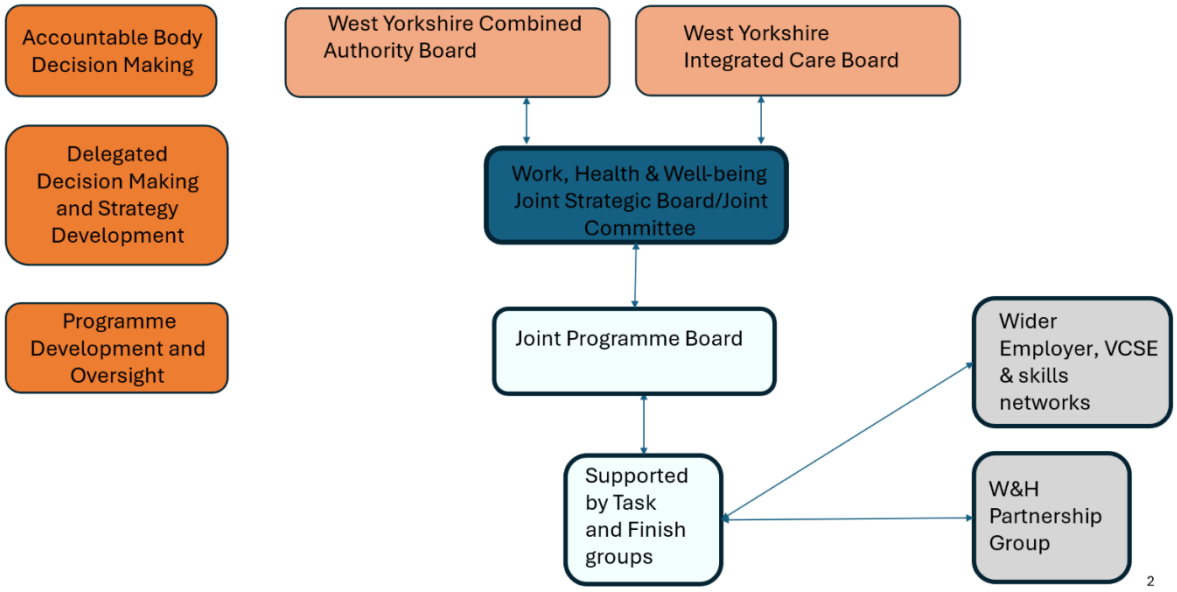
7.1.3 In addition, an officer-led **Joint Programme Board** has been created. It has representatives from across the ICB, Combined Authority, Local Authorities,

DWP, DHSC, NHSE, Skills and VCSE partners. This Board will oversee and ensure decisions from the Work, Health, & Wellbeing Strategic Board are enacted, advise and make recommendations on operational decisions and, more generally, maintain a sharp focus on reducing on economic inactivity across West Yorkshire.

7.1.4 This Joint Programme Board will be responsible for ensuring the necessary returns are made to NHS England on progress and reporting.

7.1.5 This Board met for the first time on 10th February and will continue to meet fortnightly thereafter. See figure below, a proposed governance model.

Proposed Work and Health Governance Model



7.2 **How will risk, quality, and change be managed across interventions?**

7.2.1 With multiple interventions spanning different funding streams, the management of risk, quality and change will impact the adaptability and effectiveness of this programme of work.

7.2.2 The Joint Programme Board will have oversight of programme level risks, management and delivery outcomes to make informed recommendations and provide advice to the Joint Strategic Board for decision making, or in the interim to support Accountable Body decision making, namely through CA Board and ICB.

7.2.3 The Joint Board will appoint Task and Finish Groups to oversee design and delivery of individual interventions or on specific tasks related to performance, as needed.

7.2.4 Delegated authority to the Joint Strategic Board/ Committee could allow for decisions and changes to be made mid-intervention. The Programme Board

will provide direction and recommendations, informed by Task and Finish Groups, to enable informed and timely decision-making.

7.3 Approach to programme monitoring and evaluation

7.3.1 Testing new methods and models of intervention is key to the delivery plans of both the accelerator and trailblazer.

7.3.2 Indicators to monitor progress within each intervention will be agreed as part of the project development process, and will link to the actions, outputs, outcomes and indicators included in the West Yorkshire Plan, Local Growth Plan and Integrated Care Board ambitions / Joint Forward Plan.

7.3.3 Monitoring and evaluation requirements will vary for the accelerator and trailblazer schemes of work, due to potentially differing asks from DWP, NHSE, the ICB and the Combined Authority.

7.3.4 However, consistent monitoring practices will produce a robust understanding of the performance of interventions, enabling comparisons to be made across Work and Health activity, identifying lessons to be learned and improvements to be made.

7.3.5 To enable this, officers responsible for the evaluation of accelerator and trailblazer activities have been meeting regularly to align monitoring and evaluation planning.

7.3.6 This will give West Yorkshire partners the robust information and insight that they need to support informed decision making, continuously improve the support offer, and share lessons learned and best practice more widely.

7.3.7 A joint programme-level evaluation approach is being proposed, alongside performance management activities through the Joint Programme Board.

7.3.8 Given interventions will be predominantly delivered at place, an evaluation framework is currently in development, to support co-ordinated data collection across the five places. The framework seeks to include sufficient detail for West Yorkshire colleagues to provide assurance and track collective impact across interventions, whilst minimising the data collection burden. It has been shaped by feedback from an evaluation subgroup, with representation across the places. The aim of the evaluation is to understand what health interventions are supporting people to remain or return to work in West Yorkshire.

7.3.9 The evaluation framework will include a minimum dataset to be collected by the delivering services, to enable data collation across varying interventions. Data will be combined at a West Yorkshire level, ideally into clusters of interventions e.g. musculoskeletal, mental health etc. The proposed minimum dataset is tiered, with a core element including individual demographics and employment status. The methodology of data collection and the responsibility for analysis are under consideration. The evaluation framework will continue to be adapted following the commencement of intervention delivery.

7.3.10 In addition, a national evaluation of the Health and Growth Accelerator Programme will be conducted by the National Institute of Health Research

(NIHR). It is our understanding that this evaluation will be phased, with the first phase process driven, and further information is awaited. The regional evaluation team will continue to link in with the national team, to co-ordinate work where possible.

7.4 **Public and stakeholder support, including consultations and engagement**

7.4.1 The accelerator and trailblazer delivery plans and the activities outlined in this Joint Delivery Plan have been developed from the Work, Health and Skills Plan for West Yorkshire.

7.4.2 As such, they are directly influenced by the data and insights gathered from stakeholders through consultation.

7.4.3 Ongoing public and stakeholder engagement will be critical to ensure interventions are co-designed and delivered to the benefit of our target cohorts. This will include, but not be limited to:

- Monthly Health and Growth Strategy Mornings that convene local authorities, health partners, VCSE organisations and other partners from across the region's work, health and skills system.
- Regular sessions through existing employer-focused networks.
- The further development or creation of spaces to share and learn from the lived experience of local people to inform the ongoing development of our approach.
- Place-level convening of key system partners to inform design and delivery of interventions at local authority level

8 <u>The longer-term</u>

8.1 The shared ambition is agreed in the Work and Health Plan is for West Yorkshire to have the healthiest residents and workforce in England by 2040.

8.1.1 This joint delivery plan outlines the strong foundations developed through an integrated approach to governance and system leadership, a series of evidence-based interventions that scale up existing and test new innovative approaches and a robust approach to learning and evaluation.

8.1.2 The approach and our learning will inform our future approach to delivering an accessible, coordinated and coherent approach to addressing economic inactivity in West Yorkshire in 2024 and beyond.

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Kirklees COUNCIL

REPORT TITLE: Memorandum of Understanding - Amendment

Meeting:	**West Yorkshire Joint Health Overview and Scrutiny Committee**
Date:	**30 April 2025**
Cabinet Member (if applicable)	**N/A**
Key Decision **Eligible for Call In**	**Not applicable**

Purpose of Report

To consider an amendment to the 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 and approve the amendment to the Memorandum of Understanding.

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) approved the MoU at its meeting on 25 February 2025.

1.2 The MoU was then presented to the WYICB Executive Management Team for approval In April. However, following the abolishment of NHS England, and the subsequent impact on WYICB, the Executive Management Team asked that an amendment be made to the MoU to reflect the shift in the organisation.

2. Information required to take a decision

2.1 Following the approval of the MoU by the WYJHSC, the WYICB have requested the following amendment to the MoU as described below in bold, at paragraph 46, under the heading 'Summary and Review'.

> In summary, this MoU serves as a valuable tool for fostering collaboration and cooperation and will be subject to a 12 month review ***or by exception to reflect the outcome of the consultation on ICB functions and structure as part of the WY ICB organisational change programme 2025.***

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

Should this amendment be approved, the MoU will be reviewed in 12 months' time, or earlier by exception following any organisational changes at WYICB.

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 proposed amended MoU.

11. Service Director responsible

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

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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 or by exception to reflect the outcome of the consultation on ICB functions and structure as part of the WY ICB organisational change programme 2025.

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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