

# Public Document Pack



**Service Director – Legal, Governance and  
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Date: 2 December 2025

## Notice of Meeting

Dear Member

### **West Yorkshire Joint Health Overview and Scrutiny Committee**

The **West Yorkshire Joint Health Overview and Scrutiny Committee** will meet in the **Virtual Meeting - online** at **10.00 am** on **Wednesday 10 December 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:-**

<b>Member</b>	<b>Representing</b>
Councillor Elizabeth Smaje	Kirklees Council
Councillor Colin Hutchinson	Calderdale Council
Councillor Jo Lawson	Kirklees Council
Councillor Jonathan Timbers	Calderdale Council
Councillor Rizwana Jamil	Bradford Council
Councillor Alun Griffiths	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

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**Pages**

**1: Membership of the Committee**

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

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**2: Minutes of Previous Meeting**

1 - 6

To approve the minutes of the meeting held on 16 July 2025.

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**3: Declarations of Interest**

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

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**4: 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.

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**5: West Yorkshire Integrated Neighbourhood Health Update**

7 - 14

Officers from the West Yorkshire Integrated Care Board will update

the Committee on the progression of their priorities for neighbourhood health.

Contact: Yolande Myers, Principal Governance Officer

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**6: Autism and ADHD assessments**

15 - 22

Officers from the West Yorkshire Integrated Care Board will update the Committee on the current position regarding Autism and ADHD assessments.

Contact: Yolande Myers, Principal Governance Officer

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**7: Winter Preparedness**

23 - 32

Officers from the West Yorkshire Integrated Care Board will update the Committee on their winter preparedness.

Contact: Yolande Myers, Principal Governance Officer

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Contact Officer: Yolande Myers

## KIRKLEES COUNCIL

### WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

**Wednesday 16th July 2025**

Present:

Councillor Colin Hutchinson - Calderdale Council (Chair)  
Councillor Jonathan Timbers - Calderdale Council  
Councillor - Rizwana Jamil - Bradford Council  
Councillor Andrew Scopes - Leeds Council  
Councillor Sandy Lay - Leeds Council  
Councillor Betty Rhodes - Wakefield Council  
Councillor Andy Nicholls - Wakefield Council

In attendance:

Ian Holmes – West Yorkshire Integrated Care Board  
Debra Taylor-Tate – West Yorkshire Integrated Care Board  
Adrian North – West Yorkshire Integrated Care Board  
Dave Campbell-Hemming – West Yorkshire Integrated Care Board

Apologies:

Councillor Elizabeth Smaje - Kirklees Council  
Councillor Andy Solloway - North Yorkshire Council  
Councillor Andrew Lee - North Yorkshire Council

- 1 Appointment of Chair and Deputy Chair**  
Councillor Elizabeth Smaje was appointed as Chair of the Committee and Councillor Colin Hutchinson was appointed as Deputy Chair of the Committee.
- 2 Membership of the Committee**  
Apologies for absence were received on behalf of Councillors Smaje, Solloway and Lee.
- 3 Minutes of Previous Meeting**  
The Minutes of the Meeting held on 30 April 2025 were approved as a correct record.
- 4 Declarations of Interest**  
Councillor Sandy Lay declared an 'Other Interest' as an employee of Harrogate District Foundation Trust.

Councillor Jonathan Timbers declared an 'Other Interest' as an employee of the Equality and Human Rights Commission.

Councillor Colin Hutchinson declared an 'Other Interest' as the Chair of Doctors for the NHS and a Member of Keep Our NHS Public.

### 5 Deputations/Petitions

No deputations or petitions were received.

### 6 Operational Planning

The Joint Health Overview and Scrutiny Committee (JHOSC) received a presentation on the 2025/26 operational planning framework for the West Yorkshire Integrated Care Board (ICB). The presentation outlined a whole-system approach to planning, integrating finance, workforce, activity, and performance considerations. The ICB's final plan, submitted in March 2025 and updated in April, aimed for a break-even position, supported by £49.2 million in deficit funding and £432.6 million in planned efficiencies which was equivalent to 6.7% of the ICB's total allocation. A system risk of £33.2 million was held centrally for planning purposes.

The presentation outlined that the approach to resource utilisation was underpinned by transformation initiatives, collaborative service reviews, and integrated neighbourhood health models. Key focus areas included elective recovery, productivity improvements, and the full implementation of recommendations from a Price Waterhouse Cooper external review. The ICB acknowledged there would be difficult decisions to ensure financial sustainability while maintaining service quality and access.

The Committee advised that workforce planning remained a priority, with the region seeing continued growth in the substantive healthcare workforce and a reduction in reliance on bank and agency staff. Notably, there had been a significant increase in Hospital and Community Health Service doctors and General Practitioners, largely due to the expansion of Resident Doctor posts. The Committee was advised that the ICB would continue to focus on managing vacancies, reducing temporary staffing further, and improving efficiency in the non-clinical workforce over the coming year.

It was noted that performance metrics were reviewed across several domains, including elective care, cancer, diagnostics, mental health, and learning disabilities. The ICB had set ambitious targets to reduce long waits and improve access, with planned improvements in Referral to Treatment times, cancer diagnosis standards, and diagnostic waiting times. Mental health metrics also showed progress, including reductions in out-of-area placements and improved access to talking therapies and perinatal services.

The Yorkshire Ambulance Service (YAS) operational plan was also presented, highlighting a projected 3.9% increase in demand. Despite this, deployed hours on the road were planned to be maintained, contingent on £11 million in growth funding. Improvements were expected in "hear and treat" and "see and treat" rates, with increased staffing in Emergency Operations Centres. YAS was broadly compliant with national commissioning guidance, although some areas required further system-wide support.

The presentation outlined key risks to delivery and the governance structures in place to mitigate them. These included financial pressures, national reforms, workforce challenges, and rising non-elective demand. Mitigation strategies involved cross-system collaboration, targeted programmes, and strengthened oversight

through established committees such as the Finance, Investment and Performance Committee and the System Oversight and Assurance Group. Each place within West Yorkshire would contribute to the final operational plan sign-off, ensuring local accountability and alignment with regional priorities.

During discussions, the Committee commented on the following issues: -

- The six key diagnostics monitored were MRI, CT scan, non-obstetric ultrasound, echocardiogram, endoscopy, and electrophysiology tests.
- Concerns raised about long waits for treatments like cataracts and the disparity between NHS and private sector waiting times.
- Clarification sought on whether patients who re-refer themselves are counted twice in Referral to Treatment statistics.
- In relation to Performance and Transparency, Members stressed the importance of clear, accessible reporting for public understanding.
- Emphasis placed on including detailed breakdowns of performance challenges in reports.
- Community Diagnostic Centres were discussed, with concerns about staffing shortages (e.g. radiographers) affecting their effectiveness despite investment in equipment.
- Out-of-area placements for mental health patients remained a challenge with a target to reduce from 51 to 14 by March next year.
- Talking therapies were performing well, with recovery rates above national targets.
- Annual health checks for people with learning disabilities were consistently above the 75% target.
- Inpatient care for people with learning disabilities and/or autism was still above the target of 53 at 71.
- Concerns were raised about missing or unclear data in reports, particularly around inpatient care for adults and children with learning disabilities or autism.
- Clarification provided that national reporting combined some metrics, which may obscure local detail.
- Calls for better integration of GP-level data into ICB reporting to reflect community-level needs more accurately.
- Regarding Governance and Reporting, Members requested more granular and locally relevant data to support scrutiny and decision-making.
- A Request to receive data on the use of restraint in mental health units, including breakdowns by protected characteristics.
- Demand for ambulance services had risen by 3.6% over the past year.
- Staff numbers and deployed hours were being maintained, with increased use of clinicians in control centres, from 85 to 112.
- Category 2 response times were improved at 21–24 minutes.
- Ongoing work with NHS England and ICBs to reduce conveyance rates and improve “hear and treat” and “see and treat” outcomes.

### **RESOLVED –**

- 1) That representatives of the ICB be thanked for their report and attendance at the meeting.

- 2) That the Committee be provided with the following additional information: -
  - (i) details of the NHSE commissioned piece of work to understand how each ICB handle financial support (concurrent / non-concurrent) to ensure all ICB's are applying same criteria / assumptions.
  - (ii) data regarding workforce, specifically the reliance on bank and agency staff.
  - (iii) information relating to the increase in resident doctors, specifically the split in those who are in training places vs those on locally employed contracts, and to provide the number or percentage of vacancies.
  - (iv) confirmation as to the 6 main diagnostic tests for cancer treatment, and whether patients are being 'double counted' if they have been discharged but then return for further treatment.
  - (v) further information be provided on the statistics in the WY area relating to reliance on mental health inpatient care for autistic adult
  - (vi) data on the number of restraints taking place in Mental Health Units for WY patients, compared to national data.

## **7 West Yorkshire Association of Acute Trusts**

The Committee received an update from the West Yorkshire Association of Acute Trusts (WYAAT) regarding its ongoing collaborative work across the region. The briefing outlined WYAAT's role as a provider collaborative, not a statutory organisation, comprising six NHS trusts working together to address shared challenges in acute hospital services. The Committee noted that WYAAT aimed to reduce unwarranted variation and improve access, outcomes, and patient experience across West Yorkshire and Harrogate.

The Committee was informed that WYAAT operated under a Committee in Common governance model, where Chairs and Chief Executives of the six member trusts met to direct the collaborative programme. Decisions supported by this committee required formal approval by each trust board. WYAAT also reported progress to the ICB, with the ICB retaining responsibility for decisions affecting patient access to services.

Members noted the progress of several key programmes. The Pharmacy Aseptics initiative had begun production at an interim site, with the aim of reducing reliance on commercial suppliers and freeing up nursing time. The Pathology programme had advanced with the deployment of a single Laboratory Information Management System (LIMS) and new diagnostic equipment, including the Centre for Laboratory Medicine in Leeds, enhancing efficiency and clinical decision-making.

The Imaging programme had successfully implemented over 250 home reporting stations and a shared reporting solution, enabling cross-site radiology collaboration. Additionally, all trusts had adopted AI software for Chest X-rays, supporting clinicians in diagnosing conditions such as lung cancer and pneumonia. These developments were expected to improve diagnostic accuracy and reduce delays in treatment.

The Committee was updated on the Planned Care programme, which focused on reducing waiting times through productivity improvements, benchmarking, and implementation of national recommendations such as Getting It Right First Time

(GIRFT). Collaborative efforts across trusts had also supported innovations like patient-initiated follow-up and virtual appointments, with clinical networks playing a key role in driving these improvements.

Procurement collaboration had yielded significant cost savings, with £2.3 million saved in the previous year through joint purchasing. WYAAT was exploring a more formalised procurement structure to enhance future savings. The Committee also heard about the work of the Integrated Stroke Delivery Network (ISDN), which had launched a new website for post-discharge support and implemented AI tools for stroke detection.

In response to the national 10 Year Health Plan, WYAAT had begun reviewing how to align its services with the plan's strategic shifts: moving care from hospital to community, focusing on prevention, and embracing digital transformation. The review included exploring integrated neighbourhood health models and cross-trust collaboration to optimise use of assets and ensure equitable access to care.

Finally, the Committee discussed the implications of recent structural changes to the NHS, including the absorption of NHS England into the Department of Health and Social Care and mandated reductions in ICB and provider running costs. WYAAT was actively engaging with the ICB and partners to manage this transition, recognising the importance of provider collaboration in delivering the future NHS operating model.

During discussions, the Committee commented on the following issues: -

- Members acknowledged WYAAT's growing role in shaping services due to changes in NHS commissioning structures.
- The Committee will consider how best to scrutinise WYAAT's work as its influence increases.
- Concerns were raised about the lack of reference to emergency care in the WYAAT briefing, despite its importance to public confidence in the NHS.
- It was clarified that emergency care was primarily addressed at the local "Place" level, involving primary care and community services, rather than through WYAAT collaboration.
- WYAAT did support best practice sharing in emergency care, including deployment of same-day emergency care models across trusts.
- Questions were raised about the effectiveness of centralising laboratory services, particularly microbiology, and whether it delivered the expected benefits.
- It was explained that the new laboratory at St James's Hospital offers extended hours and advanced automation, which improved turnaround times and mitigated risks associated with sample transport.
- The location of the new aseptics hub was confirmed to be on an industrial estate near the M621/M62, chosen for its accessibility to all partner trusts.

### **RESOLVED**

- 1) That WYAAT be thanked for their comprehensive and informative report.
- 2) That further updates be brought to the Committee when appropriate.



## West Yorkshire Integrated Neighbourhood Health Update

### 1. Purpose

- 1.1. This paper provides an update to the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC) on the progression of the WY Integrated Care Board (ICB) priorities for neighbourhood health.
- 1.2. It does so by providing an overview of the context, summaries of progress in each of our five places (Bradford district and Craven, Calderdale, Kirklees, Leeds and Wakefield) and at scale work across WY, and setting out next steps.
- 1.3. The West Yorkshire Joint Health Overview and Scrutiny Committee are asked to:
  - Note the progress made across in delivering our neighbourhood health priorities.
  - Note the national reforms set out the planning and delivery approach and the implications of these, as described in section 2.9.
  - Note the next steps set out in section 4.

### 2. Context

- 2.1. Neighbourhood health is one of the governments flagship priorities for the health system. It is a key driver of the “hospital to community” shift set out by the Secretary of State for Health and Social Care.
- 2.2. It is about delivering more proactive care, closer to where people live, underpinned by population health management, tackling inequalities, and making best use of our collective resources.
- 2.3. There are significant changes being made to the health and care architecture, alongside reforms to the planning and delivery remit and responsibilities which directly impact neighbourhood health. This is set out in more detail in sections 2.9 and section 4 specifically, and will be important to consider throughout.

#### National Context

- 2.4. Neighbourhood-based transformation has been set out in successive reviews and policy documents, including the New Care Models Vanguard Programme, the Fuller Stocktake Report, the 2025/26 Neighbourhood Health Guidance, and the 10 Year Health Plan.
- 2.5. The 10 Year Health Plan places neighbourhood health at the centre of NHS transformation. It sets out a vision to end a ‘hospital by default’ approach, establish a Neighbourhood Health Service with Neighbourhood Health Centres in every community by 2035, and brings together the three key shifts: from hospital to community, analogue to digital, and treatment to prevention.

- 2.6. The [Neighbourhood Health Guidance](#) provides the immediate focus and priority for health systems to deliver, and sets out the following six core components:
- **Population health management**, which requires a person-level, longitudinal, linked dataset to be in place to enable population segmentation and risk stratification, to inform commissioning intentions and interventions.
  - **Modern general practice**, whereby there is an expectation to continue progress to date in improve access and continuity for patients, including through use of the NHS App and the Pharmacy First scheme.
  - **Standardising community health services**, where ICBs are required to ensure community service pathways are an integral part of the INH model and commissioned in line with the standardising community health services framework.
  - **Neighbourhood multi-disciplinary teams**, which covers the requirement to establish integrated neighbourhood teams of teams to deliver coordinated, proactive care to multiple patient cohorts.
  - **Integrated intermediate care with a ‘Home First’ approach**, setting out requirements for supporting the step up and step down of care, with interventions delivered at home as much as possible, focusing on rehabilitation, reablement and recovery.
  - **Urgent neighbourhood services**, whereby systems should standardise, and scale urgent neighbourhood service offers for people with an escalating or acute need, to support better demand management and prevent the need for hospitalisation. This should be integrated with wider urgent pathways.
- 2.7. This guidance was later complimented by the 10 Year Health Plan, and mor recently the [Medium Term Planning Framework](#). Overall, national policy sets our initial focus on establishing the foundations for delivery for priority cohorts of patients and in specific clinical areas, as the basis of wider collaborations, with full delivery planned over 5-10 years.
- 2.8. The National Neighbourhood Health Implementation Programme (NNHIP) was launched to support rapid rollout of neighbourhood health in 43 sites. It is an accelerator programme for 43 places in England to go further, faster in implementing neighbourhood health with an initial focus on adults with multiple long-term conditions and rising risk, through a “Test-Learn-Grow” approach. There are no additional resources for the 43 NNHIP sites.
- 2.9. Reforms that have been set out to the national planning process and future architecture of the health and care system are central to neighbourhood health delivery. In summary:
- The ICB is accountable for developing a needs assessment informed, outcomes focused Five-Year Strategic Commissioning Plan, through which we will set our commissioning intentions.
  - Health and Wellbeing Boards (HWBBs) are accountable for developing neighbourhood health plans, which will be required to set out areas of

focus and delivery detail, with further guidance pending. In West Yorkshire, HWBBs are already taking a proactive and leading role in the development of plans and delivery of neighbourhood health priorities.

- Providers are accountable for developing individual and integrated delivery plans.

2.10. It will be crucial that all strategies and plans are triangulated to work together to deliver our shared system neighbourhood health priorities.

### Local Context

2.11. Across West Yorkshire and within our five places, we have a long and proud commitment to working towards neighbourhood-based healthcare.

2.12. There are several examples of good practice that have been developed which, with a renewed policy architecture, provides an opportunity to build on and mainstream.

2.13. This year, system partners agreed to progress three transformation priorities, including INH. In the immediate term, we will focus on rolling out neighbourhood services for priority patient cohorts to reduce preventable unplanned demand and increase early identification and prevention. Each place has identified priority cohorts using local data and intelligence.

2.14. In June 2025, the Board of the ICB approved the [Integrated Neighbourhood's Blueprint](#), following a significant period of engagement and development. It sets out place-based delivery plans across 1-, 3- and 5-year horizons, alongside at-scale enablers across WY.

2.15. Three of our places (Bradford, Leeds and Wakefield) were successful in joining the NNHIP. The NNHIP is focused on rolling out neighbourhood models for high priority cohorts, including patients with multiple long-term conditions, and other cohorts that are determined locally. Through the programme, places also have access to additional national support, have the opportunity to be early adopters of emerging models, and are expected to support the wider rollout of neighbourhood models of care delivery.

2.16. In addition to the specific focus on INH, there is significant work ongoing regarding the future operating model of the ICB and wider health and care system. We are aligning this work, including that ongoing within places, where work is focusing on developing place provider partnerships, and at WY which is focusing on the at at-scale requirements for strategic commissioning, including how we contract with place provider partnerships to deliver outcomes.

## **3. Delivering Neighbourhood Health in West Yorkshire**

3.1. Neighbourhood health delivery is primarily place-based. All places have developed programmes of work to deliver this locally, with leadership and governance in place, and detailed oversight from the appropriate boards and place committees of the ICB.

- 3.2. Additional work takes place across West Yorkshire, via the WY INH Board, focusing the at scale strategic foundations of neighbourhood health, and sharing and scaling learning and good practice.
- 3.3. The following are key areas of that describe how, across WY, we are progressing on our neighbourhood health priorities in line with national policy and the 1-, 3- and 5-year plans we set ourselves in the Integrated Neighbourhood's Blueprint:
- **The establishment of neighbourhood footprints and Integrated Neighbourhood Teams (INTs).** All places have established their neighbourhood geographies, building mostly on Primary Care Networks (PCNs). INTs are multidisciplinary teams of professionals from across a range of health, local authority, and voluntary sector organisations, that work together to meet people's needs. They are an important part of delivering the broader neighbourhood agenda. Delivery of care models with an MDT intervention across health and other care partners is not a new area of work. No place is starting with a blank canvas.
  - **Agreement of priority cohorts.** Using local evidence and data, all places have identified patient cohorts to prioritise for the initial roll out neighbourhood services. The cohorts are specific to each place, but generally include frailty, end of life, and long-term conditions. These are patient groups who would benefit from neighbourhood services and currently account for a disproportionate share of non-elective demand.
  - **Development of Population Health Management (PHM) and data approaches.** All places have made significant progress in establishing the shared data flows and analytical tools required to understand service demand and population health, and are working with neighbourhood teams to support proactive care delivery.
  - **Improving access to general practice.** Across WY, the majority of our practices have accessed or continue to access modern general practice access funding. This supports improvements in access to GP for patients through digital solutions, including online booking and telephony services, alongside more integrated working across primary care providers. Access to GPs and wider primary care services is a core foundation of neighbourhood health.
  - **Continued development of strong partnership working.** All places have established collaborative ways of working with local authorities, health care providers, and non-statutory partners. This continues to evolve and will be crucial to neighbourhood health delivery.
  - **Participation in the NNHIP,** as set out in section 2.14.
  - **Allocation of £4.1m of non-recurrent Service Development Funding (SDF).** This is being used to support the foundations of and transition towards neighbourhood health, and incorporates various investments in places and across WY.
  - **Developing an INH Outcomes Framework,** led through a system-wide population health management (PHM) expert reference group. This work

is focusing on how we quantify and affect the benefits we want to achieve collectively for the health of our population and system efficiency.

- **Developing the financial and contractual mechanisms** to deliver INH, including through work across the ICB as part of our future operating model to design the financial architecture for Place Provider Partnerships, and involvement in national forums that are responsible for developing the overarching approaches for single- and multi-neighbourhood providers.

3.4. In addition to the progress set out above in section 3.3., some indicative high level examples of progressing specific to each place is set out in appendix 1.

#### **4. Next Steps**

4.1. Continued delivery, building on the progress made in each place and across WY, is the foremost priority in moving towards the full establishment of a neighbourhood health service.

4.2. We are at a critical juncture with reforms to the organisation of the health and care system, and the policy and financial planning approach. It is therefore crucial that, as we set out our future intentions, we do so with a clear view of the current context and future operating model in mind.

4.3. The ICB will set out our Five-Year Strategic Commissioning Plan, which will include outcomes based commissioning intentions, by February 2026. This will be supported by detailed 1- and 3-year operational plans. From 2027/28 will contract for outcomes, in line with our Five-Year Strategic Commissioning Plan, that will be delivered through neighbourhood, provider, and provider partnership plans.

4.4. Neighbourhood plans are being developed within places, with leadership and oversight from the five Health and Wellbeing Boards. It is crucial that we acknowledge it is within this that much of the direction for action and delivery will be set.

#### **5. Recommendations**

5.1. It is recommended that the West Yorkshire Joint Health Overview and Scrutiny Committee:

- Note the progress made across in delivering our neighbourhood health priorities.
- Note the national reforms set out the planning and delivery approach and the implications of these, as described in section 2.9.
- Note the next steps set out in section 4.

## **Appendix 1: Indicative Progress Across Places**

### **1. Bradford District & Craven**

Priority Cohorts: Palliative and End of Life Care (PEOLC), Frailty and Dementia, and All Age Intermediate Care

Impact in scope: Potential for the PEOLC cohort to reduce A&E demand from 1.243 rate per 1000 population to 1.232, non-elective admissions from 0.853 to 0.848, and bed days from 8.703 to 7.850. For frailty and dementia benefits in scope include a reduction in A&E demand from 0.757/0.762 to 0.750/0.755, non-elective from 0.388/0.249 to 0.384/0.246, and bed days 3.843/1.467 to 3.805/1.453.

#### Highlights

- Selected as a first-wave NNHIP site
- New place partnership strategy published
- Series of multi-agency workshops underway to support partners within neighbourhood teams to develop the necessary ways of working.

### **2. Calderdale**

Priority Cohorts: Frailty and PEOLC

Impact in scope: Potential to reduce emergency admission growth for frailty and PEOLC by, which could generate efficiency and outcome benefits for the system and patients.

#### Highlights

- Population segmentation completed with person-level linked data and risk stratification tools
- Case finding and case management tools funded and in development
- INTs are mobilising through co-created delivery plans, building on well established PCN boundaries, and forming wider partnerships including through an agreement with General Practice and Community Services for a neighbourhood MDT approach.

### **3. Kirklees**

Priority Cohorts: Frailty, Mental Health (high intensity users), Children and Young People

Impact in scope: Based on modelling of frailty based A&E demand, there is potential to reduce demand and generate a non-cash releasing benefit of £138k. Modelling for other areas is underway.

#### Highlights

- INT mobilisation underway – 1 live, 3 by December 2025, and all 9 by September 2026
- 100% GP data-sharing agreements signed, with testing of a PHM tool linked to this underway.
- Interim INH data packs provided for neighbourhoods that have gone live or in the process of going live with additional data to be added from social care and Healthwatch, which will be used to plan service delivery in neighbourhoods.
- Dedicated care coordinator and VCSE roles recruited to support ongoing INT development.

#### **4. Leeds**

Priority Cohorts: People with Multiple Long-Term Conditions, and Frailty/Mental Health

Impact in scope: Modelling shows that the targeted proactive care population has a baseline A&E attendance of 790 (2024/25) and an unplanned bed days baseline of 4,659 (2024/25). There is potential to reduce this to 671 and 3,354 respectively, generating a non-cash releasing benefit of £564k.

##### Highlights

- Wave 1 NNHIP site, which will build on a strong foundation of proactive care work under the HomeFirst programme.
- All PCNs have agreed to adopt PHM approaches to deliver proactive care in neighbourhoods.
- Workforce ecosystem project launched with Leeds Health & Care Academy
- Further enhancement of the Leeds Shared Care Record and tech-enabled care (e.g., falls prevention).

#### **5. Wakefield**

Priority Cohorts: Chronic Obstructive Pulmonary Disease (COPD), Dementia, and PEOLC

Impact in scope: Potential to avoid 226 non-elective admissions, saving 2,736 bed days and 15 beds by March 2026.

##### Highlights

- Neighbourhood MDTs are being built from existing assets across six areas, with the core vision agreed across all.
- Innovative AI-driven PHM model predicting hospital demand, integrating housing and education data alongside.
- Working alongside Adult Social Care to progress progressing work on securing the appropriate bed base and extending the home first approach.

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## WEST YORKSHIRE MENTAL HEALTH, LEARNING DISABILITY AND AUTISM PROGRAMME

### Neurodiversity: Briefing to West Yorkshire Joint Health Overview and Scrutiny Committee December 2025

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#### 1. Purpose

This paper provides an update to the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) on the current position regarding Autism and ADHD assessments and outlines the strategic plans to address challenges in this area.

#### 2. Background

Nationally neurodevelopmental (ND) assessment services are experiencing unprecedented demand, leading to waiting times of several years, driven by a variety of factors including increased awareness, population growth, and evolving clinical understanding.

In West Yorkshire (WY) our commissioned supply of ADHD and autism services are unable to meet demand, with our population having unmet needs around ADHD and autism, resulting in inequalities in a wide range of outcomes. Additionally, non-commissioned activity is massively escalating, with consequent challenges of unplanned spend, variations in quality, and poor care outcomes for patients.

Assessments identify and diagnose conditions such as Autism, ADHD, and related neurodevelopmental differences. Often a diagnosis is critical for enabling individuals to access appropriate support and interventions. Most ND assessments in West Yorkshire are delivered by:

- Specialist ND services within NHS Trusts
- Paediatric services within NHS Trusts
- Independent providers commissioned through West Yorkshire contracts
- Independent providers accessed via Right to Choose (RTC)

Assessments also occur in inpatient settings for individuals admitted to hospital.

Context:

Between 2022 and 2024, extensive engagement with autistic individuals, people with ADHD, families, carers, and professionals, including two Neurodiversity Summits, highlighted significant challenges in West Yorkshire:

- Long waits for diagnosis
- Inconsistent post-diagnostic support
- Fragmented and confusing care pathways

Agreed Priorities from the Summits were:

1. Early support based on need, not diagnosis
2. Consistent screening and triage across services
3. Use of digital tools to improve assessment processes

Additional themes: accessible information, peer support, professional education, and workforce sustainability.

These findings shaped proposed policy changes and commissioning priorities which were then submitted to the West Yorkshire ICB System Oversight and Assurance Group (SOAG).

SOAG Agreed Actions:

- Develop a unified West Yorkshire commissioning policy to ensure funding aligns with strategic priorities.
- Establish co-produced community-based hub models as single points of access for autism and ADHD referrals, offering needs-based assessments and connecting individuals to support before diagnosis.
- Ensure stakeholder engagement and consultation across ICB and ICS.
- Work with ICB finance to manage risks and plan sustainable future options.

### **3. Ongoing Challenges**

- **Rising Demand:** Over the past five years, demand has increased across all age groups, most notably among those under 25. Figure one shows national figures



for autism referrals – West Yorkshire demand for autism and ADHD services has shown a similar trend.

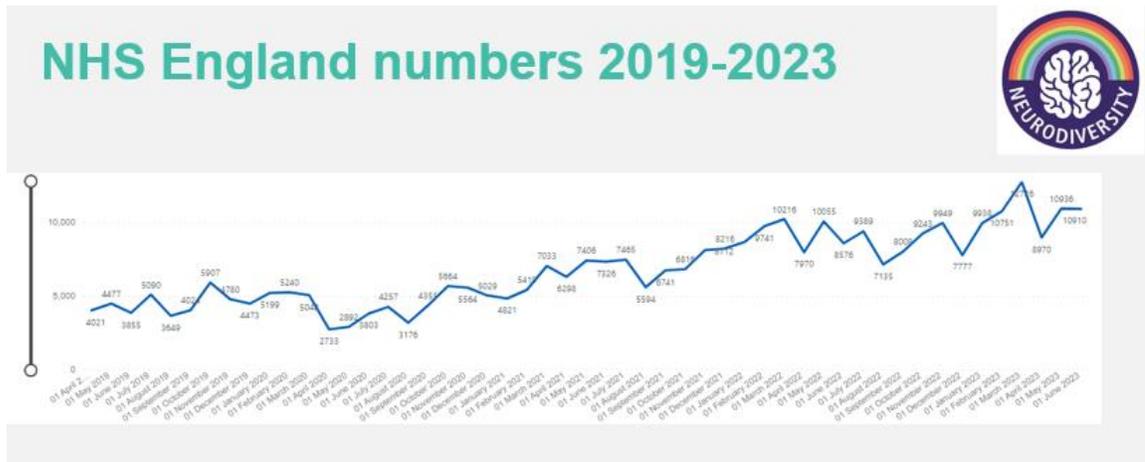


Figure 1 – ‘New Suspected Autism’ referrals per month in England.

- Historic Service Design: NHS Trusts were not structured to manage this level of activity and have faced recruitment and funding challenges.
- Right to Choose (RTC): National legislation enables individuals meeting NICE referral thresholds to seek diagnosis from any accredited provider in England.

Key Issues:

- Waiting Lists: Some pathways report projected waits of many years.
- Capacity Constraints: All of our NHS Trust providers are indicating huge demand and capacity gaps. For example, due to limited capacity, Leeds and York Partnership NHS Foundation Trust is prioritising support for individuals with complex needs only. People requiring standard assessments are being directed to RTC providers to ensure timely access to care, although this then raises issues around quality and value.
- The bottleneck created by progress along clinical gateways is creating a barrier to those trying to access non-clinical support offers.
- Poor quality outputs from some non-commissioned providers accessed through RTC, are leading to unwarranted duplication and waste, and huge difficulties for patients trying to access shared care or ongoing treatment.
- Variation Across Localities: Significant inequity in access and waiting times persists, associated with differing models and lack of consistent thresholds for assessment and triage across our providers in West Yorkshire.

Complaints received by the ICB and from NHS provider Trusts reflect recurring themes around pathways (transitioning from CYP services, transition from independent providers, moving out of area and being discharged), medication availability and prescribing, waiting times, communication.

#### 4. Actions Taken

##### Indicative Activity Plans

To manage rising demand and financial pressures sustainably, and in line with national direction, we have introduced Indicative Activity Plans (IAP) across West Yorkshire. NHSE Revenue finance and contracting guidance for 2025/26 require commissioners to exercise greater control over variable activity carried out by providers to support whole-system performance and affordability targets. These have already been agreed for elective care, but we are now expanding to include Neurodiversity.

This limits the annual growth in assessments per provider.

- Providers will complete the same number of assessments as last year, with a 10% uplift for WY accredited providers.
- This approach is not a reduction in service but a measure to address significant system-wide overspend and maintain sustainability.
- ADHD titration and medication monitoring remain outside of the IAP for 25/26

While it would be ideal for all patients to be seen rapidly, it is a reality of NHS finances that we cannot provide uncapped capacity growth in any service. We also have a duty to equalise waits across our population and to have regard to quality and value as well as speed. Uncapped growth in non-commissioned activity makes it difficult to achieve those aims.

The financial context for this is that in 23/24 our Right to Choose spend was £7m and by 25/26 it is likely to be closer to £21m, and much of this spend will be with providers that we are not able to assure the quality of, meaning we cannot leverage it to help improve services in WY.

We have reviewed the quality, and equality impacts of not increasing our activity plans beyond current outturn levels. Our primary rationale for implementing IAPs, beyond the need to maintain financial balance, is to maximise investment in services that meet our local quality standards. Increasing local capacity will also enable us to redirect patients with the longest waits from NHS Trusts, helping to equalise waiting times in line with our responsibilities for waiting list management. While this may result in longer waits for some patients than they had anticipated, it will also deliver a positive outcome for those who have been waiting the longest.

Some of the mitigations put in place because of the equality and quality impact assessments include:

- Asking providers review waiting lists to ensure they are a true reflection of waits.
- Providing clear, accessible information for patients and referrers, ensuring patients are directed and have access to navigation or advocacy support or information locally
- Prioritisation of those on waiting lists based on clinical needs and allowance of urgent cases to be seen regardless of activity caps
- Considering approaches to prioritise those groups who may have experienced poorer access, outcomes or experience as part of the wider WY ND transformation work

### West Yorkshire Contracts

The ICB is implementing a robust quality assurance framework through the Provider Selection Regime (PSR) for contracted neurodevelopmental services. This process operates on a rolling basis, with application and evaluation windows opening every three months to ensure transparency and consistency. The first round has accredited six providers, each meeting the standards set out in the agreed service specification.

These newly accredited providers are now mobilized and working together with our NHS Trust Neurodiversity service leads, prioritizing long waiters across West Yorkshire. This approach not only secures high-quality provision but also embeds systematic reporting and monitoring, ensuring that commissioned services deliver safe, effective, and equitable care across the region.

### Quality Standards

We have developed Clinical Quality Standards for autism and ADHD assessments across children, young people, and adult pathways. These standards aim to ensure consistency and high-quality reporting from our contracted providers, while also supporting smoother transitions for individuals between services. Importantly, these standards are now being adopted by other Integrated Care Boards (ICBs) across the North East and Yorkshire region, creating a shared benchmark for quality and improving alignment across providers.

### Additional Measures:

- Providers are reviewing waiting lists to monitor patient wellbeing and escalate urgent cases beyond their activity plan.



- Patients and families are being directed to resources on the [neurodiversity](#) pages on the NHS West Yorkshire ICB website, including [Frequently Asked Questions](#), [Right to Choose](#) and some helpful guidance on things one can do whilst [waiting for assessment and/or treatment](#).

#### 4. Next Steps

Following discussion at West Yorkshire ICB Executive Management Team, a new governance structure is being established for neurodiversity work in West Yorkshire. Dedicated working groups will focus on key priorities, such as standardising thresholds and ensuring consistent commissioning of services. These changes aim to reduce unwarranted variation and improve service quality.

James Thomas, ICB Medical Director has been appointed as SRO to provide strategic oversight and foster collaboration across the system, ensuring alignment in a shared direction and strategy.

##### Standardising Waiting Lists

We are utilising the increased WY capacity to address the longest waiting times in West Yorkshire by moving the longest waiters into the additional capacity created through service uplifts and RTC commissioning. This approach aims to align waiting times across the region.

##### ND Commissioning Policy

The Programme is leading development of a system-wide commissioning policy for autism and ADHD services.

##### Neurodiversity Hubs

Longer term, we are focusing on the development of Neurodiversity Hubs in our communities that can provide a single point of access for autism and ADHD assessment and treatment, as well as early support through a combination of primary care, education, VCSE and specialist services for when people are seeking help because of a potential or confirmed diagnosis. This support will be available to everyone who presents, regardless of any clinical threshold. Additionally, we are working as a system to move towards reduced reliance on diagnosis as the sole gateway to help.

Within this we will be working to ensure that consistent clinical thresholds are applied across all commissioned diagnostic providers so that the same criteria is used to support referrals and make diagnoses of Autism and ADHD – reducing some of the historic

variation in our services whereby different geographies would see higher or lower diagnostic rates.

The West Yorkshire ND programme is fully aligned with national direction as set out in the ADHD Taskforce report and the NHS Long Term Plan. The Taskforce calls for ADHD to be recognised as a mainstream health priority, with early intervention, reduced waiting times, and integrated support across health, education, and social care. These priorities mirror the NHS Long Term Plan's focus on prevention, community-based care, digital transformation, and workforce development.

West Yorkshire's approach, embedding stepped-care models, with needs-based support available regardless of diagnosis, improving data transparency, and strengthening cross-sector collaboration, directly supports these national ambitions, ensuring timely access, equity, and improved outcomes for people with ADHD.

## **6. Recommendations**

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

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## **1.Introduction**

- 1.1 This paper provides an update on winter across West Yorkshire (WY) 2025/26.
- 1.2 The paper provides an outline on the planning approach including the Winter Board Assurance Statements (WBAS), the new regional winter operating model, performance overview and a vaccination update.

## **2.Context**

- 1.1 Each year health and care systems develop and implement plans to support capacity to maintain quality and safety, resilience and our ability to respond to operational pressures during the winter months.
- 1.2 Our 2025/26 winter plan is developed through engagement and a process of co-production across the Integrated Care System (ICS) to ensure alignment with national policies and strategies including the Urgent and Emergency Care (UEC) Plan 2025/26, 2025/26 Priorities and Operational Planning Guidance, the 10 Year Health Plan for England, whilst remaining in line with our local West Yorkshire Urgent and Emergency Blueprint and Better Care Fund Plans.
- 1.3 In addition to this alignment to key strategic priorities, we have also ensured that we consider key learning from previous winter plans and delivery. 2024/25 was a challenging winter which saw increased demand, increased acuity, and workforce and capacity constraints across all areas of our system impacting on system flow through our services.
- 1.4 It is acknowledged nationally that pressures are now year-round, however we still see a greater challenge across winter due to infections. Data from winter in Australia and New Zealand showed they are experienced a 'normal' level for Flu and resultant hospitalisations, so we can potentially expect a normal flu pattern in the northern hemisphere (as historically our trends follow those of the southern hemisphere),
- 1.5 The ICB's financial allocations for 2025/26 included any monies individual places may choose to use to support flexible capacity and/or initiatives for winter. At present we have no indications of any additional winter monies for 2025/26.
- 1.6 Further industrial action by the British Medical Association (BMA) including further Resident Doctors has been considered in our plans and scenario planning. We are currently working on the processes to support the scheduled action 14-18 December 2025.

## 2. Winter Board Assurance Statement

- 2.1 The WY Integrated Care Board's (ICB) winter plan was developed from individual Place plans with extensive engagement from primary care, ambulance services, acute trusts, mental health, local authorities, and social care, supported by regular planning meetings since July 2025.
- 2.2 Each of our four A&E footprints, Calderdale and Kirklees, Wakefield and Kirklees, Leeds and Bradford and Craven developed local plan to reflect their populations. These plans informed the ICB's Winter Board Assurance Statement (WBAS) for 2025/26 (Appendix 1)
- 2.3 The WY WBAS provides comprehensive assurance to NHS England (NHSE) of the ICB's preparations to manage the challenges of the winter season winter across West Yorkshire.
- 2.4 The BAS delves into a number of key winter planning requirements to ensure ICB's have considered and are complaint with, these include:
  - **Governance** – Confirmed winter Executive Directors (Dr James Thomas and Lou Auger), Quality, system wide engagement, Equality Impact assessment, and participation in national winter exercise.
  - **Plan Content and Delivery** – National winter key actions, Key quality risks and mitigations, robust System Co-ordination Centre (SCC) infrastructure and On call rotas.
  - **Prevention** – Vaccination Campaigns, with focus on the at risk population. **See section 6**
  - **Capacity** – Demand and capacity planning, 7-discharge profiles and managing elective demand.
  - **Leadership** – Senior level on-call arrangements and monitoring and escalation of system OPEL Levels.
- 3.5 The WBAS required sign-off by the ICB Chief Executive and Chair, to ensure the governance and accountability of the winter planning process and that the delivery risks are acknowledged. The WBAS was signed off by the ICB Board 23 September 2025.
- 3.6 NHS Providers were required to submit a separate BAS directly to NHS England.

### 3. Winter Operating Model

- 3.1 The 2025/26 winter reporting has undergone a national review and as a result there have been some changes to the reporting structure.
- 3.2 Acute trusts and the Ambulance Service are only required to report when a trigger has been breached. The triggers are:
  - **Trigger 1** - to be completed by YAS ONLY. This is new trigger and not currently reported on. Multiple ambulances awaiting handover at a single or multiple sites, resulting in a risk to Community response, or other issue resulting in risk to patient safety, as determined by the ambulance service.
  - **Trigger 2** - Ambulance handover delay of >1 hour. (45-minute handover should be in place at all sites by Winter).
  - **Trigger 3** - Patient(s) waiting in Emergency Department (ED) over 12 hrs and expected to exceed 24hrs.
  - **Trigger 4** – Extensive delays in ED, the impact of which is compromising patient safety.
- 3.3 The Winter Triggers Exception Report (WTER) will be completed by the provider and signed off at trust director level before it is sent to the NHSE Regional Operations Centre and the ICB System Coordination Centre (SCC).
- 3.4 Winter reporting runs from 27<sup>th</sup> October 2025 to 31<sup>st</sup> March 2026 but may extend into April due to the timing of the Easter holidays.

### 4. Urgent and Emergency Care Performance

- 4.1 The SCC through the RAIDR system monitor the system OPEL levels throughout the day 8am-8pm. The OPEL levels provide a snapshot of the pressures within the system at between 15 minutes and 2-3 hours depending on the measure and or the trust IT systems. In addition, the Planning and Performance team will monitor system Urgent and Emergency Care (UEC) Performance against planning trajectories.
- 4.2 Appendix 2 highlights the ICB Level performance against plan and by the individual Acute trusts on the following performance metrics:
  - A&E four-hour standard
  - A&E 12 hour in department
  - Ambulance services CAT 2 response.
- 4.3 The ICB level performance for 4 hour was achieved at 77.4% against the submitted operational plan trajectory of 75.7% but remains below the

national target of 78%. For the 12 hours in department once again the ICB is better than plan with 6.4% people waiting longer than 12 hours against a trajectory of 7.7%.

4.4 The Category 2 ambulance service response time is slightly worse than plan at 27.54 minutes, against a trajectory of 27.42 minutes. The national target is 30 minutes, so we are achieving the national performance target though we have seen a decline in performance since August.

4.5 The following metrics will be the focus nationally for winter 2025/26:

- A&E 4 hours performance (all types). All WY trusts planning to achieve 78% by March 2026.
- A&E 12-hour performance (T1&2) National expectation is to reduce the percentage of 12 hour waits in department for Type 1 attendances in 2025/26 compared to 2024/25. All trusts planning to reduce the percentage of 12 hour waits for type 1 attendances
- A&E 4 hours performance for Children and Young People (CYP): All trusts are projected to improve their performance by March 2026
- Average Cat 2 response time: All trusts are looking to continue to reduce average handover times to support increased response times
- and have processes in place to meet the 45 minute maximum handover time.

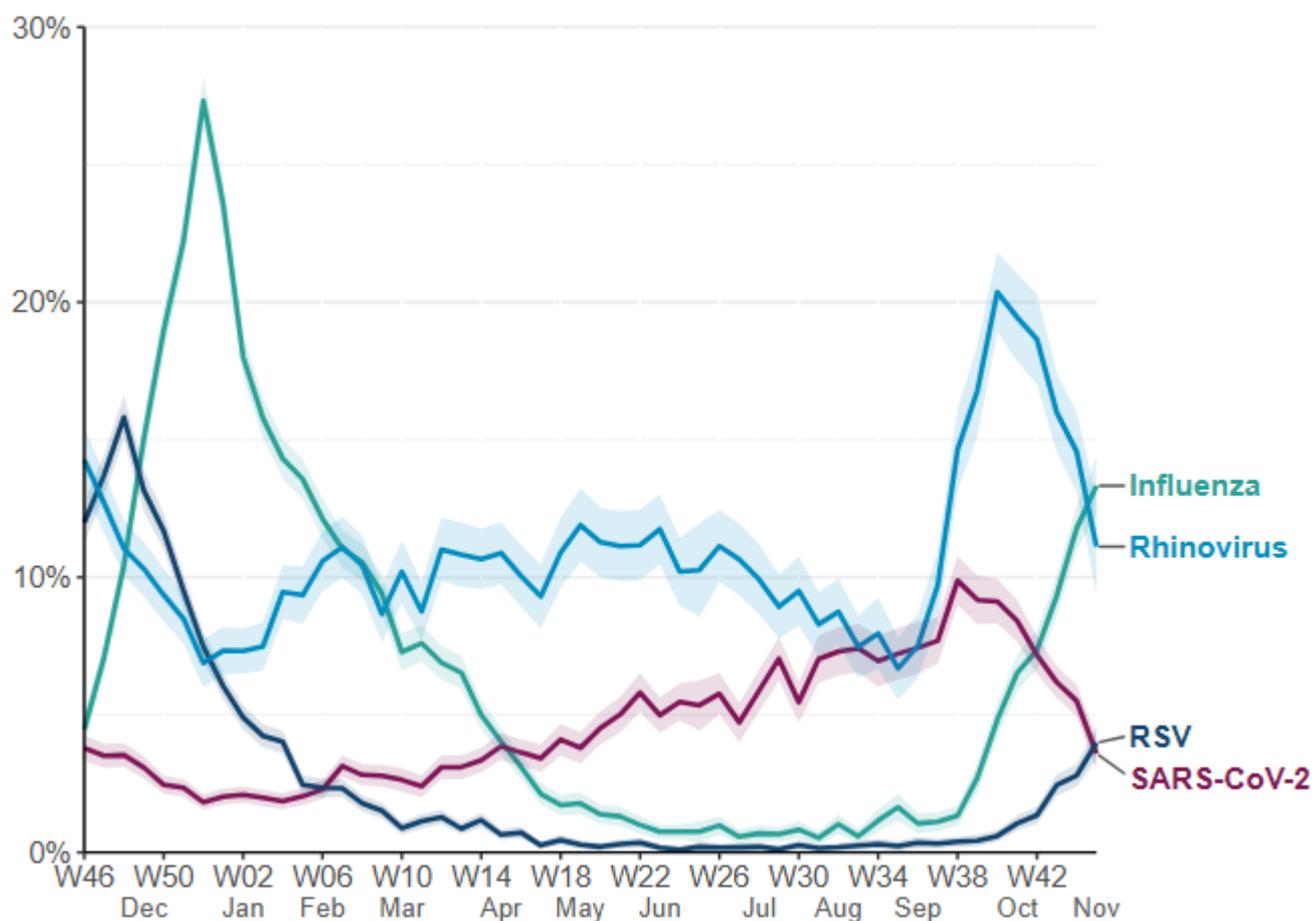
4.6 These metrics will be monitored via the dashboards shared at the ICB Board FIPC and System Oversight and Assurance Group (SOAG).

## 5. Vaccinations

### Vaccine Preventable Winter Illness

5.1 Last year in England there were approximately 8,000 deaths from flu, and over a third of a million bed days taken up for flu patients. Without vaccination, things could have been much worse, with 100,000 fewer people being hospitalised because of the vaccination programme.

5.2 For 2025/26 the Regional NHSE team have shared forecasts that show a peak in Rhinovirus around September/October, RSV around early December, and Flu around January, with uncertainty around the seasonality of Covid. As the national data below shows, we're seeing this play out, albeit with marked earlier than expected increase in Flu positivity.



## Winter Vaccination Campaigns

- 6.3 Vaccination against vaccine preventable illness is effective in protecting the health of specific cohorts, preventing transmission to vulnerable populations, and helping ensure the resilience of our health and care system over Winter.
- 6.4 The WY ICB 2025/26 flu programme has started, running from 1<sup>st</sup> September (pregnant women and eligible children) or 1<sup>st</sup> October (other cohorts), including a national focus on improving uptake by 5% across our health and care workforce.
- 6.5 The 2025/26 covid programme has started, running from 1<sup>st</sup> October, including a change to eligible cohorts from 2025/26.
- 6.6 Progress data for WY ICB and the NEY region as of the start of November is shared below (only sharable from NHSE for operational purposes).

Programme	Cohort	Metric Description	Region: NEY		ICB: WY	
			Minimum Ambition	Uptake %	Minimum Ambition	Uptake %
RSV	Catch up cohort	70% uptake on the RSV catch up cohort (aged 75-79) during 25/26 season (by 31st March)	73.14%	<b>70.10%</b>	70.82%	<b>68.00%</b>
	Routine Cohort	60% uptake on the routine cohort during 25/26 season (by 31st March)	66.86%	<b>44.99%</b>	65.98%	<b>43.80%</b>
Flu	Flu uptake for 65+	Maintain Flu Uptake for 65+ cohort	77.39%	<b>70.86%</b>	74.75%	<b>68.34%</b>
	2-3 yo Flu	Increase uptake in 2–3-year-old flu cohort	49.26%	<b>39.63%</b>	43.71%	<b>33.64%</b>
	Primary School Children	Increase uptake in Primary School Children	58.22%	<b>41.91%</b>	47.25%	<b>33.07%</b>
	Secondary School Children	Increase uptake in Secondary School Children	48.73%	<b>29.02%</b>	40.67%	<b>20.86%</b>
	Those aged under 65 years in a clinical at-risk group	Increase uptake in under 65 Clinical Risk Cohort	47.69%	<b>37.87%</b>	43.72%	<b>34.35%</b>
	Frontline Healthcare Workers	Increase uptake in Frontline Healthcare Workers	48.50%	<b>44.03%</b>	42.84%	<b>40.70%</b>
Covid	Care Home Cohort	Maintain uptake in Care Home Cohort	66.40%	<b>66.86%</b>	66.43%	<b>64.59%</b>
	75+ Cohort	Maintain uptake 75+ Cohort	62.05%	<b>62.84%</b>	59.81%	<b>60.47%</b>
	IS Cohort	Maintain uptake in IS Cohort	26.32%	<b>28.53%</b>	22.81%	<b>24.68%</b>

## Co-Ordination, Oversight and Governance.

6.7 The WY Winter Operational Oversight Group (WODG) has been established to:

- Provide leadership to the West Yorkshire system and have oversight of the planning and delivery of the 2025/26 winter vaccination programmes.
- Work collaboratively as a system across WY places to coordinate and maximise delivery of Covid-19 and Influenza vaccination programmes to the eligible population during 2025/26.
- Provide updates, and if required escalate risk, to the West Yorkshire Vaccination and Immunisation Strategic Steering Group.

6.8 Consistent and concise messaging around the campaigns has been prioritised as a joint focus between NHSE and WY ICB. An “Anchor” letter was shared by West Yorkshire ICB with WY medical directors, primary care, and directors of public health. This provided an overview of key operational details, and highlighted links to winter planning and the UEC plan.

6.9 Further letters have since been shared with more specific information around vaccination in Care Homes and vaccination of VCSE Health and Care Staff.

6.10 A similar “Do Once” approach has been taken when considering communications, with WY-co-ordinated promotion of vaccination uptake, sharing national campaign resources, and re-launching “Together We Can” on 10<sup>th</sup> November.

6.11 The WODG is supporting the above activities, sharing good practice, and looking at opportunities to do other things once across the system. For example, “community champions” have been successfully deployed across

three of our Places, and opportunities to add value through scaling this work up across the whole footprint of WY are currently being explored.

### Vaccination Winter Planning

6.12 Input around vaccination is feeding into the ICB’s Winter Planning Steering Group, and in partnership with NHSE, feedback has been provided into Place Winter Plans. Details of relevant NHSE KLOEs have been clarified, examples of good practice shared, and additional resources circulated to support delivery. Resources included NHSE developed templates on vaccination delivery, and a jointly developed document highlighting examples of good practice across both West Yorkshire and England.

### Health Care Worker Uptake

6.13 Uptake amongst the frontline workforce is important for staff wellbeing, to protect vulnerable service users, and for system resilience of Winter. The uptake of staff vaccination nationally has declined steadily year on year – falling from 74% in 2019/20 to just 38% in 2024/25. In West Yorkshire we vaccinated 37% of eligible health care workers in 2024/25.

6.14 In the June Urgent and Emergency Care Plan for Winter, NHSE targeted a 5-percentage-points improvement in HCW flu vaccine uptake, and this was emphasised in the September letter from Sir James Mackey, and supported by KLOEs, which make clear asks of Providers. Following an ask for NHS Trusts to identify SROs, NHSE are now engaging directly with Providers around these targets.

6.15 The table below provides NHSE figures around 2025/26 uptake as of November 10<sup>th</sup> (only for sharing to support operational working), compared to FDP data from Winter 2024/25, to which a 5% has been added to estimate NHSE targets. Whilst NHSE may be measuring progress differently, this gives an idea of the current situation.

	<b>2024/25 Vaccination Uptake</b>	<b>Estimated 2025/26 Target</b>	<b>Current</b>
Airedale	39%	44%	39%
Bradford District Care	40%	45%	40%
Bradford Teaching Hospitals	38%	43%	39%

Calderdale and Huddersfield	29%	34%	43%
Leeds and York Partnership	34%	39%	33%
Leeds Community Healthcare	47%	52%	48%
Leeds Teaching Hospitals	45%	50%	46%
Mid Yorkshire Teaching	39%	44%	42%
South West Yorkshire Partnership	17%	22%	44%
Yorkshire Ambulance Service	33%	38%	42%

6.16 Examples of good practice to support delivery have been shared through Winter Planning feedback and the WODG. This has included collaborations with NENC ARC, who have produced an evidence briefing around HCW vaccine hesitancy.

6.17 The ICB also aims to lead by example for its own staff, all of whom have been offered a vaccine. On-site sessions in October led to the delivery of over 100 vaccinations, with around half as many digital flu vouchers also having been issued.

### Life-course Vaccination

6.18 Flu and Covid are not the only vaccine preventable infections of relevance over Winter. RSV is a key contributor to winter infections, and is something we're including in discussion through our WODG. Measles, and MMR vaccine uptake, was also highlighted in the Regional forecast shared around Winter as something that could also have a significant impact. We've seen the consequences of decreasing MMR uptake recently with an outbreak of measles in Leeds. UKHSA released a "lessons learned report" around recent Leeds Measles Outbreak, which has been used to inform a recent outbreak exercise in Place, and next steps are in development.

6.19 Beyond this, the wider routine vaccination offer is as relevant at Winter as it is at any other time of the year. As a system, we're keen to ensure learning from Winter feeds into efforts to improve uptake across the life-course (and vice-versa). Of particular note around this wider offer:

- There has not yet been formal confirmation of how these (Section 7A) functions will be delivered, with transfer of commissioning responsibilities expected from April 2027.
- Planned launch of NHS chickenpox vaccine in January 2026, as "MMRV" combined vaccine delivered through routine GP appointments.

6.20 Finally, not all vaccinations are provided through programmes, and some are provided in response to incidents and exposures. WY ICB are leading systems mapping around outbreak/incident roles and responsibilities, to support delivery of NHSE "commissioning guidance" for ICBs around health protection functions (including vaccination) and address known gaps in provision identified in the 2023 UKHSA Y&H Health Protection Gap Analysis.