Public Document Pack

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Wednesday 22 September 2021

Notice of Meeting

Dear Member

Health and Wellbeing Board

The **Health and Wellbeing Board** will meet in the **Virtual Meeting - online** at **2.15 pm** on **Thursday 30 September 2021.**

This meeting will be live webcast. To access the webcast please go to the Council's website at the time of the meeting and follow the instructions on the page.

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 Musarrat Khan
Councillor Carole Pattison
Councillor Mark Thompson
Councillor Kath Pinnock
Richard Parry
Mel Meggs
Rachel Spencer-Henshall
Carol McKenna
Dr Khalid Naeem
Helen Hunter
Karen Jackson
Beth Hewitt

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.

2: Minutes of previous meeting

1 - 10

To approve the minutes of the meeting of the Board held on 15 July 2021.

3: Interests

11 - 12

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 meeting will hear any questions from the general public. Questions should be emailed to jenny.bryce-chan@kirklees.gov.uk no later than 10.00am Tuesday 28 September 2021.

In accordance with Council Procedure Rule 51(10) each person may submit a maximum of 4 written questions. In accordance with Council Procedure Rule 11(5), the period allowed for the asking and answering of public questions will not exceed 15 minutes.

7: Covid-19 Update

The Board will receive an update on Covid-19 in Kirklees.

Contact: Rachel Spencer-Henshall, Strategic Director, Corporate Strategy, Commissioning and Public Health. Tel: 01484 221000

8: Showcasing Innovation : Kirklees Better Outcomes Partnership

To receive a presentation on the innovative partnership-based approach to supporting vulnerable adults in Kirklees by helping them live independent and fulfilling lives in their own homes.

Contact: Emma Hanley, Senior Contracting & Procurement Manager and Sarah Cooke, KBOP Director Tel: 01484 221000

9: Shaping the partnership response to Tobacco Control in Kirklees

13 - 18

A report

a) outlining the aims of the Tobacco Alliance, and to champion the work across the partnership
b) providing an update on the All Party Parliamentary Group Smoking & Health recommendations prior to the release of the Tobacco Control Plan for England

Contact: Rebecca Gunn, Public Health Manager: Tel: 01484 221000

10: The Health and Care Bill: Preparations in West Yorkshire and Kirklees for the proposed changes

19 - 40

To receive an update on the work underway across West Yorkshire and Kirklees to prepare for the changes set out in the Health and Care Bill.

Contact: Richard Parry, Strategic Director for Adults and Health and Carol McKenna, Chief Officer

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11: Date of the next meeting

Board members are asked to note that the date of the next Health and Wellbeing Board meeting will be on the 2 December 2021.

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Contact Officer: Jenny Bryce-Chan

KIRKLEES COUNCIL

HEALTH AND WELLBEING BOARD

Thursday 15th July 2021

Present:	Councillor Viv Kendrick (Chair) Councillor Musarrat Khan Councillor Carole Pattison Councillor Kath Pinnock Mel Meggs Carol McKenna Dr Khalid Naeem Richard Parry Rachel Spencer-Henshall Helen Hunter
In attendance:	Tim Breedon, Deputy Chief Executive South West Yorkshire Partnership NHS Foundation Trust Tim Breeley-Fox, Commercial Director Locala Catherine Riley, Assistant Director of Strategic Planning Calderdale and Huddersfield NHS Foundation Trust Trudie Davies, Mid Yorkshire Hospitals NHS Trust Kelsey Clark-Davies, Kirklees Council Debra Taylor-Tate, NHS England and NHS Improvement – (NE and Yorkshire) Diane McKerracher, Chair, Locala Phil Longworth, Senior Manager, Integrated Support Cllr Habiban Zaman, Lead Member for the Health and Adults Social Care Scrutiny Panel Alex Chaplin, Strategy and Policy Officer, Integration Tom Brailsford, Service Director, Resources, Improvement and Partnership Mary White, Commissioning and Partnership Manager Richard Dresser, Local Offer, Development and Engagement Lead
Apologies:	Karen Jackson Beth Hewitt Jacqui Gedman

1 Membership of the Board/Apologies

Apologies were received from the following Board members Karen Jackson Beth Hewitt and Jacqui Gedman.

Tim Breeley-Fox attended as sub for Karen Jackson.

2 Appointment of Deputy Chair

That Dr Khalid Naeem be appointed Deputy Chair of the Health and Wellbeing Board for 2021/22.

3 Minutes of previous meeting

That the minutes of the meeting held on the 25 March 2021 be approved as a correct record.

4 Interests

No interests were declared.

5 Admission of the Public

All agenda items were considered in public session.

6 Deputations/Petitions

No deputations or petitions were received.

7 Public Question Time

No questions were asked.

8 Covid-19 Update

Rachel Spencer-Henshall, Strategic Director, Corporate Strategy, Commissioning and Public Health, provided an update on the current position regarding Covid-19 in Kirklees. The Board was informed that the roll out of the vaccination programme has been a huge achievement and is a testament to joint partnership working. The work to get local pop ups in place has been particularly heartening as the aim is to try and have drop-ins in some of the communities with the lowest vaccination uptake.

Referring to information within the presentation, the Board was advised that the information on the map depicts the areas with the lowest uptake of the vaccine and this correlates to historically where the highest Covid infections have been throughout the pandemic. It is therefore important to make sure that the areas with a low uptake are targeted to encourage people to get their first and second doses of the vaccine.

The Board was informed that a Community Champion Scheme is in operation which is working on the ground. There are 70 different groups across Kirklees who are trying to work with local people to try and encourage uptake. Recognising that sometimes this can be time consuming, conversations are taking place regarding the approach to move people from a position of being unsure about taking the vaccine to one where they feel confident. It is important that momentum is not lost as this will help the local population not to experience serious illness or death and the vaccine programme is definitely the best way to protect people.

The Board was advised that in terms of the vaccine impact so far, the link between serious illness and death is definitely what has changed in terms of this pandemic. There have been no deaths in hospital (within 28 days of a positive Covid test) since early June and although the number of patients across the two trusts being treated

for Covid has risen, it is nowhere near the peaks previously seen because of the vaccination programme.

It is still important to monitor this because there are still people within the population who are vulnerable, and everything needs to be done to support them to ensure they have access to the vaccination programme.

The Board was informed that with regard to the road map there are two key dates, the 19th July and the 16th August 2021. On the 19th July, the expectation and the legal position in relation to hands, face, space is being removed and the expectation is that if an individual is a contact of a positive case there will still be a requirement to self-isolate. This will present some challenge in the system for partners on the Board and also other settings in terms of managing how they keep the risk low whilst not having any regulatory powers.

Post the 16th August the rules for self-isolation will be removed for contacts and if individuals are a close contact of a positive case they will be encouraged to undertake a PCR test to determine if they are positive also. Things are changing based on the obvious impact of the vaccination programme in terms of serious illness and death. It is important to emphasise that wearing a face covering, washing hands regularly, keeping a distance from people and plenty of ventilation will still help to keep the virus levels down.

In response to the information presented, the Board raised a number of questions and comments as follows:

- What will happen when lateral flow tests are charged for and the availability of free tests ends and what the likely cost will be?
- With such high levels of the virus in the local population, what impact is this having on the delivery of health and care services particularly with people having to self-isolate because of their contact with someone who has tested positive?
- Information from some health partners suggests that they are planning to do vaccinations for people aged 16+ is this being looked at in this area?

The Board was advised that from an NHS England perspective it is hoped that guidance will shortly be issued around self-isolating for health and care staff. It should also include guidance around mask wearing for NHS and care staff.

RESOLVED

That Rachel Spencer-Henshall be thanked for providing an update on the current position with regard to Covid-19

9 Showcasing Innovation - The Kirklees Local Offer

Kelsey Clarke-Davies, Head of Safeguarding and Inclusion and Richard Dresser, Local Offer, Development and Engagement Lead provided the Board with an update on the relaunched Kirklees Local Offer.

In summary, the Board was informed that the local offer aims to provide a one-stop-shop for children, families and professionals working with children and young people with additional needs. It provides a signpost to all the services that are available and also identifies services that are not currently available and enables work with commissioners to develop and implement them.

There is some really innovative practice, for example, a new service that was recently launched called Inclusion Support Offer (ISO) which acts as a front door for professionals working with children and young people with additional needs.

The Board was provided with the following information:

- The local offer provides information for children and young people with SEND and their families in one single place
- The new website was soft launched in December 2020
- The local offer is constantly evolving therefore requires ongoing development for the life of it and there is a team of six people working on the offer
- It provides relevant information (inc advice and guidance) or service across education, health, social care and third sector information
- The aim of the local offer; is to provide timely information, early-intervention, and prevention, enable families and young people to use self-service principles; and to provide feedback on engagement and surveys which informs commissioning and service delivery

The Board was informed that this the third local offer that the council has had, and the previous iterations were not very comprehensive and did not have the capacity to do what it needed to do. The code of practice and the Children's and Families Act specifies that it is co-produced in conjunction with those that would use it such as children and young people. The key principles are that it is comprehensive, collaborative, up to date, transparent and assessable.

The Inclusion Support Offer is a project that has been worked on alongside Partners in Power and the aim is to provide direct support for SENCOs, who are the special needs co-ordinators who work in schools. This gives them someone they can talk to, to talk through cases and receive support, information, and resources. SENCO schools have found this very useful.

Board members were encouraged to visit the website (link) and share and promote it with others and if they identified any gaps in the information, they should contact the key officers.

The Chair of the Board suggested that a link to the local offer website should be emailed to councillors who may be able to promote it through their social media links.

RESOLVED:

That Richard Dresser and Kelsey Clarke-Davies be thanked for providing an update on the Kirklees Local Offer

10 The Kirklees SEND system

Tom Brailsford, Service Director, Resources, Improvement and Partnerships attended the meeting to provide the Board with an overview of the current developments in the Kirklees SEND system, advising on the draft Kirklees Self-Assessment Summary, Special Educational Needs and Disability and the Draft Kirklees SEND Transformation Plan.

In summary, the Board was informed that a joint CQC and Ofsted SEND inspection is overdue. Kirklees is one of the five areas in Yorkshire and Humber that has not been inspected since the changes were introduced in 2014.

The inspection will look at:

- The effectiveness of the local area in identifying children and young people who have special educational needs and/or disabilities
- The effectiveness of the local area in assessing and meeting the needs of children and young people who have special educational needs and/or disabilities
- The effectiveness of the local area in improving outcomes for children and young people who have special educational needs and/or disabilities

As part of the preparation for the inspection, an assessment of strengths and weaknesses across the board was undertaken. In addition, NHS England and the Department for Education (DfE) requested a meeting with the five areas that have not yet had an inspection to look at readiness in relation to the following nine themes

- Strategic leadership and governance
- Collaborative commissioning / JSNA
- Data and intelligence / outcomes
- Co-production / voice of children young people and families
- Local offer and provision across education, health and care
- Quality assurance, including EHCPs
- Workforce and training
- DCO/DMO roles
- Response to Covid and post recovery planning

The conversations with the DfE went very well and supportive conversations with the DfE will continue to be held.

The Board was informed that the local approach to SEND is to develop strong strategic oversight and ambitions for children and young people with additional needs to deliver the expectations of Children and Families Act. The aspirations for the children and young people with SEND are no different to all children that they have the best start in life. The aim is to move to a strength based restorative model where the focus is on less on weakness and areas for development and more on strengths and doing two co-producing plans and making sure families are really involved in person centred planning.

In addition, the approach to SEND will also include:

- Developing a strength based, restorative approach with children and families
- Encouraging innovation and diverse range of services to meet need with a Kirklees focus
- Health and Social Care White Paper offers providers opportunity for further integration
- The coronavirus pandemic has clearly brought unprecedented challenges to the way in which we deliver services how we work
- Delivering the best SEND outcomes is a significant challenge which many authorities and partners face but are we doing the best we can?

The Board was provided with information regarding the local SEND picture in Kirklees. Currently, there are approximately just over 104,000 Children and Young People of which 69,638 are school aged and 3812 children and young people have an Education, Health and Care Plan (EHCP) a 44% rise since 2015. The percentage of pupils with a statement or EHCP from 2016/17 to 2019/20 has increased in line with the national average.

In terms of outcomes, it is a mixed picture for example, exclusions for SEN Support & EHCP cohort of pupils have a fixed period exclusion rate of 21.76% which is higher than the national rate for all pupils at 5.36% and national rate for pupils with EHCPs and SEN Support at 15.7%. Educational outcomes for SEN support/EHCP learners are also less favourable than the national average in key stages. The statutory compliance in terms of completing plans has increased from 43.8% to 83.4% in 2020 an increase of 90% which is positive.

The Board was informed that some of the key achievements from the self-assessment includes re-commissioning the Local Offer produced and co-designed with parents and carers and launching the Inclusion and Support Offer to provide support to practitioners such as SENCos to support families and young people. Self-assessment challenges include some systems and services being under pressure, for example children's therapies, Neurodevelopmental provision and SENDACT capacity.

The aim of pulling together one single transformation plan is:

- Data and Intelligence led
- Sequenced in the right way
- Re-orientate whole system to early help and earlier intervention
- Transform local sufficiency, in order for children and young people to be educated and live locally
- Significant reduction in our exclusions
- Improving outcomes for our children and young people whilst controlling spending
- Having a restorative culture and system "No decision about me, without me"

The Board was informed that the SEND Transformation Programme has five workstreams, models of practice, inclusion, early intervention, commissioning, and sufficiency and preparing for adulthood. The last workstream is enablers which aims to embed young people's family engagement throughout the process it aims to

ensure that the right support services are in place, producing the self-evaluation and making sure there is good governance.

In response to the information presented as number of questions were asked as follows:

- What are the risks associated with data sharing across the different organisations and institutions, in terms of GDPR?
- Early intervention makes a huge difference, however with the rise in the numbers of children needing help now where does the funding come from to shift the resources to where it is most needed?
- Would it be helpful to include the police, youth justice and probation in some of these discussions to try and prevent young people in teenage years becoming involved in gangs, county lines, grooming as it appears, they are not included in discussions
- Young people have missed approximately 115 days of school on average since Covid and are 3-4 months behind in literacy, and children who are in the SEND category are even further behind, how as a group is this going to be addressed to achieve the ambitions?

RESOLVED

That Tom Brailsford be thanked for providing an update on the Kirklees SEND system and the board notes the content of the information presented.

11 Children and Young People's Plan priority updates

Mary White, Commissioning and Partnership Manager provided the Board with an update on the Children and Young People's Priority Plan. The Board was informed that the Kirklees Children and Young Peoples Partnership is a partnership that is open to anyone who works with and cares about children and young people who live in the area.

The partnership looks at a range of qualitative and quantitative evidence regarding children's experiences and what works to promote good outcomes for them, and the Health and Wellbeing Board provides the governance for the children's and young people plan.

There have been a lot of conversations about children and young people's mental health as a result of the pandemic as well as it being a general concern at all times. At the last partnership session there was a particular focus around children and young people's emotional health and wellbeing and mental health. The aim is to take an asset-based approach for example what provides the right circumstances, support, and environment to support good mental health outcomes for children and young people. There were good presentations which highlighted some good practice and the next step will be to reflect on the is and how this can be taken forward which might feed through into some future priorities.

The children and young people's plan is a non-statutory plan, produced with partners across the children's systems which includes some of the organisations

represented on the Health and Wellbeing Board, faith, community and voluntary organisations a whole range of organisations.

The plan intentionally focuses on complicated issues that need changes in culture. The appended report outlines the rational for the chosen priorities. Currently, there are three priority areas of focus:

1) Improving Inclusion and Outcomes for LGBT+ Young People – this work is managed by a strategic group which is made up of representatives from the council, Kirklees Youth Alliance the Brunswick centre who are the specialist LGBT local organisation, the Base Northorpe Hall which provides tier 2 mental health support services and colleagues from the university.

2) To grow our youth offer – place to go, people to see, things to do – this became a priority because of the loss in youth work provision in the borough over a three-to-four-year period up until 2019. It was recognised that the provision was important for providing an opportunity for early intervention with children and families having a trusted place in the community where people can go and a trust adult to talk to. The youth development programme was launched in 2019 with five different work streams Community Youth Work, prevention pathway, practice model, places to go and tackling inequality.

3) Reducing the effects of poverty on children – children who live in poverty are most likely to achieve the poorest outcomes, in terms of education, health etc therefore one of the ways to improve children's outcomes is by working to tackle poverty. At the same time as the children's partnership was looking at this, the poverty partnership was being relaunched and therefore it was prudent to bring the two pieces of work together and collaborate and have children, young people, and family poverty as one of the key themes in the new action plan. Over the last few months, a lot of the focus has moved to pandemic response as opposed to the longer-term developmental work, however, the next step is moving back towards that.

   The Board was provided with statistical information which highlights the impact of the pandemic. In January 2020, just before the pandemic, 19.1% of the school cohort were eligible for free school meals, 1 in 5 of children. When the census was conducted in January 2021, that figure had gone up to 23.9% 1 in 4 children. This highlights the need to focus on poverty.

RESOLVED

That

a) Mary White be thanked for providing an update on the Children and Young People's Plan priority;
b) The Board notes and endorses the working arrangements for the Children's Partnership

12 Developing the Kirklees Joint Health and Wellbeing Strategy

Phil Longworth, Senior Manager, Integrated Support and Alex Chaplin, Strategy and Policy Officer updated the Board on Developing the Kirklees Joint Health and Wellbeing Strategy. The Board was reminded that one of its responsibilities is to ensure that there is an up-to-date Joint Health and Wellbeing Strategy that reflects the joint strategic assessment that the Board signs off on an annual basis.

The Board was reminded that the first joint health and wellbeing strategy was published in 2014 and in September 2020, the Board agreed that a new Joint Health and Wellbeing Strategy should be developed in 2021. The context within which the strategy is being developed has changed significantly and some of the key changes include Covid-19 and its wide-ranging impacts and the development of new structures for example, the West Yorkshire Integrated Care System, Primary Care Networks and Provider Alliances and bringing together commissioners and providers in the Kirklees Integrated Health and Care Leadership Board.

The Kirklees Partnership has endorsed an approach to developing and inter-linked set of three top level strategies covering, Health and Wellbeing Strategy, Economy Strategy, and Inclusive Communities Framework. A common focus for these strategies in terms of outcome, inclusion and inequalities with inequalities being a theme that runs through everything.

There is already a vision, outlined in the current Joint Health and Wellbeing Strategy and a set of values, behaviours and leadership principles and part of the work will be to reflect on those to ensure they are still appropriate. Board members were reminded of the Kirklees outcomes and advised that it will be important to monitor progress against those outcomes and there are a suite of indicators to reflect on and update. Work is being undertaken on an additional citizens outcome and what the focus on that might be and trying to capture how much in control people feel of their own lives and how much they can influence what is going on.

The Board was advised that more work will be required than just developing the joint health and wellbeing strategy. The bill on the Health and Care white paper has been published and there is need to introduce a new set of partnership arrangements for our Kirklees place-based health and care partnership. There is also a need to translate the Health and Wellbeing Strategy into a plan which outlines the specific actions to be taken. While the Health and Wellbeing Plan will provide the overarching plan, there is a recognition that there will need to be locality plans, organisations will need their own plans and there will also need to be workstreams covering specific issues such as Starting Well, Living Well and Ageing Well.

The current Health and Wellbeing Plan has been summarised as a plan on a page and the aim is not to have a large document but to try and distil the key points, actions and approach into a format that is more compelling and engaging with the local offer.

A summary of the information from the Board's workshop session on the 24 June includes:

Ambitions

Maintaining Momentum

- new ways of working have been tested and momentum needs to be maintained
- Learning from previous wins and mistakes
- Covenant between people, places, and organisations
- Not just general populations, and people with care/health needs, but also staff and volunteers
- Impact of Covid and 'long Covid' on health, the fabric of communities, and the resilience of organisations
- Covid has highlighted and exacerbated inequalities – this must underpin everything we do
- Embedding co-production

Beyond Eligibility

- Increased focus on equality of access
- Self-directed support for both individuals and communities
- Eligibility to meet needs and support wellbeing throughout the pandemic, a positive risk-taking approach should be continued

The Board was advised that in terms of next steps:

a) throughout the summer and autumn to work with partners to develop a draft Joint Health and Wellbeing Strategy using the approach outlined above.
b) Hold an informal workshop with Health and Wellbeing Board members and other key senior leader in September 2021 to help shape the early draft of the new Strategy.
c) Present a draft Joint Health and Wellbeing Strategy to the Health and Wellbeing Board meeting for approval.

RESOLVED

That:

a) Phil Longworth and Alex Chaplin be thanked for presenting information on developing the Kirklees Joint Health and Wellbeing Strategy

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 & WELLBEING BOARD

MEETING DATE: 30th September 2021

TITLE OF PAPER: Shaping the partnership response to Tobacco Control in Kirklees

1. Purpose of paper

This paper intends to formalise the partnership response to Tobacco Control in Kirklees District whereby the Health and Wellbeing Board fully understand, support and influence the aims of the Tobacco Alliance, and champion this work across the partnership.

We seek a formal decision from Health and Wellbeing Board regarding the reporting arrangement and make the following recommendations:

- Tobacco Alliance is recognised as formally accountable to the Health & Wellbeing Board
- Health and Wellbeing Board will receive updates regarding the work of the Tobacco Alliance on a regular basis as agreed by the Board.
- Health and Wellbeing Board will shape the work of the Tobacco Alliance and influence the agenda at a strategic level.

This paper also provides an update on the APPG Smoking & Health recommendations prior to the release of the Tobacco Control Plan for England (expected in October 2021) and makes the following recommendations.

- Health and Wellbeing Board discuss and support the APPG recommendations detailed on pages 3-4.
- Health and Wellbeing Board support and champion the APPG recommendations to ensure they remain part of the tobacco plan and that it is funded to the levels suggested in the APPG report.
- Health and Wellbeing Board commit to registering support as a council to the ASH Smokefree Roadmap to achieving a smokefree society by 2030.
- Health and Wellbeing Board agree to review the Tobacco Control Plan for England (expected to be released in October 2021) and agree a position on behalf of the partnership.

2. Background

In February 2020, the Health Foundation published Health Equity in England: The Marmot Review 10 Years On which revealed that health inequalities are worsening, and life expectancy stalling, in some areas decreasing. Since then the COVID-19 pandemic has shone a light on the inequalities that pervade our local communities, giving renewed focus and urgency to act towards an equal society. It is evident that those who were already experiencing disadvantage before COVID-19 have since been most severely impacted across all areas of life including employment, income, housing, education and health.

Whilst the root causes are complex, smoking is the single largest driver of health inequalities in the UK accounting for half the difference in life expectancy between richest and poorest.

The most common causes of death in Kirklees are circulatory disease (31%), cancer (26%) and diseases of the respiratory system (14%), all of which are risk factors of smoking. Smoking not only kills people prematurely, but it also drives them into poverty and reduces healthy life expectancy, with smokers needing help with everyday tasks 7 years earlier than those who have never smoked. Smokers lose on average 10 years of life, and for every death caused by smoking it is estimated that another thirty people are suffering from serious illnesses attributable to smoking.

Higher smoking prevalence is associated with almost every indicator of deprivation or marginalisation. Compared to the population as a whole, smoking is more common among people with a mental health condition, people with lower incomes, people who are experiencing homelessness, people in contact with the criminal justice system, people who live in social housing, people without qualifications, lone parents and LGBT people.

In Kirklees, 14.3% of residents still smoke and 12.1% of women who give birth report smoking throughout their pregnancy (PHE, 2018/19). Dewsbury West has the highest smoking prevalence (17.1%) followed by Batley East (15.9%), Batley West (15.8%), Dewsbury East (15.8%) and Newsome (15.8%). According to the Action on Smoking (ASH) Social Care cost calculator (available here), the total additional spending on social care in Kirklees as a result of smoking for adults aged 50 and over was approximately: £9,162,617 in 2021.

Whilst smoking remains the most common form of tobacco use in all communities, shisha is a popular alternative, especially amongst South Asian and Middle Eastern communities. Ensuring that shisha cafes comply with smokefree, licensing and fire safety regulations must form part of this agenda, including equipping business owners with information to educate customers about the misconception that smoking shisha is safer than smoking cigarettes

All forms of tobacco are harmful, and regardless of whether it was bought from an illegal or legal source, one in two long-term tobacco users will die early as a result of smoking. Illicit tobacco undermines the stop smoking agenda, through increasing availability of tobacco in local communities, often at a lower price than regulated suppliers. This makes it easier for young people to start smoking and harder for smokers to quit. Understanding and managing the supply of tobacco therefore is a crucial element of a system wide approach to smoking reduction.

Not smoking can allow people to leap the health gap, with the poorest non-smokers having a substantially longer life than the richest smokers. Analysis of UK Government data carried out for ASH shows that nationally, around 1,011,000 people – including 263,000 children – live in poverty as a direct result of income lost to tobacco. One third (31.3%) of households which include at least one person who smokes live in poverty, which would reduce to one in five (22.3%) if income lost to tobacco was returned.

Furthermore, the role of effective enforcement and licensing in managing supply to tobacco and the role of environmental health and housing in achieving cleaner and smoke free environments is crucial. The Kirklees Health and Wellbeing Plan (2018-2023) states that a crucial part of smoking prevention is taking a system-wide approach to creating a smoke-free Kirklees and creating an environment in which smoking is no longer the norm.

The Government's ambition is that England will be smokefree by 2030 (defined as rates of less than 5%), which will be a challenge, particularly in areas of deprivation and among people living with mental health conditions and will require 'bold action to both discourage young people from starting in the first place, and to support smokers to quit'. In the two years since the ambition was stated, an estimated 200,000 children under the age of 16 have started smoking, two thirds of who will without action, become regular smokers. It is critical that in Kirklees we strive to drive prevalence down through discouraging people from starting in the first place, supporting smokers to quit and normalising non-smoking.

Tobacco Alliance

- It was agreed that a District Wide approach to tackling tobacco was needed. The Tobacco Alliance was established to bring together key partners to address the issues of tobacco control in Kirklees. The partnership aims to reduce smoking prevalence for a healthier

tobacco free future for children and young people in Kirklees. The current ambition, objectives and functions of the Tobacco Alliance (see below) were presented to Cllr Khan for approval in May 2021 and have informed the basis of work to date.

- Our ambition is to achieve a Smokefree Kirklees by 2030. To be smokefree is to reach a tipping point when smoking is no longer normalised in society, and the end of smoking is in sight. The UK and other Governments have defined this to be when smoking rates are 5% or less.

The objectives are:

- To strengthen partnerships and lead a district wide approach to tobacco control
- To reduce the supply of and demand for illicit tobacco
- To reduce the number of families in Kirklees living in poverty due to smoking

- The key functions are:
  1. To provide strategic leadership and drive for the tobacco control agenda in Kirklees.
  2. To develop, coordinate and monitor the Smokefree Kirklees Tobacco Control Plan.
  3. To monitor performance of activities against targets set out in the action plan.
  4. Ensure the action plans are based on evidence including learning from best practice where applicable.
  5. To promote tobacco control issues and seek to influence wider strategic partnerships.
  6. To influence, share and implement new guidance and standards relating to tobacco control.
  7. To provide local support for regional and national tobacco control initiatives.
  8. To publicise the work of the alliance and influence locally, regionally and nationally for support for the tobacco control agenda.

- The Tobacco Alliance has met twice (virtually), in May and July 2021, and will continue to meet quarterly.

- To date, there has been broad representation including WY Fire Service, WY Police, WY Trading Standards, Public Health England, Mid Yorkshire NHS Trust, Calderdale and Huddersfield Foundation Trust, South West Yorkshire NHS Foundation Trust, WY Cancer Alliance, Licensing, Housing, Community Safety, Wellness Service and Primary Care.

- We are continuing to engage with partners to encourage broad representation and an action plan is currently being drafted which will inform our work moving forward.

APPG Recommendations

- On 9th June 2021, All-Party Parliamentary Group (APPG) on Smoking and Health launched its report and recommendations for the forthcoming Tobacco Control Plan to secure the Government's ambition of a Smokefree country by 2030. On 10th June there was a Westminster Hall debate on APPG recommendations. The key recommendations are:
  - Funding for tobacco control programmes to be secured through a 'polluter pays' amendment to the Health and Social Care Bill, forcing manufacturers to pay to deliver the end of smoking. A levy on manufacturers could raise £700m in the first year, without passing costs on to smokers. The levy would pay outright for delivery of the Tobacco Control Plan and provide additional funding that would be well invested in public health priorities.

- Targeted investment to provide additional support to help smokers quit in regions and communities where smoking does most damage, such as the Yorkshire and the Humber. This includes those in routine and manual jobs and the unemployed; living in social housing; with a mental health condition; and pregnant smokers.
- Tougher tobacco regulations to protect children and young people from becoming smokers and help smokers quit, such as putting health warnings on cigarettes and consulting on raising the age of sale to 21.

- The next Tobacco Control Plan for England is expected in October 2021. This includes the introduction of a tobacco levy, where tobacco manufacturers are required to provide a fund for tobacco control activities. In line with the requirements of WHO Framework Convention on Tobacco Control, the tobacco industry would be unable to influence the use of the funds, or through their activities benefit from the fund. The 'Smokefree Fund' would provide, at no cost to the public purse, the funding needed to eradicate the social and geographical inequalities in smoking and deliver a Smokefree 2030.

- Fluctuations in desire to quit and success at quitting, have taught us that sustained declines in smoking prevalence are only achieved when government action is systematic, co-ordinated and properly resourced. If the ambition of a Smokefree 2030 is to be achieved public health must receive the funding it requires.

- Kirklees Council Public Health supports the work of Breathe2025, Yorkshire and Humber's tobacco control collaboration through the tobacco community of improvement in partnership with PHE and other LA's. Through working together, we are better at achieving our aims of a smokefree generation.

3. Proposal

<u>Tobacco Alliance</u>

1) Note the aims, objectives and functions of Tobacco Alliance.
2) Discuss and agree the reporting arrangements (including format and regularity) of the Tobacco Alliance to Health and Wellbeing Board.
3) Shape the work of the Tobacco Alliance by receiving regular updates and influencing the agenda at a strategic level.
4) Champion the work of the Tobacco Alliance across Kirklees networks to ensure it is a key strategic issue.

<u>APPG</u>

5) Note the recommendations of the APPG report detailed on pages 3-4.
6) Support and champion the APPG recommendations to ensure they remain part of the tobacco plan and that it is funded to the levels suggested in the APPG report so that together we can inspire a smokefree generation, reduce health inequalities and help build back better and fairer.

4. Financial Implications

The secretariat function of the Tobacco Alliance is held by Kirklees Public Health.

No resource implications.

5. Sign off

Approved by Rachel Spencer-Henshall on 20/09/21.

6. Next Steps

Tobacco Alliance

- The Tobacco Alliance will begin reporting to Health and Wellbeing Board as agreed.

APPG recommendations

- Cllr Khan to take a motion to full Council in October 2021 to support the APPG recommendations. The endorsement of Health and Wellbeing Board will strengthen this discussion.
- The Tobacco Control Plan is expected to be released in October 2021.

7. Recommendations

Tobacco Alliance

1) Tobacco Alliance is recognised as formally accountable to the Health & Wellbeing Board
2) Health and Wellbeing Board will receive updates regarding the work of the Tobacco Alliance on a regular basis as agreed by the Board.
3) Shape the work of the Tobacco Alliance by receiving regular updates and influencing the agenda at a strategic level.

APPG

4) Health and Wellbeing Board discuss and support the recommendations (see pages 3-4).
5) Health and Wellbeing Board support and champion the APPG recommendations to ensure they remain part of the tobacco plan and that it is funded to the levels suggested in the APPG report so that together we can inspire a smokefree generation, reduce health inequalities and help build back better and fairer.
6) Health and Wellbeing Board commit to registering support as a council to the ASH Smokefree Roadmap to achieving a smokefree society by 2030.
7) Health and Wellbeing Board agree to review the Tobacco Control Plan for England (expected to be released in October 2021) and agree a position on behalf of the partnership.

8. Contact Officer

Rebecca Gunn, Public Health Manager: rgunn@kirklees.gov.uk

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West Yorkshire and Harrogate Health and Care Partnership

Update on Health and Care Bill Proposals
September 2021

Summary

As part of preparations for the legislative changes set out in the Health and Care Bill for integrated care systems, NHS England and the Department of Health and Social Care have published a range of guidance designed to support the establishment of Integrated Care Boards (ICBs) by 1 April 2022.

The guidance published during August and September all build on the expectations set out in the ICS Design Framework, and are intended to help us prepare for our next steps. You can read all guidance here.

Integrated care systems

The first reading of the Health and Care Bill took place in the House of Commons on 7 July with the second reading on 14 July. The Bill is currently in the Committee Stage. The Bill follows on from the White Paper *Integration and innovation: working together to improve health and social care for all* and sets out legislation to establish Integrated Care Boards (formerly known as Integrated Care Systems) as statutory bodies.

NHS England and NHS Improvement (NHSEI) published the Integrated Care System (ICS) Design Framework to guide next steps in developing ICS' in line with the Bill and the White Paper.

Until the legislation is agreed by Parliament the move to create new statutory NHS bodies to replace clinical commissioning groups remains a proposal.

Terminology

The following information regarding integrated care systems may help in terms of terminology which can be confusing.

NHS Integrated Care Board (ICB)

The NHS Integrated Care Board (ICB) will involve:

- Chair - appointed by NHS England, with local panels (see below), approved by Secretary of State
- Chief executive - appointed and approved by NHS England. This will involve the chair if in post
- The Board will include an independent chair and a minimum of three ordinary members with a minimum of two independent non-executives. We await guidance on the constitution which is being worked through locally in anticipation of publication. Duties of the board including finance, health and wellbeing, quality of services, efficiency, and sustainability
- Functions of the Board will be discharged at a local place-based partnership level (PBP) – some of you may know these currently as integrated care partnerships (ICPs).

Integrated Care Partnership (currently known as an ICS – West Yorkshire and Harrogate Health and Care Partnership)

Our plan is to have an Integrated Care Partnership Board. This will be like the Partnership Board we currently have in place. Board members will be responsible for the integrated care strategy.

New national guidance

As part of preparations for the legislative changes set out in the Health and Care Bill, NHS England and the Department of Health and Social Care have published a range of guidance designed to support the establishment of Integrated Care Boards (ICBs) by 1 April 2022.

The guidance published on Thursday 19 August, and those to come over the next few weeks, all build on the expectations set out in the ICS Design Framework, and are intended to help us prepare for our next steps.

The guidance includes the interim guidance on: the functions and governance of the integrated care board; partnerships with the voluntary, community and social enterprise sector; effective clinical and care professional leadership; working with people and communities and guidance on the ICS people function. This is all in-line with the work already underway across our Partnership and in many ways is an evolution of the journey we have been on for the past five years.

The Bill recognizes the importance of 'places', and this is set out in 'Thriving places: Guidance on the development of place-based partnerships as part of statutory integrated care systems'.
The guidance sets out the potential activities and approaches of place-based partnerships

- Health and care strategy and planning at place
- Service planning
- Service delivery and transformation
- Population health management
- Connect support in the community
- Promote health and wellbeing
- Align management support

In addition, each Place will have delegated authority from the ICB for some elements of funding and performance.

NHS England / Improvement have also published 'Working together at scale: guidance on provider Collaboratives' in August. The guidance sets out that:

- Trusts providing acute and mental health services, must be part of a provider collaborative by April 2022
- Community trusts, ambulance trusts and independent providers can participate in collaboratives "where this would benefit patients and makes sense for the providers and systems involved"
- Collaboratives distinguished from "place-based partnerships", as the former will involve providers operating across multiple places and potentially multiple systems
- Provider collaborative should be formed with one or more of following goals in mind:
- Reducing unwarranted variation and inequality in health outcomes, access to services and experience, improving resilience by, for e.g., providing mutual aid
- Ensuring that specialisation and consolidation occur where this will provide better outcomes and value
- Emphasis on the benefits of scale, helping to address key challenges including Covid-19 recovery and scarce resources such as workforce and capital.

We already have excellent provider collaboratives across our area, for example West Yorkshire Association of Acute Trusts, and the Mental Health, Learning Disabilities and Autism Collaborative. Our model will build on the solid foundation already in place.

You can read all guidance here.

Recruitment for Chair of the NHS Integrated Care Board and Chief Executive role

The national aim is to have NHS Integrated Care Board (ICB) chair designate and chief executive designate appointments made by October 2021. The recruitment process for our chair designate has begun, with the appointee ready to assume the new role from April 2022 if the Bill is passed and in a designate capacity prior to this. The interviews will take place in September with:

- A citizen and patients' panel: Which will focus on the outcomes, inequality, and citizen engagement.
- A staff network panel: Which will focus on leadership style and behaviours, including equality and diversity.
- A Partnership members panel: Which will focus on the understanding of our system and fit with our ways of working.

The assessment of the candidates from the stakeholder panels will be summarised and fed into the interview panel which was held on 14 September 2021.

It is expected that the recruitment for the NHS ICB chief executive roles will begin early September to conclude early October 2021.

West Yorkshire and Harrogate current position

Over the last few months, various work streams have been focusing on the new statutory arrangements to strengthen our well-established approach to working together. This includes working towards the HR framework.

All ICSs will be established in statute from April 2022, subject to Parliamentary approval. There is a national expectation for ICSs to be operating in 'shadow form' from October. Our Partnership's established relationships, ways of working and team infrastructure mean that we are already operating to a large extent in 'shadow form' – i.e.

- We have clear well defined places building effective partnerships at a local level
- Mature provider collaboratives for mental and physical health and a strong and inclusive set of working arrangements at West Yorkshire and Harrogate level, which are transparent and backed by good governance.

We see the changes taking place between now and April as further evolution and extension of our way of working, rather than step changes to shadow form in October then full statutory arrangements in April 2022.

Public involvement and communications

Our West Yorkshire and Harrogate Health and Care Partnership communications and involvement plan sets out our principles for communications, engagement and consultation and our approach to working with local place-based colleagues and people for 2021/2021.

We also have a summary 'plan on a page' version of the communications and involvement plan and you can also view our easy read version here. We are committed to transparency and meaningful involvement in our work. We have also developed a draft involvement framework which builds on the communications and involvement plan to describe at a West Yorkshire and Harrogate level our approach and the way we work with programmes and local place-based colleagues.

Following on from the engagement to date about the White Paper and independent involvement review, a further event for those citizens and carers involved with organisations took take place on the 9 September.

Keeping you informed throughout

As we receive clarification and guidance, we will keep everyone updated. There is a dedicated section on the Partnership's website, and we will provide updates through our weekly bulletin and briefings. A series of listening events have been taking place across clinical commissioning groups and for West Yorkshire and Harrogate programme and core team colleagues.

What next?

- We are having conversations with each Health and Wellbeing Board to ensure joined up working across the area
- The Chairs and Leaders Reference Group (council leaders and chairs of Trusts) will met on Friday 27 August to discuss governance arrangements and finance.
- We will continue to engage with colleagues as our work develops.
- We will co-produce our draft Partnership constitution with partners over the next few months, so that it can be formally agreed in April 2022 when the new Health and Care Act comes into force (subject to parliamentary approval)
- Recruitment to the CEO role for our ICS is expected to begin in September.
- Coproduction on public involvement will continue.

West Yorkshire and Harrogate Health and Care Partnership

WY&H Health and Care Partnership Board

7 September 2021

Summary report	
Item No:	32/21
Item:	**The Health and Care Bill: Developing our governance arrangements**
Report author:	Stephen Gregg, Governance Lead, WY&H Health and Care Partnership
Presenter:	Stephen Gregg, Governance Lead, WY&H Health and Care Partnership

Executive summary

This paper updates the WY&H Partnership Board on work to develop our governance arrangements in readiness for the establishment of the statutory Integrated Care System (ICS) from April 2022.

The Health and Care Bill, published on 6 July 2021, reflects much of how we work in WY&H. It recognises that collaborative working produces better health and wellbeing outcomes and a more effective approach to reducing health inequalities. We have demonstrated the value of collaboration in our response to COVID and a wide range of other initiatives that are making a positive difference for local people. We believe that the legislation is 'catching up' with how we work and will help us to further improve the health and wellbeing of everyone across our area.

We have a mature partnership, in which Health and Wellbeing Boards and the Partnership Board set strategic direction. We have strong place arrangements, mature provider collaboratives and inclusive and transparent system leadership. We start from the basis that our existing arrangements, as set out in our Partnership Memorandum of Understanding, are fundamentally sound and are helping us to achieve better outcomes for local people. We will align with what the legislation and statutory guidance requires, rather than be driven by it.

A Governance Working Group, Chaired by Tim Ryley, the Accountable Officer for Leeds CCG, includes partners from across our system and is working to align our place and system governance arrangements. The Group reports regularly to the Future Design and Transition Group and the Chairs and Leaders Reference Group. We have shared our developing thinking with Health and Wellbeing Boards, place partnership forums, CCG Governing bodies and health overview and scrutiny committees. At system level, we have engaged with the West Yorkshire Health Overview and Scrutiny Committee.

Development work to date has focused on:

- establishing clear, outcome-focused governance standards on transparency, independent challenge and accountability;
- models for delegating ICS functions and resources to place
- place leadership and accountability arrangements; and
- system governance arrangements.

Whilst the Bill signals a welcome degree of permissiveness, much of the national guidance which will accompany it, including the ICS functions and governance guidance and the ICS model constitution, had only just been published at the time of writing this report. Initial review of the guidance shows that it supports our direction of travel and we will now be able to progress further work on the detail of our

arrangements in the light of these documents. In particular, we will be able to align our constitution with the national model. CCGs are legally responsible for the development of ICB constitutions, but the process will be led by the designate ICS chair and CEO, with system partners engaged throughout in its development. We are awaiting further guidance on how this will need to work and the implications for the Partnership.

Now that the national guidance has been published, our intention is to share a draft constitution and other governance documents as soon as we are able. We have adjusted other timelines in anticipation of publication. In particular, we will soon be in a position to 'stress test' our proposed arrangements in partner workshops, using case studies. We are planning these for September and October 2021.

We remain confident that we are well placed to transition to 'shadow' operation in November 201, in preparation for new statutory arrangements from April 2022.

Recommendations and next steps

The WY&H Partnership Board is recommended to:

- comment on progress to date in developing our governance arrangements; and
- request a further update to the WY&H Partnership Board meeting in December 2021.

WY&H Partnership Board

7 September 2021

The Health and Care Bill: Developing our governance arrangements

Purpose

1. This report summarises progress in developing our governance arrangements in readiness for the establishment of the Integrated Care System (ICS) as a statutory body from 1 April 2022.

Background and context

2. At its meeting on 1 June 2021, the WY&H Partnership Board considered a report on the development of partnership governance arrangements in response to the White Paper *"Integration and Innovation: Working together to improve integration and innovation for all"* . Subsequently, the Health and Care Bill was laid before Parliament on 6 July 2021. The key elements of the Bill are as follows:

3. **A statutory ICS** will be made up of a statutory NHS body – the **Integrated Care Board (ICB)** and a statutory joint committee - the **Integrated Care Partnership (ICP) -** bringing together the NHS, Local Government and partners. ICSs will be able to **delegate significantly to place level** and to **provider collaboratives**.

4. The ICB will be directly **accountable for NHS spend and performance** within the system. As a minimum, the ICB board must include a chair and 2 non executives, the ICB Chief Executive and clinical and professional leaders, and representatives from NHS trusts, primary care and local authorities. Others may be determined locally. A summary of ICB functions is attached at Annex A.

5. The ICP will be a wider group than the ICB and will develop an **integrated care strategy** to address the health, social care and public health needs of their system. The membership and detailed functions of the ICP will be up to local areas to decide.

6. **Place-based arrangements** between local authorities, the NHS and providers of health and care will be left to local areas to arrange. The statutory ICB will work to support places to integrate services and improve outcomes. **Health and Wellbeing Boards** will continue to have an important role in local places. **NHS provider organisations** will remain separate statutory bodies and retain their current structures and governance, but will be expected to work collaboratively with partners.

7. A **duty to co-operate will** be introduced to promote collaboration across the healthcare, public health and social care system. ICSs, NHS England and NHS providers will be required to have regard to the '**Triple Aim**' of better health and wellbeing for everyone, better care for all people, and sustainable use of NHS resources.

8. Our Governance Working Group, Chaired by Tim Ryley, Accountable Officer for Leeds CCG, has representation from across our places, providers and sectors including NHS commissioners, provider collaboratives, local authorities, voluntary, community AND

social enterprise (VCSE) sector, Healthwatch and our Race Equality Network. The Group is sharing learning from across our places and system, advising on where consistency is required and on the linkages between place, ICB and ICP arrangements.

9. On 19 August 2021, NHS England and Improvement published a model ICS constitution and Interim ICS functions and governance guide. We anticipate further guidance from NHS England over the rest of this calendar year, which we reflect as our work develops.

Key governance issues

10. **Values and behaviours** – strong and effective governance is as much about living our values as about arrangements and structures. It will be critical that our new arrangements reflect and strengthen our principles and behaviours and support the culture that we have established as a genuine partnership over the last 5 years. In particular, we will ensure that the arrangements support our commitment to diversity and equality. We are eager to make progress in ensuring that our leadership and involvement in decision-making reflects the diversity of our communities and are exploring how we can take this forward. Equality impact assessments will play an important role in our new arrangements.

11. **Governance standards** – our principles of subsidiarity mean that places are developing arrangements that meet their local circumstances, within a common framework of good governance. The Governance Working Group has drafted the governance section of our place development framework and has also developed a set of draft standards which we will apply across our system. The standards cover outcomes, values, transparency, citizen involvement, diversity, independent challenge and probity and are attached at Annex B.

12. **Subsidiarity and delegation** – under statutory arrangements, the vast majority of ICS capacity and resources will remain in our places. To enable this delegation, places are developing governance models and committee structures to fit local circumstances, within the context of our core governance standards and our place development framework. Common to each of them are:

- Health and Wellbeing boards continuing to play a key role in bringing partners together and setting strategy.
- building on existing strong place arrangements to enable effective collaborative decision making
- involving statutory and non-statutory partners and ensuring that the citizen voice is heard
- ensuring that providers working across footprints are effectively represented without duplication and overlap.

13. Places are focusing largely on two models of delegation - a place-based **Committee of the ICB** and a **Joint Committee** between statutory partners. Both of these models enable transparent, accountable collaborative decision making within the context of our governance standards. The detail of these arrangements will need to be aligned with national guidance and reflected in our constitution**.** Places have also been exploring leadership models designed to both support distributed leadership and ensure clear accountability.

14. **System arrangements** – the **Integrated Care Partnership** will be a statutory joint committee between partners. Our existing Partnership Board is already a key part of our leadership and governance arrangements. Through our five year plan, it has set out our strategic direction and how we will work together as partners to improve health and wellbeing and reduce health inequalities. The Partnership Board focuses on the wider connections between health and wider issues including socio-economic development, housing, employment and environment. It takes a collective approach to decision-making and supports mutual accountability across our system. Our current arrangements mean that we are well placed to transition to a statutory joint committee and we will be reviewing the membership and terms of reference of the Partnership Board in line with the national guidance on Integrated Care Partnerships, once published.

15. Our Integrated Care Partnership will set the overall strategy for our ICS, it will be built from the five place-based strategies which in turn will have been signed off by Health and Wellbeing Boards and delivered through place based partnership arrangements. This will ensure that the specific needs of all our populations will be met. The decision making framework which supports the setting and delivery of the ICS strategy is much broader than the ICB Board and ICP and includes place which is where we expect most decisions to be made under the principles of subsidiarity.

16. We are carrying out initial design work on the membership and working arrangements for the **ICB board.** We want our board to look, feel and function differently from traditional boards and to align with the legislation, rather than be driven by it. Our collaborative culture and behaviours will be paramount, and nomenclature is important in setting the tone. We propose to use our system language of places and providers, supported by system executive, clinical and professional leadership and overseen by independent lay members. The board will be built on principles of inclusivity, independent challenge and effectiveness and will reflect the scale and complexity of a diverse system which serves a population of 2.7 million. It will be part of a complex, mature and inclusive decision making framework, focused on delivery of our shared outcomes and with independent challenge built in at all levels. Annex C sets out an initial proposition on the proposed membership and way of working Annex D is a draft schematic of wider partnership governance arrangements.

17. National guidance setting out the functions of the ICB Board is set out in Annex A however, it is important to note that these are the technical description of the responsibilities as set out in guidance and West Yorkshire will look to discharge these in a way that aligns much more with our approach through Places and with support.

18. The ICB will be required to establish 2 statutory committees – **audit** and **remuneration**. We will also need to establish other committees to focus on oversight and assurance and provide the board with assurance on the delivery of key functions including system quality and finance. The Partnership already has a number of effective collaborative forums such as the System Leadership Executive, System Oversight and Assurance Group, Quality Surveillance Group, Clinical Forum and Finance Forum. Development work is focusing on how the role, membership and ways of working of these groups may need to be adapted in line with new statutory arrangements.

19. As part of the changes, we are proposing a name change for our ICS from April 2022 to West Yorkshire Health and Care Partnership. It's important to note that whilst Harrogate place will be part of the Humber, Coast and Vale Health and Care Partnership (ICS), our work with Harrogate and District NHS Foundation Trust will continue as part of our West Yorkshire provider collaborative (West Yorkshire Association of Acute Trusts) and clinical networks. Existing patient flows will be unaffected by this change.

Next steps and outline timeline

20. **ICS constitution –** the Governance Working Group is leading the co-production of the ICS constitution in which we will set out our governance arrangements. We will align our ICS constitution with the national model, now that it has been published. The national model is largely permissive and initial gap analysis against its requirements suggests that we will have the flexibility to base our approach and much of the content on our existing MoU. We will need to accompany this with detail on key issues such as our delegation arrangements and ICB board arrangements.

21. **Case studies –** a key element of our plan to take an inclusive and iterative approach is through the use of partner workshops to 'stress test' our emerging arrangements, using case studies. Now that the national guidance has been published we will be able to progress the detail of our arrangements and we are planning to arrange these workshops for late September-October. Engagement with partners has suggested a range of scenarios including:

    - serious quality and financial performance issues
    - major hospital reconfiguration
    - reducing health inequalities

22. **Engagement** --The Governance Working Group reports regularly to the Future Design and Transition Group and the Chairs and Leaders Reference Group. We have shared developing thinking with Health and Wellbeing Boards, place partnership forums, CCG Governing bodies and health overview and scrutiny committees. At system level, we have engaged with the West Yorkshire Health Overview and Scrutiny Committee. We will continue this engagement as we further refine our arrangements over the next six months.

23. The Health and Care Bill requires CCGs to both formally propose the ICS constitution and carry out consultation on it, but the process will be led by the designate ICS chair and CEO, with system partners engaged throughout in its development. We are awaiting guidance on how this will need to work in practice and the implications for our Partnership. It should be noted that the consultation will be on the content of the constitution, not on whether ICSs should be established. In anticipation of the guidance, we are developing our thinking on the approach to consultation including local authorities, Healthwatch and other stakeholders such as VCSE partners and overview and scrutiny committees. To ensure transparency and reduce the risk of challenge, we will publish our draft constitution to enable all interested parties to contribute. Our consultation process will be 'designed once and delivered five times' across our places. Our intention remains that we will share the draft constitution as soon as we are able.

24. **Shadow arrangements -** given the maturity of our Partnership and the strong leadership and governance arrangements that are already in place, in many respects, we are already operating in shadow form. The move towards statutory arrangements from April 2022 will largely be a gradual transition rather than a 'step change'. Groups such as the System Leadership Executive will continue to have a key role, recognising the importance of distributed leadership and retaining the 'us and us' culture. Groups like the Clinical Forum, Finance Forum, System Oversight and Assurance group and Provider collaborative committees in common will also continue to play a key role in supporting collaborative working and mutual accountability.

25. Some new groups will need to be established, including the board of the Integrated Care Board and place-based decision making forums. We envisage that these will start to operate in 'shadow' form and hold their first meetings in November. Some parts of our shadow governance machinery will need to operate in a more formal way before April. For example, a Remuneration Committee will be required to oversee senior remuneration in relation to appointments to the ICB. We are currently working through the practical implications of this. In addition once guidance around the Integrated Care Partnership is published, details setting out the broader decision making framework that sits around the ICB (including the ICP) and the Place Based Decision making arrangements will be brought back for consideration.

26. A key element for operating in shadow form will be agreeing the future leadership arrangements for the ICS including the ICS Chair and Chief Executive, place leads, members of the Board of the Integrated Care Board and WY&H director level appointments. The timelines we are operating to are partially determined by the national recruitment process. The Chair recruitment process is underway and we hope to have the chair designate identified by mid-September. Our expectation at the time of writing is that the Chief Executive post will be advertised at the beginning of September, and identified by the end of October, with other mandated Director posts advertised shortly afterwards.

Conclusion and recommendation

27. Now that the national guidance has been published, we are confident that we are well placed to transition to 'shadow' operation in November 2021 in preparation for new statutory arrangements from April 2022. A revised timeline is attached at Annex E.

28. The WY&H Partnership Board is recommended to:

- comment on the work to develop our governance arrangements; and
- request a further update to the WY&H Partnership Board at its December 2021 meeting.

Stephen Gregg
Governance Lead, WY&H Health and Care Partnership

The integrated care board

ICBs will bring partner organisations together in a new collaborative way with common purpose. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.

Table 3: Functions of the integrated care board

1	Developing a plan to meet the health and healthcare needs of the population (all ages) within their area, having regard to the Partnership's strategy.
2	Allocating resources to deliver the plan across the system, determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.
3	Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
4	Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.
5	Arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including: a) putting contracts and agreements in place to secure delivery of its plan by providers b) convening and supporting providers (working both at scale and at place) to lead[6] major service transformation programmes to achieve agreed outcomes c) support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships,

[6] It is expected that the ICB will be able to delegate functions to statutory providers to enable this.

	including through investment in PCN management support, data and digital capabilities, workforce development and estates d) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care.
6	Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers.
7	Leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
8	Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes.
9	Through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability.
10	Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.
11	Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
12	Functions to be delegated by NHS England and NHS Improvement include commissioning of primary care and appropriate specialised services.

Statutory CCG functions to be conferred on ICBs

Statutory functions, like those currently exercised by CCGs, will be conferred on ICBs from 1 April 2022, along with the transfer of all CCG staff, assets and liabilities (including commissioning responsibilities and contracts). Relevant duties of CCGs include those regarding health inequalities, quality, safeguarding, children in care and children and young people with special educational needs and (SEN) or disability.[7].

The full expected list of CCG functions to be conferred will be made available to NHS organisations via the NHS England and NHS Improvement ICS implementation hub.

Delegating direct commissioning functions to ICBs

It is the intention to delegate some of the direct commissioning functions of NHS England and NHS Improvement to ICBs as soon as operationally feasible from April 2022.

Our expectation is that from April 2022 ICBs will:

- assume delegated responsibility for Primary Medical Services (currently delegated to all CCGs, and continuing to exclude Section 7A Public Health functions)
- be able to take on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services (including dispensing doctors and dispensing appliance contractors)
- establish mechanisms to strengthen joint working between NHS England and NHS Improvement and ICSs, including through joint committees, across all areas of direct commissioning (in systems where they are not already delegated).

By April 2023, all ICBs will have:

- taken on delegated responsibility for dental (primary, secondary and community), general ophthalmic services, and pharmaceutical services
- taken on delegated commissioning responsibility for a proportion of specialised services (subject to system and service readiness) with national standards and access policies remaining at a national level
- worked collaboratively with our organisation to determine whether some Section 7A Public Health services, and Health and Justice, Sexual Assault and Abuse

[7] Further guidance will be developed to support the transition of functions to ensure ICSs deliver for babies, children and young people.

Service commissioning functions will be delegated, with decisions on the appropriate model and timescale.

Commissioning healthcare for serving members of the Armed Forces and their families registered with defence medical services, veterans' mental health and prosthetic services will remain with NHS England and Improvement.

DRAFT ICS Governance standards

(Applicable to: the ICP and ICB, joint committees, committees and sub committees with delegated authority from the ICB.)

Principles	Standards
Outcome-focus Our arrangements focus on reducing health inequalities, better health and wellbeing, better quality of care and efficient use of resources.	• Agenda items set out how they contribute to the delivery of the outcomes in Health and Wellbeing strategy/ICB plan/ICP integrated care strategy. • Where relevant, papers are supported by quality and equality impact assessments. • Annual report focuses on delivery of outcomes.
Values Our arrangements reflect our values and ways of working - equal partnership, subsidiarity, collaboration, mutual accountability.	• The agreed principles, values and behaviours of the ICS are set out in the Terms of Reference
Involving citizens and stakeholders We have an inclusive approach, involving citizens and partners from across the system. We are committed to improving diversity in leadership and decision-making.	• Citizens are involved in all relevant decisions. • Decision making involves partners from across our system, including statutory and non-statutory partners.
Transparency We are committed to transparency. We make our decisions in public and publish key policies and registers.	• Decision-taking meetings held in public (unless not in the public interest). • Agenda papers are published at least 5 working days before each meeting. • Key documents are published e.g. minutes, register of procurement decisions.
Probity and independent challenge Our decisions meet high standards of probity and are subject to robust independent challenge.	• Decision-making groups include members independent of any statutory partner. • ICB policy for managing conflicts of interest adopted and implemented.
Accountability and assurance Our arrangements support clear accountability.	• Accountability set out in scheme of delegation or delegation agreement. • Terms of reference agreed and reviewed annually. • Minutes reported in line with agreed reporting mechanisms • Annual report and annual review of performance.

ICB Board – outline proposition on membership and working arrangements

1. This report presents for discussion an outline proposition for the membership and working arrangements of the board of the Integrated Care Board (ICB). In line with our 'form follows function' approach, the proposition is designed to ensure that our board arrangements contribute to better health and wellbeing and reduced health inequalities for our population. The proposition supports our values and principles - we want our board to look, feel and function differently from traditional boards and to align with legislation, rather than be driven by it.

2. Our principles of subsidiarity mean that the ICB will primarily discharge its duties through delegation to place, alongside work that is delivered at WY&H level. We expect that most decisions will be made at place level, in support of local Health and Wellbeing Board priorities. At system level, the ICB board will have a key role in executing the strategy set by the Integrated Care Partnership; its delivery in place and through provider collaboratives; and through engagement with partners at WY&H level. This will include overseeing the delivery of and being accountable for all ICB functions, including those delegated to place. To do this, it will need to have a wide-ranging perspective on the business of the ICB, shape proposals on strategy and priorities, enable constructive challenge and champion the partnership's principles and values, including the expression of different views.

3. The membership of the ICB board will be important, and equally so will be the tone the leadership sets to create an environment in which it operates, including our culture of networking and collaboration. In designing our arrangements, we need to balance the following principles:

   - **Inclusivity -** our well-established partnership approach demonstrates the value of inclusivity and diversity in decision making. Through a combination of its membership, and the ways in which members engage with partners, the board will need to take into account the perspectives and expertise of our places, providers, citizens, clinical and professional leaders, sectors and functions. It will also need to progress our ambition for our leadership to reflect the diversity of our communities.
   - **Independent challenge –** this is essential to robust decision making and we will need to ensure that it is built into both our board membership and ways of working.
   - **Effectiveness -** the ICB Board will need to be of an appropriate size to allow for effective decision making. Accountability will need to be set out clearly.

4. There are tensions between these principles, for example maximising inclusiveness is likely to lead to a larger than optimum board. It is therefore important that we consider the board not in isolation, but as one component of our collaborative decision-making arrangements, such as those in place, programmes and the system leadership executive.

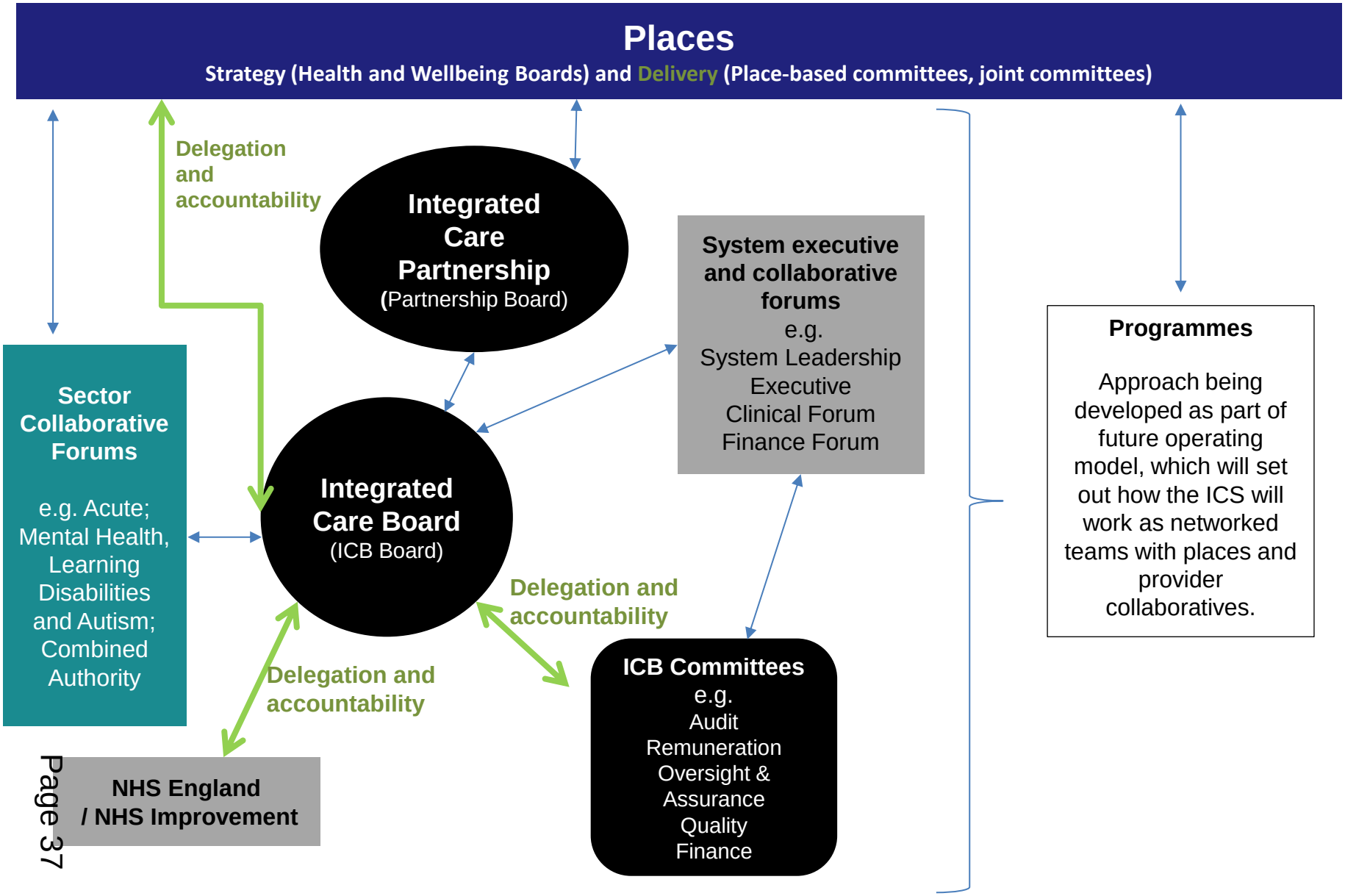
5. We want our board to reflect our partnership ethos. Our collaborative culture and behaviours will be paramount, and nomenclature is important in setting the tone. We propose to use our system language of places and providers, supported by system executive, clinical and professional leadership and overseen by independent lay members.

Proposition

6. Taking into account our partnership ethos and the principles of inclusivity, independent challenge and effectiveness, a proposed board membership is attached which balances independent lay members, place, providers, statutory and non-statutory partners and executive, clinical and professional roles. This is larger than optimum but is intended to reflect the scale and complexity of a diverse system which serves a population of 2.7 million. The board will be part of a complex, mature and inclusive decision making framework, focused on delivery of our shared outcomes and with independent challenge built in at all levels.

WY&H proposition	**Minimum national requirement**
Independent Lay perspective Chair Lay members x2	 Chair Non- Executive directors x2
Healthwatch perspective • Healthwatch	 No minimum requirement.
Place perspective • Place representative x5 • Local authority	 • No minimum place requirement • One local authority member
Provider perspectives • Acute provider • Mental health, learning disability and autism provider • Voluntary, community and social enterprise sector • Primary medical services	One member drawn from • NHS trusts and foundation trusts • primary medical services (general practice) providers
System executive, clinical and professional • Chief Executive • Director of Finance • Director of Nursing • Medical Director • Director of Public Health	 • Chief Executive • Director of Finance • Director of Nursing • Medical Director
Subject matter experts • Invited to be in attendance permanently or as required, e.g. workforce, digital.	No minimum requirements.
Total board size: 19	**10**

DRAFT Our Integrated Care System - a partnership of places, programmes and sectors



Governance timeline (as at 19 August 2021)

National planning timelines – as amended by ICS Design Framework	Outline WY&H timeline	WY&H reporting
By end Q1 (30 June 2021) Update System Development Plans and confirm proposed boundaries, constituent partner organisations and place-based arrangements.	**April – June 2021** Develop the governance arrangements for the ICS: • Map out proposed place, provider and system arrangements. • Map out delegation arrangements and how decisions will be taken. • Co-produce draft proposed structure for ICS constitution.. • Wider engagement with partners and stakeholders on emerging thinking.	**31.03.21 Future Design and Transition Group** • Approach to governance arrangements. **28.04.21** • Place leadership arrangements. **30.04.21 Chairs and Leaders** • Approach to governance arrangements. **01.06.21 Partnership Board** • Approach, emerging thinking and timeline. **09.06.21 FD&TG** • Update **25.06.21 Chairs & Leaders** • Update
By end Q2 (30 September 2021) Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive. Draft proposed ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance. Begin due diligence planning.	**July – September 2021** Timings to be refined in line with key national dependencies including: • **Functions and governance guidance** • **ICS model constitution.** • **ICP guidance** Further iteration of governance development process: • Refine and adapt proposed arrangements in the light of legislation and national guidance. • Co-produce with partners a draft ICS constitution. • Test emerging arrangements through partner workshops • Start recruitment to key roles, including Chair and Chief Executive of the Integrated Care Board.	**7.07.21 FD&TG** • ICS design framework • delegation to place • ICP development framework **30.07.21 Chairs & Leaders** • Place leadership arrangements. **27.08.21 Chairs & Leaders** • Update, including ICB board proposition. **01.09.21 FD&TG** • Update, including ICB board proposition. **07.09.21 Partnership Board** • Update. including ICB board proposition

National planning timelines	Outline WY&H timeline	WY&H reporting
By end Q3 (31 December 2021) Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form. Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.	**October – December 2021** Further iteration of governance development process outlined above. • Refine and adapt proposed arrangements. • Co-produce with partners revised draft ICS constitution • Complete testing of arrangements through partner workshops • Complete appointments for leadership roles. • Put in place 'Shadow' arrangements and ways of working.	**FD&TG, Chairs and Leaders** • Draft constitution and governance arrangements • Timings in line with dependencies. **07.12.21 Partnership Board** • Draft constitution and governance arrangements
By end Q4 (31 March 2022) Confirm designate appointments to any remaining senior ICS roles. Complete due diligence and preparations for staff and property (assets and liabilities, including contracts). Submit the ICS constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement.	**January – March 2022** Further iteration of governance development process outlined above. • Finalise proposed arrangements. • Submit final draft ICS constitution to NHS England for approval • Complete appointments processes, due diligence as outlined in the planning guidance.	**FD&TG and Chairs and Leaders** • Updates in line with dependencies. **01.03.22 Partnership Board** • Final draft constitution and governance arrangements.
1 April 2022 Establish new ICS NHS body, with staff and property (assets and liabilities) transferred and boards in place.		**April 2022** • ICS formally established. • First formal meetings of ICB Board, ICP and place-based committees.

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