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Date Not Specified

Notice of Meeting

Dear Member

West Yorkshire Joint Health Overview and Scrutiny Committee

The **West Yorkshire Joint Health Overview and Scrutiny Committee** will meet in the **Virtual Meeting - online** at **10.00 am** on **Wednesday 16 July 2025**.

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

A handwritten signature in black ink, appearing to read "S Lawton".

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

Member	Representing
Councillor Elizabeth Smaje	Kirklees Council
Councillor Colin Hutchinson	Calderdale Council
Vacancy	Kirklees Council
Councillor Jonathan Timbers	Calderdale Council
Councillor Rizwana Jamil	Bradford Council
Vacancy	Bradford Council
Councillor Andrew Scopes	Leeds City Council
Councillor Sandy Lay	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: Appointment of Chair and Deputy Chair

The Committee will appoint a Chair and Deputy Chair of the West Yorkshire Joint Health Overview and Scrutiny Committee.

2: Membership of the Committee

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

3: Minutes of Previous Meeting

1 - 6

To approve the minutes of the meeting held on 30 April 2025.

4: 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.

5: 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.

6: Operational Planning

7 - 22

Representatives from West Yorkshire Integrated Care Board will provide a summary of its operational planning.

Contact: Yolande Myers, Principal Governance Officer

7: West Yorkshire Association of Acute Trusts

23 - 26

Representatives from West Yorkshire Association of Acute Trusts will provide an update on its work programme.

Contact: Yolande Myers, Principal Governance Officer

Contact Officer: Yolande Myers

KIRKLEES COUNCIL

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 30th April 2025

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

Apologies: Councillor Caroline Anderson - Leeds Council
Councillor Alison Coates – Bradford Council

1 Membership of the Committee

Apologies were received on behalf of Councillors Anderson and Coates.

2 Minutes of the Previous Meeting

RESOLVED – That the Minutes of the Meeting held on 25 February 2025 be approved as a correct record.

3 Declarations of Interest

No interests were declared.

4 Public Deputations/Petitions

There were no deputations or petitions.

5 Cancer Early Diagnosis

The Committee welcomed Jason Pawluk, Associate Director for Cancer West Yorkshire Integrated Care Board (ICB) and Programme Director for the West Yorkshire and Harrogate Cancer Alliance (CA) to the meeting.

Mr Pawluk advised the Committee that the ICB had set cancer early diagnosis as one of their top 10 priority big ambitions now that more curative treatments were available than in the past to improve cancer survival and experience. The aim was to have 1000 more patients diagnosed at an early stage, and in appreciating there was still more work to do, the current figures showed 1382 more people were diagnosed at early stage, usually at stage one or two, making curative treatment possible.

The Committee was advised that the CA were now seeing important initiatives such as screening availability (particularly lung cancers), liver cancer surveillance, breast, cervical and bowel screening with an increase in take up of screening.

The Committee noted the work being undertaken to break down artificial barriers which prevented patients coming forward for screening by making people more aware of signs and symptoms. There was also an emphasis by the ICB and CA about the whole cancer pathway, living beyond cancer, and treatment and diagnosis pathways.

In relation to performance, particularly how quickly a patient received treatment, it was noted that the trusts in WY were some of the best in the country with a couple of trusts meeting NHS standards. Whilst this wasn't seen as a 'job done' it was, nonetheless, a positive picture.

In response to a question about health inequalities, and whether there were any groups which were being consistently missed, Mr Pawluk explained he had more detailed analysis, sub parameters, which look at Primary Care Networks (PCN), and the index of multiple deprivation groups. In some patients, routes to presentation were more likely to present through emergency departments, rather than PCN particularly when considering lower socio-economic groups. However, the Committee noted that lung cancer screening was not included in this, with a patient in WY more likely to have early diagnosis if they came from lower social economic backgrounds, due to targeted and deliberately profiled patients being offered screening.

The Committee was advised that focused work was also being undertaken with minority population screening awareness, such as with the South Asian community, cervical screening in trans gender and younger population groups.

The Committee felt that more could be done with minority screening especially amongst South Asian women, where uptake was low. It was important to get into the communities to educate them and talk to them about the benefits of having screening, going into faith centres and talking to men to ask them to speak to their wives and daughters encouraging them to take up the screening.

In reply, Mr Pawluk explained that there was more work to do to understand what the CA could do to make services more inclusive. However, work was ongoing and was often volunteer led, such as the cancer smart campaign, and CA was using social media and Instagram influencers in those communities to try and get the message out.

The Committee was informed that the CA was involved in an academic collaboration with Bradford University to understand barriers and its impact on participation rates with South Asian women.

The Committee queried how cancers, such as for abdominal cancer would be referred, particularly if a GP did not suspect it, but noting that abdominal cancers could present with varied symptoms. Mr Pawluk responded to say that the CA considers figures for PCN's with unexpected variations in referral rates and do

targeted education work, advising the PCN that their population was not behaving, in either increased or decreased referrals, as the CA would expect them to.

The Committee heard that CA was looking at the significance of waiting times and the differences in referral rates to then use that research to advise PCN's on the differing referral rates and outcomes across PCN areas.

The Committee, in noting it had been briefed on the review of the reconfiguration of non-surgical oncology, asked what the main challenges were in improving the speed of cancer diagnosis at the specialist Leeds Cancer Centre. The Committee also asked how vacancy rates for non-surgical oncologists and radiologists impacted this, and how well the training programme was in supplying the anticipated level of staff required.

Mr Pawluk explained that Leeds saw the most complex cases, but in comparison to other cancer centres, it does as well or better than other similar centres. Leeds Cancer Centre had seen improved performance for radiotherapy, workforce redesign, training up posts and supporting progression for staff. The specialist nurse recruitment was going well but would continue as a focus.

The Committee was informed that more patients were being diagnosed with cancer, who often needed more complex treatment taking longer to deliver and this had an impact on workforce. However, the Committee noted that all the highest priority patients were receiving treatment within 31 days.

The Committee asked broadly speaking, how the NHS compared in its cancer and diagnostic rates internationally. The Committee heard that the NHS did not compare favourably, particularly with Scandinavian systems, and most of western Europe. This was partly due to the rate at which the NHS brought innovation, diagnostic capacity and engaged its population. However, there were broader social policy factors, in that the more people lived healthy lifestyles, the more preventable cancers were, and often Scandinavian countries were better placed in this regard.

The Committee voiced their concerns about how difficult it could be for patients to get appointments at the GP, and particularly how well a patient would be able to get across to a receptionist the need for a more urgent appointment.

The Committee noted in previous years that a mobile Xray unit would visit a community and asked if there was any way of reintroducing that. Mr Pawluk advised that this was being considered as a proposal, and the Manchester CA had seen success in their area with awareness raising vans, especially in relation to encouraging people to come forward. When patients visited the vans, they were given signposting and advice, and a 'golden ticket' which advised that there were some concerns which need to be checked, and the ticket assisted them through the access barrier.

In relation to lung cancer, the CA was reviewing PCN records for any patients with a smoking history, past or present who would be eligible for screening. This also

extended to patients who became eligible more recently due to their age, or who had moved into the West Yorkshire area.

RESOLVED –

- 1) That the representatives be thanked for their presentation to the Committee.
- 2) That further information be provided to the Committee in relation to
 - (i) Data relating to targeted screening.
 - (ii) the research being undertaken with Bradford University.
 - (iii) lung cancer screening programme developing into a national scheme.

6 Work and Health Plan and Programmes

The Committee welcomed Jen Connolly – Associate Director for Improving Population Health, who advised that she worked jointly with the WY ICB and West Yorkshire Combined Authority (WYCA).

Ms Connolly advised that the work being undertaken aligned with one of the ICB's 10 big ambitions relating to social and economic development, and work on the health agenda was being undertaken with the combined authorities alongside LA's and the Department for Work and Pensions (DWP).

The Committee heard that alongside national announcements, such as the 'Get Britain Working' white paper, was the accelerator of which the ICB was responsible for £11m for WY, and the trailblazer, for which WYCA was responsible for £10m over a period of one year.

The plan had five key objectives to allow for oversight and better-informed decision making. A key objective was understanding and addressing barriers, to empower SME's in taking action to better support their workforce and providing incentives to support people into work. It was noted that more work was needed to develop networks to support people working in this way.

As part of the accelerator, Ms Connolly advised that she had worked with place leads within the ICB to develop intervention plans to target key populations. The work had been informed by data they already had. A model was then taken to set a framework to allow each place to design an intervention needed which was relevant to their population.

The Committee noted that funding to places was based on need rather than a headcount approach and on proportion of inactivity related to ill-health.

For the wider population the schemes offered variety, led by places to target people to stay in work, increasing rehabilitation offers such as vocational rehabilitation and support for unpaid carers. The schemes would expand offers to stop conditions declining or further conditions developing, along with support in managing pain. Increased mental health support and access to talking therapies would be provided along with support for those diagnosed with ADHD.

The Committee was advised that the target was to support 1300 people across WY to remain in work that would otherwise have fallen out of work. The aim was also to stop the growth in that number.

The Committee asked what support was available for employers, such as for intermittent work attendees, to allow employers to be confident in the risk of continued employment for those people. In response, the Committee heard that direct work was undertaken with employers to look at reasonable adjustments from pro-active conversations with their employees.

In understanding that often the reason people were out of work with ill health was inequality and poverty, the Committee questioned whether there were any examples of best practice from employers in addressing the wider issues around barriers to work.

Following a question from the Committee relating to when the accelerator funding ends and how the support would continue, Ms Connolly explained that whilst the funding was for a single year, requests were being made to extend it as part of the spending review. However, the programme was making sure that there was a clear exit route for when the funding ended, and it would ensure that the opportunity to learn was maximised through the current funded year and change services to build on that learning.

Ms Connolly advised the Committee that 90% of budgets were delegated to place, and commissioned activity based on plans developed, and each LA's place committees could request that information.

The Committee commented on many ideas across the WY footprint in back to work schemes and in invigorating innovation, but asked how the system could change to ensure that smaller innovators were included within that. The Committee noted that a joint programme board was in place which concentrated on delivery, with encouragement to replicate these locally. Each LA area would have a different programme which could be shared if requested.

The Committee noted the ICB and WYCA's recognition of the Voluntary, Community and Social Enterprise Sector (VCSE) and their initiatives to support health and wellbeing. Ms Connolly explained that had been picked up through accelerator funding, but the trailblazer was committed to finding routes to the VCSE and was one of the key principles in the framework. The roles of VCSE varied across place and a number had commissioned work directly with VCSE.

In relation to the Fair Work Charter, this would be strengthened with employers and would look to increase the number of fair work employers. It was important for employers to know what networks they would get access to, the support of other employers, but that part of WYCA's wider role, alongside LA's was how to grow that engagement and understanding of good and fair work across the region. A coaching model was part of this offer and was about people taking control of their own life and in supporting their conversations with employers.

The Committee was advised that there were clear monitoring arrangements with NHSE about how the programme was progressing. Different monitoring matrix were being considered and would be available later in the year.

RESOLVED –

- 1) That the representatives be thanked for their presentation to the Committee.
- 2) That further information be provided to the Committee in relation to
 - (i) Contact details for the programme for each LA place
 - (ii) The budget figures split down for each LA place.

7 Amendment to Memorandum of Understanding

Considering recent changes to NHSE and the subsequent change to the ICB's way of working, the Committee received a request from the ICB to make a minor amendment to the Memorandum of Understanding which was approved at the meeting on 25 February 2025.

The amendment would allow for a review of the document before the 12-month period.

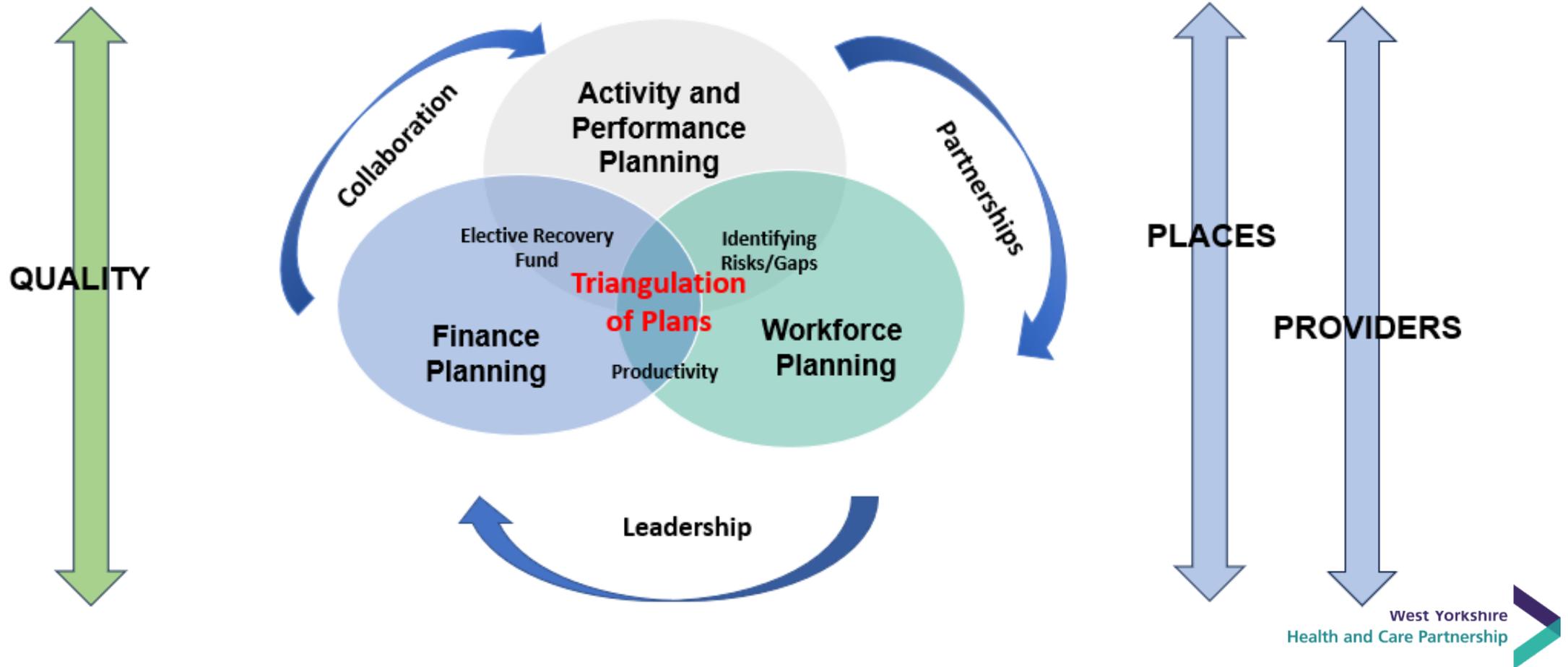
RESOLVED – That an amendment be made to the Memorandum of Understanding at Para 46, which would now allow for a review of the document by exception to reflect the outcome of the consultation on ICB functions and structure as part of the WY ICB organisational change programme 2025.



NHS West Yorkshire
Integrated Care Board

Operational Planning Summary

West Yorkshire ICB Whole System Approach to Operational Planning





NHS West Yorkshire
Integrated Care Board

High Level Summary

Finance, Workforce, Activity and Performance

Finance headlines



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- Final plan submission on 27 March 2025 aggregate break-even
- Updated submission 30 April – reflected technical corrections, and small changes in efficiency value and profile.
- Includes **system risk** held, for the purposes of planning only, against WY ICB of £33.2m
- Plans include **deficit support funding of £49.2m** (plan would have been deficit of £49.2m without)
- Plans include efficiency plans of **£432.6m (6.7% of overall ICB allocation)**



Overall approach to resource utilisation



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- System transformation
 - Provider collaborative service reviews
 - Integrated neighbourhood health (*link to cost drivers re: non-elective activity*)
 - Work and health
- Productivity
 - Productivity packs
 - Elective recovery plans
- Grip and control
 - Complete implementation of all action plans in response to PwC external review
- Difficult decisions





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Workforce



Workforce Headlines



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- The substantive healthcare workforce across West Yorkshire continued to grow during the last year, with a reduced reliance on bank and agency staff.
- Strong workforce growth in Hospital and Community Health Service (HCHS) Doctors and General Practitioners (GP) is largely driven by an increase in the number of Resident Doctors (formerly known as doctors in training grade posts)
- The focus over the coming year will be on vacancy management, further reductions in bank and agency usage and increasing efficiencies in the non-clinical workforce.



NHS Hospital & Community Health Service Substantive Workforce 2024-2025



NHS West Yorkshire
Integrated Care Board

	April 2024 wte	March 2025 wte	In year change wte	In year change %
HCHS Doctors	5,707	6,047	340	6%
Nurses and Health Visitors	14,230	14,735	505	4%
Midwives	1,055	1,106	51	5%
Amulance Staff	1,816	2,036	220	12%
Scientific, therapeutic & technical staff	7,904	8,109	205	3%
Support to clinical staff	20,576	20,696	120	1%
NHS Infrastructure support	11,347	11,608	261	2%
West Yorkshire ICB Total	62,635	64,337	1,702	3%
<i>Data source: NHS Workforce Statistics, April 2024 and March 2025</i>				



General Practice and Primary Care Network Workforce 2024-2025



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	April 2024 wte	March 2025 wte	In year change wte	In year change %
GP (including Resident Doctors)	1,714	1,788	74	4%
Nurses	871	858	- 13	-1%
Direct Patient Care	1,748	1,770	22	1%
Admin/Non Clinical	3,489	3,581	92	3%
West Yorkshire ICB Total	7,822	7,997	175	2%
<i>Data source: General Practice Workforce Statistics, April 2024 and March 2025</i>				



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Activity and Performance



West Yorkshire ICB Commissioner Metrics



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Area	Metric	Baseline Position Date	WY ICB Commissioner			
			Baseline Position	2025/26 Plan	Target	Variance (Plan to Target)
Elective	Percentage RTT incompletes over 52 weeks	Dec-24	2.30%	0.55%	1.00	-0.45%
	Number of 52+ week RTT waits	Dec-24	5102	1251		
	Percentage RTT incompletes 18 weeks and under	Dec-24	64.10%	71.40%	69.10%	2.30%
	RTT waiting list	Dec-24	223969	225802		
Outpatients	Time to First Attendance	Nov-24	70.40%	74.92%	75.40%	-0.48%
Cancer	Cancer 62 Day Standard	Dec-24	71.20%	77.68%	75.00%	2.68%
	Cancer 28 Day Faster Diagnosis Standard	Dec-24	80.00%	82.18%	80.00%	2.18%
Diagnostics	Total Aggregate seen within 6 weeks	Nov-24	87.70%	95.78%	95.00%	0.78%

West Yorkshire ICB Commissioner Metrics



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Area	Metric	Baseline Position Date	WY ICB Commissioner			
			Baseline Position	2025/26 Plan	Target	Variance (Plan to Target)
MH	*Active inappropriate adult acute mental health out of areas placements (OAPs)	Mar-25	51	14	0	14
	Average length of stay for adult acute beds	Nov-24	68.00	55.03	67.90	-12.87
	Access to NHS talking therapies for anxiety and depression - reliable recovery	Sep-24	49.00%	48.74%	48.00%	0.74%
	Access to NHS talking therapies for anxiety and depression - reliable improvement	Sep-24	70.00%	67.79%	67.00%	0.79%
	People Accessing Specialist Community Perinatal Mental Health Services	Sep-24	2405	2604	3041	-437
	Access to Children and Young People Mental Health Services	Sep-24	36645	34529	33335	1194
LDA	Learning disability registers and annual health checks delivered by GPs	On track to deliver >75%		78.61%	75.00%	3.61%
	Reliance on mental health inpatient care for adults with a learning disability	Dec-24	36	28	53 across both	2
	Reliance on mental health inpatient care for autistic adults	Dec-24	34	27		
	Reliance on inpatient care for people with a learning disability and/or autism - Care for children	Dec-24	7	7	8	-1

Yorkshire Ambulance Service (YAS)



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Demand, Activity and Performance

	24/25	Baseline: Handover & Crew Clear Efficiencies, 3% reduction in Deployed Hours on the Road	Improvement with growth £11: maintain deployed hours, handover & crew clear efficiencies & increased clinicians in EOC
Demand (all incidents)	Actual/forecast	+3.9%	+3.9%
Deployed Hours on Road	Actual/forecast	-3%	Maintained
H&T (% & volume)	15.3%	15% (24/25 volume maintained)	18% (increased % & volume)
Clinicians in EOC (FTE)	85	85	112
C2 Performance (Trust Forecast)	31:56	33:12	28:48

Compliance with the ambulance commissioning guidance (with assumed £11m growth funding)

Ambulance Commissioning Guidance 'ask'	Does' YAS Plan Delivery Y/N	Comments
Reduce avoidable ambulance dispatches and conveyances to Emergency Departments (ED).	Y – Conveyance reduced from 59% to 57%	YAS have plans to further reduce conveyance rates
Improve 'hear and treat' rates and reduce variation	Y – Hear and Treat Rates increase from 15 to 18%	Includes increase in EOC clinicians. System actions also required to support
Improve 'see and treat' rates	Partially – Increased volume of S&T but slightly lower % of overall demand	Increasing H&T rates will have the impact of reducing S&T rates
Maintain deployed staff hours on the road	Y – deployed hours maintained at 2024/25 levels	Only maintained with growth funding – see table on risks and issues
Delivery and Optimised Operational Delivery Model	Details set out in Narrative Check-list to deliver the requirements	System actions required to support some elements





NHS West Yorkshire
Integrated Care Board

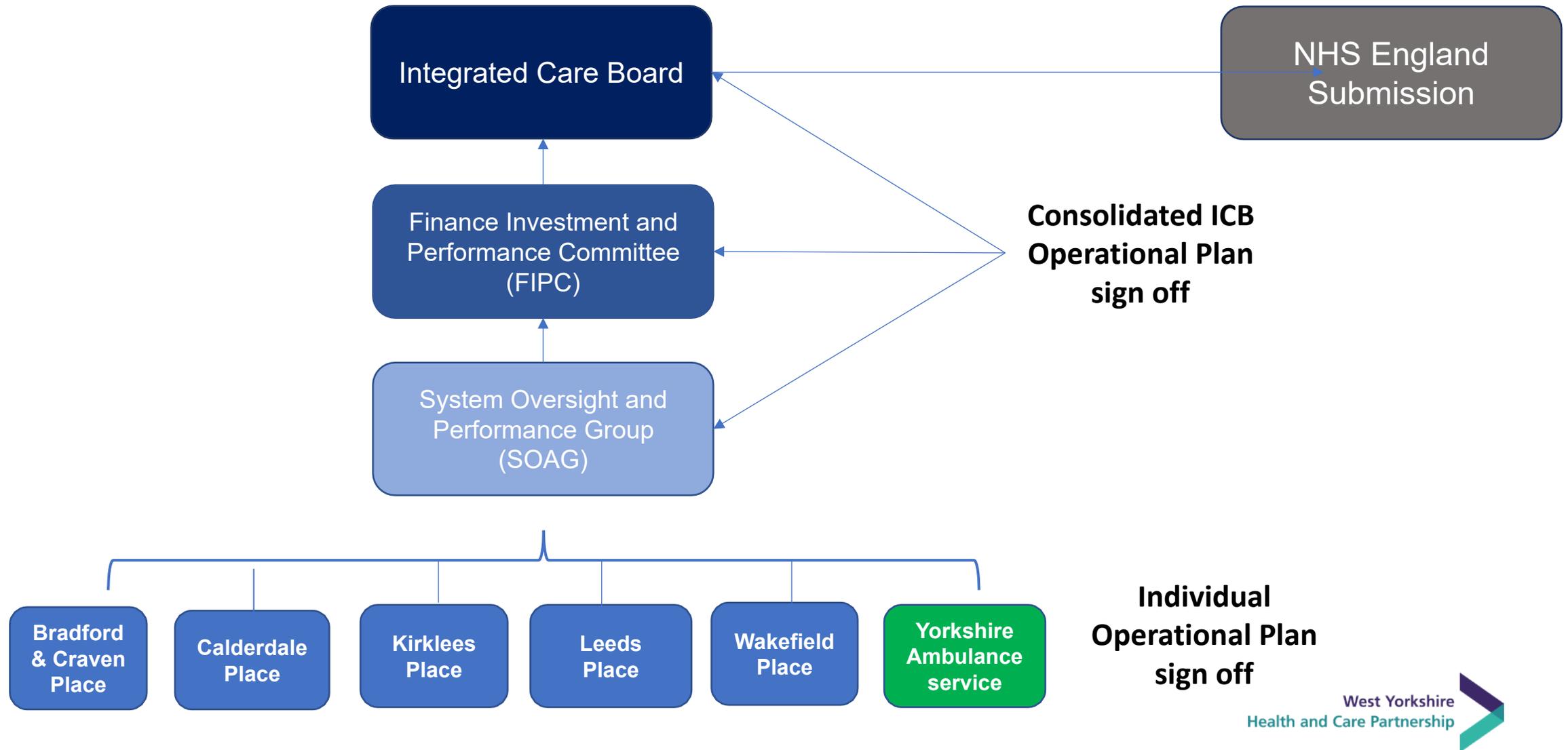
Risks to Delivery, Mitigation and Governance



WY System Key Risks and Mitigation

Risk	Mitigation
Financial balance within allocations and the challenges to meeting national targets	Well established and active directors of finance group working across West Yorkshire
Impact of National reform and current political landscape	Active management of the running cost reductions. Established working group and identified resources to complete work at pace
Challenging workforce targets against levels of activity required and maintaining safe staffing levels and staff morale	Quality oversight arrangements in place for workforce
Understand the system response to pressures in GP Direct Access, impact of collective action and high-cost drugs and devices	Working closely through regional leads on GP action and locally with Local Medical Committees (LMCs)
Changes to lead role for specialised commissioning services including future governance arrangements, performance management and potential financial impact	We worked with NHSE and the regional ICBs to oversee a robust process of delegation and are sighted on the quality, finance and service risks. We have Established Specialised Commissioning Programme Board chaired by CEO of LTHT to ensure we have the right leadership and engagement going forward.
High-cost packages for statutory responsibilities (S117, court orders, at risk children); Right to Choose in Neurodiversity and Weight Management services where data and processes for managing activity are not yet clear and costs and capacity in the market have escalated	Joint programme on managing CHC across West Yorkshire. Neurodiversity Right to Choose programme managed through the Transformation Committee
Financial pressures faced by Councils and other partners such as the VSCE	Established partnership working with active representation by partners in programmes and committee arrangements
Risk in non-elective demand and associated pressures	Managed work programme for Integrated Neighbourhood Health Services

WY ICB Operational Plan Assurance and Governance



WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

Briefing to West Yorkshire Joint Health Overview and Scrutiny Committee July 2025

1. Purpose

The purpose of the paper is to provide a briefing to the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) on the work programme of the West Yorkshire Association of Acute Trusts (WYAAT).

2. Background

WYAAT is part of the West Yorkshire Health and Care Partnership. WYAAT is an innovative provider collaborative (not an organisation) which brings together six NHS trusts across West Yorkshire and Harrogate to deliver joined up acute hospital services. The six member trusts work together through WYAAT because they believe that the health and care challenges and opportunities facing our area cannot be solved by each hospital working alone. WYAAT provides a mechanism to share best practice and learn from each other to tackle unwarranted variation or inequalities in access, outcomes, and experience. WYAAT aims to organise services around the needs of people living in West Yorkshire and Harrogate as a whole, rather than solely planning at individual organisational level. This will enable our trusts to deliver more joined up care, high-quality, cost-effective care for patients.

The organisations which make up WYAAT are:

- Airedale NHS Foundation Trust (AFT)
- Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)
- Calderdale and Huddersfield NHS Foundation Trust (CHFT)
- Harrogate and District NHS Foundation Trust (HDFT)
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Mid Yorkshire Teaching NHS Trust (MYTT).

WYAAT set a [Five Year Strategy 2024-2029](#) focused around its continued collaboration in six core areas:

- Service Delivery
- Workforce
- Productivity and Efficiency
- Infrastructure
- Research, Innovation and Improvement
- Ways of Working.

3. Governance and decision-making

WYAAT is a collaboration of the six member trusts, each with statutory boards. WYAAT utilises a Committee in Common model, where the six Chairs and Chief Executives of each of the member trusts meet to consider priorities and direct and oversee the collaborative work

WYAAT incorporates Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, and Mid Yorkshire Teaching NHS Trust.



programme. This is set out in a Memorandum of Understanding. The Committee is a formal committee of each of the trust boards. In practice this means that any decisions supported by the Committee in Common will need to be formally approved by each of the trust boards, reporting is therefore through each of these boards.

WYAAT reports progress on the relevant areas of its workplan to NHS West Yorkshire ICB. Any decisions which impact the way in which patients access services remain with the ICB as the commissioner, with appropriate engagement with Health Overview and Scrutiny Committees and wider partners, in line with statutory responsibilities.

4. Current work programme

The current formal programmes of work across WYAAT are:

- **Pharmacy Aseptics** – WYAAT is part of a national ‘pathfinder’ programme and has received national capital investment to build an aseptic manufacturing facility which will prepare large quantities of standardised pre-prepared medicines to our hospitals. This will allow the trusts to provide products currently purchased from the commercial sector which has experienced supply issues, at a lower unit cost and will release nursing time to care on hospital wards, where some of these products are currently prepared by nursing staff. Production has commenced from the existing site in smaller numbers to deliver benefits to staff and patients ahead of the completed construction of the hub. Existing aseptic units at every trust will remain in place, with a focus on preparing more bespoke patient-specific products.
- **Pathology** – pathology has been a long-term programme of work across WYAAT, following reports by Lord Carter on productivity in 2008 and 2016, and a national programme of work to develop pathology networks. Our pathology network includes all WYAAT trusts. The programme is focused on consolidation of direct access testing (from primary care) to fewer sites, in order to maximise the available automation and equipment. To enable this, WYAAT has been focused on the deployment of a single Laboratory Information Management System (LIMS) which enables trusts to share work across laboratories and upgrade old infrastructure. Alongside this, software has been deployed which provides visibility of pathology results across all WYAAT trusts, reducing unnecessary repeat testing for patients and improving clinicians’ access to information to support diagnosis and treatment. This work is also enabled by new state of the art equipment at a number of sites, including the new Centre for Laboratory Medicine at St James’s Hospital in Leeds which will be a hub for blood sciences and microbiology, and the specialist reference centre for the region.
- **Imaging** – the imaging programme has focused on technical solutions to support networked working between radiology departments. This has included the deployment of over 250 home working stations for radiologists and reporting radiographers, and a shared reporting solution which allows cross-site reporting of patient images. Additionally, all trusts are adopting an Artificial Intelligence (AI) software for Chest X-Rays. Chest X-rays provide clinicians with useful information regarding the possibility of lung cancer and infections such as pneumonia or empyema, as well as helping to rule out other conditions such as fluid in the lungs or complications caused by



misplaced feeding tubes. The software provides clinicians with comprehensively annotated images to help with clinical decision making.

- **Planned care** – the planned care programme is focused on improvements across planned care pathways, with the objective to reduce waiting times for patients. This includes a focus on improving productivity, using benchmarking information and through implementation of national recommendations such as [Getting It Right First Time](#), new ways of working such as provision of advice and guidance between primary and secondary care clinicians, patient initiated follow-up (PIFU) and appropriate use of virtual appointments, collaborative working across trusts to share improve access and reduce waiting times for patients for surgical procedures. Much of this work is driven through WYAAT clinical networks, specialty-based meetings of clinical experts across secondary, often engaging with primary care to identify and implement improvements across WYAAT trusts.
- **Procurement** – by working collaboratively on a number of procurement projects, the teams across WYAAT and with wider NHS providers in West Yorkshire, were able to save £2.3m last year by purchasing goods and services together. Further work is focused on a more formalised collaborative structure which can deliver more savings in future.

Additionally, WYAAT hosts the Integrated Stroke Delivery Network (ISDN), an NHS England commissioned network for West Yorkshire and Harrogate which supports a series of improvement projects across the stroke pathway. This includes implementation of AI software to support detection of strokes on X-rays. The Network has launched the 'All Things Stroke' website to provide essential post-discharge support for patients, their families, and carers, further work is planned this year to provide resources for professionals.

5. Responding to the 10 Year Health Plan

The [10 Year Health Plan](#) is focused on how the NHS makes the three shifts:

- hospital to community, with a focus on delivering an integrated neighbourhood health service
- treatment to prevention
- analogue to digital.

Alongside these strategic shifts to deliver a sustainable NHS, there remains a medium-term focus over the next 3-4 years to deliver the constitutional commitments with emphasis on driving down waiting lists with the recognition of the wider economic impact of large numbers of people waiting for planned care, and ensuring the NHS lives within its resource allocation.

In response to this, WYAAT is currently reviewing how it will need to respond to these imperatives and organise its services:

- at **Place** working alongside primary care, community services, social care, and voluntary and community sector organisations to meet the physical and mental health

needs of local populations, through and Integrated Neighbourhood Health (INH) model.

- through **collaboration with secondary care partners** to provide equitable patient access, outcomes, and experience and ensuring these services are clinically and financially sustainable. This could include working with a neighbouring trust to make best use of assets like surgical hubs and community diagnostic centres or planning services once across WYAAT but delivering these across multiple places.

This work is also considering how corporate and support functions can be provided most efficiently and effectively in future.

The outputs from this work will inform the future priorities and workplan for WYAAT.

6. Impact of changes to the NHS structure

In March 2025, the Secretary of State announced that NHS England (NHSE) will be absorbed into the Department of Health and Social Care (DHSC) and headcount will be reduced by 50%, to reduce over-regulation, duplication, and bureaucracy. Integrated Care Boards (ICBs) have been directed to make 50% reductions in running costs in 2025/26 and provider trusts asked to reduce the growth in corporate services budgets since 2018/19.

As part of these changes, there is clear direction that ICBs will move to a role as strategic commissioners ([Model ICB Blueprint, May 2025](#)), with groups of providers working together to deliver coordinated services to local populations. Whilst there is further work required to determine how the new model will be implemented, collaboration between providers, whether across sector at Place, or within sectors (like WYAAT) will be key partners in the delivery of the care and outcomes commissioned by the ICB.

WYAAT trusts, like all providers, continue to work with the ICB and wider partners to manage this transition to a new way of working.

7. Recommendations

West Yorkshire Joint Health Overview and Scrutiny Committee is recommended to note the contents of this briefing note.