Contact Officer: Yolande Myers

KIRKLEES COUNCIL

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 6th December 2024

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

Apologies: Councillor Howard Blagbrough – Calderdale Council

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

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

3 Declarations of Interest
No interests were declared.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED - The committee noted the information and agreed that:

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

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

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

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

6 Suicide Prevention

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED - The committee noted the information and agreed that:

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

7 Life Expectancy

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

The report provided to the Committee advised that the programme could be considered in terms of primary (addressing the wider determinants of health), secondary (early diagnosis and treatment), and tertiary prevention (preventing further deterioration of health). Although the exact details differ for different mental health conditions, for autism and ADHD, and for learning disabilities, the following broader areas of focus had been picked up at a WY level for particular focus.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 Next Steps

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