Public Document Pack

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Wednesday 5 June 2019

Notice of Meeting

Dear Member

Health and Wellbeing Board

The **Health and Wellbeing Board** will meet in the **Old Court Room - Town Hall, Huddersfield** at **2.00 pm** on **Thursday 13 June 2019.**

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

Julie Muscroft

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 Health and Wellbeing Board members are:-

Member

Councillor Viv Kendrick (Chair)

Councillor Carole Pattison
Councillor Musarrat Khan
Councillor Kath Pinnock
Councillor Mark Thompson
Dr David Kelly
Mel Meggs
Carol McKenna
Dr Steve Ollerton
Richard Parry
Rachel Spencer-Henshall
Helen Hunter

Agenda
Reports or Explanatory Notes Attached

Pages

1: Membership of the Board/Apologies

This is where members who are attending as substitutes will say for whom they are attending.

Contact: Jenny Bryce-Chan, Principal Governance Officer, Tel: 01484 221000

2: Minutes of previous meeting — 1 - 6

To approve the minutes of the meeting of the Board held on 28 March 2019

Contact: Jenny Bryce-Chan, Principal Governance Officer, Tel: 01484 221000

3: Interests — 7 - 8

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

4: Admission of the Public

Most debates take place in public. This only changes when there is a need to consider certain issues, for instance, commercially sensitive information or details concerning an individual. You will be told at this point whether there are any items on the Agenda which are to be discussed in private.

5: Deputations/Petitions

The Board will receive any petitions and hear any 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 hand in a petition at the meeting but that petition should relate to something on which the body has powers and responsibilities.

In accordance with Council Procedure Rule 10 (2), Members of the Public should provide at least 24 hours' notice of presenting a deputation.

6: Public Question Time

The Board will hear any questions from the general public.

7: Appointment of Deputy Chair

To consider nominations for the Deputy Chair of the Health and Wellbeing Board for the 2019 - 2020 Municipal Year

Contact: Jenny Bryce-Chan, Principal Governance Officer Tel: 01484 221000

8: Loneliness Strategy for Kirklees

9 - 16

A report outlining the progress on the development of an integrated partnership strategy and action plan on loneliness in Kirklees

Contact: Jill Greenfield, Head of Integrated Local Partnerships, Helen Gilchrist Development Officer and Sharron McMahon, Health Improvement Practitioner Tel: 01484 221000

9: Domestic Abuse Strategy

17 - 32

A report to inform members of the Health and Wellbeing Board regarding the progress and sign off of the Kirklees Domestic Abuse Strategy 2019/21 and its associated strategic priorities

Contact: Alexia Gray, Service Manager, Domestic Abuse and Safeguarding Partnership Tel: 01484 221000

10: Opportunities for Oral Health improvement 33 - 54

To update Kirklees Health and Wellbeing Board regarding the work on oral health needs assessment of the local population and highlight opportunities to improve oral health in light of the Councils statutory responsibilities

Contact: Emily Parry-Harries, Consultant in Public Health, Tel 01484 221000

11: Development of the West Yorkshire and Harrogate 5 Year Plan Strategy for Health and Care 55 - 68

A report:

a) Seeking the views, ideas and input of the Kirklees Health and Wellbeing Board into the development of the 5 Year Strategy for Health and Care in West Yorkshire and Harrogate

b) To update the Kirklees Health and Wellbeing Board on the progress of the West Yorkshire and Harrogate Health and Care Partnership

Contact: Rachael Loftus, Head of Regional Health Partnerships and Ian Holmes, Director

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12: Kirklees Primary Care Network registration and development Update 69 - 94

A report to provide an update on the development and registration process of Primary Care Networks in Kirklees

Contact: Catherine Wormstone Head of Primary Care Strategy and Commissioning and Alan Turner, Primary Care Network Programme Manager – Greater Huddersfield CCG and North Kirklees CCG

13: West Yorkshire and Harrogate Health and Care Partnership Transformation Funding 95 - 100

A proposal for principles and approach to Kirklees Place Based recommendations on the use of transformation funding

Contact: Richard Parry, Strategic Director for Adults and Health, Tel 01484 221000

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Contact Officer: Jenny Bryce-Chan

KIRKLEES COUNCIL

HEALTH AND WELLBEING BOARD

Thursday 28th March 2019

Present:	Councillor Viv Kendrick (Chair) Dr David Kelly Carol McKenna Dr Steve Ollerton Richard Parry Helen Hunter Jacqui Gedman
In attendance:	Nicola Bush, Public Health Pharmaceutical Advisor Alan Seasman, Theme Lead Place and Inward Investments Catherine Wormstone, Head of Primary Care Alan Turner, Programme Manager, Primary Care Networks Jo-Anne Sanders, Service Director, Learning and Early Support Emily Parry-Harries, Consultant in Public Health Phil Longworth, Senior Manager, Integrated Support Jenny Bryce-Chan, Principal Governance Officer
Observers:	Councillor Elizabeth Smaje – Chair of Health and Adults Social Care Scrutiny Panel Rachel Foster, Locala Lisa Williams, Calderdale and Huddersfield NHS Foundation Trust Sanele Mhlanga, Partnership Officer
Apologies:	Councillor Shabir Pandor Councillor Musarrat Khan Councillor Kath Pinnock Mel Meggs Rachel Spencer-Henshall Fatima Khan-Shah

1 Membership of the Board/Apologies

Apologies were received from the following Board members: Cllr Shabir Pandor, Cllr Kath Pinnock, Cllr Musarrat Khan, Mel Meggs, Rachel Spencer-Henshall and Fatima Khan-Shah.

Jo-Anne Sanders, attended as sub for Mel Meggs and Emily Parry-Harries attended as sub for Rachel Spencer-Henshall.

2 Minutes of previous meeting

That the minutes of the meeting held on 31 January 2019 be approved subject to a correction to the wording in respect of agenda item 8 West Yorkshire Cancer Programme - Lung Health Checks.

3 Interests

Dr Kelly, declared an 'other' interest in agenda item 8, Primary Care Network Development.

4 Admission of the Public

All agenda items be considered in public session.

5 Deputations/Petitions

No deputations or petitions received.

6 Supplementary Statement to The Pharmaceutical Needs Assessment

The Board was advised that since the publication of the Pharmaceutical Needs Assessment (PNA) in April 2018, three pharmacies had closed and in line with the Regulations, a Health and Wellbeing Board must make a revised assessment as soon as is reasonably practical after identifying changes since the previous assessment.

The PNA Group has concluded that these closures were not of a significant extent to affect pharmaceutical services and neither do they create any gaps in services in the Denby Dale, Dewsbury East and Holme Valley South Wards. The appended statement is a statement of fact and is issued as the first update to the PNA during its 3-year period. The PNA will be fully revised in 2021.

The Board expressed concern regarding the impact on the community of three pharmacies closing and enquired whether they had already closed. The Board was advised that they had already ceased operating, however these closures were not concerning as there is adequate provision. As part of this process it was necessary for the PNA Group to look at the impact of these closures on local communities. The PNA takes into account the general population served by pharmacies including proximity of pharmacies to each other, to GP practices and to health services.

The Board questioned whether it had any powers with regard to the opening of pharmacies having previously raised concerns. The Board was informed that NHS England uses the PNA to assess pharmacy applications and as NHS England is the fund holder for the pharmacy contracts. The Board has no direct powers over the opening or closure of pharmacies.

NHS England can grant pharmacy applications in certain circumstances (outside of the PNA) where the applicant is offering improvement in/better access to pharmaceutical services e.g for people with protected characteristics, or under the unforeseen benefits category (benefits not foreseen at the time of PNA publication).
The Board was further informed that it is consulted with each time there is a Market Entry application and that part of the role of Public Health Pharmaceutical Advisor, is to provide comment within 45 days on the opening of pharmacies on behalf of the

Health and Wellbeing Board. The Board was informed that the PNA takes into account the Local Plan in the profiles sections under "planned developments".

The Board commented that the PNA makes no reference to the use of pharmacies for reducing the pressure on GP surgeries. The Board was informed that any new nationally commissioned services provided by pharmacies to improve urgent care will be detailed in the next PNA revision and that a comment about the limited commissioning of the minor ailment service is detailed in the PNA Executive Summary. The Board was advised that Greater Huddersfield CCG has commissioned a minor ailment services, however North Kirklees has no such provision.

It was agreed that the Board would continue to receive its annual update and in addition it would receive a half yearly briefing paper.

RESOLVED - That the Supplementary Statement be approved for publication

7 Kirklees Economic Strategy

Alan Seasman, Theme Lead Place and Inward Investment attended the meeting to advice on the ongoing strategic alignment between health and wellbeing and the local economy.

The Board was informed that the current Kirklees Economic Strategy (KES) was produced in 2014, with the KES and the Kirklees Joint Health and Wellbeing Strategy intended to reinforce one another. Whilst much in the 2014 strategy is still relevant quite a lot has changed. For example, the government is introducing an industrial strategy with increased emphasis on productivity, the Council has refreshed its Council priorities, with inclusive growth being a new and important focus. Following a scoping review in 2018, it was confirmed that there had been sufficient change to necessitate a refresh of the KES.

From July to December 2018, the development of the new KES included engagement and consultation, in depth economic analysis, and the production of the final draft. The Board was advised that while the strategy had been to Cabinet and Full Council it was important to emphasise that this was not a council document but a Kirklees document.

The strategy aims to be more ambitious highlighting the benefits of growth and making sure people can benefit from growth.

There are five new priorities in the updated KES which will help to deliver the vision for inclusive and a productive economy. These priorities will be taken forward through a 12 point action programme with five big wins. The priorities are:-

- Modern, innovate business
- Skilled and ambitious people
- Active Partnerships
- Advanced connectivity and infrastructure
- Revitalising and promoting key centres

There are five priorities in the health and wellbeing plan, including, creating communities where people can start well, live well and age well and is the place based plan as part of the West Yorkshire Health and Care partnership. There are numerous suppliers and providers of service across Kirklees and the aim is to try and connect these and do things better. One in 10 of the workforce is employed in health and social care, and the aim is to work with colleges, universities and anchor institutions and starting to connect these in a more practical way.

The Board was informed that by focusing on inclusivity and productivity the KES and the Joint Health and Wellbeing Plan will continue to reinforce one another.

The Board questioned the actions behind the KES and Joint Health and Wellbeing Plan and suggested it would be beneficial for the Board to hold a session focusing on the wider determinants of health.

RESOLVED - That the Kirklees Economic Strategy be noted by the Board and that a further update be provided in 12 months.

8 Primary Care Network Development

Catherine Wormstone and Alan Turner attended the meeting to provide the Board with an update on the development of the Primary Care Networks (PCN) in Kirklees. The Board was informed that the PCNs are a critical part of the vision for health and social care as set out in the Kirklees Health and Wellbeing Plan. PCNs will help to deliver the aims of both the Clinical Commissioning Group's existing Primary Care Strategies and is a key focus of the Integrated Commissioning Strategy and the Integrated Provider Board.

In Kirklees, work has commenced develop nine Primary Care Networks, five in the Greater Huddersfield CCG area and four within the North Kirklees CCG area.

The Board was informed that the 2018/19 NHS Planning Guidance sets out the ambition for Clinical Commissioning Groups to actively encourage every GP practice to be part of a local primary care network and in Kirklees, this work is well underway. In addition, the publication of the GP contract framework marks some of the biggest changes to general practice contracts in over a decade and will ensure general practice plays a key role in every Primary Care Network.

The Board was advised that the NHS has set a deadline of the 15 May 2019, whereby each network is required to confirm:

- The name of the accountable clinical director
- Names of member practices
- List size
- A map marking the agreed network area
- The initial network agreement signed by all member practices
- Single practice or provider that will receive funding on behalf of the PCN

A high level summary will be shared with the Board.

The Board was informed that seven national service specifications will be introduced in line with the NHS Long Term Plan and phased into PCNs during 2019/20.

While networks are going at different pace, some good work has already started for example partnership and joint working provides a positive start to the networks. The Board noted that the days of GP practices working in isolation are gone.

The Board questioned how governance arrangements will be developed as there will be some early decisions to be made. A PCN Leadership Forum is being developed and the Integrated Commissioning Board and Integrated Provider Board will play an active role in shaping and supporting the development of the PCNs. The CCG has commissioned the National Association of Primary Care, who have been working on PCN development across the country for several years, to support the process in Kirklees.

Public Health have provided all PCNs with a data pack to highlight the key characteristics and needs of the local populations. The PCNs are using this to shape their initial priorities.

The Board questioned whether the networks had talked to patient groups as patient involvement was important and in response was advised that those conversations were starting to happen with an event to be held in North Kirklees. In addition a communication strategy is being developed.

The Board commented that the list of people who want to be involved in PCNs resonates with what schools are doing, and links are already being made between the PCNs and (schools as) community hubs.

All partners expressed a commitment to being actively involved in the PCNs. The Board noted the importance of the PCNs being inclusive local partnerships, and not being exclusively focussed on General Practice specific issues.

The Board agreed that an update on the PCNs should be provided at every board meeting.

RESOLVED –

(1) That the development of the Primary Care Networks in Kirklees be noted by the Board.

(2) That an update on Primary Care Networks should be provided as every meeting of the Board.

9 Kirklees Health and Wellbeing Plan and local partnership planning arrangements

Phil Longworth, provided the Board with an update on progress implementing the Kirklees Health and Wellbeing Plan and emerging changes to the Kirklees partnership planning arrangements.

The Board was informed that in order to better communicate the outcomes and priorities that the plan is seeking to deliver, a one page summary (appendix 1 to the appended report) had been developed which should tell the 'Kirklees story' in a more succinct and consistent way.

The Board was advised that work is being undertaken and there will be a lot developing over the next for few months with people coming together building relationships. For example, the Integrated Commissioning Board is well established and is meeting regularly. The draft terms of reference and work programme for the Integrated Provider Board will be presented to the Board in June. Work is also underway streamlining partnership groups and clarifying which groups are working to deliver key programme in the Health and Wellbeing Plan. The Director of Childrens Services is working with partners to develop new partnership planning arrangements for children and young people.

The board noted that the West Yorkshire & Harrogate Partnership Board meets for the first time on the 6 June 2019.

RESOLVED - That the Board endorses the one page summary of the Kirklees Health and Wellbeing Plan.

10 Proposed Revisions to the Terms of Reference for The Health and Wellbeing Board

Phil Longworth, outlined proposed revisions to the Terms of Reference for the Health and Wellbeing Board. The Board was advised that the national and regional context in which the Board is operating, has undergone significant changes over the last 12-18 months for example:-

- Publication of the NHS Long Term Plan with its emphasis on promoting collaboration
- The West Yorkshire Health and Care Partnership has formally become an 'Integrated Care System' and the new partnership Board will meet from June 2019
- The emergence of Primary Care Networks, which has been formalised in the new GP contract

The current membership has not changed since the Board was established in April 2013 and in light of a much more collaborative approach, it is timely to update the membership.

The proposed revision is intended to extend the membership of the Board to include a nominated representative of the Kirklees Integrated Provider Board and; add a representative of Kirklees Overview and Scrutiny as an invited observer.

RESOLVED - That the revisions to the Terms of Reference for the Health and Wellbeing Board be approved by the Board.

KIRKLEES COUNCIL

COUNCIL/CABINET/COMMITTEE MEETINGS ETC
DECLARATION OF INTERESTS

HEALTH AND WELL BEING BOARD

Name of Councillor

Item in which you have an interest	Type of interest (eg a disclosable pecuniary interest or an "Other Interest")	Does the nature of the interest require you to withdraw from the meeting while the item in which you have an interest is under consideration? [Y/N]	Brief description of your interest

Signed: …………………………………………… **Dated:** ……………………………………..

NOTES

Disclosable Pecuniary Interests

If you have any of the following pecuniary interests, they are your disclosable pecuniary interests under the new national rules. Any reference to spouse or civil partner includes any person with whom you are living as husband or wife, or as if they were your civil partner.

Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses.

Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -

- under which goods or services are to be provided or works are to be executed; and
- which has not been fully discharged.

Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

Any tenancy where (to your knowledge) - the landlord is your council or authority; and the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -
(a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
(b) either -

the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or

if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

KIRKLEES HEALTH AND WELLBEING BOARD
MEETING DATE: 13 June 2019
TITLE OF PAPER: Loneliness Strategy for Kirklees

1. Purpose of paper

- To share progress on the development of an integrated partnership strategy and action plan on loneliness in Kirklees.
- To seek support for the current direction of the work.
- To help further shape our local response.
- To seek input and advice on next steps.

2. Background

2.1 Why is it Important

There is a growing body of evidence that loneliness is linked to:

- greater risk of inactivity, smoking and risk taking behaviour (such as substance use and sexual risk taking),
- increased risk of heart disease and stroke,
- increased risk of depression, low self-esteem, reported sleep problems and increased stress response,
- cognitive decline and increased risk of Alzheimer's disease,
- increased use of health and social care services. Lonely people are more likely to be readmitted to hospital or have a longer stay, are more likely to visit a GP or A&E or enter local authority funded care,
- lower performance at work.

This highlights the importance of tackling loneliness as a preventative measure. A national strategy was published in October 2018: https://www.gov.uk/government/publications/a-connected-society-a-strategy-for-tackling-loneliness

2.2 Who Experiences Loneliness?

National research indicates that loneliness **fluctuates across the life course** with different needs at different ages. It is unique to the individual's personal circumstances, identity, personality and personal resilience. However, common themes and triggers have been identified such being in poor health, long term disability, being unemployed, living in rented accommodation, a feeling of lack of belonging in the local area or having little trust of others in the local area. These findings are echoed in the Current Living in Kirklees Survey (2016).

A large amount of research and campaigning has focussed particularly on older people but Age UK have concluded that the chances of being lonely **do not necessarily differ because of age but the circumstances that increase the risk do, such as onset of illness and disability or bereavement.** The effects of social isolation have been shown to accumulate over time, and the health risks associated with isolation and loneliness increase as people age.

According the Current Living in Kirklees Survey (2016)

- **7%** of overall sample reported feeling lonely or socially isolated where they currently live **most or all of the time.**

- **51%** of overall sample reported feeling lonely or socially isolated where they currently live, **some of the time or not very often**
- **58%** of overall sample reported **ever feeling lonely or socially isolated** where they currently live.
- People living in the most deprived areas were more likely to feel lonely or less socially connected than those in the least deprived areas.
- Younger and middle aged men were significantly more likely to feel lonelier that the overall population sample.

The 2017/2018 Adult Social Care Survey of people in receipt of social care services indicated that:

- **47.9% of people had as much social contact as they wanted with people they wanted.** People in Residential/Nursing Care (60%) and Day Care (55.1%) had the most social contact with people they liked.

2.3 Local Approach and Action to Date

2.3.1 Kirklees Health and Wellbeing Plan (2018-2023) prioritises '**Community Connection'** as a key ambition - aiming 'to increase the proportion of people who feel connected to their communities, reducing the proportion of people who feel lonely or socially isolated and reducing the prevalence of mental health conditions amongst our population' (p3).

2.3.2 As part of 'Living Well' the plan aims to ***'Create resilient, connected and vibrant communities using all available assets' (p15)*** and specifically mentions: exploring the impact of intergenerational work on reducing loneliness; the role of community capacity building work and integrated wellness model; engaging with people who are about to retire from paid employment to continue to strengthen volunteer network and prevent isolation and loneliness in this group (p17).

2.3.3 In March 2019, the Health and Wellbeing Board endorsed a number of major local programmes for 2019/20 to support delivery of the Health and Wellbeing Plan. These are relatively new areas of activity that require significant partnership input. This included developing a partnership wide Loneliness Vision and Action Plan.

2.3.4 The Community Plus Collaborative Board mandated the initiation of a Loneliness strategy to bring together existing work in and around these issues, to take a systems wide, life course approach.

2.3.5 A Strategy Group was set up drawing on a wide range of stakeholders from Voluntary and Community Sector (VCS), Health, Social Care and wider colleagues within the council and Kirklees. The group is co-chaired between the CCG and Kirklees Council. The group are taking a co-productive approach to harness the views, expertise and support of partners and community members and are keen to embed this approach further. Key pieces of work have included:

- Scoping exercise to collate existing local and national prevalence data on loneliness and evidence of effective interventions – November 18.
- Review of current work on loneliness from a council perspective based on the LGA's 'How do you know your council is actively tackling loneliness?' Assessment tool - November 18.
- Mapping exercise of current assets and opportunities using the Campaign to End Loneliness Framework - November 18.
- Professionals feedback exercises through the partnership and within Adults, Children and Public Health service areas - October 18 - June 19.

- Consultation with adult members of the community through a focus group in each of the 4 localities in Kirklees January to March 19.
- Exploring approaches in some neighbouring local authorities - January – March 19
- Holding a workshop on loneliness at the Integrated Commissioning Away Day – January 19.
- Creating an infographics data pack summarising key information on national and local picture – February 19
- Visioning session for the partnership/ strategy group - February 19.
- Visioning session for carers/ service users/ community members - March 19.
- Development a draft vision and strategic goals - May 19 (Appendix 1).

3. Proposal

3.1 Emerging Priorities

Based on the local mapping, intelligence gathering and visioning sessions so far, the following recurring themes emerged, which we are initially proposing as our strategic goals.

3.1.1 Making Tackling Loneliness Everyone's Business

a) Overall, Kirklees need to take a whole systems approach to tackling loneliness if it is to have an impact. This would involve influencing local agendas, so that it is considered as part of all planning, strategies, commissioning and development of services and support where appropriate. A key message from the visioning sessions was that tackling loneliness should be 'everyone's business' in view of the complex interrelationship of factors that both influence and address loneliness. Loneliness needs to be embedded into relevant agendas.

b) For example, in acknowledgment of the relationship between loneliness and mental health, mental health strategy work has been identified as a key component of the 'Mental Health Prevention Concordat' (now renamed the 'Mental Health Prevention Pledge').

c) Whilst key enablers such as transport and technology are not specifically mentioned in the strategic goals or actions in the attached outline (Appendix 1), these topics have been discussed at strategy board meetings, visioning sessions and have emerged in the focus groups also. It is anticipated that these are considered as part of the systems approach and there may be specific actions that emerge as we move further in to the process.

3.1.2 Making the Most of Existing Assets to Tackle Loneliness

a) There is a need to harness existing and emerging local assets as much as possible. Currently there are a wide range of activities taking place in Kirklees that contribute to tackling loneliness.

Examples of current assets include: identification of issues at the Adult Services 'Front door', care navigation linked to 'Front Door' and hospital teams, identification of issues as social care assessment, social prescribing, individual support and community capacity building from Community Plus, the Local Area Co-ordination pilot (LAC) pilot, Volunteering, activities linked to universal offer in libraries and specialist activities such as home delivery support service, Care Companions initiative, Making Every Contact Count, Locala initiatives to identify loneliness as part of routine visits and sign posting into VCS services, the emerging Wellness model, befriending, community mental health services and cohesion work, the Good Gym, intergenerational work, West Yorkshire Fire and Rescue Safe and Well Visits,

Voluntary and Community Sector groups and activities, Community Transport Scheme, Carer's Support Groups and bereavement groups, Care Companions, Community Hubs (supporting children and families and communities), Auntie Pam's (maternal support).

b) However it has been identified that more can be done to streamline this and work in a more integrated way across partners and there needs to be a better, simpler way for staff and the public to find out about services, activities and groups in their local areas, as well as informal spaces for people to meet.

c) There are more opportunities to identify people who may be lonely ('Make Every Contact Count') by ensuring that as many front line workers understand and can support, sign post and refer people that may be feeling lonely.

d) The most important assets are the people within our local communities, who have a vital role to play in looking out for their neighbours, friends and families and can make a real difference on a day to day basis from everyday interactions to more formal volunteering. The recent example is the 'Looking Out for our Neighbours' West Yorkshire and Harrogate Health and Care Partnership Alliance, which partners in Kirklees are contributing to.

e) Any strategic work needs to support community development approaches which act as a catalyst to empowering communities to support each other and build solutions. Community capacity building remains key as does awareness raising and campaigning to reduce stigma.

f) Some communities are very well connected whilst other may be less so. We need to learn from these lessons and share any good practice. Making more of existing communal spaces and 'informal hangouts' for community members and supporting virtual connections could help people to do this.

3.1.3 Understanding the experiences and appropriate responses for different groups and communities

a) Loneliness is not a homogenous experience, taking many forms at different stages of the life course and is personal to the individual.

b) Scoping work so far has identified that there isn't currently enough intelligence about the experiences of loneliness and how it can be overcome for BAME and specific communities of interest, so that responses can be targeted accordingly.

c) Whilst there has been some work to date to explore this, in view of the scale of the task, a more detailed focused piece of work is needed. This could potentially be a rolling programme of deeper reviews in to prevalence and effective interventions for specific groups of people. This could be supported by having a dedicated section in the Kirklees Joint Strategic Assessment. We can also make use of local place based intelligence via the Place Standard template.

3.1.4 Fostering personalised approaches for those that need extra support to overcome barriers to developing meaningful connections

a) As loneliness is an individual experience, those experiencing chronic loneliness due to physical and emotional barriers need personalised, tailored support and this should be made available where needed. This is embodied in an approach that ensures good quality conversations with people which focus on

strengths and assets.

b) As detailed in 3.1.3, there are currently a range of activities that contribute to this but there is a need to ensure that they are more streamlined and operate in a more integrated way in relation to tackling loneliness.

c) It is acknowledged that tackling loneliness is not simply about formal services. Also, the evidence base of effective interventions suggests that people do not necessarily benefit from being referred to a 'loneliness service' in view of the potential stigma associated with this. This further emphasises the need for loneliness support to be embedded into a wide range of non-specialist responses.

3.1.5 Development of a Strategy on a Page

The above themes are woven into a draft strategic vision, goals and some emerging actions (see Appendix 1). Further work is to take place to shape these into more concrete actions, timescales with lead officers allocated. In order to do this this a systems mapping approach is recommended that includes the full range of stakeholders – strategic partners, front–line workers and community members. Following on from this resources for implementation of the strategy will be needed.

There are different approaches to measuring loneliness and this has been identified as a key challenge to forming a reliable evidence base on the impact of interventions. The national strategy pledged to explore this and develop guidance. The following was released and covers:

- what is meant by loneliness and what the evidence says so far;
- the national measures for adults and children, and how to use them;
- other related measures that can help build a picture of people's social relationships;
- how to have conversations about loneliness and capture qualitative data;
- how to make sense of the results, and how to compare them to the national picture.

https://whatworkswellbeing.org/product/brief-guide-to-measuring-loneliness/

The questions covered in the new publication are not the same as those in the Current Living in Kirklees Survey (2016). https://www.kirklees.gov.uk/involve/entry.aspx?id=816

We would like explore approaches to measuring outcomes/ impact from an individual, population and systems perspective, once actions have been developed. There is an option to include piloting new approaches with Community Plus and Local Area Co-ordination, for example.

3.2 Specific Questions for the Health and Wellbeing Board

- We would welcome initial feedback on the approach taken so far and the draft outline of the vision, strategic goals and emerging actions.
- We would like to seek endorsement to move to the next stage in the development of the strategy/ actions.
- We would like to seek advice on how we can ensure that we include the Health and Wellbeing Board and other relevant strategic leads in continuing to shape, lead and embed the strategy alongside officers, partners and community members.
- We are keen to explore if the Health and Wellbeing Board members can act as systems leaders for the parts of the system that they represent to ensure that the final action plan is supported, owned, resourced, implemented and monitored.

4. Financial Implications

None currently – although resources in terms of staff time will be needed to progress actions once agreed and resources will be required to set up and support a stakeholder event.

5. Sign off

Richard Parry, Strategic Director Adults and Health, Kirklees Council.

6. Next Steps

- Organise a stakeholder event (if approach endorsed) to shape actions.
- The strategy group/ stakeholders will continue to meet and oversee development of the strategy and action plan based on any advice from the board.

7. Recommendations

The Kirklees Health and Wellbeing Board to:

- acknowledge the work that has been carried out to date
- endorse the recommendations and /or suggest any further ideas, actions and approaches that can be adopted to develop strategy.

8. Contact Officer(s)

- Jill Greenfield, Head of Integrated Local Partnerships: Jill.Greenfield@kirklees.gov.uk
- Helen Gilchrist, Development Officer, Adults and Health Integration: Helen.Gilchrist@kirklees.gov.uk
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Kirklees Loneliness Strategy - DRAFT

Vision

Kirklees is a place where people and communities are more connected and support each other to develop meaningful relationships and reduce loneliness

Goals

Making tackling loneliness everyone's business	Making the most of existing assets to tackle loneliness	Understanding the experiences and appropriate responses for different groups and communities	Fostering personalised approaches for those that need extra support to overcome barriers to developing meaningful connections

Actions

Making tackling loneliness everyone's business

- Ensure loneliness is considered in any relevant planning, impact assessments, commissioning, decommissioning and development of services and support
- Ensure stakeholders across Kirklees have a part to play to tackle the underlying risk factors and triggers to loneliness
- Create a culture across Kirklees whereby we design in inclusion and design out loneliness

Making the most of existing assets to tackle loneliness

- Maximise the use of communal and informal 'hang out' space, ensure that they are welcoming and that people are aware of what's available
- Make every contact count so that people, communities and front line services identify loneliness and support, refer and signpost as necessary
- Ensure easy access to information on local groups, activities and support
- Value individual contributions and support people to be proactive in their community including continuing to promote volunteering
- Foster a culture of trust and the importance of people taking time to talk to each other, support each other and develop meaningful relationships
- Learn from, promote and share positive community developments and success stories
- Ensure a presence of community workers/ connectors on the ground to act as catalysts to action in local communities

Understanding the experiences and appropriate responses for different groups and communities

- Continue to research national and local evidence of people's experience of loneliness and the evidence base for appropriate support or interventions
- Identify any gaps in targeted support needed for particular groups and communities
- Look at how these can be addressed using existing assets and where appropriate look for resource opportunities to fill the gaps.

Fostering personalised approaches for those that need extra support to overcome barriers to developing meaningful connections

- Review what's currently available in statutory and voluntary and community sector to provide specific personalised support to overcome barriers to developing meaningful connections
- Identify any gaps or duplications in current offer
- Look at how these can be addressed using existing assets and where appropriate look for resource opportunities to fill the gaps
- Streamline current loneliness support offer to ensure that services work in a more integrated and collaborative way

Principles and Values

- Ongoing reflection/ evaluation of approach and impacts and shared learning
- Influencing approach linked to other agendas
- Non stigmatising approach/ tackling stigma
- Partnership approach that includes organisations as well as communities and citizens (co-production)
- Asset (strengths) based approach
- Empowering communities to tackle loneliness themselves not just formal service responses
- People have choice about how and when they connect
- Realistic approach
- Creative and innovative approaches

KIRKLEES HEALTH & WELLBEING BOARD
MEETING DATE: 13th June 2019
TITLE OF PAPER: Kirklees Domestic Abuse Strategy 2019/21

1. Purpose of paper

To inform members of the Health and Wellbeing Board about the progress and sign off of the Kirklees Domestic Abuse Strategy 2019/21 and its associated strategic priorities.

2. Background

Whilst the governance (and therefore formal sign off) of the Domestic Abuse Strategy sits with the Kirklees Communities Partnership Board, it is recognised that domestic abuse is a cross cutting area that links to a number of policy themes and therefore required the contribution and oversight of wider Council Boards. As part of the engagement plan, the strategy has been shared more widely so that key stakeholders and groups are cited on strategy development, plans for implementation and the partnership capabilities required to respond to this agenda.

3. Proposal

The strategy will be presented at the Health and Wellbeing Board for information and for members to note the key areas of work that are planned for Year 1.

Domestic abuse is a complex social problem that can have major human and financial impacts on children, adults, families and communities. Domestic abuse affects people from all demographics and backgrounds and the damage caused to health and wellbeing can often last throughout the person's life course.

In addition to the disruption caused by domestic abuse to individuals and families, there are also significant costs involved in addressing domestic abuse across all agencies so a strong partnership response is required to be able to tackle this.

The Domestic Abuse Strategy 2019/21 will directly link to the vision outlined in the Kirklees JHWS of *'no matter* ***where*** *they live,* ***people in Kirklees*** *live their lives* ***confidently****, in* ***better health****, for* ***longer*** *and experience* ***less inequality****.'*

4. Financial Implications

None, although as part of on-going commissioning arrangements, the Domestic Abuse Strategic Partnership will continue to seek funds from partner agencies to enable continuation of joint programmes (such as the Independent Domestic Violence Advocate contract which is due for re-tender this year) and any new, evidence based initiatives.

5. Sign off

The Domestic Abuse Strategy has been created by the Domestic Abuse Strategic Partnership which has a wide membership of senior leaders from the council, partners and voluntary and community sector agencies. The emerging plans for the new strategy, along with progress of the 2015/18 strategy and identification of risks/funding implications were discussed at the Council's Overview

and Scrutiny Management Committee on 3rd September 2018. This was followed up by another progress update on 5th November 2019 and shared with the Council's Executive Team on 8th January 2019, where further commitment and funding for the agenda were secured. The new strategy has been communicated with Strategic Directors within Adult Social Care and the Council's Corporate Policy and Strategy Directorate, with formal sign off at the Communities Board on 10th May 2019. In addition to this, the strategy will be presented to the Council's Executive Team on Tuesday 11th June 2019.

6. Next Steps

Once the Domestic Abuse Strategy is shared with the Health and Wellbeing Board, it is anticipated that members will continue to support this agenda and remain receptive to receiving further updates as work progresses. The detailed Year 1 Action Plan is currently being finalised and can be shared with the Board once complete.

7. Recommendations

- That the Board supports the Domestic Abuse Strategy 2019/21, given the links between domestic abuse and the Kirklees JHWS
- That the Board receives further updates regarding progress if required

8. Contact Officer

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Kirklees Domestic Abuse Strategy 2019-2021 DRAFT – V7

Lead Responsible Officer	Saf Bhuta Head of Adult Safeguarding and Quality and Chair of Domestic Abuse Strategic Partnership
Author (s)	Alexia Gray Service Manager – Domestic Abuse & Safeguarding Partnerships
Version	V7
Date	01/05/2019
Revision Update	• First draft of Domestic Abuse Strategy (content only) • 29/01/2019 – Reformat to put SafeLives info first • 06/03/2019 – Re-worded foreword from Cllr Mather • 06/03/2019 – Revised narrative to support SafeLives model and to reflect draft Domestic Abuse Bill • 19/03/2019 – changes in red to narrative • 19/03/2019 – insertion of draft vision • 19/03/2019 – addition of definition • 27/03/2019 – Foreword (amended Children's Safeguarding arrangements and any abbreviations now in full) • 29/03/2019 - Definition – caveat/clarity re sexual violence • 29/03/2019 - Reworded para on page 7 under the vision • 29/03/2019 - Change wording on page 10 (priority 2) • 29/03/2019 - Change narrative under Kirklees vision and approach • 29/03/2019 - Confirm vision and emphasise 'everyone' • 29/03/2019 - Take out reference to 'standard risk' in bullet point 2 of strategic priority 2 • 18/04/2019 – added governance structure • 01/05/2019 – added more clarity on foreword re voluntary, community, faith and social enterprise sectors • 01/05/2019 – added 'restorative' page 6 • 01/05/2019 – added more clarity on 'leadership capabilities' • 08/05/2019 – typos amended
Review Date	

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Foreword from Cllr Mather

Domestic abuse has a major impact on children, young people, adults and communities in Kirklees and tackling it is an absolute priority for Kirklees Council and its partners. One of our shared outcomes, developed alongside our partners, is, for "people in Kirklees to live in cohesive communities, feel safe and are safe/protected from harm." Our workforce, our politicians and our partners are absolutely committed to translating this outcome into reality and our determination to tackle domestic abuse is a key feature of how we will achieve this. This new, refreshed domestic abuse strategy represents a shift in emphasis as we move towards a "whole picture approach," to tackling this issue. This style of approach is championed by the SafeLives[1] organisation.

This way of working is hallmarked by 4 key features

- **The Whole Person –** which means seeing and responding to the whole person, rather than addressing a series of issues.
- **The Whole Family –** which means looking at victims, survivors, those who harm, individuals connected to the victim/perpetrator including extended family.
- **The Whole Community –** which means all communities of geography, identity and online spaces have responsibility for preventing domestic abuse.
- **The Whole Society –** which means the general public and those who influence them – the media, politicians, employers, key opinion formers and commentators for example – understand their role in protecting the safety and well-being of those at risk.

The whole picture approach will mean increased awareness raising about domestic abuse in order to give people the courage and knowledge to challenge it wherever they may come across it, as the only way to truly tackle domestic abuse is for the solution to become everyone's business.

We know that critical to the success of this strategy, is working in partnership. This is why this strategy has been developed by the Domestic Abuse Strategy Partnership, which consists of key partners from the Council, Police, Health Services, Community Rehabilitation Company and voluntary, community, faith and social enterprise sectors. It features heavily the information and intelligence gathered from a number of local data sets to ensure our work is properly targeted and focused. It also links closely to wider Kirklees strategies such as the Joint Health and Well-being Strategy and the work of local Safeguarding Children's arrangements and the Safeguarding Adults Board.

I make no apology for the scale of our ambition demonstrated by this strategy – any domestic abuse **is** too much – and I am confident that, even within the context of increasing volume and financial pressure, this strategy will serve to make a real and positive difference to the lives of people in Kirklees.

Cllr Mather, Chair of the Kirklees Communities Board

[1] SafeLives are a national charity dedicated to transforming the UK's response to domestic abuse and ending domestic abuse for good by combining insight from services, survivors and statistics to support people to become safe, well and rebuild their lives.

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Definition

Kirklees adopts the Home Office definition of domestic abuse:

'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality.' Partners in Kirklees have agreed that these areas of abuse will be addressed through this strategy. The abuse can encompass, but is not limited to:

- psychological and emotional including verbal abuse
- physical
- sexual[2]
- financial

This definition also acknowledges the coercive and controlling nature of abusers and reflects the demography of victims (16 - 19 year old girls who are most at risk).

Controlling behaviour is a range of acts which make a person subordinate or dependent, by isolating them from support, exploiting them for personal gain, depriving them of independence, resistance and escape and regulating everyday behaviour.

Coercive behaviour can be acts of assault, threats, humiliation and intimidation, or other abuse used to harm, punish, or frighten the victim. The current definition includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage.

In addition to the Home Office definition, Kirklees accepts that domestic violence and abuse can take place in many forms and in a number of different intimate and familial settings which are outlined below (not an exhaustive list)

- **Situational Couple Violence**

➢ Involves a relationship dynamic in which conflict can get out of hand to cause one or both partners lashing out. These acts can occur by men and women at fairly equal rates and are not generally committed in an attempt to control a partner[3] However, they can contribute to increases in reporting.

- **Elder/Carer Abuse**

➢ From a definition put forward by Action on Elder Abuse in the UK, the World Health Organization (WHO) defines Elder Abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person." It includes harms by people the older person knows, or has a relationship with, such as a spouse, partner, or family member; a friend or neighbor; or

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[2] *It should be noted that this strategy encompasses sexual violence & abuse where it occurs in a domestic setting but will not extend to the wider issues around sexual violence (such as 'stranger rape')*

[3] *Johnson, M.P. (2008). A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. Boston: Northeastern University Press.*

people that the older person relies on for services. Many forms of elder abuse are recognised as types of domestic abuse since they are committed by family members. Paid caregivers have also been known to prey on their elderly patients.

- **Teen Violence and Abuse Against Parents**

➢ Young people displaying violent and abusive behaviour towards their parents which could include but is not limited to coercive and controlling tactics. This is becoming increasingly recognised as a feature in families with complex needs and can often have a detrimental impact on other siblings within the family as well as the parents.

- **Peer on peer abuse**

➢ Abuse within early relationships between younger people where there may be all the elements of intimate partner violence and abuse but with less understanding about boundaries, what constitutes healthy relationships and even identifying that the relationship is or is becoming abusive

The Scale and Challenge of Domestic Abuse

In January 2019, the Government unveiled their most comprehensive package ever to tackle domestic abuse, aimed at supporting victims and their families and pursuing offenders. This was supported by a Home Office report that revealed the economic and social cost of domestic abuse cost the country £66 billion in 2016 to 2017. According to the research, the vast majority of this cost (£47 billion) was a result of the physical and emotional harm of domestic abuse, however it also includes other factors such as cost to health services (£2.3 billion), police (£1.3 billion) and victim services (£724 million). While the £66 billion estimate of the costs of domestic abuse appear large, they are likely to be an under-estimate. In particular, the Crime Survey for England and Wales data at the heart of the estimate does not enable full consideration of the number of injuries incurred by victims during their abuse, so the physical harms are likely to be under-estimated.

The £66 billion estimate represents the most comprehensive estimate yet of the economic and social costs of domestic abuse. The report reinforces the need to tackle domestic abuse, ideally through preventative efforts that stop the abuse from happening in the first place. It also highlights how domestic abuse impacts on many sectors of society, suggesting that the response should be similarly wide-ranging.

As well as making a set of commitments to tackle domestic abuse, the Government will also be bringing in new legislation and one of these changes will be to introduce the first ever statutory government definition of domestic abuse to specifically include economic abuse and controlling and manipulative non-physical abuse which will enable everyone, including victims themselves, to understand what constitutes abuse and will encourage more victims to come forward. This move illustrates and strengthens the notion that domestic abuse now encompasses much broader types of abuse that can be less easy to identify, and that the relationships of those experiencing domestic abuse extend far more widely than the stereotypical heterosexual relationship. At the time of the Kirklees strategy being signed off, the draft Bill was still at parliamentary scrutiny stage so we will refer to the current definition of domestic abuse but will make changes to the strategy once new legislation is in statute.

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In 2016, HM Government published their 'Ending Violence Against Women and Girls Strategy: 2016-2020[4], followed shortly afterwards by the West Yorkshire Office of the Police & Crime Commissioner publishing their Domestic and Sexual Abuse Strategy. It should be noted that HM Gov's Strategy is particularly focussed on women and, whilst it is widely accepted that domestic abuse is disproportionately gendered, both the West Yorkshire and Kirklees approaches are not limited to this as it was felt that local responses need to be considered across all demographics (many of whom could be considered 'hidden victims') Indeed, it is true to say that victims of domestic abuse are not confined to a particular gender, ethnic group or sexual orientation and abuse affects whole families, including children and the elderly.

It is accepted that the majority of those affected by domestic abuse do not report their experiences to the police and of those incidents reported to the police, only a minority are resolved through the criminal justice system. Whilst some victims will be supported where they meet safeguarding and risk thresholds, not everyone will receive support. Therefore partner agencies have a significant role to play in addressing domestic abuse, whether the violence is reported to the police or not, and in particular to intervene early and prevent further abuse. Partners across Kirklees work dynamically to deal with the changing landscape of domestic abuse but the scale of the issue does present challenges particularly as statutory services have faced unprecedented budget restraints in recent years. It is therefore more vital than ever that new approaches are implemented and that the progress of the Kirklees strategy and subsequent priorities can be measured through a range of partnership intelligence and data.

Domestic abuse rarely affects just one person and every case will include different family dynamics; types of abuse and levels of risk posed by the perpetrator. In this sense, the SafeLives model seeks to encourage agencies to employ an effective, restorative and empathetic response that is tailored to the needs of the person and/or family's circumstances that helps them become safe in a way that is right for them. More and more research is emerging, including from the direct experiences of victims, that places control and coercion at the core of domestic abuse so it is imperative that staff across the partnership are able to recognise this and use their professional judgment appropriately to support people to best effect.

A great deal of progress has been made throughout the journey of the 2015-18 'Taking up the Challenge Towards Freedom' strategy, with a number of initiatives and specialist services available for those experiencing domestic abuse in Kirklees[5]. However, in order to truly tackle the issue, the approach needs to be holistic with more emphasis placed on preventing abuse and harm from happening in the first place. It is well documented that domestic abuse can have a devastating and long lasting impact on children and this can often be in conjunction with other adverse childhood experiences. The Domestic Abuse Strategic Partnership are therefore committed to understanding these and the links to other safeguarding issues. To prevent the incidence of domestic abuse in the future, it is recognized locally that further targeted, preventative work must be undertaken to change the social norms and reduce the number of children and young people being exposed to domestic abuse at home through engagement with schools and further education providers; through community provision, and by using innovative approaches and social media.

[4] Refreshed in March 2019 with the addition of a position statement relating to male victims
[5] Summary at Appendix 1

Preventative work in this area will also address the increase in incidents of intergenerational violence involving adolescents and parents and help children understand the difference between unhealthy and healthy relationships.

Similarly, there is increasing evidence locally and nationally in adult cases of neglect and abuse of the impact of cumulative risk. This is where a combination of mental health, domestic abuse and drugs and alcohol are prevalent in the home and result in negative, long term outcomes for families. There are also emerging concerns across children's and adult services where certain health conditions can contribute to the abusive behavior (ie. Dementia or Autistic Spectrum Disorders). The Health sector specifically can often be the first point of call for many living with domestic abuse (including GPs, A&E, Mental Health Services) so their commitment and engagement with the agenda is crucial.

Domestic abuse is disproportionately gendered but it is imperative to recognise that domestic abuse can affect everyone at some point on their lives but some groups of people can have additional vulnerabilities and/or characteristics that may require a different response. Male victims; those in LGBT+ relationships; those with physical and learning disabilities; older people; those with insecure immigration status and/or of different cultural/ethnic backgrounds should be able to feel equally as supported in accessing services and confident about how to report any concerns.

Evidence shows that those experiencing domestic abuse are more likely to face housing and/or homelessness issues, so the role of Housing Providers is key to ensure that supported housing and adequate refuge accommodation is available and able to respond locally to these needs.

In summary, the challenge of tackling domestic abuse and encouraging a tolerant society cannot rest with any one agency and it is only by adopting a 'whole family' ethos and seeing domestic abuse as part of a bigger picture, affecting multiple families and communities that Kirklees will be able to start changing perceptions and contribute to preventing abuse from happening at the earliest stage.

The 2019-21 Kirklees Vision and Approach

Tackling domestic abuse has been a key priority for Kirklees for many years. We continue to adopt a zero tolerance approach and our ambition is that people treat one another with respect and compassion. The Kirklees vision for the next three years is:

'FOR EVERYONE TO UNDERSTAND THEIR RESPONSIBILITY AND CONTRIBUTE TO TACKLING DOMESTIC ABUSE IN KIRKLEES'

Kirklees supports SafeLives' 'The Whole Picture - our strategy to end domestic abuse, for good' and in particular, the pro-active approach to widen the response to domestic abuse. This includes challenging the whole of society to deconstruct stereotypes to encourage communities to have a low tolerance and high urgency about identifying abuse. This also extends to looking at geographical communities, online spaces and employers/businesses so that they understand the risks posed by those who abuse and their role in protecting those at risk of harm. SafeLives state that 'domestic abuse is never all of someone's experiences or

situation' and with this in mind, the Kirklees Strategy will aim to provide the best provision of services for those who have already experienced abuse and violence at all levels of risk by promoting a 'whole family' approach so that the needs of the individual are not considered and acted on in isolation. Furthermore, the early intervention and prevention focus (ie. acting before someone harms or is harmed) will provide an opportunity to work far more with our communities, elected members, schools, health providers, businesses and voluntary sector services to raise awareness of the issue and increase confidence for people to report and confidence to respond when a disclosure may be made. It is paramount that communities and society are strengthened to support people experiencing domestic abuse to be safe, well and resilient but this will also need a sustainable, strong infrastructure of statutory services and provision to be in place for those most vulnerable and at highest risk.

SafeLives outlines a framework to set out the comprehensive and enduring whole picture approach that needs to be in place to tackle domestic abuse in a bid to eradicate it. This model is equally as applicable in a partnership setting and in Kirklees, we believe this is an innovative way to enable all stakeholders and communities to better understand the role we all have in this crucial agenda. Following on from this there are a number of strategic priorities that have been agreed across the partnership which will be supported by a detailed action plan and a set of capabilities that all those within the sector will need to apply.

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We believe the following framework sets out the comprehensive and enduring whole picture approach that needs to be in place for domestic abuse to be ended for good. In Section 4 we set out what role we will play in delivering this approach.

Section 1

A whole picture approach:

Ending domestic abuse, for good

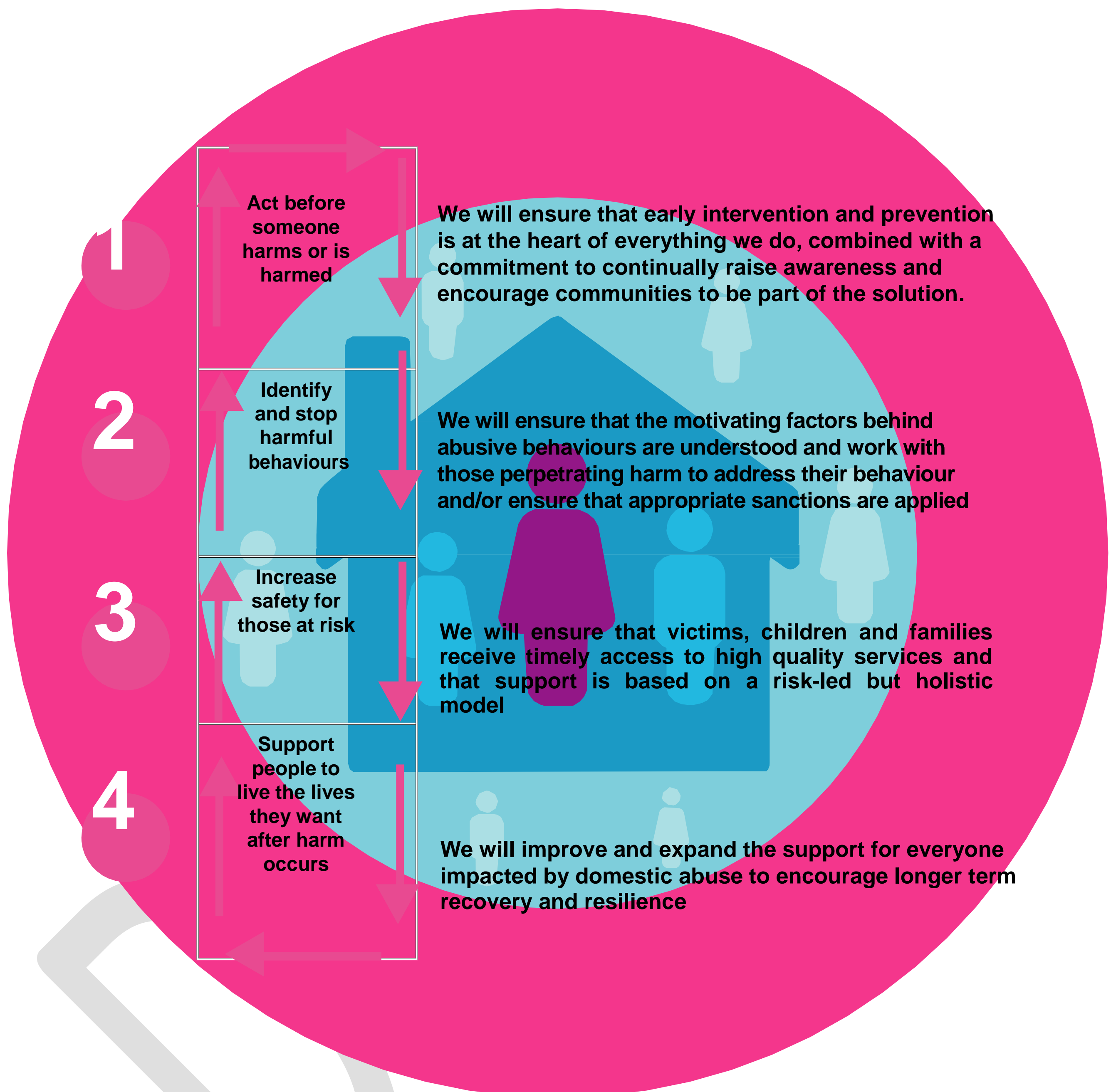
	Whole Person Seeing and responding to the whole person, not addressing a series of issues	Whole Family Adult victims, survivors, those who harm, individuals connected to the victim/perpetrator including extended family	Whole Community All communities of geography, identity and online spaces	Whole Society The general public and those who influence them: the media, politicians, employers, key opinion formers and commentators
1 Act before someone harms or is harmed	People are treated as just that – people, and not issues. The complexity of domestic abuse and links to other adverse experiences are understood.[4]	Protective factors are put in place for those at risk of abusing or being abused – people and services sufficiently understand domestic abuse and what makes it more or less likely to happen.	Communities[5] of geography, identity and online spaces are equipped to identify and act on early risk factors and warning signs of abusive situations.	Gender stereotypes are challenged and deconstructed – particularly those of masculinity – supporting boys and men to break these norms. Societal shifts see a reduction in the motivation and opportunity for different types of power to be abused.
2 Identify and stop harmful behaviours	Harmful behaviour is addressed by proactively identifying all motivating factors and consequences, such as other violence, abuse and criminality.	Individuals who abuse any family member are appropriately assessed for the risk they pose to *all* family members – and themselves.	Community members know they are more than passive bystanders – there is low tolerance and high urgency about identifying and holding to account those who abuse.	
3 Increase safety for those at risk	The protection offered to people means proactively checking that all risks posed have been addressed, not just the initial presenting issue.	The safety and wellbeing of all non-abusive family members – physical, mental and emotional – is defended from those who pose a risk to them.	Communities of geography, identity, online spaces and employers/ businesses understand the risks posed by those who abuse and their role in protecting the safety and wellbeing of those at risk.	
4 Support people to live the lives they want after harm occurs	People are responded to as people, not an issue or series of issues. Both crisis and longer-term responses to people who have experienced abuse are sensitive to their possible vulnerability to future adverse experiences.	When an immediate experience of abuse is over, all family members' safety and wellbeing – physical, mental and emotional – are (re)built. People are supported to live the lives they want, drawing strength from each other.	People who speak about their experience of abuse are believed. Communities and society validate their experience and support their process of creating safety, wellbeing and resilience so they can live the lives they want. The voices, strengths and needs of survivors are paramount, and survivors draw further strength from one another.	

The whole person: domestic abuse is never all of someone's experiences or situation.

[4]Such as child abuse, child sexual abuse, child sexual exploitation, sexual violence, trauma, mental ill health,

[5]Individuals might form an identifiable community; we work on the basis that within that community will also be a

During 2019/21 we will:



Strategic priority 1

Act before someone harms or is harmed

- Use evidence based, local and national research with a strong emphasis on survivor and 'lived' experiences to inform and implement change

- Raise awareness of domestic abuse through continued public information campaigns to influence and change attitudes and behaviours, with a focus on any emerging issues where targeted campaigns may be required

- Focus on working with schools and education to fully understand the offer within schools for both pupils and staff and build on the work of 'schools as Community Hubs'

- Increase the offer and confidence within communities to respond to domestic abuse that builds community capacity and encourages a thriving, high quality voluntary sector

Strategic priority 2

Identify and stop harmful behaviours

- Ensure that assessments and responses fully address the factors that can contribute to someone causing harm

- Place an emphasis on cases that may not necessarily require social care or formal safeguarding interventions in a bid to reduce the risk of harm and harm escalating at the earliest opportunity

- Focus on the connections between other adverse childhood experiences and domestic abuse so that children and families are supported to make the positive changes that they are involved in

- Support those perpetrating harm to address their behaviour to put the onus of responsibility on them and increase their understanding of the impact of their actions on others. Where this is not evidenced, appropriate sanctions should be applied

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Strategic priority 3

Increase safety for those at risk

- Ensure that those experiencing domestic abuse are supported through effective pathways and timely access to services (both statutory and non-statutory) so that the needs of the individuals and families are considered in a holistic way (rather than simply focusing on the initial presenting issue)

- Ensure that where disclosures are made, the partnership can support those going through the criminal justice system to achieve positive outcomes

- Where gaps in service are identified, the partnership can employ smart commissioning arrangements to ensure that all victims are supported in a way that involves them in the solution

- Ensure that there is a focus on victims with protected characteristic or other vulnerabilities that may make them 'invisible' and therefore, more susceptible to harm

Strategic priority 4

Supporting people to live the lives they want after harm occurs

- People who are experiencing abuse can retain or access safe and suitable accommodation

- Build on existing support services for those affected by domestic abuse to aid longer term recovery through traditional methods (such as therapeutic services and counselling) as well as exploring new innovative ways (such as digital and web based opportunities)

- Support those who have experienced domestic abuse to become actively involved in the agenda at a time that is right for them

- Continue to work across the partnership and communities so that the longer term impact of abuse is understood and strive to provide longer term capacity where there may still be difficulties (such as financial hardship, issues over child contact, insecure immigration status).

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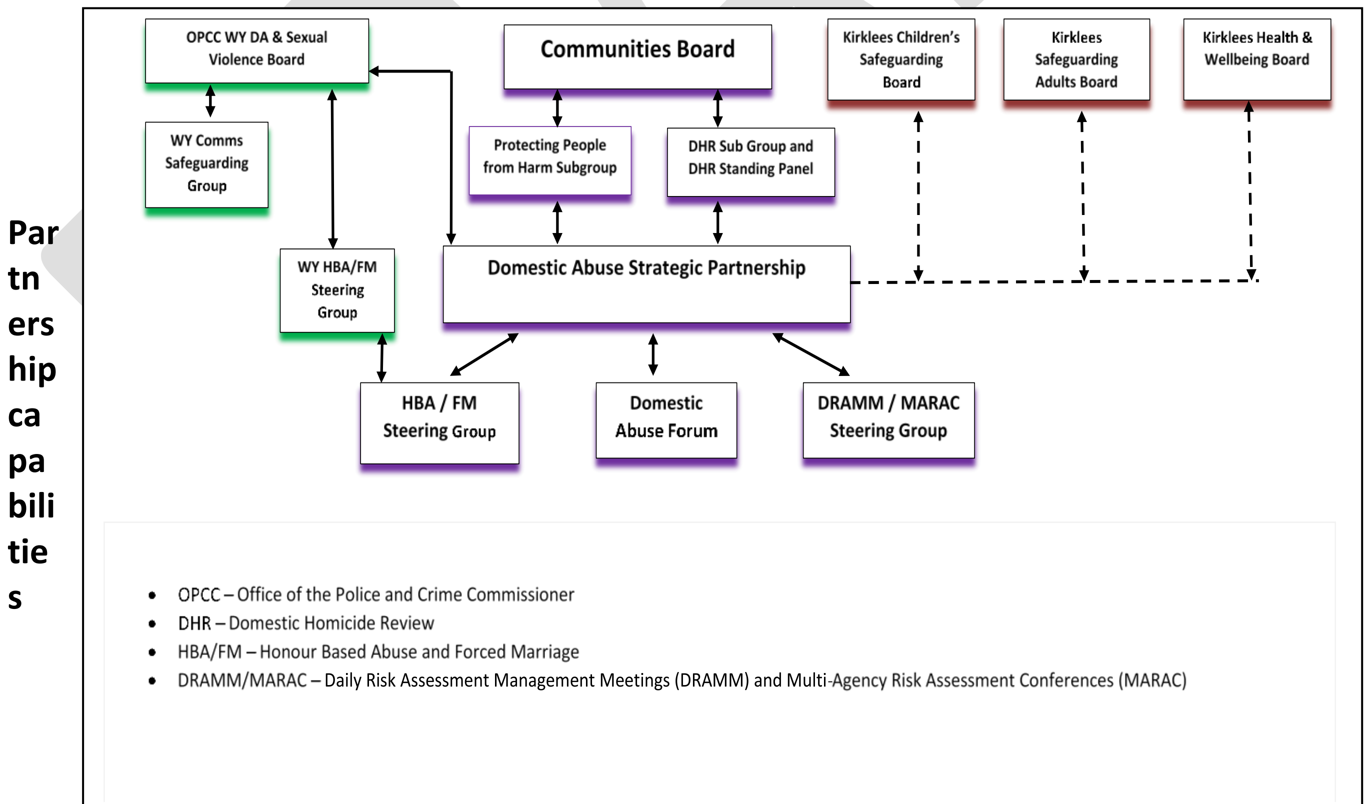
Governance

The area of Domestic Abuse is governed by the Kirklees Communities Board and is a priority in the Safer Kirklees Partnership Plan under the strand of 'Protecting People from Harm.' Given the cross cutting nature of Domestic Abuse and the impact this has on all communities and groups of people, it is also linked to the key objectives set out in the Safeguarding Adults Board Strategic Plan; the Children's Safeguarding Board's Business Plan as well as complementing wider Kirklees strategic groups such as the Health & Wellbeing Board and other connected agendas (sexual abuse, Child Sexual Exploitation, Prevent, Modern Day Slavery, Female Genital Mutilation and Gangs/Gang Violence).
Reducing the prevalence of Domestic Abuse is a key priority for Kirklees and the main group established to lead on implementing the Kirklees Domestic Abuse Strategy and associated action plans is the Domestic Abuse Strategic Partnership (DASP). The DASP is an effective, multi-agency group of senior representatives from all relevant agencies and is committed to addressing the impact of domestic abuse in Kirklees.
There are also a number of operational subgroups that feed into this group, namely the Domestic Abuse Forum; the Daily Risk Assessment Management Meetings (DRAMM) and Multi-Agency Risk Assessment Conferences (MARAC) Steering Group and the Honour Based Abuse and Forced Marriage Steering Group, In addition to this, Domestic Abuse is considered and tackled at a regional level through the Office of the Police and Crime Commissioner's (OPCC) Domestic Abuse and Sexual Violence Board.



Partnership capabilities

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der to achieve the vision set out in this strategy, it is critical that the partnership collectively apply the following capabilities**:**

Leadership and strong partnerships, evidenced by:

- validation at all levels of all organisations
- engagement and buy in by elected members and strategic leads with an increased offer to help them in their roles as community leaders
- successful collaborations outside the partnership (ie. with businesses; other authorities and organisations) to create funding opportunities

Understanding and knowledge, evidenced by

- research, including using the learning from DHRs, SARS and SCRs
- using the voice of the victim and experiences of those who have lived with/witnessed domestic abuse (including children)

Skills, confidence and motivation, evidenced by

- the workforce stability and ability to attract and retain staff from a range of backgrounds and experiences
- quality of staff and client interventions
- continual learning to enhance existing skills
- reflective supervision

Continual learning, evidenced by

- dynamic and quality assured training delivery which responds continually to new and emerging issues (ie. legislative and/or following local research)
- practitioner events being established quarterly
- training records and evaluations

Quality assurance and accountability, evidenced by

- partnership inspections and case file audits
- good quality DHRs, SARs and SCRs
- critical friend and peer reviews
- acting and implementing national best practice in a range of settings

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KIRKLEES HEALTH & WELLBEING BOARD
MEETING DATE: 13.06.2019
TITLE OF PAPER: Opportunities for oral health improvement

1. Purpose of paper

To update Kirklees Health and Wellbeing Board about the work on oral health needs assessment of the local population and highlight opportunities to improve oral health in light of the Councils statutory responsibilities.

2. Background

Local authorities have statutory responsibilities for oral health as outlined in The Health and Social Care Act 2012. Some of these responsibilities are to:

- secure the provision of oral health improvement programmes to improve the health of the local population to the extent that they consider appropriate in their areas
- secure the provision of oral health surveys
- participate in any oral health survey conducted or commissioned by the secretary of state
- make proposals regarding water fluoridation schemes, including a duty to conduct public consultations in relation to such proposals and powers to make decisions about such proposals.

Good oral health is an integral component of general health and wellbeing. The Oral Health Strategy is in line with Kirklees Joint Strategic Assessment (KJSA) and aims to capture the good practices for oral health improvement and provide a baseline evaluation of the oral health of the local population in regional and national context. Furthermore, the Strategy will support the coordinated activities in Kirklees and Calderdale in order to reduce oral health inequalities and to achieve sustainable improvements in oral health with a particular emphasis on children and vulnerable adults. The Strategy will provide a shared platform for partnership working with NHS England, local dentists, oral health promotion services, Healthwatch and other stakeholders to deliver improvements in oral health

3. Proposal

We hope to achieve the goals mentioned above by setting up a joint Oral Health Action Group (OHAG) between Kirklees and Calderdale Councils which will report directly to the Health and Wellbeing Boards of each Council. The joint OHAG will have separate actions plans which are in line with the specific priorities and ways of working of the two Councils.

4. Financial Implications

The are no financial implication for the Council. The actions are evidence-based interventions developed in line with recommendations from Public Health England (PHE) Commissioning Better Oral Health and Return on Investment Tool.

5. Sign off

Rachel Spencer-Henshall
Strategic Director – Corporate Strategy, Commissioning and Public Health

6. Next Steps

The first OHAG is will meet on the 28th of June 2019 to agree the Terms of Reference and adopt the Strategy and Action Plan and any recommendations from The Health and Wellbeing Board.

7. Recommendations

- For the Health and Wellbeing Board to endorse and support the development of the joint Oral Health Advisory Group

8. Contact Officer

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Kirklees Council: opportunities for oral health improvement

Stefan Serban DMD, MPH, PhD
Specialty registrar (ST5) in Dental Public Health
NIHR Clinical Lecturer

Public Health
England

Overview

- Regulatory Framework
- Impact of good oral health on life course approach
- Oral health needs assessment
- Evidence base
- Current activities and opportunities for working together

Public Health
England

Regulatory framework

Statutory dental public health responsibilities of local authorities include:

- securing the provision of oral health improvement programmes to improve the health of the local population to the extent that they consider appropriate in their areas
- securing the provision of oral health surveys
- participation in any oral health survey conducted or commissioned by the secretary of state
- making proposals regarding water fluoridation schemes, including a duty to conduct public consultations in relation to such proposals and powers to make decisions about such proposals

The Health and Social Care Act 2012

Public Health
England

Impact of good oral health life course approach

Life course stages
Source: Action across the life course, Marmot Review, 2010

Oral Health through a **life course** lens

Decay in baby teeth can lead to misaligned, unhealthy and malformed adult teeth.

Time off school.

Impact upon aesthetics/ reduced self-esteem.

Monetary and time costs.

Poor oral hygiene and periodontal disease are risk factors for pneumonia and adversely affect diabetes outcomes.

In adults and older people, tooth loss can severely restrict dietary intake, particularly fresh fruits and vegetables[8].

Public Health England

Prevalence of tooth decay in 5 year old children

% d3mft > 0

Area	% d3mft > 0
Barnsley	
Bradford	39.8
Calderdale	29.3
Craven	21.4
Doncaster	
East Riding of Yorkshire	
Hambleton	22.5
Harrogate	19.1
Kingston upon Hull	32.8
Kirklees	32.5
Leeds	31.1
North East Lincolnshire	22.9
North Lincolnshire	22.2
Richmondshire	22.3
Rotherham	
Ryedale	18.6
Scarborough	29.4
Selby	29.3
Sheffield	
Wakefield	28.8
York	15.9
Yorkshire and The Humber	30.4
England	23.3

National Dental Public Health Epidemiology Survey 2017

Public Health England

Mean d3mft (total) 5 year olds

Mean d3mft

Area	Mean d3mft
Barnsley	
Bradford	1.8
Calderdale	1
Craven	0.7
Doncaster	
East Riding of Yorkshire	
Hambleton	0.6
Harrogate	0.5
Kingston upon Hull	1.1
Kirklees	1.1
Leeds	1.1
North East Lincolnshire	0.9
North Lincolnshire	0.6
Richmondshire	0.7
Rotherham	
Ryedale	0.5
Scarborough	0.7
Selby	0.8
Sheffield	
Wakefield	0.9
York	0.6
Yorkshire and The Humber	1.1
England	0.8

National Dental Public Health Epidemiology Survey 2017

Public Health England

% with incisor caries 5 year olds

Area	%
Barnsley	
Bradford	11.4
Calderdale	5.1
Craven	6.8
Doncaster	
East Riding of Yorkshire	
Hambleton	2.3
Harrogate	1.7
Kingston upon Hull	8
Kirklees	9.3
Leeds	9.5
North East Lincolnshire	5.7
North Lincolnshire	3.6
Richmondshire	4.7
Rotherham	
Ryedale	2.1
Scarborough	4.8
Selby	3.2
Sheffield	
Wakefield	5.2
York	3.6
Yorkshire and The Humber	7.5
England	5.1

National Dental Public Health Epidemiology Survey 2017

Public Health England

Ward	Prevalence (%)	Average dmft (n)
Dewsbury West	51.5	4.79
Batley West	43.8	5.19
Newsome	40	3.2
Dewsbury South	38.9	3.22
Dewsbury East	33.3	2.33
Heckmondwike	33.3	1.93
Crosland Moor and Netherton	25	2.75
Liversedge and Gomersal	24.4	0.93
Ashbrow	20	0.2
Holme Valley North	20	0.95
Cleckheaton	19.4	1.65
Colne Valley	16.7	0.75
Golcar	16.7	4.17
Mirfield	10.5	0.37
Denby Dale	7.7	0.15
Holme Valley South	5	0.3
Almondbury	0	0
Birstall and Birkenshaw	0	0
Kirkburton	0	0
Kirklees	**28.9**	**1.1**
Yorkshire and Humber	**28.5**	**1**
England	**24.7**	**0.8**

National Dental Public Health Epidemiology Survey 2017

Public Health
England

dmft (decayed, missing or filled teeth) in 5 year olds

Mean dmft

2.5
2
1.5
1
0.5
0

2007/08
2011/12
2014/15
2016/17

England
Yorkshire and Humber
Calderdale
Kirklees

Other vulnerable groups

- People living with dementia
- People living in care homes
- Looked after children
- Refugees
- Homeless

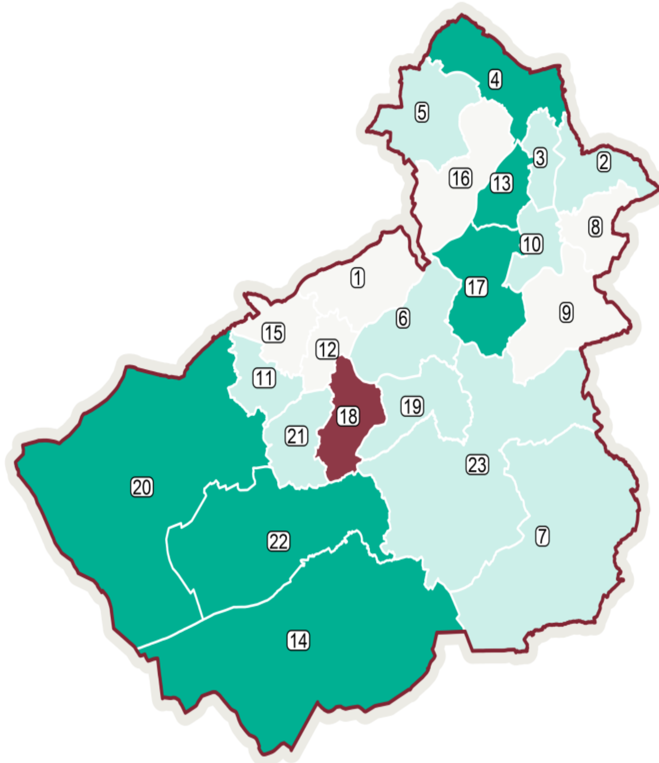
Access to dental services

Local Authority	Population (ONS Mid-2015 Estimates)	Number of Contracts	Patients Seen in Previous 24 Months (at March 2017)	Patients Seen in Previous 24 Months as % of Population
Calderdale	208,402	25	128,807	62%
Kirklees	434,321	52	254,491	59%
Yorkshire and the Humber	5,512,158	651	3,173,133	57.6%
England	54,786,327	NA	NA	55.4%

NHS BSA Data 2017

Public Health
England

Dental access rate by ward 2016/17: Kirklees



Kirklees	
1 Ashbrow	21 Crosland Moor and Netherton
2 Batley East	22 Holme Valley North
3 Batley West	23 Kirkburton
4 Birstall and Birkenshaw	
5 Cleckheaton	
6 Dalton	
7 Denby Dale	
8 Dewsbury East	
9 Dewsbury South	
10 Dewsbury West	
11 Golcar	
12 Greenhead	
13 Heckmondwike	
14 Holme Valley South	
15 Lindley	
16 Liversedge and Gomersal	
17 Mirfield	
18 Newsome	
19 Almondbury	
20 Colne Valley	

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Access 0-4 year olds

Wards in Kirklees	0-4 years (%)
Colne V	58
Holme V North	57.5
Mirfield	56.8
Golcar	56.3
Birstall&birke	55.8
Holme v south	53.7
Liversedge	52.4
Heckmondwike	51.9
Lindley	51.6
Cleckheaton	51.4
Dews South	50.6
Kirkburton	50.1
Almondbury	48.9
Batley East	48
Dalton	47.6
Dewsbury East	47.1
Newsome	47
Greenhead	46.5
Batley W	46.3
Dewsbury West	45.2
Denby Dale	44.4
Crossland Moor	42.2
Ashbrow	41.8

NHS BSA Data 2017

Public Health England

Hospital extraction data

	Age 0-4 years (%)	Age 5-9 years (%)	Age 10-14 years (%)	Age 15-19 years (%)	Total (n)
Calderdale	22.1	61.4	14.2	2.2	402
Kirklees	20.7	60.9	14.1	4.3	668
England	19.3	58.2	15.0	7.5	39,010

NHS BSA Data 2017

Public Health England

Percentage of FP17s for 3-16 year olds which include fluoride varnish (2016-17)

Local authority	Percentage
Barnsley	70.0%
Rotherham	68.7%
Doncaster	66.3%
East Riding of Yorkshire	65.8%
Sheffield	65.6%
North Lincolnshire	62.3%
Kingston Upon Hull	58.4%
North Yorkshire	57.4%
Bradford	55.4%
Kirklees	53.0%
Wakefield	52.8%
Leeds	52.0%
York	51.7%
Calderdale	46.5%
North East Lincolnshire	39.0%

0% 10% 20% 30% 40% 50% 60% 70% 80%

Public Health England

Return on investment of oral health improvement programmes for 0-5 year olds*

Reviews of clinical effectiveness by NICE (PH55) and PHE (Commissioning Better Oral Health for Children and Young People, 2014) have found that the following programmes effectively reduced tooth decay in 5 year olds:

£1=	Targeted supervised tooth brushing programme	A targeted fluoride varnish programme	Water fluoridation provides a universal programme	Targeted provision of toothbrushes and paste by post	Targeted provision of toothbrushes and paste by post and by health visitors
After 5 years	£1 spent = £3.06	£1 spent = £2.29	£1 spent = £12.71	£1 spent = £1.03	£1 spent = £4.89
After 10 years	£1 spent = £3.66	£1 spent = £2.74	£1 spent = £21.98	£1 spent = £1.54	£1 spent = £7.34

Varnish

*All targeted programmes modelled on population decayed, missing or filled teeth (dmft) index of 2, and universal programme on dmft for England of 0.8. The modelling has used the PHE Return on Investment Tool for oral health interventions (PHE, 2016). The best available evidence has been used in this tool and where assumptions are made these have been clearly stated

PHE Publications gateway number: 2016321

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Public Health
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Current activity

- Whole systems approach to tackling obesity, which will take a multi-pronged approach to reducing sugar consumption amongst C & YP.
- Oral health advice provided to parents at all core 0-19 Practitioner contacts, including:
  - Breastfeeding
  - Infant feeding
  - Diet and nutrition
  - Dental check by one
  - Importance of regular dental check-ups
  - Importance of early introduction of effective brushing of teeth with fluoride toothpaste

This advice is given in line with PHE Guidance:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605266/Delivering_better_oral_health.pdf

Public Health
England

Opportunities for working together

- Integration of oral health in all policies
- Training of the workforce in the latest evidence based information
- System leadership
- Oral health advisory group: access (NHSE), FV GDPs, FC

KIRKLEES HEALTH & WELLBEING BOARD
MEETING DATE: 13th June
TITLE OF PAPER: Development of the West Yorkshire and Harrogate 5-Year Strategy for Health and Care

1. Purpose of paper

1.1 To seek the views, ideas and input of the Kirklees Health and Wellbeing Board into the development of the 5 Year Strategy for Health and Care in West Yorkshire and Harrogate.

1.2 To update the Kirklees Health and Wellbeing Board on the progress of the West Yorkshire and Harrogate Health and Care Partnership.

2. Background

2.1 Kirklees has been part of the West Yorkshire and Harrogate Health and Care Partnership since it began in March 2016. Last year, in May 2018 the Partnership became an Integrated Care System (ICS)[i] in development and has been working to develop the sophistication of process and relationships that means, in future, the partnership itself will be able to take on some powers and budgets from national bodies. This will mean that decisions about investment in health and care can be taken more locally by those with a closer relationship to the impact of the funds and decisions.

2.2 In February 2018, the WYH HCP published 'Our Next Steps to Better Health and Care for Everyone'[ii] that described the partnership outcomes that have been agreed are important: investment in prevention, primary care and mental health, community-wellbeing, better join up between 'health' and 'care' and democratic accountability and transparency about where all partners direct our collective resources.

2.3 "Our Next Steps" also described some of the early successes that have been achieved by working together in partnership, particularly in the 15 Programmes[iii] of work that pass the subsidiarity test for things that need to be worked on jointly at the West Yorkshire and Harrogate level. Case studies[iv] from each of these programmes can also be downloaded from the West Yorkshire and Harrogate Partnership website.

2.4 On 7th January 2019 the NHS Long Term Planv for England was published. This sets out the Government's ambition for how the NHS can respond to the challenge of planning future health services for England in the context of demographic changes, increased demand and the overall environment of finite financial resources.

2.5 The document contains a bold vision that situates health services in the context of Population Health[vi] – and includes references to health services set within the wider policies and outcomes that impact on health and wellbeing. This is something that Health and Wellbeing Boards have been advocating for, for many years.

2.6 The NHS Plan includes the commitment that every Integrated Care System in the country will develop a new 5 Year Strategy for Health and Care.

2.7 An NHS England/NHS Improvement "5-year Strategy Implementation Framework" is expected to be published imminently. At this point we are not clear on the depth or specificity of the document. Our clear message to NHSE/I is that this should be a high level enabling framework that creates space for 5-year strategies to respond to local priorities.

2.8 Within this, we anticipate that there will be some specific 'must do's' for all systems around the country, most likely to be framed around the priorities contained in the NHS long term plan. As a Partnership, we have agreed that our approach will continue to be to develop our own strategy that relates to our local area, which we will then cross-check against these national requirements.

2.9 The final deadline for submission to NHSE/I of the 5-Year Strategy will be the end of October 2019.

2.10 On 4th June 2019, the first meeting of the West Yorkshire and Harrogate Health and Care Partnership Board will take place. This will be a meeting in public and will take place in the Council Chamber in Leeds Civic Hall.

2.11 The Partnership Board will discuss how it wishes to develop the 5-Year Strategy and how to involve and seek the views and ideas from the 6 Health and Wellbeing Boards that cover West and North Yorkshire.

2.12 At the time of writing, this Partnership Board meeting has not yet taken place, but a verbal update will be include during the Health and Wellbeing Board meeting.

3. Proposal

3.1 In Kirklees, the Health and Wellbeing Strategy 2014-2020 continues to guide our efforts to improve health and care for people in Kirklees – in particular, creating a better place for the future, for healthy people enjoying a great quality of life for longer via a strong and growing economy.

3.2 In common with most ICS around the country, the WY&H Partnership estimates that approximately 80% of the work of partners is arranged around either neighbourhood or Health and Wellbeing Board footprints. And that we only work at West Yorkshire and Harrogate level when it makes sense to do so. The WY&H Partnership has been clear from the beginning on the principle of subsidiarity. WY&H Partnership is the servant of place.

3.3 The development of the 5 Year Strategy is a significant opportunity for Kirklees, as part of the wide West Yorkshire and Harrogate Health and Care Partnership, to work with others on a wider footprint to provide better outcomes from specialist services, to learn from and share learning with our neighbours to improve outcomes and to be able to access funds, resources and experts that we would not be able to attract if working in isolation.

3.4 As a wider partnership, we have already set out our shared ambition to work together so that all 2.6m people in West Yorkshire and Harrogate can:

- live and work in healthy environments, and have the right kind of information, opportunities and support to look after our own health and wellbeing

- have quick and easy local access to holistic primary and community care services

- have clear routes and pathways to world class care, free at the point of delivery, when needed

3.5 The development of the 5 Year Strategy enables us to ensure that we are putting our efforts and resources in the right places, to make this ambition a reality.

3.6 As well as a continued commitment to integrating services so that they are high quality and easy to access, the partnership nature of the strategy will allow for us to articulate more clearly the emphasis we place on the wider determinants of health. Encouraging all partners to work together in influencing the factors that ensure healthy environments: decent housing, access to green and blue space, health integrated into planning and urban design, and the kind of inclusive growth that expands employment and opportunity that drives good lifetime health.

3.7 It also offers the opportunity to review what things we work on at the West Yorkshire and Harrogate level and to update the way we describe why we are working at that level and what outcomes we want to see from it.

3.8 A cross-partnership working group has done some initial thinking on this and proses to re-frame the programmes into 4 broad categories:

  - Those with an emphasis on Improving Population Health – including explicit reference to tackling health inequalities and the wider determinants of health

  - Those that are focused on improving care and outcomes for specific population groups / cohorts – including the new focus on Children, Young People and Families

  - Transformation programmes which aim to change the way people access or interact with services

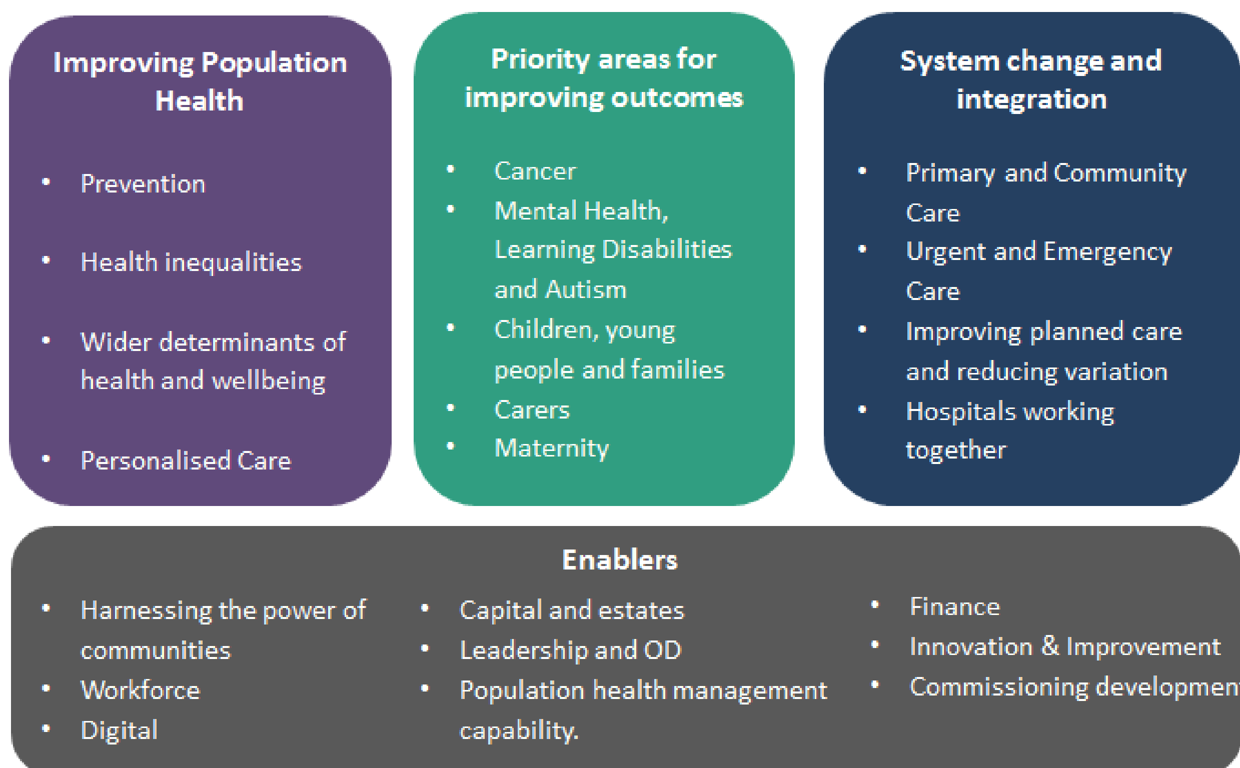

Fig 1. This draft of proposed Programmes will be considered by the Partnership Board on 4th June

- Expanding the set of enabling work streams, to include leadership and Organisational Development, commissioning development and the ICS financial framework

3.9 This includes It is proposed to develop working arrangements at West Yorkshire and Harrogate to two new priority areas:

- Children Young People and Families and
- Improving Population Health

3.10 **Children, young people and families**

3.11 The development of the 5 Year Strategy enables us to ensure that we are putting our efforts and resources in the right places, to make this ambition a reality.

3.12 As well as a continued commitment to integrating services so that they are high quality and easy to access, the partnership nature of the strategy will allow for us to articulate more clearly the emphasis we place on the wider determinants

3.13 We know that the health and wellbeing of children and young people is determined by far more than healthcare services. Household income, education; housing, stable and loving family life and a healthy environment all significantly influence young people's health and life chances. In isolation, better healthcare services could never fully counteract the health impact of wider social and economic influences.

3.14 The NHS Long Term Plan (LTP) sets the direction and priorities for a Strong Start in Life for Children and Young People and nationally, a Children and Young People's Transformation Programme will be established.

3.15 In February 2019 the House of Commons published the First 1000 Days of Life Report[vii] that recommends that Government set demanding goals to reduce adverse childhood experiences, improve school readiness and reduce infant mortality and child poverty.

3.16 In 2019 the Royal College of Children's and Paediatric Health published a report the State of Our Childs Health – Two Years On[viii] which revealed alarming health inequalities between the UK's most disadvantaged children and young people and their more affluent peers. Nearly one in five children in the UK is living in poverty and inequality is blighting their lives, with those from the most deprived backgrounds experiencing much worse health compared with the most affluent.

3.17 In West Yorkshire and Harrogate Children and young people (aged 0-18) account for 23% (570,000) of the total population. Improving the health and wellbeing of children and young people is an investment in future generations and the prosperity of this country.

3.18 Many of our children and young people are already achieving positive outcomes across aspects of well-being and enjoy life to the full. Over recent years we have seen improvements across WY&H (including North Yorkshire) most notably school readiness has increased from 51.2% in 2012/13 to 67.5% in 2017/18.

3.19 However, we know that too many of our children and young people still live with poor mental health, in poverty, experience homelessness or insecure or unsafe environments. Recent figures for West and North Yorkshire show:

- Infant death rates for England are declining, however in WY&H the rates have been increasing year on year since 2012.
- The rate of hospital admissions for dental caries (0-5 years) per 100,000 is 64% higher in WY&H (534 per 100,000) compared to England (325 per 100,000).
- 19.2% of WY&H children aged 0-16 are living in families in receipt of Child Tax Credit whose reported income is less than 60 per cent of the median income or in receipt of ISA/JSA. The England average in 2016 was 17%.
- The rate of children who started to be looked after due to abuse or neglect across WY&H is 17 per 10,000 children aged under 18.
- The rate of Children and young people killed and seriously injured (KSI) on England's roads per 100.000 is 10% higher in WY&H (45 per 100,000) compared to England (41 per 100,000).

3.20 Each local authority area has a Children and Young People's Plan[ix]. Ofsted inspection findings vary across WY&H for Education, Children's Homes,

Childcare,Children’s Social Care, Local Area Special Educational Needs or Disability (SEND) and Providers of support to looked after children.

3.21 The local child health profiles show that there are common health outcomes across the system where challenges are shared e.g. children and young people road accidents, and there are outcomes where inequalities can be seen consistently across the system.

3.22 Currently there is not an infrastructure across the health and care system for integrated working that would allow for the sharing and learning of good practice. We also know there are significant challenges in the workforce, particularly in paediatrics, which creates challenges not only for children’s care but for maternity and neonatal care.

3.23 Many of the WY&H HCP programmes already include a focus on children, young people and families. The West Yorkshire Association of Acute Trusts have been developing a Clinical Strategy on behalf of the WY&H HCP and have produced a report on the early engagement work on CYP&F.

3.24 Regionally there are also a number of work programmes addressing CYP&F health provision including: Public Health England, Yorkshire and the Humber (Y&H) Maternity and CYP Mental Health Clinical Networks, Y&H Palliative Care Network, Y&H Children’s Partnership Group. There are also a number of partnership approaches addressing CYP&F social care and wellbeing, for looked after children, there is White Rose approach across 12 Local Authorities, and the 5 West Yorkshire Local Authorities collaborate around the provision of fostering services.

3.25 **Proposed Ways of Working**

3.26 It is proposed that we develop a new programme at West Yorkshire and Harrogate level that will focus on the added value of working together as a system and will include opportunities to address heath inequalities, complex issues and influence or implement actions at scale or standardise practice to improve outcomes for all children, young people and families in our area.

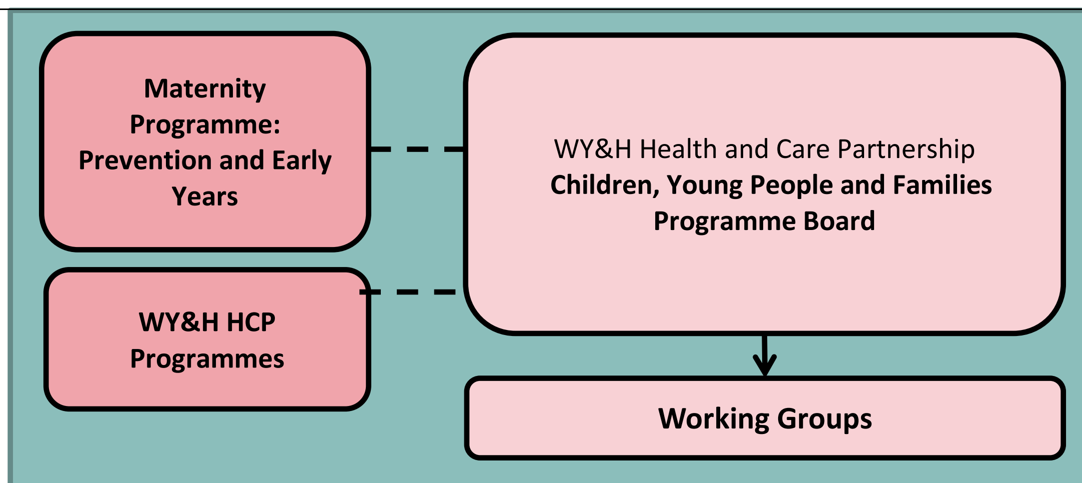

Fig 2. Proposed structure for the Children and Young People's Programme

3.27 The programme will be guided by the agreed principles of subsidiary and only work where there is added value to the joint work already going on between local Health and Wellbeing Boards and Children's Trust Boards.

3.28 It is proposed to establish a Children Young People and Families Programme Board, and extend the Maternity Prevention Work to cover Pre-conception to First 1000 Days. These will have clear links to the existing WY&H HCP Programmes.

3.29 Further working groups will then provide dedicated focus taking forward specific priority areas as agreed by the Board.

3.30 **Improving Population Health**

3.31 The NHS Long Term Plan states an expectation that the NHS should contribute more to the prevention of ill health, reducing health inequalities and stepping up its efforts at addressing the wider determinants of health.

3.32 "Health inequalities" are the unjust differences in health experienced by people from different population groups. For example in West Yorkshire and Harrogate, the more socio-economic deprivation that a person experiences in their life, the higher their chance of dying prematurely and living for more years in ill-health.

3.33 The "wider determinants" are similar to the factors stated in the previous section on children's health, we know that determinants for healthy lives are more significantly impacted by socio-economic, education and environmental factors than just the quality of health and care services available.

3.34 The NHS Long Term Plan also proposes new models of care and ways of working which provide opportunities to embed a population health approach including; the development of Primary Care Networks, Social Prescribing, Personalised Care, Population Health Management, Workforce Development and Digital.

3.35 The forthcoming Green Paper on Prevention also has anticipated opportunities for partnership working.

3.36 Manifestly, no one part of the system can achieve this step change in isolation and all partners recognise the need to work together on the shared ambition to improve the conditions for healthy lives and actively reducing the inequality in healthy life expectancy.

3.37 The Improving Population Health Programme proposes that we take the opportunity of working as a partnership to help tackle these inequalities through maximising prevention across health and social care and through our influence on wider public services.

3.38 This would include:

- Prioritising collective population health action across the system
- Enhancing effort and resources towards action that improves health and wellbeing outcomes as far upstream as possible.

3.39 We know that ppeople in WY&H have a shorter average life expectancy than the rest of England. Males lives are, on average, 1 year shorter than the England average and females almost 10 months shorter.

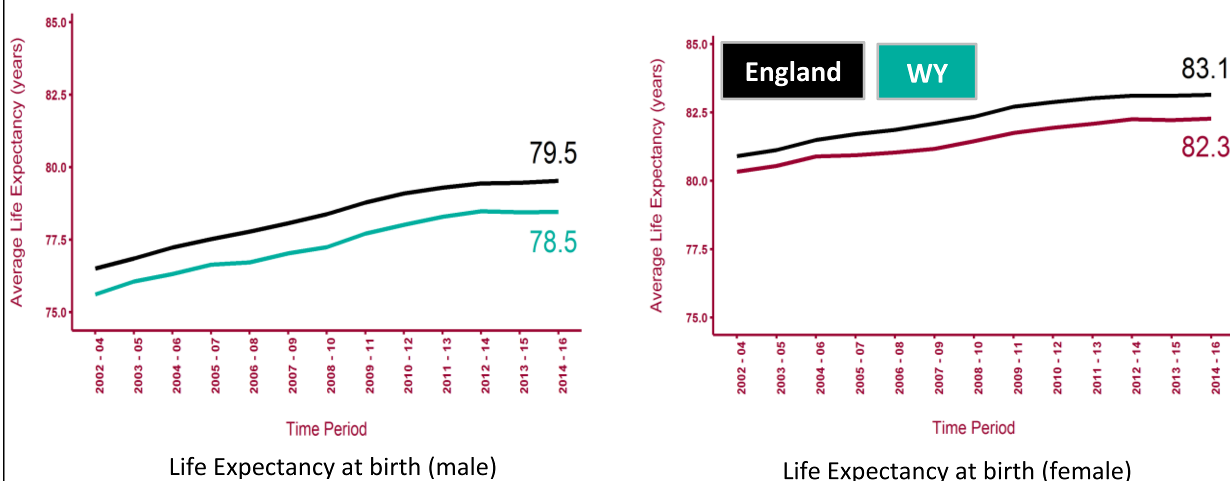

Figure 3: Average Life Expectancy for Males and Females in WYH and England

3.40 Life expectancy varies between the Health and Wellbeing Board areas in the partnership and also within them and this can be as much as 17 years difference.

3.41 There is a strong association with health outcomes and deprivation. Around 480,000 people in West Yorkshire and Harrogate live in areas that fall into the 10% most disadvantaged areas in the country

3.42 Working together as a partnership provides an opportunity to collectively address the wider determinants such as income which have a pronounced impact on inequalities in health.

3.43 <u>Current Prevention at Scale Programme</u>

3.44 In October 2016 the partnership set out three ambitions for prevention:

3.45 To reduce smoking prevalence from 18.6% in 2015/16 to 13% by 2020-21. To date, the programme is on target, and has seen a reduction to 17.3%- meaning 23,000 fewer people smoking across the WY&H footprint.

3.46 To reduce alcohol related hospital admissions by 500 a year and achieve a 3% reduction in alcohol related non-elective admissions by 2021. We have already seen a reduction of 9%, which greatly exceeds the trajectory of 3%.

3.47 To reduce the number of people at higher risk of diabetes developing the condition. The ambition was to offer 50% of those at high risk of diabetes preventative support through the National Diabetes Prevention Programme. To date the programme has exceeded the target for number of referrals, with 5022 referrals received against a target of 4829, from June 2017 – November 2018.

3.48 These ambitions were underpinned with the aim of improving the prevention contribution of the health and care workforce.

3.49 The rationale for these ambitions was to prioritise areas that would have the greatest potential impact in the shortest timescale to reduce demand on NHS services. For example achieving the proposed reduction in smoking prevalence will mean a saving to the NHS of £94 million over 5 years. In addition those 125,000 people would no longer be spending £456 million on tobacco products each year.

3.50 **Proposed Ways of Working**

3.51 The majority of Improving Population Health actions will continue to be implemented in local places.

3.52 The work covered by the proposed Improving Population Health programme would be only those activities that would pass the subsidiarity test and be best worked on at the wider population level. Working together would also provide the opportunity to identify what good looks like at place, share good practice and help make the case for shifting or investing in further targeted resources.

3.53 The new programme at West Yorkshire and Harrogate level would require:

- Some additional capacity to deliver Public Health input from place into the WY&H ICS Programmes
- Continued Clinical engagement where appropriate into the Prevention Programme.
- Continued capacity from Public Health England
- Some access to additional financial resource in the system to address identified priorities

3.54 The proposed governance is set out in the diagram below. This includes the creation of an Improving Population Health Programme Board that would have clear

links to WY&H HCP Programmes, specifically the Population Health Management Network, the Prevention Workstream, Health Inequalities Workstream and the Health and Housing Group.

3.55 Any further working groups can then provide dedicated focus taking forward specific priority areas as agreed by the Improving Population Health Programme Board.

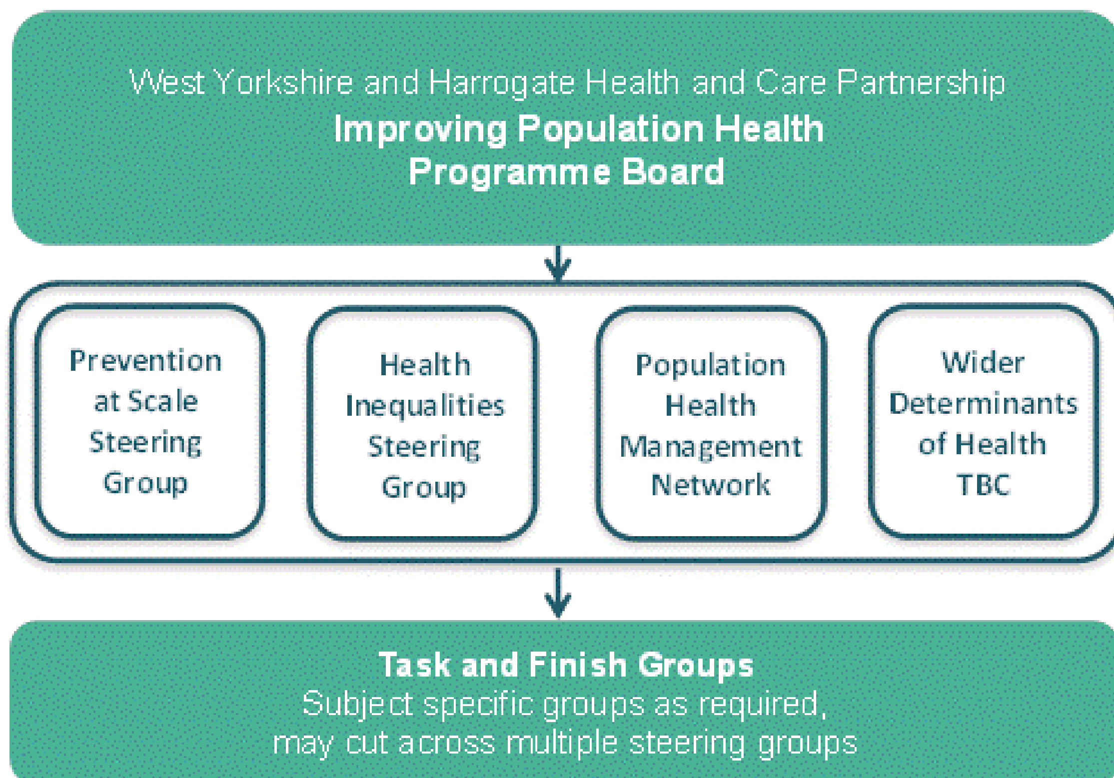

Fig 3. Proposed governance for the Improving Population Health Programme

3.55 Health and Wellbeing Board governance

3.56 **Consultation, engagement and hearing citizen voice**

3.56.1 Consultation on the 5-year strategy will build on the extensive engagement that has been undertaken at place and WY&H level over recent years. Our engagement work is a continuous activity, working with the right people, on the right issues at the right time. We have benefited from local networks, the reach of the third sector and novel approaches to engaging the public.

3.56.2 Recently, this has included over 1,500 people across WY&H who have completed surveys on the NHS Long Term Plan This work has been co-ordinated by Healthwatch and engagement leads from across partner organisations. There were two surveys - one on long term conditions and another on personalisation and digital. A series of focus groups aimed at seldom heard groups of people also took place covering personalisation, digitalisation and local place conversations. A focus group also took place with the Cancer Alliance. This work ended on 3 May 2019. Findings will be shared in a report submitted to NHS England, National Healthwatch and the WYH HCP at the end of June 2019.

3.56.3 As part of the process, NHS England has commissioned each local Healthwatch to undertake a piece of specific engagement work on the NHS Long Term plan, particularly focusing on "hearing the voices of the seldom heard". This will feed into the development of our Partnership's 5-year strategy.

3.56.4 The intention is for Healthwatch to complete a report in June to share with Healthwatch England and the Partnership. This will continue the strong role of Healthwatch on our Partnership.

3.57 **Consultation, engagement and hearing citizen voice**

3.57.1 Consultation on the 5-year strategy will build on the extensive engagement that has been undertaken at place and WY&H level over recent years. Our engagement work is a continuous activity, working with the right people, on the right issues at the right time. We have benefited from local networks, the reach of the third sector and novel approaches to engaging the public.

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3.57.4 The intention is for Healthwatch to complete a report in June to share with Healthwatch England and the Partnership. This will continue the strong role of Healthwatch on our Partnership.

3.57.5 Equality and diversity / cohesion and integration

3.57.6 The development of the 5 Year Strategy in this way is intended to specifically step up our efforts across the Partnership and in all partner organisations to reduce health inequalities, tackle the causes of health inequalities and to reduce all unnecessary variation across population groups and geographies of West Yorkshire and Harrogate.

4. Financial Implications

4.1 There is a net financial gain to the West Yorkshire and Harrogate footprint through working together in this way. This includes access to transformation monies that are

exclusive to Integrated Care Systems and improved joint bidding capacity for other types of funding such as academic research, and monies from non-NHS sources such as Charitable Foundations.

5. Sign off

Richard Parry – Strategic Director of Adults and Health

6. Next Steps

6.1 There are significant opportunities for Kirklees to develop and enhance the progress of the West Yorkshire and Harrogate 5 Year Strategy for Health and Care.

6.2 The ambitions of the 5 Year Strategy are informed by and dependant on the 6 Health and Wellbeing Boards across West and North Yorkshire and the WYH HCP will continue to work with and through Health and Wellbeing Boards to implement the strategy.

7. Recommendations

The Kirklees Health and Wellbeing Board is asked to:

7.1 Input views and ideas into the overall development of the 5 Year Strategy for Health and Care in West Yorkshire and Harrogate.

7.2 Contribute specific feedback to the development of the 2 new programmes including how these can be achieved through closer working with the 6 Health and Wellbeing Boards across West and North Yorkshire.

8. Contact Officer

Rachael Loftus and Ian Holmes

Tel: 07891 271054/ 07983 583158

[i] Integrated Care System (ICS) are partnerships of health and care organisations (including the Ambulance Service, Community Healthcare providers, Clinical Commissioning Groups, Healthwatches, Hospital Trusts, Local Authorities, Mental Health Trusts and the Voluntary and Community Sector) that work collectively to plan health and care services on a larger footprint. West Yorkshire and Harrogate Health and Care Partnership is an ICS in development – meaning it has some limited responsibilities for system oversight, but no devolved responsibilities or budgets.

[ii] 'Our Next Steps to Better Health and Care for Everyone' https://www.wyhpartnership.co.uk/news-and-blog/news/our-next-steps-better-health-and-care-everyone-west-yorkshire-and-harrogate

[iii] The 16 Programmes are: (national priorities) Cancer, Urgent and Emergency Care, Mental Health, Maternity, Primary and Community Services, (WYH priorities) Stroke, Preventing Ill-health, Planned Care and Reducing Variation, and Hospitals Working Together. There are also 6 enabling work streams of Best Practice and Innovation, Workforce, Digital Ways of Working, Harnessing the Power of Communities, Capital and Estates, Business Intelligence.

[iv] The Difference Our Partnership Is Making can be read here: https://www.wyhpartnership.co.uk/our-priorities/difference-our-partnership-making

[v] The NHS England Long Term Plan can be read here: https://www.longtermplan.nhs.uk/

[vi] "Population Health" has been defined as an approach to health that aims to improve the health of all the population, not just those accessing health services.

[vii] The Health and Social Care Select Committee Report First 1000 Days of Life 2019 https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1496/1496.pdf

[viii] State of Our Child's Health England Two Years on (RSCPH) 2019 https://www.rcpch.ac.uk/resources/state-child-health-england-two-years

[ix] Leeds Children and Young People's Plan: https://democracy.leeds.gov.uk/documents/s172514/CYPP%20Refresh%20Report%20Appendix%202%20090318.pdf

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KIRKLEES HEALTH & WELLBEING BOARD
MEETING DATE: **13 June 2019**
TITLE OF PAPER: Kirklees Primary Care network registration and development update

1. Purpose of paper

The purpose of this paper is to provide an update on the development and registration process of Primary Care Networks in Kirklees. This is of strategic importance to all Partners and the debate at the Board will be a significant influence on the future direction of the issue discussed.

2. Background

Primary Care Networks (PCNs) are a critical component of the vision for health and social care set out in the Kirklees Health and Wellbeing Plan. Primary Care Networks are much more than groups of General Practices. They represent a fundamental shift in the way health and care is provided to our population. GP practices, community services, social care and others will be expected to work together in a way they have never done before.

An exceptional meeting of the Primary Care Commissioning Committee (PCCC) had been scheduled on the 22nd May 2019 to ensure that registration information submitted by the nine Kirklees Primary Care Networks is considered and approved by the 31 May 2019.

By 15 May, each Network had to provide:
a) The names and ODS codes of the member practices
b) The network list size as at 1 January 2019
c) A map clearly marking the agreed Network Area
d) The initial Network Agreement signed by all member practices
e) The single practice of provider that will receive funding on behalf of the PCN
f) The named accountable Clinical Director

This paper summarises the process of development of Primary Care Networks in Kirklees and the approval process for the registration of nine Primary Care Networks in Kirklees:

- The Valleys Health and Social Care Network
- The Mast Primary Care Network
- Viaducts Care Network
- Greenwood Network
- Tolson Care Partnership
- Spen Health and Wellbeing (Primary Care) Network (SHAWN)
- Batley and Birstall Primary Care Network
- Three Centres Primary Care Network
- Dewsbury and Thornhill Primary Care Network

This paper will refer to, and can be read in conjunction with, publically discussed PCCC papers which can be found at:

https://www.northkirkleesccg.nhs.uk/wp-content/uploads/2019/05/Agenda-Item-3-Additional-Papers.pdf

https://www.greaterhuddersfieldccg.nhs.uk/wp-content/uploads/2019/05/Agenda-Item-3-Additional-Papers.pdf

3. Financial Implications

Not applicable – Financial implications are being picked up through existing CCG Primary Care Commissioning Committees

4. Sign off

Dr Steve Ollerton, Clinical Chair, Greater Huddersfield CCG

Dr David Kelly, Clinical Chair, North Kirklees CCG

5. Next Steps

A programme plan with key milestones and deliverables is in place to support the implementation of the five year framework for GP contract reform and the goals set out in the NHS Long Term Plan. This will form the basis of the next steps and is further detailed in Appendix 1

6. Recommendations

The Health and Wellbeing Board is asked to:

a) Receive the update on the development of Primary Care Networks in Kirklees
b) Note the importance of the GP contract reform
c) Consider and discuss implications, next steps and challenges for Primary Care Networks

7. Contact Officer

Catherine Wormstone

Head of Primary Care Strategy and Commissioning – Greater Huddersfield Clinical Commissioning Group and North Kirklees Clinical Commissioning Group

Alan Turner – Primary Care Network Programme Manager - Greater Huddersfield Clinical Commissioning Group and North Kirklees Clinical Commissioning Group

Appendix 1

1. Introduction

1.1 Primary Care Networks (PCNs) are a critical component of the vision for health and social care set out in the Kirklees Health and Wellbeing Plan. Primary Care Networks are much more than groups of General Practices. They represent a fundamental shift in the way health and care is provided to our population. GP practices, community services, social care and others will be expected to work together in a way they have never done before.

1.2 The development of Primary Care Networks will help to deliver the aims of both Kirklees Clinical Commissioning Group's existing Primary Care Strategies, and it is a key focus of the Integrated Commissioning Strategy and the Integrated Provider Board.

1.3 The 2018/19 NHS Planning Guidance set out the ambition for Clinical Commissioning Groups to actively encourage every GP practice to be part of a local primary care network ensuring there is complete geographical contiguous population coverage by the end of 2018/19.

1.4 The publication of the NHS Long Term Plan on the 6 January 2019 committed £4.5 billion more for primary medical and community health services by 2023/24. Shortly afterwards on 31 January 2019, NHS England and the British Medical Association's General Practitioners Committee published a five-year GP (General Medical Services) contract framework from 2019/20.

1.5 The new contract framework marks some of the biggest General Practice contract changes in over a decade and will be essential to deliver the ambitions set out in the NHS Long Term Plan through strong primary care. The contract increases investment and more certainty around funding and looks to reduce pressure and stabilise general practice. It will ensure General Practice plays a leading role in every Primary Care Network (PCN) which will include bigger teams of health professionals working together in local communities.

1.6 The principles of integration and closer working between Health and Social Care in these key NHS policy documents very much reinforce the way in which Kirklees had commenced the journey locally and are in alignment with the Kirklees Health and Wellbeing Plan 2018-2023 as well as the Primary Care Strategy documents for both CCGs.

1.7 Additional guidance to support the development of Primary Care Networks was released in March 2019 and key deadlines, expectations and milestones were set out to register Primary Care Networks covering the whole population by 31 May 2019. Although 2019/20 is described as a preparatory year, some elements of the contract and associated funding commence from 1 July 2019 therefore it is important that the CCGs adhere to the national timescales set out to approve the primary care network registration requirements.

1.8 An exceptional meeting of the Primary Care Commissioning Committee has been scheduled to ensure that registration information submitted by the nine Kirklees Primary Care Networks is considered and approved by the 31 May 2019.

By 15 May 2019, each Network had to provide:

a) The names and ODS codes of the member practices
b) The network list size as at 1 January 2019
c) A map clearly marking the agreed Network Area
d) The initial Network Agreement signed by all member practices
e) The single practice of provider that will receive funding on behalf of the PCN and
f) The named accountable Clinical Director

1.9 This paper summarises the process of development of Primary Care Networks in Kirklees and was used to secure approval for the registration of nine Primary Care Networks in North Kirklees and Greater Huddersfield CCGs:

- The Valleys Health and Social Care Network
- The Mast Primary Care Network
- Viaducts Care Network
- Greenwood Network
- Tolson Care Partnership
- Spen Health and Wellbeing (Primary Care) Network (SHAWN)
- Batley and Birstall Primary Care Network
- Three Centres Primary Care Network
- Dewsbury and Thornhill Primary Care Network

2. Detail

2.1 Local Context

Greater Huddersfield CCG and North Kirklees CCGs had both started their journey towards integration and had different arrangements in place as a starting point. Both CCGs had recognised the ambition to work at scale within their individual Primary Care Strategies. GP practices in both CCG areas were coming together in groupings but these were not necessarily geographically arranged and were focussed on the commissioning priorities of the CCG for example, review of referrals.

2.2 Across Kirklees some groups of practices had already proactively reached out to start closer working with partners whilst some were less able or aware of the need to work in a different way due to the immense pressure on GP practice services.

2.3 The development of Primary Care Networks across Kirklees will reflect some of the differences in pace and understanding whilst at the same time, working towards the same goals and contractual requirements. NHS England describes has developed an outline ‘maturity matrix’ to help Networks and to acknowledge that networks will not be reach full maturity overnight.

2.4 In North Kirklees, Curo the GP Federation supported the CCG with a valuable piece of engagement during the autumn of 2018 to realign the historic ‘Cluster’ groupings into geographically arranged networks of practices. This work had the support of the Local Medical Committee (LMC) and formed the basis of the four current Primary Care Networks. One practice changed groupings as a result.

2.5 In Greater Huddersfield, the GP Federation – My Health Huddersfield (MHH) had undertaken a valuable piece of engagement during the summer of 2018 to realign the historic ‘Commissioning for Value’ groupings into geographically arranged networks of practices. This work had the support of the Local Medical

Committee (LMC) and formed the basis of the five current Primary Care Networks.

2.6 During 2018/19, great efforts were taken to support the local GP practices and the wider system with understanding the benefits of Primary Care Networks and to engage with as many stakeholders as possible to ensure the Kirklees place would see the benefits of strong, resilient and integrated primary and community care services.

2.7 Programme Management

2.8 As part of being an Integrated Care System (ICS), the West Yorkshire and Harrogate Health and Care Partnership allocated some non-recurrent resource in 2018/19 to accelerate and embed the development of Primary Care Networks in Kirklees. This was primarily directed towards freeing up the time to make change for GP practices, holding a number of engagement events, developing intelligence packs for networks and establishing a programme management approach for the work.

2.9 A temporary Programme Manager is in place for the development of Kirklees-wide Primary Care Networks (secured on a temporary basis from Attain) and a comprehensive programme plan with a number of work streams was set up with links into the Integrated Provider Board. Regular briefings have also been provided to the Health and Wellbeing Board.

2.10 Key work streams/Task and Finish Groups within this programme include:

- Data and Intelligence
- Communications and Engagement
- Data Sharing and IG
- Finance /Commercial

To be developed / linked into existing work streams:

- Workforce/Additional Roles (including Organisational Development and Leadership)
- Digital First

There are separate links to a number of pilots. These primarily relate to data sharing and the establishment of sound Primary Care Network Governance arrangements which is being supported by the National Association of Primary Care in two PCNs (one in Greater Huddersfield and one in North Kirklees).

2.11 The five-year framework for GP contract reform to implement The NHS Long Term Plan (31 Jan 2019)

Key milestones for the establishment of Primary Care Networks and the introduction of a Network Contract Directed Enhanced Service have been set nationally and can be seen in Figure 1 below.

Figure 1 – Timetable for Network Contract DES introduction:

Date	Action
Jan-Apr 2019	PCNs prepare to meet the Network Contract DES registration requirements
By 29 Mar 2019	NHS England and GPC England jointly issue the Network Agreement and 2019/20 Network Contract DES
By 15 May 2019	**All Primary Care Networks submit registration information to their CCG**
By 31 May 2019	**CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts**
Early Jun	NHS England and GPC England jointly work with CCGs and LMCs to resolve any issues
1 Jul 2019	**Network Contract DES goes live across 100% of the country**
Jul 2019-Mar 2020	National entitlements under the 2019/20 Network Contract start: • year 1 of the additional workforce reimbursement scheme • ongoing support funding for the Clinical Director • ongoing £1.50/head from CCG allocations
Apr 2020 onwards	National Network Services start under the 2020/21 Network Contract DES

2.12 Primary Care Network – Core Criteria

It is emphasised in national guidance that the success of a Primary Care Network will depend on the **strength of its relationships** and in particular the bonds of affiliation between its members and the wider health and social care community who care for the population.

NHS England is committed to **100% geographical coverage** of the Network Contract DES by Monday 1 July 2019 'go-live' date. Close working is needed by CCGs and Local Medical Committees to ensure this goal is met.

Primary Care Networks will:

a) **Typically serve populations between 30,000 and 50,000** –
b) **Consist of more than one GP practice**.
c) **Cover a boundary (Network Area)** that makes sense to its:
   - Constituent members
   - Other community based providers who configure their teams accordingly
   - the local community, and would normally cover a geographically contiguous area
d) **Have the network area agreed** through the registration process.
e) Have a single practice or provider (who must hold a primary medical care contract) to receive payments on behalf of the PCN – the **'nominated payee'**
f) Have in place an underlying **Network Agreement** signed by all PCN members using the mandatory national template.
g) Ensure that an accountable **Clinical Director** is in place at all times during the term of the Network Contract DES. This will be a practicing clinician from within the PCN member practices – most likely a GP but not an absolute requirement.

h) Have in place appropriate arrangements for **patient record sharing** before service delivery commences in July 2019.

2.13 Registration Requirements

In line with the national timetable and co-ordinated through the Primary Care Team, all Primary Care Networks were required to submit the registration information set out below to the CCG by 5pm on 15 May 2019.

a) The names and ODS codes of the member practices
b) The network list size as at 1 January 2019
c) A map clearly marking the agreed Network Area
d) The initial Network Agreement signed by all member practices
e) The single practice of provider that will receive funding on behalf of the PCN
f) The named accountable Clinical Director and the process the PCN had followed to appoint them

2.14 Commissioner Requirements

In taking the role of the Commissioner, it had been agreed and confirmed by NHS England that Primary Care Commissioning Committee was the appropriate route to manage the process of Primary Care Network registration (part of negotiated changes to primary care contracts and therefore delegated responsibilities under Co-Commissioning). Therefore, Committee members needed to note the following responsibilities:

No.	Commissioner / CCG Requirements and PCN Approval Process
1.	Commissioners must confirm to PCNs how completed registration forms must be submitted.
2.	During the period 16 May 2019 to 31 May 2019, commissioners will seek to confirm and approve all Network Areas in a single process that ensures that all patients in every GP practice are covered by a PCN and that there is 100 per cent geographical coverage. The CCG, 22 May 2019, approved the relevant documentation, set against the national guidelines, through the relevant governance between 16th May 2019 and the 31st May 2019.
3.	By 31 May 2019, Commissioners should have reached agreement with practices on any issues relating to the proposals in registration forms, such as PCN list size and the Network Area. Commissioners should also have agreed the workforce baseline with the PCN. The CCG are continuing to work with NHS England on this elements and will share with networks at the earliest opportunity
4.	By 31 May 2019, it is expected that commissioners will confirm that registration requirements have been met, including discussing and agreeing the Network Areas across the CCG. Where this is not possible due to ongoing discussions about the information set out in the registration form, commissioners will aim to confirm to PCNs that registration requirements have been met as soon as possible after this date, but prior to 30 June 2019.

5.	Commissioners will work closely with Local Medical Committees (LMCs) during the registration period to resolve any issues in order to secure 100 per cent geographical coverage of PCNs. This will include ensuring any patients with a GP practice not participating in the Network Contract DES are covered by a PCN (for example through commissioning a local incentive scheme).
6.	Where 100 per cent coverage is not achieved, commissioners and LMCs should, after all local options have been explored, seek discussion and agreement to Network Areas with NHS England Regional Teams and GPC England.

2.15 Appointment of Clinical Directors

A fundamental role within the Primary Care Networks will be the named accountable Clinical Director.

It is the responsibility of the Primary Care Network to agree who their Clinical Director will be. The selection process will be for the Primary Care Network to determine but may include:

- Election – nomination and voting
- Mutual agreement between the members;
- Selection – via application and interview; or
- Rotation within a fixed term

As part of the authorisation of the network registration, Primary Care Networks have been asked to identify the selection process they have opted for.

Nominated Clinical Directors have been submitted as follows:

Primary Care Network	Nominated Clinical Director	Method of Selection
Dewsbury & Thornhill Network	Dr Indira Kasibhatla*	Mutual agreement between the members
Three Centres Network	Dr M Hussain	Election - nomination and voting
Batley & Birstall Network	Dr C Ratcliffe	Mutual agreement between the members
SHAWN Network	Dr Imad Riaz	Election - nomination and voting
The Valleys Health and Social Care Network	Dr Dilshad Ashraf*	Election - nomination and voting
The Mast Primary Care Network	Dr Louise James	Mutual agreement between the members
Viaducts Care Network	Dr Hannah Ruth Hayward	Election - nomination and voting
Greenwood Network	Dr Jane Ford*	Mutual agreement between the members
Tolson Care Partnership	Dr Sarah Milligan	Election - nomination and voting

* it should be noted that these are existing CCG Governing Body members and that the two roles are unlikely to be compatible in the longer term but in the shorter term, this can be managed

2.16 Submissions for Primary Care Networks

Registration information has been received within the specified deadline to establish nine Primary Care Networks in the North Kirklees and Greater Huddersfield CCG areas.(4 and 5 networks respectively)

A summary of the information received can be found at:
- Appendix 1 **North Kirklees CCG Network registration Summaries**
- Appendix 2- **Greater Huddersfield CCG Network registration Summaries**

Following receipt of the registration information and **in addition to the checks on the core criteria** listed in 2.11 above, a number of validation and assurance checks were undertaken. These checks have required excellent teamwork, a very quick turnaround and support from the Finance, Contracting and Primary Care teams. The responsiveness of the PCNs to address outstanding queries has also been commendable.

2.17 Primary Care Network Areas

Each Primary Care Network was required to submit a map outlining the Network area. In order to be consistent with scale and methodology, the CCG has worked closely with colleagues in the Local Authority Intelligence & Performance Service to produce a suite of maps. Given the timescales and the complexity of the task, the support from this service has been greatly appreciated.

PCN Network Area Maps have been created using:
- **Existing GP contractual boundaries (inner) – downloaded from Primary Care Web tool (prior to 31 March 2019) and cross checked with the CCG contracting team**
- **Contractual boundaries were overlaid to form a PCN area and boundary**
- **Collation of PCN boundaries at CCG level and comparison to CCG boundary**
- **Collation of PCN area coverage across Kirklees**

Each PCN map was shared with the PCN lead for checking and approval and subsequent inclusion in the network registration documents by 15 May 2019.

It should be emphasised that no patient registrations with GP practices are affected in the creation of Primary Care Network areas and there will usually be a number of patients who are registered with a GP practice and live outside of the existing practice boundary. Similarly, practice boundaries may cross CCG boundaries, will overlap with each other and patients living within one area, may be registered with a GP practice in a neighbouring CCG. This scenario is more complex in areas with higher population density. In the establishment of the Primary Care Network area, these arrangements will remain as they are.

Primary Care Commissioning Committee is specifically required to approve all Primary Care Network registration applications at one time to ensure that:
a) Every constituent practice of a CCG is covered and

b) 100% of its geographical area are included within Primary Care Networks

Appendix 1 and 2 show set of two maps. These set out the proposed Primary Care Network boundaries, but also show the coverage of the whole CCG areas. For the avoidance of doubt, nothing has been changed in the creation of these maps. Practices will only join one Network.

2.18 Exceptional Issues

The PCCC papers discuss and detail four exceptional issues required to highlight to the committee:

- **100% Geographical Coverage**
- **Special Allocation Scheme (SAS)**
- **Network Population**
- **Greenhead Family Doctors**

Advice from NHS England has suggested that these issues needed to not prevent the registration of the Primary Care Networks and therefore recommended the approval of the existing applications, subject the CCG, the LMC and NHSE undertaking the appropriate remedial actions.

Work with the Local Authority has commenced to identify any patients not covered within the mapped areas to provide assurance that 100% of the population is covered by the nine networks.

Work is continuing with NHS England and relevant stakeholders to ensure that the SAS associated patients are included appropriately within the networks populations

Mediation between the Greenhead Family Doctors and the Tolson network members has commenced with meetings held; supported by the CCG and LMC. It is expected that this process will be concluded by the 11th June 2019.

Should this not be possible, delegated authority will be sought from Primary Care Commissioning Committee and the national timescale adhered to which allows for “NHS England and GPC England jointly work with CCGs and LMCs to resolve any issues” in June 2019. The guidance also acknowledges that in some CCGs, marginal adjustment of PCN membership and boundaries may prove necessary.

2.19 Engagement of partners and in discussions

Key stakeholders have been included in the configuration of Kirklees Primary Care Networks from the outset. These include:

- The Local Medical Committee
- GP Federations (Curo and My Health Huddersfield)
- Member practices
- Healthwatch
- The Local Authority – including Adult Social Care and Community Plus (Social Prescribing)
- Locala CIC as the provider of community nursing services
- The two acute providers – Mid Yorkshire Hospitals NHS Trust and Calderdale and Huddersfield NHS Foundation Trust

- Integrated Provider Board – including both acute trusts, mental health providers, Kirklees Hospice and third sector representation
- Kirklees Health and Wellbeing Board

All stakeholders are aware of the proposed configuration of Primary Care Networks and are supportive of the establishment of nine Primary Care Networks in Kirklees. A number of successful and well attended engagement events have been organised since the autumn of 2018 and all partners have been given an opportunity to comment and engage.

National Association of Primary Care has supported two engagement events though none of the Primary Care Networks are formally entering into the process to become a 'Primary Care Home' (NAPC brand of PCN) at this point however there are a number of networks that are in discussions with NAPC to understand this further prior to making any commitment.

Locala and the Local Authority have been proactively considering the impact on the provision and configuration of their own services since the Kirklees Health and Wellbeing plan set out populations of 30,000-50,000 patients as a key enabler for integrating and delivering community based services. Senior leadership support and direction from these organisations has been an enabler for discussions and relationship development with the emerging Primary Care Networks and will be fundamental in developing their maturity.

GP member practices within the Primary Care Network will have requirements relating to patient engagement under their primary medical services contracts.

The Primary Care Networks will therefore be expected to reflect those requirements by engaging, liaising and communicating with their collective registered population in the most appropriate way, informing and/or involving them in developing services and changes related to service delivery. This includes engaging with a range of communities, including 'seldom heard' groups.

Our approach to public voice in the development of Primary Care Networks is still evolving but will encompass existing/ongoing work as well as new initiatives, and take into account learning from the experience gained from engagement activities in other areas. This will include information on CCG websites and conveyed through our public engagement events, other public-facing meetings, briefings and news channels.

Both CCGs have engaged extensively with the public/patients around primary care services and community services. It is essential to ensure that the views and concerns of patients and service users are gathered are taken into account by Primary Care Networks as they develop.

Existing Patient Reference Groups (which all GP practices should have) will have a significant role to play in supporting Primary Care Network development. Wider partners including; Locality based 'Community Hubs', Local Authority Community Plus team and Social Care are aligning (or working to align themselves) with Primary Care Networks. Community and voluntary organisations will all have a role to play in providing or harnessing the public voice.

2.19.1 The programme work stream (Communications and Engagement) will continue to work with wider partners and the Primary Care Networks to develop an appropriate model of engagement, but also explore how to involve patients and the general population in decision making activities.

3. Next Steps

3.1 A programme plan with key milestones and deliverables is in place to support the implementation of the five year framework for GP contract reform and the goals set out in the NHS Long Term Plan. This will form the basis of the next steps. However, there are a number of milestones and issues which should be noted here in relation to the registration of Primary Care Networks.

3.2 National Guidance

Additional national guidance is still awaited in a number of key areas for example, template data sharing agreement, workforce baselining activity (relevant to the additional roles scheme) and supplementary guidance to support the role of Social Prescribing Link workers. As before, none of this prevents the registration of the Primary Care Networks at this point but may influence the ability to support the readiness of the networks before the 1 July 2019 'go-live' date.

3.3 Network Readiness

As Primary Care Networks are not legal entities or organisations at the present time, there will be a significant programme of development and support needed for both the Clinical Directors and the Networks themselves. Whilst some of this development is promised nationally and regionally, the key to the success will be the timeliness of the support to enable the networks to function from July.

Crucially this centres on

- Network governance
- Data sharing
- Leadership Development
- Legal support (particularly relating to employment and HR issues)
- Financial advice (shared accounts and shared liabilities)
- Organisational Development

Key changes from 1 July 2019 impact on:

- The employment of shared Social Prescribing Link workers and Clinical Pharmacists
- Shared network delivery models for the Extended Hours DES (in place of individual practice provision and separate to the Extended Access Service)
- Preparation for the seven national service specifications from 2020/21

Further work on data sharing and the impact of working within a Primary Care Network is being under taken by the separate Programme work stream but the key requirement to have in place appropriate data sharing and data processing arrangements between members of the Primary Care Network should be noted.

4. Appendices

- Appendix 1 **North Kirklees CCG Network registration Summaries**
- Appendix 2- **Greater Huddersfield CCG Network registration Summaries**

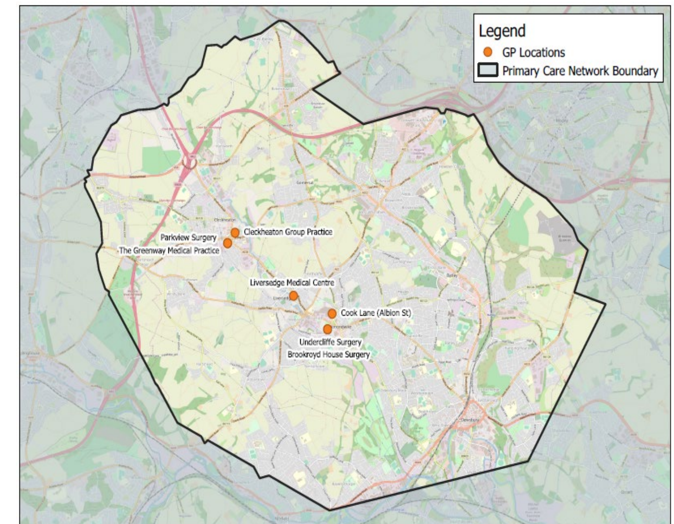
Appendix 1

North Kirklees CCG Primary Care Networks

Spen Health And Wellbeing (Primary Care) Network (SHAWN)

Network	Registration Form Received on Time	Network Agreement Schedule 1 Received and Verified	Mandatory Network Agreement Received and Verified	Mandatory Network Agreement Signed by all Practices	All Network Member Practices Named	PCN List Sizes and ODS codes completed	PCN List Sizes and ODS codes match records	Network List size correct (sum of list sizes) at 1 jan 2019	Clinical Director Agreed	Practicing Clinician within PCN	Method of CD Selection	PCN funding Recipient type	Funding Recipient holds a Primary Care Contract	Bank account detail verified as accurate with Finance
Spen Health And Wellbeing (Primary Care) Network - SHAWN	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Election - nomination and voting;	Provider (Signatory of PCN Registration)	Yes	Yes

Network	Clincal Director	CCG Primary Care Lead	Practice Code	Practices	List Size (Raw at Jan 2019)	List Size
Spen Health And Wellbeing (Primary Care) Network - SHAWN	Dr Imad Riaz	Chris Nicholls	B85021	Cleckheaton Group Practice	9,753	52,604
			B85619	Cook Lane (Albion St)	2,837	
			B85612	Liversedge Medical Centre	3,479	
			B85001	Parkview Surgery	7,628	
			B85030	The Greenway Medical Practice	8,297	
			B85014	Brookroyd House Surgery	9,612	
			B85012	Undercliffe Surgery	10,998	



Actions	YES	NO
Does this network registration meet all minimum requirements	X	
Is it recommended that PCCC verify this networks registration	X	
Are there outstanding issues Relating to this Network		x
Are the LMC aware of the outstanding issue	NA	
Are there any further Comments:		

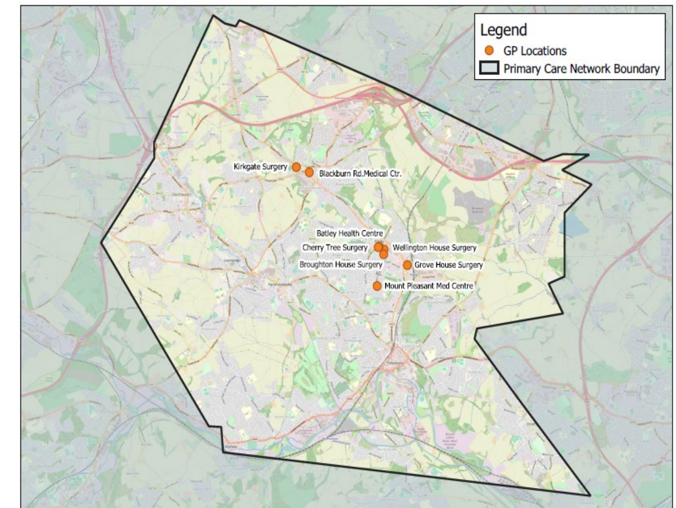
Actions	YES	NO
Is the Population criteria 30,000 -50,000		x
Does the Network area cover a boundary that makes sense to it:		
• Constituent Practices	X	
• Partners	X	
• Local Community	X	

The network is deemed to be of a viable, sustainable and manageable size. Please refer to **'Exceptional Issue (3) - Network population size criteria'**

Batley Birstall Primary Care Network

Network	Registration Form Received on Time	Network Agreement Schedule 1 Received and Verified	Mandatory Network Agreement Received and Verified	Mandatory Network Agreement Signed by all Practices	All Network Member Practices Named	PCN List Sizes and ODS codes completed	PCN List Sizes and ODS codes match records	Network List size correct (sum of list sizes) at 1 jan 2019	Clinical Director Agreed	Practicing Clinician within PCN	Method of CD Selection	PCN funding Recipient type	Funding Recipient holds a Primary Care Contract	Bank account detail verified as accurate with Finance
Batley Birstall Primary Care Network	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Mutual agreement between the members;	Provider (Signatory of PCN Registration)	Yes	Yes

Network	Clincal Director	CCG Primary Care Lead	Practice Code	Practices	List Size (Raw at Jan 2019)	List Size
Batley Birstall Primary Care Network	Dr C Ratcliffe	Natalie Sykes	B85655	Cherry Tree Surgery	2,479	59,506
			B85640	Kirkgate Surgery	3,345	
			B85622	Broughton House Surgery	3,752	
			B85008	Batley Health Centre	5,051	
			B85018	Grove House Surgery	9,114	
			B85015	Wellington House Surgery	8,981	
			B85025	Blackburn Rd.Medical Ctr.	11,836	
			B85041	Mount Pleasant Med Centre	14,948	



Actions	YES	NO
Does this network registration meet all minimum requirements	X	
Is it recommended that PCCC verify this networks registration	X	
Are there outstanding issues Relating to this Network		x
Are the LMC aware of the outstanding issue	NA	
Are there any further Comments:		

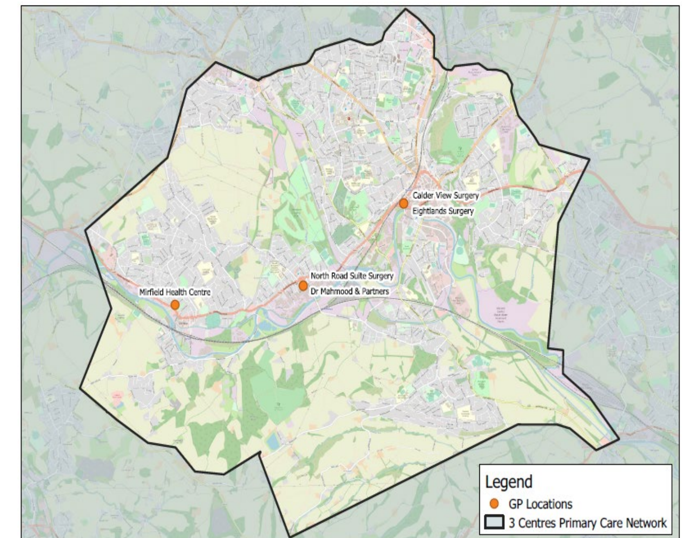
Actions	YES	NO
Is the Population criteria 30,000 -50,000		x
Does the Network area cover a boundary that makes sense to it:		
• Constituent Practices	X	
• Partners	X	
• Local Community	X	

The network is deemed to be of a viable, sustainable and manageable size. Please refer to **'Exceptional Issue (3) - Network population size criteria'**

3 Centres Primary Care Network

Network	Registration Form Received on Time	Network Agreement Schedule 1 Received and Verified	Mandatory Network Agreement Received and Verified	Mandatory Network Agreement Signed by all Practices	All Network Member Practices Named	PCN List Sizes and ODS codes completed	PCN List Sizes and ODS codes match records	Network List size correct (sum of list sizes) at 1 jan 2019	Clinical Director Agreed	Practicing Clinician within PCN	Method of CD Selection	PCN funding Recipient type	Funding Recipient holds a Primary Care Contract	Bank account detail verified as accurate with Finance
3 Centres Primary Care Network	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Election - nomination and voting;	Provider (Signatory of PCN Registration)	Yes	Yes

Network	Clincal Director	CCG Primary Care Lead	Practice Code	Practices	List Size (Raw at Jan 2019)	List Size
3 Centres Primary Care Network	Dr M Hussain	Joanne Davis	B85650	Dr Mahmood & Partners	4,217	42,478
			B85004	Calder View Surgery	5,488	
			B85020	Eightlands Surgery	6,704	
			B85009	North Road Suite Surgery	8,712	
			B85019	Mirfield Health Centre	17,357	



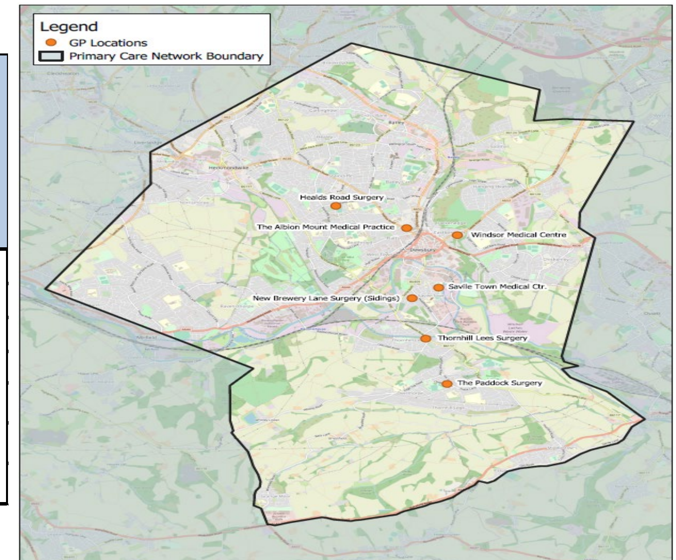
Actions	YES	NO
Does this network registration meet all minimum requirements	X	
Is it recommended that PCCC verify this networks registration	X	
Are there outstanding issues Relating to this Network		x
Are the LMC aware of the outstanding issue	NA	
Are there any further Comments:		

Actions	YES	NO
Is the Population criteria 30,000 -50,000	X	
Does the Network area cover a boundary that makes sense to it:		
• Constituent Practices	X	
• Partners	X	
• Local Community	X	

Dewsbury & Thornhill Primary Care Network

Network	Registration Form Received on Time	Network Agreement Schedule 1 Received and Verified	Mandatory Network Agreement Received and Verified	Mandatory Network Agreement Signed by all Practices	All Network Member Practices Named	PCN List Sizes and ODS codes completed	PCN List Sizes and ODS codes match records	Network List size correct (sum of list sizes) at 1 jan 2019	Clinical Director Agreed	Practicing Clinician within PCN	Method of CD Selection	PCN funding Recipient type	Funding Recipient holds a Primary Care Contract	Bank account detail verified as accurate with Finance
Dewsbury & Thornhill Primary Care Network	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Mutual agreement between the members;	Provider (Signatory of PCN Registration)	Yes	Yes

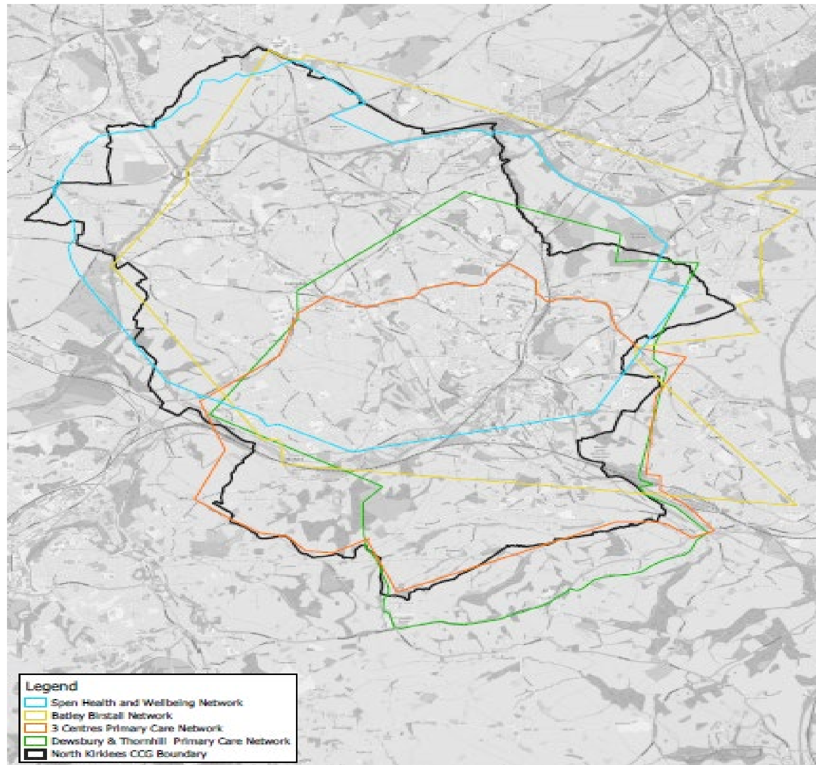
Network	Clincal Director	CCG Primary Care Lead	Practice Code	Practices	List Size (Raw at Jan 2019)	List Size
Dewsbury & Thornhill Primary Care Network	Dr Indira Kasibhatla	Chris Nicholls	B85645	Savile Town Medical Ctr.	2,804	40,019
			B85606	Thornhill Lees Surgery	4,822	
			B85038	The Paddock Surgery	5,827	
			B85646	The Albion Mount Medical Practice	6,564	
			B85652	New Brewery Lane Surgery (Sidings)	7,757	
			B85620	Windsor Medical Centre	2,034	
			B85055	Healds Road Surgery	10,211	

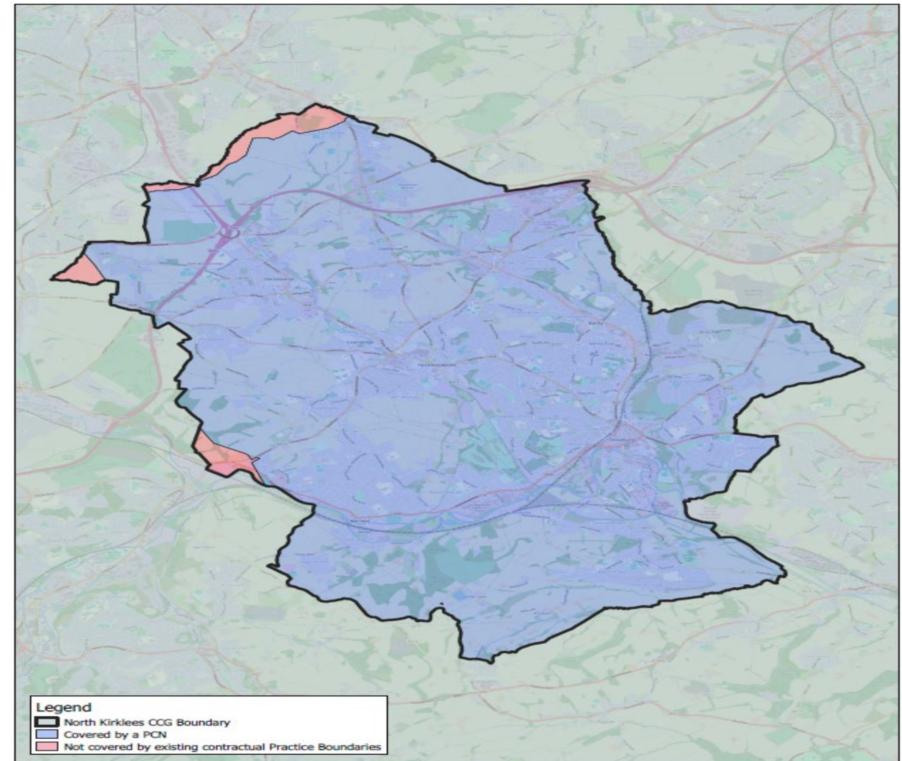


Actions	YES	NO
Does this network registration meet all minimum requirements	X	
Is it recommended that PCCC verify this networks registration	X	
Are there outstanding issues Relating to this Network		x
Are the LMC aware of the outstanding issue	NA	
Are there any further Comments:		

Actions	YES	NO
Is the Population criteria 30,000 -50,000	X	
Does the Network area cover a boundary that makes sense to it:		
• Constituent Practices	X	
• Partners	X	
• Local Community	X	

North Kirklees CCG Primary Care Networks





Actions	YES	NO	Comments
Primary Care Commissioning Committee is specifically required to approve all PCN registration applications at one time to ensure that:			
100% of its geographical area is included within Primary Care Networks		x	Please refer to '**Exceptional Issue (1) – 100% Geographical Coverage in North Kirklees**
Every constituent practice of a CCG is covered	x		
100% of the registered population is included within a network		x	Please refer to '**Exceptional Issue (2) - Special Allocation**
The registered population of each network 30,000 -50,000		x	Please refer to '**Exceptional Issue (3) - Network population size criteria'**
Any further comments required			

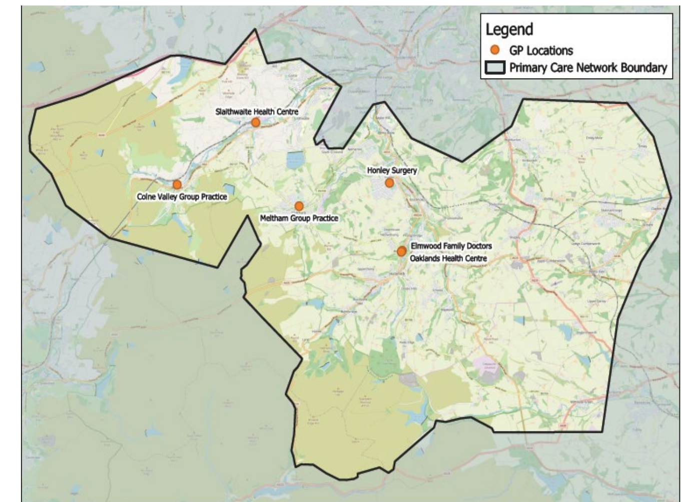
Appendix 2

Greater Huddersfield CCG Primary Care Networks

The Valleys Health and Social Care Network

Network	Registration Form Received on Time	Network Agreement Schedule 1 Received and Verified	Mandatory Network Agreement Received and Verified	Mandatory Network Agreement Signed by all Practices	All Network Member Practices Named	PCN List Sizes and ODS codes completed	PCN List Sizes and ODS codes match records	Network List size correct (sum of list sizes) at 1 jan 2019	Clinical Director Agreed	Practicing Clinician within PCN	Method of CD Selection	PCN funding Recipient type	Funding Recipient holds a Primary Care Contract	Bank account detail verified as accurate with Finance
The Valleys Health and Social Care Network	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Election - nomination and voting;	Single Practice within PCN	Yes	Yes

Network Summary	Clincal Director	CCG Primary Care Lead	Practice Code	Practices	List Size (Raw at Jan 2019)	List Size
The Valleys Health and Social Care Network	Dr Dil Ashraf	Sarah Rothery	B85610	Oaklands Health Centre	9,782	54,105
			B85022	Honley Surgery	7,665	
			B85006	Elmwood Family Doctors	14,610	
			B85059	Slaithwaite Health Centre	5,471	
			B85032	Meltham Group Practice	6,355	
			B85054	Colne Valley Group Practice	10,222	



Actions	YES	NO
Does this network registration meet all minimum requirements	X	
Is it recommended that PCCC verify this networks registration	X	
Are there outstanding issues Relating to this Network		x
Are the LMC aware of the outstanding issue	NA	
Are there any further Comments:		

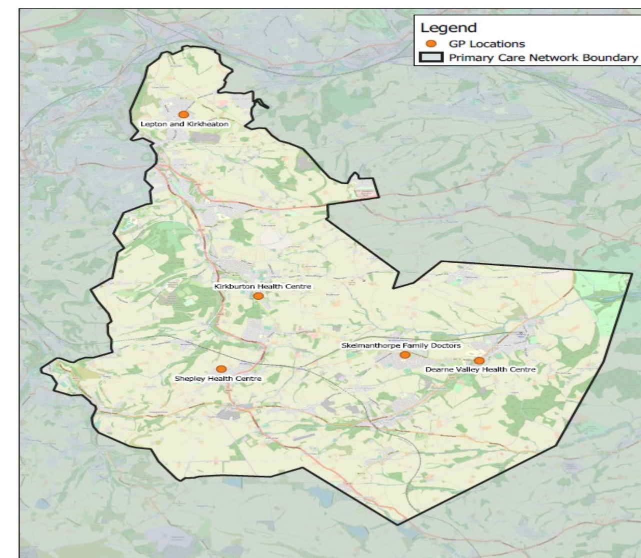
Actions	YES	NO
Is the Population criteria 30,000 -50,000		x
Does the Network area cover a boundary that makes sense to it:		
• Constituent Practices	X	
• Partners	X	
• Local Community	X	

The network is deemed to be of a viable, sustainable and manageable size. Please refer to **'Exceptional Issue (4) - Network population size criteria'**

The Mast Primary Care Network

Network	Registration Form Received on Time	Network Agreement Schedule 1 Received and Verified	Mandatory Network Agreement Received and Verified	Mandatory Network Agreement Signed by all Practices	All Network Member Practices Named	PCN List Sizes and ODS codes completed	PCN List Sizes and ODS codes match records	Network List size correct (sum of list sizes) at 1 jan 2019	Clinical Director Agreed	Practicing Clinician within PCN	Method of CD Selection	PCN funding Recipient type	Funding Recipient holds a Primary Care Contract	Bank account detail verified as accurate with Finance
The Mast Primary Care Network	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Mutual agreement between the members;	Single Practice within PCN	Yes	Yes

Network Summary	Clincal Director	CCG Primary Care Lead	Practice Code	Practices	List Size (Raw at Jan 2019)	List Size
The Mast Primary Care Network	Dr Louise James	Diane Lane	B85002	Dearne Valley Health Centre	3,939	35,120
			B85061	Skelmanthorpe Family Doctors	9,434	
			B85031	Lepton and Kirkheaton	7,101	
			B85026	Kirkburton Health Centre	8,107	
			B85005	Shepley Health Centre	6,539	



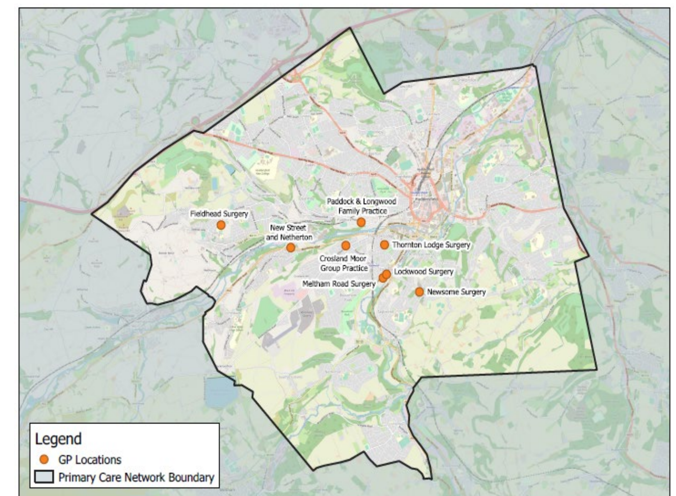
Actions	YES	NO
Does this network registration meet all minimum requirements	X	
Is it recommended that PCCC verify this networks registration	X	
Are there outstanding issues Relating to this Network		x
Are the LMC aware of the outstanding issue	NA	
Are there any further Comments:		

Actions	YES	NO
Is the Population criteria 30,000 -50,000	X	
Does the Network area cover a boundary that makes sense to it:		
• Constituent Practices	X	
• Partners	X	
• Local Community	X	

Viaduct Care Network

Network	Registration Form Received on Time	Network Agreement Schedule 1 Received and Verified	Mandatory Network Agreement Received and Verified	Mandatory Network Agreement Signed by all Practices	All Network Member Practices Named	PCN List Sizes and ODS codes completed	PCN List Sizes and ODS codes match records	Network List size correct (sum of list sizes) at 1 jan 2019	Clinical Director Agreed	Practicing Clinician within PCN	Method of CD Selection	PCN funding Recipient type	Funding Recipient holds a Primary Care Contract	Bank account detail verified as accurate with Finance
The Viaduct Care Network	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Election - nomination and voting;	Single Practice within PCN	Yes	Yes

Network Summary	Clincal Director	CCG Primary Care Lead	Practice Code	Practices	List Size (Raw at Jan 2019)	List Size
The Viaduct Care Network	Dr Hannah Ruth Hayward	Jan Giles	B85036	New Street and Netherton	7,420	52,364
			B85016	Meltham Road Surgery	9,966	
			B85044	Thornton Lodge Surgery	2,517	
			B85051	Fieldhead Surgery	8,775	
			Y04266	Crosland Moor Group Practice	4,038	
			B85037	Newsome Surgery	6,215	
			B85042	Paddock & Longwood Family Practice	8,703	
			B85641	Lockwood Surgery	4,730	



Actions	YES	NO
Does this network registration meet all minimum requirements	X	
Is it recommended that PCCC verify this networks registration	X	
Are there outstanding issues Relating to this Network		x
Are the LMC aware of the outstanding issue	NA	
Are there any further Comments:		

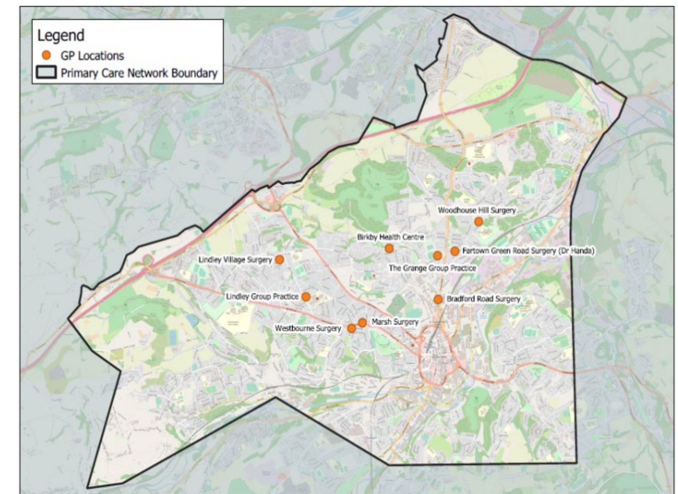
Actions	YES	NO
Is the Population criteria 30,000 -50,000		x
Does the Network area cover a boundary that makes sense to it:		
• Constituent Practices	X	
• Partners	X	
• Local Community	X	

The network is deemed to be of a viable, sustainable and manageable size. Please refer to **'Exceptional Issue (4) - Network population size criteria'**

Greenwood Network

Network	Registration Form Received on Time	Network Agreement Schedule 1 Received and Verified	Mandatory Network Agreement Received and Verified	Mandatory Network Agreement Signed by all Practices	All Network Member Practices Named	PCN List Sizes and ODS codes completed	PCN List Sizes and ODS codes match records	Network List size correct (sum of list sizes) at 1 jan 2019	Clinical Director Agreed	Practicing Clinician within PCN	Method of CD Selection	PCN funding Recipient type	Funding Recipient holds a Primary Care Contract	Bank account detail verified as accurate with Finance
Greenwood Network	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Mutual agreement between the members;	Single Practice within PCN	Yes	Yes

Network Summary	Clincal Director	CCG Primary Care Lead	Practice Code	Practices	List Size (Raw at Jan 2019)	List Size
Greenwood Network	Dr Jane Ford	Jen Love	B85028	The Grange Group Practice	15,905	57,914
			B85048	Woodhouse Hill Surgery	3,618	
			B85611	Fartown Green Road Surgery (Dr Handa)	3,741	
			B85614	Bradford Road Surgery	5,168	
			B85623	Marsh Surgery	3,000	
			B85636	Westbourne Surgery	3,695	
			B85033	Lindley Village Surgery	4,892	
			B85027	Lindley Group Practice	10,891	
			B85634	Birkby Health Centre	3,553	
				Nook Surgery & Clifton Group	3,451	



Actions	YES	NO
Does this network registration meet all minimum requirements	X	
Is it recommended that PCCC verify this networks registration	X	
Are there outstanding issues Relating to this Network		x
Are the LMC aware of the outstanding issue	NA	
Are there any further Comments:		

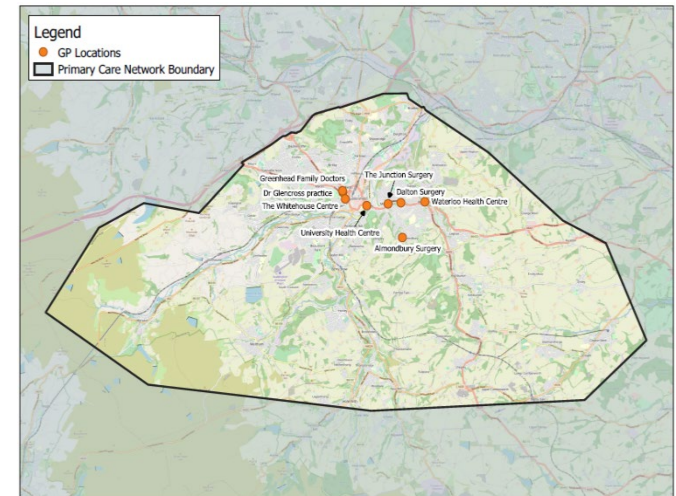
Actions	YES	NO
Is the Population criteria 30,000 -50,000		x
Does the Network area cover a boundary that makes sense to it:		
• Constituent Practices	X	
• Partners	X	
• Local Community	X	

The network is deemed to be of a viable, sustainable and manageable size. Please refer to **'Exceptional Issue (4) - Network population size criteria'**

Tolson Care Partnership

Network	Registration Form Received on Time	Network Agreement Schedule 1 Received and Verified	Mandatory Network Agreement Received and Verified	Mandatory Network Agreement Signed by all Practices	All Network Member Practices Named	PCN List Sizes and ODS codes completed	PCN List Sizes and ODS codes match records	Network List size correct (sum of list sizes) at 1 jan 2019	Clinical Director Agreed	Practicing Clinician within PCN	Method of CD Selection	PCN funding Recipient type	Funding Recipient holds a Primary Care Contract	Bank account detail verified as accurate with Finance
Tolson Care Partnership	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Election - nomination and voting;	Single Practice within PCN	Yes	Yes

Network Summary	Clincal Director	CCG Primary Care Lead	Practice Code	Practices	List Size (Raw at Jan 2019)	List Size
Tolson Care Partnership	Dr Sarah Milligan	Sarah Rothery	B85659	The Whitehouse Centre	1,479	50,503
			B85060	Greenhead Family Doctors	2,642	
			B85058	Dr Glencross practice	2,540	
			B85062	University Health Centre	15,142	
			B85010	Dalton Surgery	6,949	
			B85024	Waterloo Health Centre	9,572	
			B85660	The Junction Surgery	5,677	
			B85023	Almondbury Surgery	6,502	

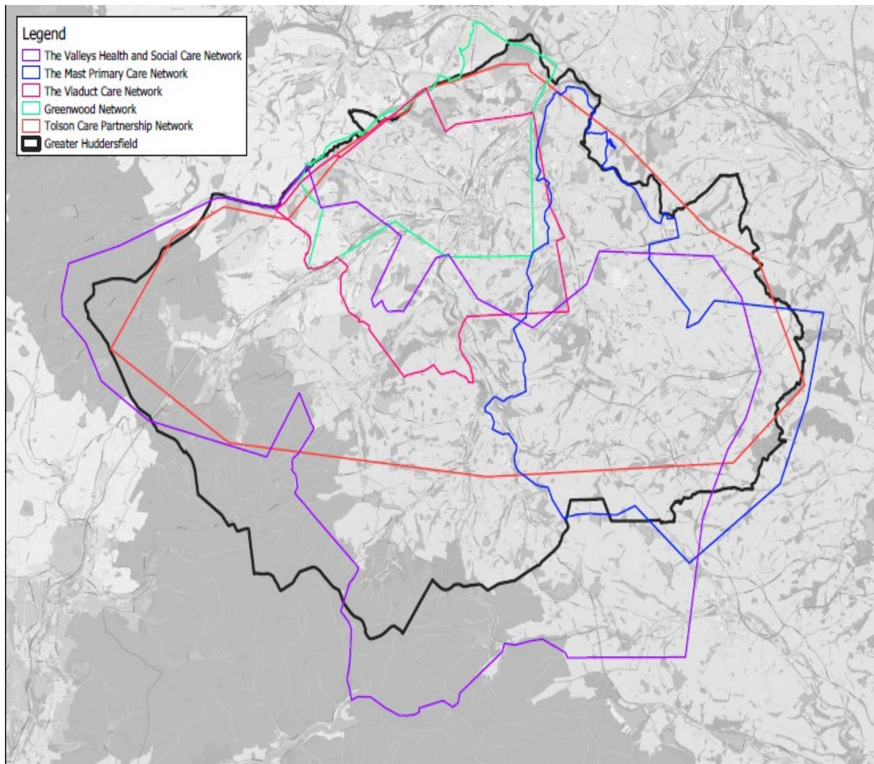


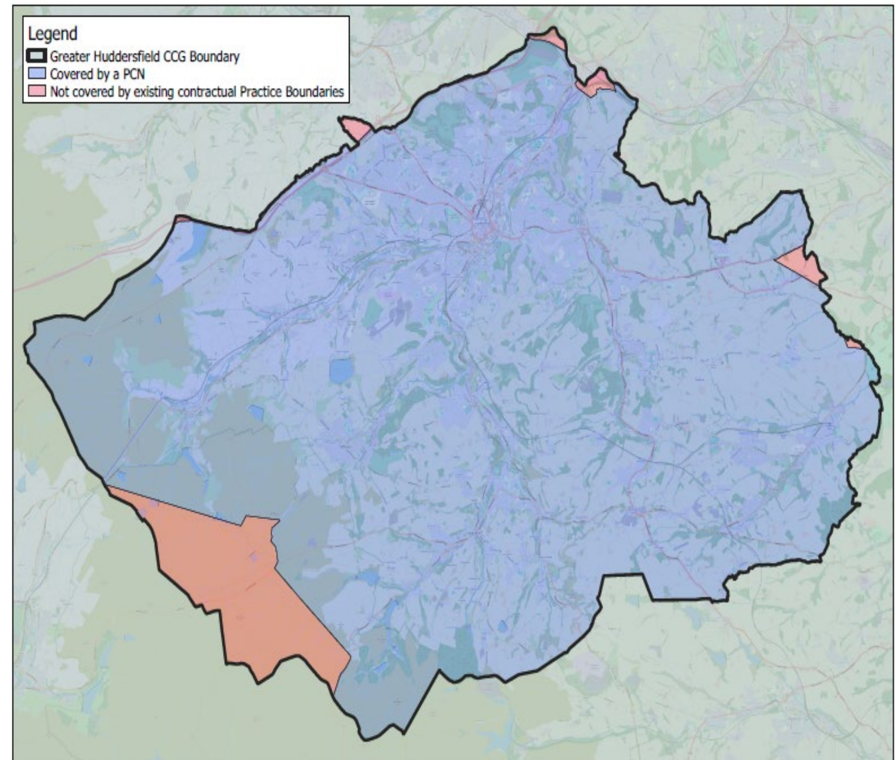
Actions	YES	NO
Does this network registration meet all minimum requirements	x	
Is it recommended that PCCC verify this networks registration	x	
Are there outstanding issues Relating to this Network	x	
Are the LMC aware of the outstanding issue	x	
Are there any further Comments:		
Please refer to 'Exceptional Issue (2) – Greenhead Family Doctors (B85060)'		

Actions	YES	NO
Is the Population criteria 30,000 -50,000		x
Does the Network area cover a boundary that makes sense to it:		
• Constituent Practices	x	
• Partners	x	
• Local Community	x	

The network is deemed to be of a viable, sustainable and manageable size.
Please refer to **'Exceptional Issue (4) - Network population size criteria'**

Greater Huddersfield CCG Primary Care Networks





Actions	YES	NO	Comments
Primary Care Commissioning Committee is specifically required to approve all PCN registration applications at one time to ensure that:			
100% of its geographical area is included within Primary Care Networks		x	Please refer to '**Exceptional Issue (1) – 100% Geographical Coverage in Greater Huddersfield'**
Every constituent practice of a CCG is covered		x	Please refer to '**Exceptional Issue (2) – Greenhead Family Doctors (B85060)'**
100% of the registered population is included within a network		x	Please refer to **'Exceptional Issue (3) - Special Allocation**
The registered population of each network 30,000 -50,000		x	Please refer to **'Exceptional Issue (4) - Network population size criteria'**
Any further comments required			

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KIRKLEES HEALTH & WELLBEING BOARD
MEETING DATE: 13th June 2019
TITLE OF PAPER: West Yorkshire and Harrogate Health and Care Partnership Transformation Funding

1. Purpose of paper

A proposal for principles and approach to developing Kirklees Place Based proposals for the use of transformation funding allocated to the West Yorkshire & Harrogate Integrated Care System (WY&H ICS).

2. Background

The WY&H ICS spends around £5.8bn on the commissioning and delivery of health and care services; this relates to services commissioned by the NHS (clinical commissioning groups and NHS England / Improvement) and those commissioned by local authorities across social care and public health services.

In addition to this core expenditure, there are a number of other funding streams that are received directly by the ICS to support transformation and change across West Yorkshire and Harrogate. These funding streams are relatively small compared to core funding; but if deployed well can be an important catalyst for change and can support the delivery of change programmes at scale.

At the first meeting of the West Yorkshire & Harrogate Health and Care Partnership Board on the 6th June, a paper was presented setting out the principles, approach and proposed prioritisation for Integrated Care System (ICS) transformation funding in 2019/20.

In 2018/19, the ICS received non-recurrent funding from NHS England / Improvement to support transformation and change. This comprised two main elements:

a) "Hypothecated" national transformation funding to support specific national priority areas (£8.5m) – see Appendix A

b) "Flexible" national transformation (£8.75m)

The prioritisation of the flexible transformation funding (£8.75m) was undertaken collectively by all partner organisations in WY&H and the key programmes supported were:

- Urgent and emergency care (£4.0m);
- sector Primary care network development (£2.6m);
- Voluntary and community / loneliness (£1.0m); and
- Programme support (£1.2m).

The hypothecated transformation funding expected to be received by the ICS in 2019/20 is between £15m and £20m (based on a population share of the national hypothecated funding available for ICS's). The value of flexible transformation funding anticipated for 2019/20 in £8.75m

This funding is provided to those ICSs who have signed up to the ICS financial framework in 2019/20. The key element of the framework is that NHS organisations in the partnership have agreed to combine “individual control totals” and operate within a “system control total”. In practice this means that an element of incentive funding provided to provider trusts for delivering their financial targets is now explicitly reliant on the achievement of the system control total; either through every organisation delivering its plan or through a “system offset” approach where under performance in one organisation is offset by over performance in another.

It should be noted that the proposed WY&H Partnership approach is on the premise that the vast majority of flexible funding is prioritised in the first instance to a West Yorkshire and Harrogate programme and then allocated to place for development of more detailed proposals and implementation.

The WY&H paper notes that there were different views across the 6 places of local proprieties, with urgent and emergency care the only programme areas prioritised by all 6 areas.

Principles

The primary purpose of these resources is to support the transformation priorities of the WY&H Partnership and to ensure it is put to the best use to further the strategic objectives that have been agreed and are set out in the Memorandum of Understanding (MoU). The MoU states that:

> *“The partners intend that any transformational funding made available to the Partnership will be used within the places. Funds will be allocated through collective decision making by the Partnership in line with agreed priorities. The method of allocation may vary according to agreed priorities. However, funds will not be allocated through expensive and protracted bidding and prioritisation processes, and will be deployed in those areas where the partners have agreed that they will deliver the maximum leverage for change and address financial risk”.*

The MOU also states that the WY&H Partnership Board will take the decisions around the allocation of transformation funds.

The WY&H Partnership Board Report notes that the ICS was notified in early May 2019 that it was likely to receive the £8.75m of flexible transformation funding in 2019/20. As such there was little time for wide engagement and discussion and local Health and Wellbeing Boards have not been involved in specific discussions about the proposed approach, but there will be further discussions with Health and Wellbeing Boards about the impact of utilisation of this resource on local priorities.

The intent is that the majority of the resource will be allocated at a notional level to specific priority programmes. Each of the six places will then develop proposals as to how this resource will be deployed and the expected benefits/outcomes agreed. This will be led at place level, with discussion and sharing of ideas and best practice within the relevant programme management arrangements.

The use of hypothecated transformation resources will continue to be overseen by the relevant Programme SRO and Programme Board; again recognising that this resource is spent in place.

High level proposition from WY&H for "Flexible" national transformation funding (£8.75m)

Proposed allocation across programme areas:

- Urgent and emergency care (£4.0m)
- Mental health and learning disabilities (£1.5m)
- Preventing ill-health/reducing health inequalities (£1.5m)
- Specific priority areas in place (could focus on voluntary and community services) (£0.9m)
- Programme capacity/system issues (£0.85m).

Resources allocated to programmes/places (the first three priorities) would be spent at place level with high-level oversight undertaken at the Programme workstreams and the System Leadership Executive Group (SLEG). The resource identified for specific priority areas in place could allow some local prioritisation to address specific transformation proposals, or could be used to focus on a theme – for instance development of voluntary and community services. The detailed use of programme capacity/system resource would be developed by the System Oversight and Assurance Group and recommended to the System Leadership Executive Group for approval.

3. Proposed approach in Kirklees

The WY&H partnership is built on 'primacy of place', and the approach outlined above recognises this by proposing that each of the six places will develop proposals as to how the flexible transformation resource will be deployed along with the expected benefits/ outcomes.

The proposed approach for Kirklees is set out below and has been developed through discussions across a range of partners. This approach will enable there to be a coherent Kirklees Place based voice into the WY&H Partnership.

Principles

- Use the Kirklees place based architecture, specifically the Integrated Commissioning Board (ICB) and Integrated Provider Board (IPB), to work up proposals on behalf of the Health and Wellbeing Board (HWBB) to enable a Kirklees Place perspective.
- Recognise the role of the A&E boards in planning for urgent and emergency care and use the common membership across the ICB, IPB and A&E boards to ensure strategic fit of proposals.
- Proposals should reflect the priorities set out in the Health and Wellbeing Plan and the associated Integrated Commissioning Strategy and Integrated Provider Board deliverables.
- Focus the funding on transformation activity rather than mitigation of existing system pressures.
- Our approach must promote transparency around the allocation and use of resources across the Kirklees system.
- For 2019/20 endorse the proposed allocation across WY&H programme areas.

- Kirklees Health and Wellbeing Board to be responsible for signing off Kirklees Place proposals.
- Kirklees ICB and IPB to maintain oversight of funded programmes to ensure effective delivery and connections across the system.

Issues to consider

- Scale: the transformation funding is welcome but very limited (approximately 0.2% of overall annual health and social care spending). It is estimated at approximately £1.3m for Kirklees assuming a population based share of the overall WY&H funding available (Kirklees figures in red below), therefore ..
- It is crucial to ensure proposals complement existing and planned transformation programmes, including links with other funding e.g. BCF/iBCF (including Winter Funding), Local Workforce Advisory Board, Primary Care Networks, A&E Board sponsored projects etc.
- The WY&H Partnership has recognised that the existing Partnership priorities need updating, and agreed at the recent Partnership Board meeting that work on children, young people and families needs strengthening, both through increasing the focus on children and young people in existing programmes such as Urgent & Emergency Care, Cancer and Primary and Community Care; and by developing a specific Children, Young People & Families programme. Therefore it important to bring children, young people and families into view when developing local proposals.
- It is important to recognise that in order to achieve the best return for the available investment some transformation programmes might need to operate at a supra-district level egg Calderdale, Kirklees and Wakefield; West Yorkshire or for Urgent & Emergency Care – Calderdale & Huddersfield or North Kirklees & Wakefield.

Developing Kirklees place based proposals

- Kirklees Place proposals to be developed through the Integrated Commissioning Board and Integrated Provider Boards for:
    - Mental health and learning disabilities (£225k)
    - Preventing ill-health/reducing health inequalities (£225k)
    - Specific priority areas in place (could focus on VCS) (£135k)
    - Urgent and emergency care(£600k)
    - Other WY&H programmes that are allocated flexible transformation funding

  All proposals to consider issues for children, young people and families as appropriate.
- The WY&H timeline for final sign-off is yet to be confirmed, but we anticipate that this will be before the next Kirklees Health and Wellbeing Board. Therefore the proposed approach is for the Chair of the Health and Wellbeing Board to be given the authority to sign off the proposals on behalf of the Board in consultation with the Chairs of the Integrated Commissioning Board (ICB) and Integrated Provider Board (IPB).
- A paper outlining the Kirklees Place based proposals to be presented to the Health and Wellbeing Board meeting on the 23rd July.

4. Financial Implications

These are discussed above.

5. Sign off

Richard Parry, Strategic Director – Corporate Strategy, Commissioning and Public Health
Carol McKenna, Chief Officer, Greater Huddersfield & North Kirklees CCGs
Karen Jackson, Chief Executive, Locala Community Partnerships

6. Next Steps

Date	Board/Group	Action
7 June	Integrated Commissioning Board (ICB)	Discuss proposed approach and how to work up proposals
11 June	Integrated Provider Board (IPB)	Discuss proposed approach and how to work up proposals
13 June	HWBB	Seek approval for proposed approach
4 July	Integrated Commissioning Board (ICB)	Endorse proposals
9 July	Integrated Provider Board (IPB)	Endorse proposals
	HWBB Chair, Chairs of ICB and IPB	Sign off Kirklees place based proposals.
23 July	HWBB	Report to Board on proposals submitted

7. Recommendations

That the Health and Wellbeing Board

- Endorse the principles and proposed approach to the development of Kirklees Place based proposals for the use of 'flexible' transformation funding in 2019/20 (see Section 3).
- Agree that the Chair can sign off the Kirklees place based proposals on behalf of the Board in consultation with the Chairs of the Integrated Commissioning Board (ICB) and Integrated Provider Board (IPB).
- Agree that a paper summarising the Kirklees Place based proposals be presented to the next Board meeting.

8. Contact Officer

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Appendix A: NHS England Hypothecated Funding

	2018/19	2019/20
Maternity	£707,000	£1.7m
Elective care	£293,000	tbc
Personalised care demonstrator sites	£335,000	£0.3m
Suicide prevention	£20,000	tbc
Urgent and Emergency Care	£726,000	tbc
Cancer Alliance	£5,412,000	£6.6m
Communications	£93,000	tbc
Population Health Management	£651,000	tbc
WYAAT Networked Services	£100,000	tbc
Harnessing the power of communities (VCSE)	£28,000	tbc
Organisational Development	£75,000	tbc
Enhanced health in care homes	£86,000	tbc
GP Forward View	-	£2.1m
TOTAL	£8,526,000	£15m-£20m