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**Service Director – Legal, Governance and
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Date: 18 February 2026

Notice of Meeting

Dear Member

West Yorkshire Joint Health Overview and Scrutiny Committee

The **West Yorkshire Joint Health Overview and Scrutiny Committee** will meet in the **Virtual Meeting - online** at **1.00 pm** on **Wednesday 25 February 2026**.

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

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

Samantha Lawton

Service Director – Legal, Governance and Commissioning

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

The West Yorkshire Joint Health Overview and Scrutiny Committee members are:-

Member	Representing
Councillor Elizabeth Smaje	Kirklees Council
Councillor Colin Hutchinson	Calderdale Council
Councillor Jo Lawson	Kirklees Council
Councillor Jonathan Timbers	Calderdale Council
Councillor Rizwana Jamil	Bradford Council
Councillor Alun Griffiths	Bradford Council
Councillor Andrew Scopes	Leeds City Council
Councillor Sandy Lay	Leeds City Council
Councillor Betty Rhodes	Wakefield Council
Cllr Andy Nicholls	Wakefield Council
Cllr Andy Solloway	North Yorkshire Council
Cllr Andrew Lee	North Yorkshire Council

Agenda

Reports or Explanatory Notes Attached

Pages

1: Membership of the Committee

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

2: Minutes of Previous Meeting

1 - 8

To approve the minutes of the meeting held on 10 December 2025.

3: Declarations of Interest

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

4: Deputations/Petitions

The Committee will receive any petitions and/or deputations from members of the public. A deputation is where up to five people can attend the meeting and make a presentation on some particular issue of concern. A member of the public can also submit a petition at the meeting relating to a matter on which the body has powers and responsibilities.

In accordance with Council Procedure Rule 10, members of the public must submit a deputation in writing, at least three clear working days in advance of the meeting and shall subsequently be notified if the deputation shall be heard. A maximum of four deputations shall be heard at any one meeting.

5: Proposed Place Provider Partnerships

9 - 96

Officers from the West Yorkshire Integrated Care Board will update the Committee on the proposal to introduce Place Provider

Partnerships.

Contact: Yolande Myers, Principal Governance Officer

Contact Officer: Yolande Myers

KIRKLEES COUNCIL

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 10th December 2025

- Present:
- Councillor Elizabeth Smaje – Kirklees Council (Chair)
 - Councillor Colin Hutchinson - Calderdale Council
 - Councillor Jonathan Timbers - Calderdale Council
 - Councillor Rizwana Jamil - Bradford Council
 - Councillor Alun Griffiths - Bradford Council
 - Councillor Jo Lawson- Kirklees Council
 - Councillor Andrew Scopes - Leeds Council
 - Councillor Andy Solloway - North Yorkshire Council
 - Councillor Betty Rhodes - Wakefield Council
 - Councillor Andy Nicholls - Wakefield Council
- In attendance:
- Ian Holmes - Director for Strategy and Partnerships, WYICB
 - Debra Taylor-Tate – Head of Planning and Performance, WYICB
 - Adrian North – Deputy Director of Finance, WYICB
 - Dave Campbell-Hemming, WYICB
 - Hayden Ridsdale – Senior Strategy and Transformation Manager, WYICB
 - Dr James Thomas – Medical Director, WYICB
 - Rob Goodyear – Associate Director, Clinical & Professional Directorate, WYICB
 - Keir Shillaker – Programme Director for Mental Health, Learning Disability & Autism, WYICB
- Apologies:
- Councillor Sandy Lay - Leeds Council
 - Councillor Andrew Lee - North Yorkshire Council

- 8 Membership of the Committee**
Apologies were received on behalf of Councillors Lay and Lee.
- 9 Minutes of Previous Meeting**
The Minutes of the meeting held on 16 July 2025 were approved as a correct record.
- 10 Declarations of Interest**
Councillor Hutchinson declared his memberships of the BMA, Royal College of Ophthalmologists, Doctors for the NHS, and Keep Our NHS Public.
- 11 Deputations/Petitions**
No deputations or petitions were received.

12 West Yorkshire Integrated Neighbourhood Health Update

The Committee received an update on the development of the Neighbourhood Health model across West Yorkshire, which formed part of the national shift toward neighbourhood-based, community-centred health services. Members were advised that national policy positioned neighbourhood health as a priority within NHS transformation, aiming to reduce the historic “hospital by default” approach and establish Neighbourhood Health Centres in every community by 2035. The Committee noted that the model sought to bring care closer to communities and support more proactive, preventative, and integrated provision across health and care services.

The report highlighted that national guidance set out six core components required for the neighbourhood health approach (i) population health management (ii) modern general practice (iii) standardised community health services (iv) neighbourhood multi-disciplinary teams (v) integrated intermediate care and (vi) home first approach to admissions avoidance and discharge support. Members heard that these components were intended to improve access, continuity of care, and coordination across different patient cohorts. The Committee acknowledged that these requirements formed the baseline for the Integrated Care Board’s planning, commissioning intentions, and outcome-focused strategies.

The Committee was reminded of the national accelerator programme involving 43 sites across England, designed to speed up implementation of the neighbourhood health model. The programme operated through a “Test–Learn–Grow” approach, with an initial focus on adults with multiple long-term conditions and those at rising risk. It was highlighted that the West Yorkshire system was developing the necessary foundations, data infrastructure, and integrated working arrangements to support this accelerated neighbourhood-based transformation.

Members noted that the Integrated Care Board held accountability for developing a needs-assessment-informed, five-year strategic commissioning plan to support delivery of neighbourhood health priorities. The Committee recognised that further national guidance was awaited to provide more detail on delivery expectations, and that local work would continue to align commissioning, workforce models, community pathways, and prevention-focused interventions with the neighbourhood health framework.

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

- Clarification on implementation timescales was sought as the national neighbourhood health guidance was still awaited. The Committee was advised that the Integrated Care Board’s Five-Year Strategic Commissioning Plan would be submitted to NHS England by February 2026 and would be reviewed annually.
- Concerns were raised relating to the number of emerging plans and frameworks, including neighbourhood health guidance, the ten-year plan, and the Medium-Term Planning Framework, and the need for alignment into a single coherent strategic approach.

- The Committee highlighted the importance of prevention, particularly in relation to rising levels of mental ill-health and suicide and were advised that prevention formed a core focus of the neighbourhood model.
- Workforce challenges were discussed, with the Committee highlighting reductions in district nursing numbers nationally and the need for a confident, skilled community workforce.
- Members queried the size and configuration of neighbourhood footprints, noting that PCNs varied and some were not geographically aligned.
- Concerns were raised regarding digital access, particularly that the shift towards digital solutions should not exclude individuals without digital literacy or access to technology.

RESOLVED –

1. That the Committee thanked officers from the West Yorkshire Integrated Care Board for their attendance and the update provided.
2. That regular updates be provided on the delivery of the Neighbourhood Health Model, including assurance on how implementation was progressing and how effective the model was in ensuring that services met the needs of local communities.

13 Autism and ADHD assessments

The Committee received an update on the West Yorkshire Mental Health, Learning Disability and Autism Programme, which outlined significant pressures across neurodevelopmental services, including autism and Attention Deficit Hyperactivity Disorder (ADHD) assessment pathways. The Committee was advised that referrals for ADHD assessments alone had more than doubled over the previous five years, mirroring trends were seen nationally and contributed to long waiting times that extended into months or years. The Committee noted that rising demand stemmed from greater public awareness, population growth, and evolving clinical understanding, with services now unable to keep pace.

The Committee was advised that services were facing systemic challenges beyond demand alone, including the absence of a standardised national diagnostic framework and significant variation between providers. Diagnoses, while clinically important, also had substantial implications for individuals' access to social support, education, and wider community resources. The Committee recognised the challenges created by the Right to Choose (RTC) policy, which enabled individuals to obtain diagnoses from independent providers but often resulted in follow-up medication requests being redirected back into local NHS systems, thereby adding pressure and causing additional delays.

The Committee noted that the RTC pathway had also led to escalating financial and quality-assurance risks, with system costs having tripled over a three-year period and limited ability to assure the diagnostic quality of all external providers. The Committee was further advised that the autistic population continued to experience

poorer outcomes than the general population, including significantly longer inpatient stays. These factors collectively highlighted the urgent need for a more coherent, equitable and sustainable approach to neurodevelopmental assessments and support.

The Committee was informed that extensive engagement had taken place between 2022 and 2024 with autistic individuals, people with ADHD, families, carers and a range of professionals. This included two large regional Neurodiversity Summits, which surfaced strong and sometimes conflicting views about priorities and approaches. Through this engagement process, a set of shared priorities had been agreed, including early support based on need rather than diagnosis, consistent triage and screening, clearer pathways, improved post-diagnostic support, and better use of digital tools.

The Committee noted the programme's overarching strategy, which sought to establish a unified, equitable, needs-led neurodevelopmental pathway across West Yorkshire. This strategy included developing a unified commissioning policy, establishing community neurodiversity hubs as single points of access, and would embed consistent pathway principles and diagnostic thresholds across the region. It was explained that these hubs would provide needs-based support prior to diagnosis and reduce inequities in access.

The Committee also heard that several areas of operational work had already been undertaken. This included the development of West Yorkshire clinical quality standards intended for adoption across both NHS and independent providers, with early interest shown by neighbouring ICBs. Indicative activity plans had been produced to ensure a minimum baseline of assessment activity, particularly to address the longest waiters. Providers had also been supported to review waiting lists more effectively and escalate urgent cases as needed.

The Committee was advised that further work was underway to standardise diagnostic thresholds across the region so that individuals would not be more or less likely to receive a diagnosis depending on which provider assessed them. This work was essential to achieving equity in waiting lists and ensuring that assessments were consistent and clinically robust. The Committee also noted concerns regarding the limited availability and quality of autism and ADHD data nationally.

The Committee was informed that longer-term work would focus on developing the business case for the full neurodiversity hub model and understanding how it would integrate with neighbourhood health teams, community mental health services, primary care, education, and voluntary and community sector partners. It was noted that much of the support required by autistic people and people with ADHD was non-clinical and needed a coordinated system-wide approach.

During discussions, Members commented on the following issues: -

- That updates be provided at an earlier stage in future, particularly regarding any proposed changes to pathways, thresholds or commissioning activity, to support timely and effective scrutiny.

- The Committee sought clarification regarding the development of clinical thresholds across West Yorkshire, noting variation in assessment practices and requesting assurance that unified thresholds would not exclude individuals with genuine need.
- The Committee queried the timescales for establishing neurodiversity hubs, noting that none had yet been developed and that implementation was expected by the end of the 2026/27 financial year.
- A question was raised relating to the number of patients in the area who were on the waiting list for an assessment.
- Concerns were raised regarding the Right to Choose (RTC) pathway, noting that some independent providers offered diagnosis without treatment, resulting in further delays when individuals had to re-enter local pathways for medication.
- The Committee highlighted inequalities in access, noting that families with financial means were able to pay for private assessments while others faced long waits, and emphasised the need for hubs to support early identification and reduce reliance on diagnosis-led pathways.
- The Committee questioned how transitions between children's and adult services would be addressed, stressing that support services, not only diagnosis, required improvement to prevent gaps in care.
- The Committee sought assurance that referral processes would be consistent across West Yorkshire, noting that variations in referral quality could lead to inequitable prioritisation.
- The Committee noted concerns regarding activity planning, highlighting that provider capacity increases of 10% would not match the rising levels of demand and risked extending waiting times.
- The Committee queried whether gender based masking behaviours, particularly among girls with autism, were being accounted for within assessment frameworks.
- Further clarification was sought on how the National Review would affect ongoing regional work and received assurance that the direction of travel was aligned with national expectations.
- The Committee emphasised the need for strengthened partnership working with education, local authority and voluntary sector partners, noting that such collaboration should begin immediately rather than awaiting formal hub establishment.

RESOLVED –

1. That representatives of the ICB be thanked for their report and attendance at the meeting.
2. That the Committee be provided with the numbers on the waiting lists for neurodevelopmental assessments, together with the criteria used to determine complex needs.

3. That an update on the development of clinical thresholds be provided, noting that this work was expected to continue until March.
4. That ongoing reporting on waiting times be provided to ensure that the current activity plan did not lead to extended delays for patients in any part of West Yorkshire.

14 Winter Preparedness

The Committee received an update on the 2025/26 West Yorkshire winter plan, which had been developed across the Integrated Care System through engagement with primary care, ambulance services, acute trusts, mental health providers, local authorities and social care partners. It was noted that the plan aligned with national priorities, including the Urgent and Emergency Care Plan and the 10-Year Health Plan for England, while also drawing on learning from the 2024/25 winter period, which had seen significant pressures from increased demand, acuity, and workforce challenges.

The Committee was informed that the West Yorkshire Winter Board Assurance Statement had been submitted to NHS England, providing assurance around governance, quality, risk mitigations, system coordination and delivery readiness for the coming winter. Key national requirements were highlighted, including the need to improve ambulance Category 2 response times, reduce ambulance handover delays, ensure 78% of patients were admitted, transferred or discharged within four hours, and to reduce long stays in emergency departments for both physical and mental health presentations. Members also heard that a range of system measures were in place to support winter pressures, including Urgent Community Response services, Same Day Emergency Care, Urgent Treatment Centres, Acute Respiratory Infection hubs, and enhanced community and primary care capacity.

The Committee noted that discharge and flow continued to be central to winter resilience, with the rollout of Home First pathways, Virtual Wards and improved discharge coordination intended to reduce delays and support timely movement of patients through the system. Vaccination planning was also underway to maximise protection against flu and COVID-19 and minimise infection-driven surges through the winter period.

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

- Clarification was sought on the winter viral illnesses graph, specifically querying what the percentage values represented. It was confirmed that the percentages indicated the proportion of the population expected to have influenza, rhinovirus, RSV or COVID.
- Information was requested on measures within the winter plan to maintain continuity of primary and community care services over the festive period to prevent post-holiday surges in acute demand.

- The Committee noted the pharmacy and general practice capacity, extended hours, 24-hour out-of-hours GP services, and proactive risk management for vulnerable patients.
- The Committee queried whether the predicted January figures implied that around 28% of the population could have flu at that point, and it was confirmed that this reflected Public Health projections.
- The Committee sought clarification on whether corridor care formed part of the winter trigger system, and it noted that whilst it was not a formal trigger, corridor care was reported daily to NHS England, though data collection varied across trusts.
- The Committee asked whether reporting of corridor care and temporary escalation areas would become standardised in future. It was acknowledged there was national inconsistency and that a standardised dataset would be required before this could be achieved.

RESOLVED –

1. That representatives of the ICB be thanked for their report and attendance at the meeting.
2. That future updates include information on projected and actual infection peaks, workforce resilience planning, and any emerging pressures affecting ambulance services, emergency departments, or discharge pathways.
3. That in noting the progress on the vaccination programme, ongoing updates regarding uptake be provided for rates across key cohorts and any anticipated impact on system pressures.

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REPORT TITLE: CHANGES TO ICB – PLACE-BASED PROVIDER PARTNERSHIPS

Meeting:	West Yorkshire Joint Health Overview and Scrutiny Committee
Date:	25 February 2026
Cabinet Member (if applicable)	N/A
Key Decision Eligible for Call In	No
<p>Purpose of Report Representatives from the West Yorkshire Integrated Care Board will update / provide the Committee with detailed information on the proposed changes to ICB functions, including the development of Place-based Provider Partnerships.</p>	
<p>Recommendations</p> <ul style="list-style-type: none"> To consider the update / detailed information presented. <p>Reasons for Recommendations</p> <ul style="list-style-type: none"> To understand the proposed changes in more detail and to work collaboratively towards a shared understanding of the proposals. 	
<p>Resource Implications: Unknown.</p>	
<p>Date signed off by <u>Executive Director</u> & name</p>	<p>Give name and date for Cabinet / Scrutiny reports N/A</p>
<p>Is it also signed off by the Service Director for Finance?</p>	<p>Give name and date for Cabinet reports N/A</p>
<p>Is it also signed off by the Service Director for Legal Governance and Commissioning (Monitoring Officer)?</p>	<p>Give name and date for Cabinet reports N/A</p>

Electoral wards affected: All Wards

Ward councillors consulted: N/A

Public or private: Public

Has GDPR been considered? Yes, and there are no implications.

1. Executive Summary

Councils were made aware of the ICB's proposals to develop Place-based Provider Partnerships in 2027-28 following a transitional year in 2026-27 (Leeds, Bradford and Calderdale, Kirklees and Wakefield). Place-based Provider Partnerships (Partnership) were set to become a core delivery mechanism within England's Integrated Care System (ICS) architecture and provided a forum for providers to jointly plan and coordinate services, manage shared risks, support workforce sustainability, and contribute to delivery of Health and Wellbeing Strategies within places.

On the 2nd February 2026, a Memorandum of Understanding and Terms of Reference were circulated in relation to the transitional year 2026-27 for each Local Authority to agree and sign before 13th February 2026. Concerns were raised across Calderdale, Kirklees and Wakefield Councils regarding the lack of Local Authority involvement, the level of communication and transparency, and the timescale proposed for sign off.

2. Information required to take a decision

West Yorkshire ICB are asked to provide the Committee with details of the new proposals, in particular:

- The composition of the Place Provider Partnership
- The respective roles of partners (e.g. Members / Attendees)
- How arrangements will function across Calderdale, Kirklees and Wakefield, including whether roles will be shared
- Governance arrangements
- Decision-making processes and budget responsibilities
- Overall accountability
- Transparency mechanisms
- Confirmation of full partner sign-up
- How integrator teams fit within place provider partnerships
- How the shadow arrangements will move into the Partnership arrangements from 2027.

3. Implications for the Council

Unknown.

3.1 Council Plan

N/A

3.2 Financial Implications

N/A

3.3 Legal Implications

N/A

3.4 Climate Change and Air Quality

N/A

3.5 Risk, Integrated Impact Assessment (IIA) or Human Resources

N/A

4. Consultation

N/A

- 5. Engagement**
N/A
- 6. Options**
N/A
- 6.1 Options considered**
N/A
- 6.2 Reasons for recommended option**
N/A
- 7. Next steps and timelines**
That the West Yorkshire JHOSC takes account of the information presented and considers the next steps.
- 8. Contact officer**
Laura Murphy
Democracy Officer
laura.murphy@kirklees.gov.uk
- 9. Background Papers and History of Decisions**
N/a
- 10. Appendices**
1. ICB Overview Report
2. Timeline
3. Kirklees Provider Alliance MoU
4. Calderdale Provider Collaboration MoU
5. Wakefield Provider Partnership MoU
- 11. Service Director responsible**
N/a

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Brief to WY JHOSC on Proposed Place Provider Partnerships and associated documents – 16 February 2026

Wider Context

Legislative and national policy changes underpin this direction of travel, first laid out within the Health and Care Act 2022 which provided a legal framework for agencies to work together more easily.

As part of these reforms *Thriving places: guidance on the development of place-based partnerships* defined a “place” as the level at which providers can best understand population need, reduce health inequalities, and design services around people rather than institutions.

The 10 Year Health Plan for England: fit for the future published July 2025 set out the reforms for the NHS operating model, including a significant opportunity for Providers to hold outcome-based contracts for a local population. This direction aligns with the key findings of the Darzi Review, which highlighted the importance of locking in the shift of care closer to home by hardwiring financial flows; simplification and innovative care delivery for neighbourhoods; drive productivity in hospitals; and tilt towards technology.

Intentions

Place-Based Provider Partnerships (Partnership) are set to become a core delivery mechanism within England’s Integrated Care System (ICS) architecture. They support the Integrated Care Systems as they provide a forum for providers to jointly plan and coordinate services, manage shared risks, support workforce sustainability, and contribute to delivery of Health and Wellbeing Strategies within places.

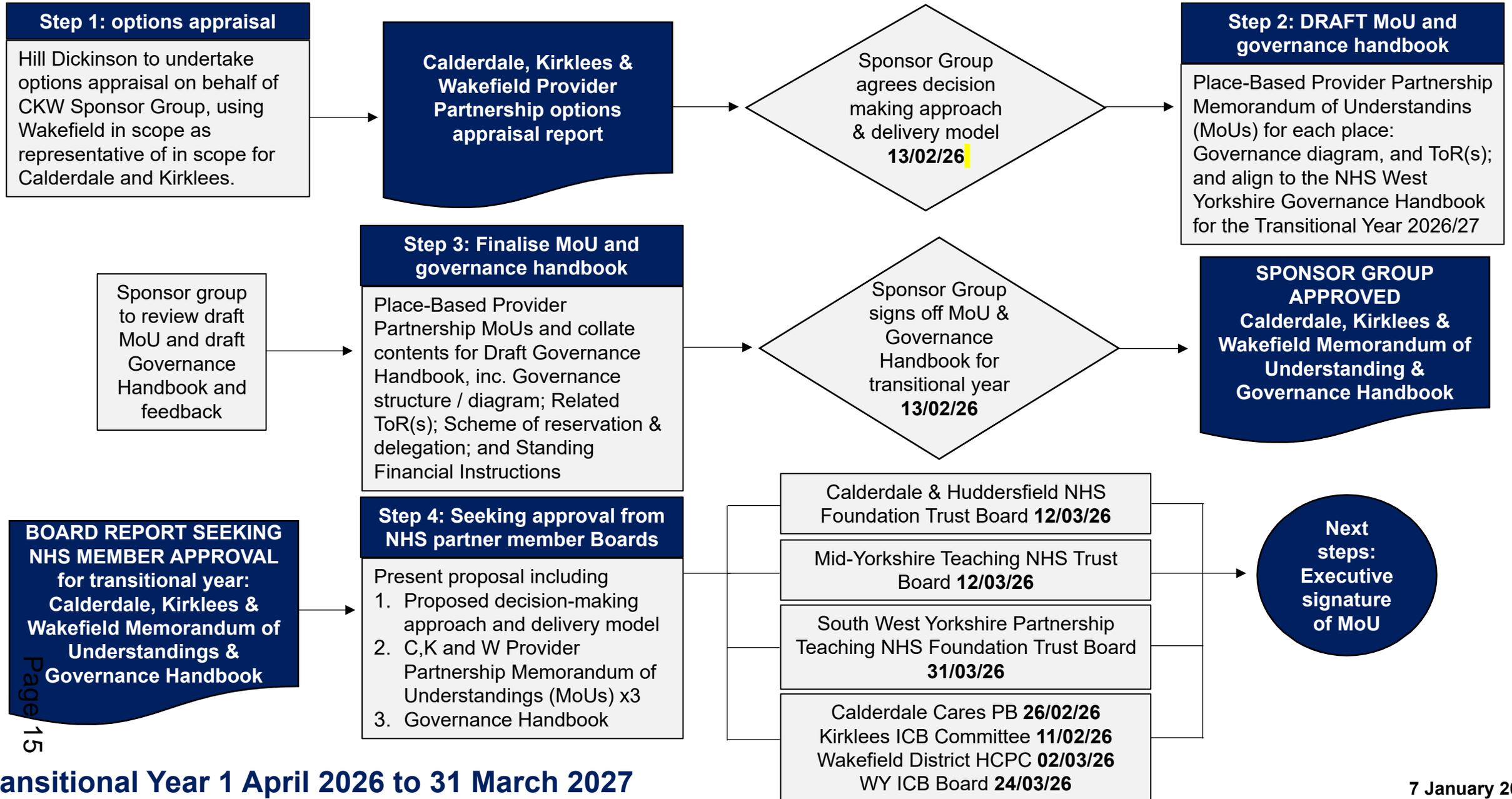
Taking account of the strategic direction locally and nationally and the changes to the operating model Calderdale, Kirklees and Wakefield each have an emergent Place-Based Provider Partnership, and separate Memorandum of Understanding (MoUs) have been drafted.

The MoUs set out the shared intent, principles, and arrangements through which partner organisations will collaborate at place, while retaining their individual statutory duties and organisational autonomy as Partner Members. Each MoU describes an approach to shared decision making and how resources are committed. Included within the appendices of the MoUs are the Place-Based Provider Partnerships Terms of Reference for 2026/27.

Through 2026/27 transitional year, until the NHS contract is agreed and signed by Provider Partners, decision making will continue to be discharged through ICB delegation as it is now. This may be through delegated decisions to ICB officers, or to the Place Committees (there are separate Place Committees for each of the

Places). Therefore, for the transitional year 2026/27 the governance arrangements set out in the MoUs are aligned to the governance framework of the ICB and should be read alongside the [NHS West Yorkshire Integrated Care Board's Constitution](#) and associated documents including the Scheme of Reservation and Delegation (SoRD), the Financial Scheme of Delegation (FSoD), and the Standing Financial Instructions (SFIs).

Calderdale, Kirklees and Wakefield Place Provider Partnerships: decision flowchart for NHS Provider Partners



Calderdale, Kirklees and Wakefield Place Provider Partnerships: decision flowchart for Councils and other Provider Partners

BOARD REPORT SEEKING MEMBER APPROVAL for transitional year: Calderdale, Kirklees & Wakefield Memorandum of Understanding & Governance Handbook

Step 4: Seeking approval from all other partner members (Boards / Cabinets)

Present proposal including

1. Proposed decision-making approach and delivery model
2. CKW Provider Partnership Memorandum of Understanding
3. Governance Handbook

Calderdale Council
Council Cabinet **16/03/26**
Health and Wellbeing Board **26/02/26**

Kirklees Council
Council Cabinet **24/03/26**
Health and Wellbeing Board **26/03/26**

Wakefield Council
Council Cabinet **24/03/26**
Health and Wellbeing Board **12/03/26**

Calderdale other Partners 31/03/26

- GP provider collaborative (representation from Calderdale LMC Ltd until its established)
- VCSE via Voluntary Action Calderdale (VAC)

Kirklees other Partners 31/03/26

- Locala Health and Wellbeing
- GP representative
- VCSE representative
- Representative from CYP services

Wakefield other Partners 31/03/26

- GP representative (nomination led by Connexus)
- Healthwatch Wakefield
- VCSE (nomination via Nova Wakefield & District)

Next steps: Executive signature of MoU

**CALDERDALE PROVIDER COLLABORATIVE
and NHS WY ICB**

MEMORANDUM OF UNDERSTANDING

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1. Parties and Members

The Parties to this Agreement are:

- (1) Calderdale Provider Collaborative; and
- (2) NHS West Yorkshire ICB

1.1 Calderdale Provider Collaborative Members

- Calderdale and Huddersfield NHS Foundation Trust
- Calderdale Metropolitan Borough Council
- GP Provider Collaborative (Note: this organisation is currently being formed and will be represented by Calderdale LMC in the interim)
- South West Yorkshire Partnership NHS Foundation Trust
- Voluntary Action Calderdale acting for and on behalf of VCSE
- NHS West Yorkshire ICB

2. Background

Place-Based Provider Partnerships (Partnership) are set to become a core delivery mechanism within England's Integrated Care System (ICS) architecture. They support the Integrated Care Systems as they provide a forum for providers to jointly plan and coordinate services, manage shared risks, support workforce sustainability, and contribute to delivery of Health and Wellbeing Strategies within places. This Memorandum of Understanding Agreement (Agreement) sets out the shared intent, principles, and arrangements through which partner organisations will collaborate at place, while retaining their individual statutory duties and organisational autonomy.

Legislative and national policy changes underpin this direction of travel, first laid out within the Health and Care Act 2022 which provided a legal framework for agencies to work together more easily. It placed a duty on the NHS to consider effects of their decisions on better health and wellbeing; quality of care for all patients and the sustainable use of NHS resources (triple aim). As part of these reforms Thriving places: guidance on the development of place-based partnerships defined a "place" as the level at which providers can best understand population need, reduce health inequalities, and design services around people rather than institutions.

The 10 Year Health Plan for England: fit for the future published July 2025 set out the reforms for the NHS operating model, including a significant opportunity for Providers to hold outcome-based contracts for a local population. This direction aligns with the key findings of the Darzi Review, which highlighted the importance of locking in the shift of care closer to home by hardwiring financial flows; simplification and innovative care delivery for neighbourhoods; drive productivity in hospitals; and tilt towards technology.

3. Introduction

3.1 Vision

During the transitional shadow year, the Calderdale Provider Collaborative will operate as a collaborative forum through which partners develop shared understanding, confidence and ways of working across community, primary, mental health, VCSE and local authority provision. The focus of this period will be on behaving as a provider collaborative in practice: agreeing priorities, shaping collective recommendations, and beginning to work differently across organisational boundaries, while remaining within existing statutory and contractual arrangements.

The Collaborative will concentrate on improving outcomes that matter most to the Calderdale population, particularly those that rely on coordinated action across providers rather than the performance of individual organisations alone. This includes reducing avoidable hospital activity, strengthening neighbourhood-based models of care, improving outcomes for people living with frailty and for children and young people, and tackling health inequalities through prevention and earlier intervention. The shadow year will be used to build a shared evidence base, improve transparency around current activity and spend, and test approaches to joint problem-solving and improvement.

It is important to note that the collaborative is a developmental body and is not intended to reflect any form of “end state” governance in its current form. Throughout the shadow year, it will continually test and iterate on its structure, purpose and intended outcomes and be subject to change throughout the shadow year and beyond.

Over time, the Calderdale Provider Collaborative aspires to operate as a mature place-based provider collaborative, capable of holding greater responsibility for the planning, coordination and delivery of integrated out-of-hospital services. At full operation, the Collaborative will support more coherent pathways across settings, enable services to be delivered closer to home where appropriate, and provide a stable platform for population-based approaches to commissioning and provision, aligned to Calderdale’s wider health and wellbeing ambitions and the West Yorkshire system.

3.2 Aims

The Calderdale Provider Collaborative will aim to strengthen how local providers work together at place, recognising that many of the outcomes that matter most to residents cannot be achieved by organisations acting independently. The Collaborative is intended to provide a structured forum in which NHS providers, the local authority, primary care and the VCSE sector can develop shared understanding, trust and ways of working, while remaining within existing statutory and contractual arrangements. It responds to growing pressures across community,

neighbourhood and out-of-hospital services, and to the need for more coordinated, preventative and population-focused approaches that reflect Calderdale's specific needs, assets and health inequalities. Rather than creating a new statutory body, the Collaborative is designed to support better alignment of priorities, transparency of activity and collective problem-solving at place.

3.3 Objectives

Initial scope based on Community Services and Integrated Neighbourhood Health/Teams (recognising 2 different things). Service clearly linked to keeping people healthy and out of hospital. Phase 1 to include:

- Community Services;
- Better Care Fund;
- Intermediate Beds;
- Core20plus5;
- VCSE Grants;
- Virtual wards/Urgent Community Response; and
- ARRS roles / GP out of hours/ various LESSs.

3.4 Principles

- Collaboration rather than competition:** The Calderdale Provider Collaborative will operate on the basis of collaboration rather than competition. Members will commit to working together in the interests of the population of Calderdale, recognising that many of the challenges faced cannot be addressed effectively by individual organisations acting alone. Decisions and recommendations will be shaped collectively, with an emphasis on trust, transparency and mutual respect.
- Outcomes-focus:** The Collaborative will be outcomes-focused and improvement-led. Its work will be guided by a shared understanding of the outcomes it is seeking to achieve, rather than solely by organisational performance or contractual boundaries. During the shadow year, this will include developing clarity on priorities, understanding variation and opportunity, and using this insight to drive continuous improvement rather than large-scale structural change.
- Adapt and learn:** The Collaborative will take a pragmatic and proportionate approach to change. The shadow year is intended to support learning, testing and confidence-building, not to introduce unnecessary complexity, duplicative layers of governance or extra layers of risk. Members recognise the importance of clear guardrails during transition and will focus on influencing, shaping and recommending change, rather than seeking to exercise authority beyond a collectively-agreed scope.
- Neighbourhood-focus:** The Collaborative will support neighbourhood-based and community-led models of care as the foundation for improving outcomes

and reducing demand on acute services. This includes valuing the contribution of primary care, community services, mental health services and the VCSE sector, and ensuring that neighbourhood working is enabled rather than fragmented by place-level arrangements.

- v. **Financial governance:** The Collaborative will act as a steward of collective resources. While statutory accountability for budgets remains with individual organisations during the shadow period, partners commit to openness about current spend, activity and risk, and to using this shared understanding to identify opportunities to improve value, reduce duplication and better align resources with need over time.
- vi. **Remain accountable:** The Collaborative will operate with clear and transparent accountability. It will be accountable to member organisations, to NHS West Yorkshire ICB through place-based governance, and to the Calderdale Health and Wellbeing Board as the primary forum for public accountability. Where collective recommendations cannot be progressed, partners commit to explaining why and to working together to resolve barriers.
- vii. **Flexibility and adaptability:** The Collaborative will remain adaptive and iterative. Members recognise that the provider collaborative model will continue to evolve in response to national policy, system direction and local learning. The Calderdale approach will therefore be reviewed and refined over time, with changes agreed collaboratively and grounded in experience rather than assumption.

3.5 Intended Outcomes

The primary aim of the Calderdale Provider Collaborative (Collaborative) is to improve outcomes for the local population by enabling providers to work together more effectively around neighbourhood-based models of care, prevention, and earlier intervention. Through its shadow phase, the Collaborative will focus on learning, testing and shaping recommendations that support integrated working across community services, primary care, mental health, social care and the VCSE sector, with the ultimate goal of improving population health. Reductions in avoidable hospital activity are expected to flow from doing this well, rather than being the sole objective in themselves. Over time, the Collaborative is intended to support clearer pathways, better use of collective resources, and more coherent input into place-based planning and decision-making, while respecting organisational sovereignty and the democratic and statutory role of the Health and Wellbeing Board.

The initial focus will be guided by a statement of intent and principles, which sets out the scope and ambitions for the Collaborative, and includes responsibility for:

- NHS funded Community services

- Better Care Fund
- Intermediate Beds
- Core20plus5
- VCSE Grants
- Virtual wards/Urgent Community Response
- ARRS roles / GP out of hours/ various GP Locally Commissioned Services

4. Status of this Agreement

The Parties have agreed to adopt a Memorandum of Understanding as set out in this Agreement.

For the avoidance of doubt this Agreement is not an NHS Contract pursuant to s.9 of the National Health Service Act 2006 and is not intended to be legally binding and no legal obligations or legal rights shall arise between the Parties.

The Parties enter into the Agreement intending to meet the purpose, aims and objectives of this Agreement whilst retaining their own statutory duties, responsibilities and all sovereignties.

A Partner may withdraw from this Agreement by giving not less than 6 months' written notice to each of the other Partners' representatives. A Partner may be excluded from this Agreement on notice from the other Partners (acting in consensus) in the event of:

- the termination of their Services Contract; or
- an event of Insolvency affecting them.

5. Implementation

This Agreement comes into effect on 1 April 2026 and remains in place until 31 March 2027 after which this Agreement will lapse unless reviewed and amended in accordance with Clause 6 (Review and Amend) below.

6. Review and Amendment

The Parties to this Agreement may, at any time on or before 31 March 2027, review and amend this Agreement. Any amendment(s) to this Agreement must be agreed by all Parties.

7. Purpose of this Agreement

The purpose of this Agreement is to improve outcomes for the benefit of patients, residents and service users across the Place.

- i) The Parties working together for and on behalf of the people within the Place Provider Collaborative will work in an integrated way in a manner that embeds collaboration and joint working as the basis for delivery of services;
- ii) Ensuring there is an associated operational work programme adopted that drives forward transformation between Parties to enable collaboration and joint working as the basis for delivery of services;
- iii) Parties working together to reduce health inequalities and implement the England Neighbourhood Health Guidelines 2025/26 – NHS England published on 30 January 2025; and
- iv) Ensuring there is a focus on prevention to support the Place-Based Provider Partnership in managing demand across the wider system in a collaborative and integrated way.

8. Aims and Objectives

8.1 Partnership Working and Leadership

- gain a full understanding of their individual responsibilities and those which require collaboration and co-operation to achieve shared objectives;
- develop and embrace leadership styles that embrace and embody the Values and Behaviors set out in this Agreement and consistently demonstrate the agreed values and behaviors of their Places;
- develop and agree non-clinical and clinical leadership principles and behaviours; and
- agree a contractual structure with general agreement on mutual and individual responsibilities.

8.2 Population and Health Management

- gain a full understanding of the actions that they can take individually and collectively, to address inequalities in service provision;
- agree actions to address inequalities, including prevention, and ensure these are built into transformation design;
- ensure population segmentation is being utilised to plan and deliver services at Place and Neighbourhood levels;

- ensure information governance is in place to ensure de-identified data for care design and re-identified data for clinical purposes;
- ensure VCSE organisations in the Place-Based Provider Partnership are part of both decision making, service delivery and design ensuring sustainability of the sector to support emerging neighbourhood models;
- ensure contracting supports shared accountability for improved patient outcomes;
- ensure costs and performance analysis is patient focused; and
- ensure data and information is clearly directed to support evidence of impact on required outcomes and clear processes to inform strategic commissioning intentions and contract outcomes.

8.3 Transformation and Delivery

To ensure that Transformation Programmes are:

- being scaled within the context of the local neighborhood health model and enabled through changes to the development of financial and people resource between providers within the Provider Collaborative;
- enabled through the local implementation of Single Neighbourhood Provider and Multi-Neighbourhood Provider contracts;

And Transformation methodology includes:

- stakeholder engagement and NHS best possible value and LEAN approaches;
- an agreed evaluation methodology, which includes qualitative and quantitative metrics for assessing competing risks (e.g.: capacity and travel further vs access to excellent centre);

And Transformation delivers:

- the objectives and approach of the Placed-Based Provider Partnership uphold values and are aligned to the assumptions regarding the impact of possible situations and are rigorously tested;
- providers, services and/or clinical pathways which are designed to ensure adherence with relevant standards and accreditation schemes;
- an operating model which will enable Place-Based Provider Partnership to hold population/pathway-based contracts that span multiple care settings and multi-year time horizons; and
- clarity and agreement regarding the map of services and who is responsible for different elements of delivery which will form the basis of contractual structure and identify any gaps in required provision.

8.4 Financial and risk management principles

- ensure allocated funds for programmes of work are utilised effectively;
- the Place-Based Provider Partnership’s operating model enables the Place to hold population, services or pathways-based contracts that span multiple care setting and multi-year time horizons;
- there is clear financial governance in the Place-Based Provider Partnership to support shared decision making/pooled budgets;
- able to demonstrate how financial savings have benefited the Place-Based Provider Partnership with the use of clear robust benefits realisations models;
- work has been undertaken to scope options and implications for existing Local Authority (“LA”) commissioning arrangements and options and plans management of joint LA / WY ICB commissioning arrangements and associated pooled budgets;
- there has been formal agreement of each Place-Based Provider Partnership’s contractual structure and format, and the role of each Place Based Provider Partnership Member has been identified, and consideration has been given in respect of a process for partners to join or leave the Place Based Provider Partnership;
- a dispute resolution mechanism has been established; and
- there is an understanding of where potential risk/gain share approaches could be utilised to mitigate, remove or reduce identified risks.

8.5 Communication and Engagement

- to review, with the involvement of local communities, the stakeholder map to ensure full representation of diversity of the population of Place;
- for a Place-Based Provider Partnership communications plan which is aligned to the system plan, and which sets out agreed key messages and supports joint messages around NHS provision;
- for Place-Based Provider Partnership Members to demonstrate how communication and engagement has influenced decision making and transformation design;
- data gathered from different stakeholders’ sources is distilled and deployed within formal governance arrangements;
- for stakeholders to be involved in making strategic decisions on behalf of communities; and
- for the Place-Based Provider Partnership to have strong relationships within the WY ICB and the Regional Team, ensuring engagement with the development of strategic and operational plans.

8.6 Workforce and Capacity principles

- be on track in the delivery of its capacity and capability maturity plan and to have confirmed capacity and capability arrangements required to safely host, on behalf of the Place-Based Provider Partnership, the contract with the WY ICB;
- enable the operational delivery of the Place-Based Provider Partnership Committee arrangement and undertake commissioning and contracting activities with the LA;
- ensure arrangements are in place for the teams and functions to transfer to the organisation(s) hosting the system and integrator function at the transition date of 1 April 2027;
- secure capacity and capabilities to the System Integrator via this Agreement with the WY ICB and other organisations where there are benefits in sharing existing partnership functions/joint ventures;
- establish a programme to align continuous improvement methodologies across partner organisations; and
- pool clinical governance.

8.7 Quality

In its role to arrange and deliver high quality care, the Place-Based Provider Partnership will ensure improving quality is a key outcome of system transformation through its collaborative arrangements with partners. Quality in a thriving partnership is:

- coordinated, person-centered and grounded in population health need;
- delivered through strong partnership working across NHS, Local Authority, health and care provision and VCSE organisations;
- focused on equitable access, experience, outcomes and reducing health inequalities;
- informed by lived experience insight and community voices triangulated with reliable quantitative data; and
- involves professionals, people and communities in planning, design, decision-making and evaluation to ensure accountability and improve experience of care.

The Place-Based Provider Partnership's approach to quality oversight, assurance and improvement needs to be consistent with the requirements of national guidance. Overarching quality functions will build on existing guidance from the National Quality Board and be set out in the forthcoming National Quality Strategy. There is an expectation, that can apply to the Place-Based Provider Partnership, that Providers will implement a Quality Management System (QMS) approach incorporating four key functions:

- Quality Planning – what do we need?

- Quality Control – what is our performance?
- Quality Improvement – what could be better and how do we get there?
- Quality Assurance – are we meeting standards?

Core responsibilities for each function are being developed for Regions, ICBs and service providers. Once published these will need to be reviewed and adapted for the Place-Based Partnership to identify which could be delegated from an ICB or be a shared responsibility with the ICB.

8.8 Embedding Quality in the Transitional Year

- develop a single understanding of quality, shared and visible across the Place-Based Provider Partnership;
- identify shared quality improvement priorities responding to unwarranted variation or quality concerns;
- redesign specific care pathways using evidence-based models, including relevant modern service frameworks when published, to improve outcomes and drive quality;
- conduct impact assessments in respect of quality, equality and health inequalities where service redesign or reconfiguration may be required;
- develop meaningful approaches to involve residents, communities, staff and stakeholders in shaping how services are designed, delivered and evaluated;
- evaluate impact of redesigned care pathways or reconfigured service delivery collecting relevant patient safety indicators, patient and staff reported experience, outcome measures and wider feedback and intelligence;
- agree and implement a Quality Management System for the Place-Based Provider Partnership which aligns to the WY ICB and NHS England Regional approach, including management of quality issues or concerns; and
- ensure Place Based Provider Partnership governance arrangements enable shared decision-making, transparency, and mutual accountability.

9. Values and Behaviours

The Parties are committed to abide by the following values:

- Honesty
- Integrity
- Ambition
- Mutual respect
- Be bold
- Develop unity

- Deliver what we say

The Parties agree to demonstrate the following behaviours, we:

- are leaders of our organisation, our Place and of West Yorkshire;
- support each other and work collaboratively;
- act with honesty and integrity, and trust each other to do the same;
- challenge constructively when we need to;
- assume good intentions; and
- will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

10. Building Recommendations and Making Decisions

The Place-Based Provider Partnership will meet to develop recommendations for the population and communities across their Place. Every recommendation made by the Place-Based Provider Partnership will be taken through their WY ICB Place Committee as referred to in Clause 13 (Arrangements and Accountability) below.

Each WY ICB Place Committee, established by the ICB have delegated authority to make decisions in accordance with the WY ICB Financial Scheme of Delegation (FSoD), Scheme of Reservation and Delegation (SoRD), Operational Scheme of Delegation (OSoD) and Standing Financial Instructions) SFIs.

11. Conflicts of Interest

Subject to compliance with Law and contractual obligations of confidentiality the Parties agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner. Parties must ensure compliance with the following:

- WY ICB Conflicts of Interest Policy; and
- NHS England Managing Conflicts of Interest in the NHS Guidance for Staff and Organisations (Published 7 February 2017; updated 17 September 2024)

The Parties agree to declare, in line with NHS guidance, any real or potential conflict of interest arising in connection with this Agreement as soon as they become aware of the same.

The Parties will:

- disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the operation of the Partnership governance immediately upon becoming aware of

the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of this Agreement;

- not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and
- use best endeavours to ensure that their appointed members also comply with the requirements of this Clause 11 as relevant when acting in connection with this Agreement.

12. Dispute resolution

The Parties commit at all times, to working cooperatively to identify and resolve issues to their mutual satisfaction to avoid all forms of dispute or conflict in performing their obligations under this Agreement. The Parties believe that by focusing on the Values and Behaviors set out in this Agreement and being collectively responsible for all risks will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this Agreement. The Parties agree to:

- seek solutions within a shared culture of ‘no fault, no blame’;
- seek to resolve any disputes in an open, amicable and communicative manner;
- treat each other as equal parties; and
- ensure, to the best of their ability, that their representatives on the Place-Based Provider Partnership comply with the terms and spirit of this Agreement above when acting within its remit.

If a problem, issue, concern or complaint comes to the attention of a Partner in relation to any matter in this Agreement such Partner shall notify the other Partners in writing. The Partners shall then try to resolve the issue in a proportionate manner within 20 Operational Days of written notification. If they are not able to do this, the matter will be resolved in accordance with **Schedule 1** (*Dispute Resolution Procedure*).

If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this Agreement (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act relating to this Agreement) the receiving Partner will liaise with the other Partners as to the contents of any response before a response is issued.

13. Arrangements and Accountability

The Place-Based Provider Partnership will be supported by the following WY ICB Place Committee, in discharging their purpose:

- Calderdale Provider Collaborative: Calderdale Cares Partnership Board

The WY ICB Place Committee remains accountable to WY ICB as set out in Clause 10 (Building Recommendations and Making Decisions) above.

Full details of the Placed-Based Provider Partnership can be found in Schedule 2: Terms of Reference for the Calderdale Provider Collaborative.

14. Endorsements

The Parties to this Agreement acknowledge and confirm that they have the necessary authorisation to enter into this Agreement and that its own Board, Cabinet and/or Governing Body has approved the content of this Agreement.

By signing this Agreement, the Place-Based Provider Partnership Members are setting forth their shared understanding and commitment to the values and behaviours set out above. This is not intended to be a legally binding Agreement, but rather a symbolic commitment to the Parties shared vision and a framework for collaborative working during the Transitional Year:

13.1 Signed by Members of the Calderdale Provider Collaborative:

Organisations	Signatures
Signed by Rob Aitchison CEO on behalf of Calderdale and Huddersfield NHS Foundation Trust	
Signed by Robin Tuddenham, Chief Executive for and on behalf of Calderdale Metropolitan Borough Council	
Signed by GP on behalf of the Calderdale GP Provider Collaborative	
Signed by Mark Brooks	

Organisations	Signatures
for on behalf of South West Yorkshire Partnership Teaching NHS Foundation Trust	
Signed by On behalf of the VCSE via Voluntary Action Calderdale	
Signed by Robin Tuddenham, Accountable Officer, for and on behalf of NHS West Yorkshire Integrated Care Board	

15. Definitions

Terms	Definitions
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in Schedule 1 for the resolution of disputes which are not capable of resolution under Clause 12 (Disputes Resolution).
FSoD	WY ICB Financial Scheme of Delegation
OSoD	WY ICB Operational Scheme of Delegation
Parties	Calderdale Provider Collaborative, and NHS West Yorkshire ICB
Place	The geographical level at which most of the work to join up health care services happens which is, for the purposes of this Agreement, Calderdale.

Terms	Definitions
Place-Based Provider Partnership	Collaborative arrangements formed by organisations responsible for arranging and delivering care services in Places
SFIs	WY ICB Standing Financial Instructions
SoRD	WY ICB Scheme of Delegation and Reservation
Transitional Year	1 April 2026 to 31 March 2027
WY ICB	NHS West Yorkshire Integrated Care Board
WY ICB Place Committee	Calderdale Cares Partnership Board

SCHEDULE 1: DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 12 (Disputes Resolution) prior to commencing this procedure.

The Partners believe that by focusing on their agreed Objectives and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the Partnership arrangements set out in this Agreement.

The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the Partnership (each a '**Dispute**') when it arises.

In the first instance the relevant Partners' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the relevant Partners. If the Dispute cannot be resolved by the relevant Partners' representatives within 10 Operational Days of the Dispute being referred to them, the Dispute shall be referred to senior officers of the relevant Partners, such senior officers not to have had direct day-to-day involvement in the matter and having the authority to settle the Dispute. The senior officers shall deal proactively with any Dispute on a Best for the Place-Based Provider Partnership basis in accordance with this Agreement so as to seek to reach a unanimous decision.

The Partners agree that the senior officers may, on a Best for the Place-Based Provider Partnership basis, determine whatever action it believes is necessary including the following:

- If the senior officers cannot resolve a Dispute, they may agree by consensus to select an independent facilitator to assist with resolving the Dispute; and
- The independent facilitator shall:
 - (i) be provided with any information he or she requests about the Dispute;
 - (ii) assist the senior officers to work towards a consensus decision in respect of the Dispute;
 - (iii) regulate his or her own procedure;
 - (iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and
 - (v) have its costs and disbursements met by the Partners in Dispute

equally.

- If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 1 and only after such further consideration again fails to resolve the Dispute, the Partners may agree to:
 - (a) terminate this Agreement in accordance with Clause 4 (Status of this Agreement); or
 - (b) agree that the Dispute need not be resolved.

SCHEDULE 2: CALDERDALE PROVIDER COLLABORATIVE TERMS OF REFERENCE

Terms of reference

Calderdale Provider Collaborative Shadow Committee

Version control

Version: 0.5
Approved by: Provider Partner Members
Date Approved: [TBC]
Responsible Officer: Senior Provider Executive
Date Issued: [1 April 2026]
Date to be reviewed: [1 April 2027]

Change history

Version number	Changes applied	By	Date
0.1	Calderdale Provider Partnership	Sue Baxter, Head of Partnership Governance	10/12/25
0.2	Calder context and narrative	Debbie Robinson	22/12/2025
0.3	Calder context and narrative	Alex Harris	23/12/2025
0.4	Follow-up after 7 Jan design group	Alex Harrs	13/01/2026
0.5	Proofing	Sue Baxter	02/02/2026

1. Purpose

This Shadow Committee is established as a time-limited, developmental forum for the 2026/27 transitional year. Its primary purpose is to test, learn and develop collaborative ways of working at place, to shape future arrangements. For the purposes of this document, 'Provider Collaborative' refers to a voluntary, non-statutory forum for collective working and recommendation, and does not imply pooled accountability or contractual obligation.

The Collaborative Committee is established for 2026/27, as a committee of the Calderdale Cares Partnership, to enable recommendations to be made on business falling within the scope agreed with the Provider Collaborative, with the aim of enabling the emergent Calderdale Provider Collaborative, together with all NHS Statutory Provider organisations and other health and care provider organisations to operate in shadow format within Calderdale from 1 April 2026. The initial scope shared has been based on the presumption that Community Services and Integrated Neighbourhood Health/Teams would be the prime focus of the collaborative, and the collaborative will aim to enable these to operate as effectively as possible.

The further aim of the collaborative and any subsidiary governance structures, working groups or organisational design connected to the collaborative will be clearly linked to improving population outcomes through stronger neighbourhood, community and preventative models of care, with reductions in avoidable hospital activity and any other outcomes expected as a consequence of effective collaboration. Phase 1 of the shadow operations will include within its scope:

- Community services
- Better Care Fund
- Intermediate Beds
- Core20plus5
- VCSE Grants
- Virtual wards/Urgent Community Response
- ARRS roles
- GP out of hours & various GP Locally Commissioned Services at both practice and scale levels

2. Remit and responsibilities

The following responsibilities will fall under the remit of this Shadow Calderdale Provider Collaborative Committee. The committee will operate in shadow form during what will be termed a "transitional year" from 1 April 2026 until no later than the 31 March 2027; shadow arrangements will cease once agreement on the Place Provider Collaborative contract with West Yorkshire ICB is reached and signed.

The remit of this Shadow Committee is to:

- a) To develop, test and recommend collective approaches on behalf of Partners, operating as Calderdale Provider Collaborative, in line with NHS West Yorkshire ICB delegation of the following key areas of responsibility for the transitional year:**
- i. develop recommendations regarding the future Calderdale Provider Collaborative approach, by no later than 1 April 2027;
 - ii. develop joint working arrangements that embed collaboration as the basis for delivery, with NHS statutory provider partners within the place and with other provider partners, as well as the wider West Yorkshire (WY) Integrated Care System;
 - iii. develop accountability arrangements and clear lines of report to the Health and Wellbeing Board, member Partner Boards (where necessary) and to the Calderdale Cares Partnership Board;
 - iv. oversee a structured due diligence exercise which includes a thorough assessment of financial, legal, operational and strategic factors to identify any potential risks or opportunities. Ensuring this exercise provides a robust evaluation and verification of accurate information in relation to the transferring functions prior to entering into a contract with the ICB for those functions;
 - v. collaborate across Calderdale and ensure arrangements for complying with the Provider Self Assessment Framework / Readiness Checklist across NHS West Yorkshire ICB
 - vi. be sighted on evolving arrangements for Integrated Neighbourhood Health services within Calderdale including risk sharing and / or risk pooling with other organisations (for example pooled budget arrangements under section 75 of the NHS Act 2006), for approval by this Shadow Committee;
 - vii. arrange for the provision of health services ensuring a focus on reducing health inequalities in line with the allocated resources across Calderdale through a range of activities including:
 - a. oversee and / or recommend the agreement of contracts to secure delivery of the strategic goals and operational plans;
 - b. convene and lead major service transformation programmes to achieve agreed strategic outcomes working at scale at place, across Calderdale and across West Yorkshire, as appropriate;
 - c. sponsor the delivery of high quality and effective care shifting care delivery into integrated neighbourhood health services, aimed at tackling health inequalities whilst shifting more service provision out of hospital and into community, shifting from analogue to digital, and shifting from sickness to prevention;
 - d. work together with NHS West Yorkshire ICB Integrator team to:
 - collaborate with partners to create the integrated neighbourhood health model;

- support and enable primary care operations and transformation within the scope services, functions and budgets, and excluding nationally contracted services unless agreed within scope;
 - develop pathway and service development programmes.
- e. sponsor new Provider service developments including support of GP practices working towards larger footprints with the development of new neighbourhood provider services (c50k) via single neighbourhood provider contracts. Work with PCNs/GP Federations over larger geographies (c250k population) via multi-neighbourhood provider contracts;
 - f. sponsor work 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; and
 - g. sponsor work with the Providers as a first order priority to move from hospital by default to digital-by-default.

All formal decisions remain subject to the approval of the ICB place committee, in line with ICB delegation.

b) To make recommendations to the place committee on behalf of Partners operating as Calderdale Provider Collaborative, in line with NHS West Yorkshire ICB delegation, for the benefit of the patients, service users, carers and population

- i. establish governance arrangements to support collective accountability between partner organisations for Calderdale Provider Collaborative's system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations;
- ii. Where relevant, the Shadow Committee may provide a forum for sharing learning and understanding system implications associated with provider development pathways, without implying collective commitment or resource reallocation.
- iii. develop and recommend priorities, principles and options to inform place-based planning undertaken through statutory bodies, having regard to health and care strategy, planning requirements and the Calderdale health and wellbeing strategy;
- iv. allocate resources to deliver the plan, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital); and
- v. sponsor and draw assurance from Place Provider Partnership's strategic and operational risk management approach.

The Shadow Committee's primary accountability is to Calderdale Place. Collaboration with Kirklees and Wakefield will be purposeful and time-limited, focused on shared learning or agreed programmes, and will not require partners to provide assurance or oversight for services outside their statutory responsibility.

3. Statutory and Financial Safeguards

Nothing in these Terms of Reference shall be interpreted as delegating statutory responsibilities, financial authority, or regulatory accountability from individual partner organisations. All activity will be conducted in line with each organisation's Standing Financial Instructions, Schemes of Delegation, statutory duties or any other applicable considerations.

4. Members

The Members of the Calderdale Place Provider Collaborative Committee are:

- Calderdale and Huddersfield NHS Foundation Trust
- GP Provider Collaborative (this is currently being formed) (representation from Calderdale LMC Ltd, until its established)
- Calderdale Metropolitan Borough Council
- South West Yorkshire Partnership Teaching NHS Foundation Trust;
- VCSE via Voluntary Action Calderdale

5. Attendees

The following individuals will be invited to attend each meeting of this Shadow Committee as Attendees. Attendees attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote. The Attendees are:

- Deputy Director of Integration; (ICB- Calderdale Place)
- Shadow Committee Secretariat;

The Chair may invite such other Attendees to attend any meeting of this Shadow Committee as the Chair considers appropriate.

6. Deputies

Members will nominate a deputy to attend a meeting of the Shadow Committee that the Member is unable to attend. The deputy may speak and vote on their behalf.

7. Chair

The Chair of this Shadow Committee shall be an Senior Provider Executive. If the Chair is unable to attend, then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.

8. Quoracy and Decisions

The quorum for meetings shall be a minimum of three members, representing at least 50% of the membership, and must include:

- at least one NHS Trust Chief Executive (or deputy), furthermore;
- any recommendation or decision that materially impacts a member organisation shall not be made in the absence of said organisation.
- Decisions will be reached by consensus wherever possible. If a proposal has a significant impact on a specific sector or organisation and their representatives do not agree, the decision may be deferred once to allow further discussion within that sector or organisation. Any deferral must:
 - Have a clear and agreed purpose
 - Be time-limited – to be agreed by the collaborative
 - Include a clear narrative to be recorded in the minutes that explains what needs to be resolved and the pathway for resolution
 - After the agreed period, the matter will return for decision-making, and a recommendation will be made based on the information available at that point.

9. Frequency of meetings

This Shadow Committee will meet monthly, and papers shall be circulated at least five Working Days before the meeting. Any need for additional meetings at any time will be agreed by the members. Shadow arrangements during the transitional year from 1 April 2026 to 31 March 2027, and will focus on implementation (phase two of development).

10. Urgent decisions

Recommendations for an urgent decisions may only be taken between meetings where delay would result in material risk. Recommendations for an urgent decisions will be made via convening an extraordinary meeting of the provider collaborative. Where this is not possible, consensus will be sought from members via e-mail. Any recommendations for an urgent decision taken must be noted at the next formal meeting.

11. Declarations of interest

All members are required to declare any actual or potential conflicts of interest in line with NHS guidance. A register of interests will be maintained.

12. Secretariat support

Secretariat support will operate on behalf of the Shadow Committee collectively and independently of any single member organisation. Secretariat support will be provided to this Shadow Committee by [to be confirmed].

This will include:

- agreement of the agenda with the Chair;
- sending out agendas and supporting papers to Members and Attendees at least five Working Days before the meeting;
- taking minutes of the meetings, including an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward;
- drafting minutes for comment and approval by the Chair within five Working Days of the meeting. Following Chair's approval, distributing the minutes to all Members and Attendees within five Working Days of the approval. Updating minutes in accordance with any amendments agreed at subsequent meetings;
- maintaining an on-going list of actions, specifying the Member(s) responsible for each action, due dates, progress and completion;
- maintaining an annual work plan; and
- receiving notifications and requests on behalf of the Chair, including notifications relating to conflicts of interest, requests for meetings and/or nomination of deputies.

Notifications and requests to the Chair must be sent to [\[insert email of secretariat support\]](#)

13. Authority

All Members and Attendees will operate within the Calderdale, Kirklees and Wakefield Provider Partnership's Memorandum of Understanding and any other relevant policies or documents agreed by the Shadow Committee.

As the Shadow Committee is not authorised to commit finances on behalf of NHS West Yorkshire ICB, whilst operating in shadow, decisions will be taken by one of five ICB's place committees. Financial decisions can be built by the Shadow Committee and recommended to the relevant NHS West Yorkshire ICB Place Committee. Where the decision required has a value in excess of the place

committee's limit of £20m the Shadow Committee shall make a recommendation to the place committee for escalation to the ICB's Board.

Note: decision taking will be carried out in-line with the ICB's Constitution, Scheme of Reservation and Delegation (SoRD), Standing Financial Instructions (SFIs), Financial Scheme of Delegation (FSOD), and Operational Scheme of Delegation (OSoD).

Fora reporting to this Shadow Committee are:

- [Insert here](#)

14. Reporting

This Shadow Committee shall submit its minutes to NHS West Yorkshire ICB's place committee in Calderdale; to the Health and Wellbeing Board; and to Partner Member Boards.

This Shadow Committee will receive for approval the minutes of meetings that report into it, as set out in the Authority section.

The Shadow Committee will work in partnership with the Health and Wellbeing Board, recognising its role in setting strategic priorities, overseeing delivery against agreed plans, and providing democratic accountability.

15. Review date

These Terms of Reference will be reviewed after three months of operation, and thereafter as required during the transitional year.

16. Implementation

These terms of reference come into effect on 1 April 2026.

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**KIRKLEES PROVIDER ALLIANCE
and NHS WY ICB**

MEMORANDUM OF UNDERSTANDING

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1. Parties and Members

The Parties to this Agreement are:

- (1) Kirklees Provider Alliance; and
- (2) NHS West Yorkshire ICB

1.1 Kirklees Provider Alliance Members

- Calderdale and Huddersfield NHS Foundation Trust
- General Practice Representative/s
- Kirklees Metropolitan Borough Council
- Locala Health and Wellbeing
- Mid Yorkshire Teaching NHS Trust
- South West Yorkshire Partnership Teaching NHS Foundation Trust
- Voluntary and Community Sector Representative(s)
- NHS West Yorkshire ICB

2. Background

Place-Based Provider Partnerships (Partnership) are set to become a core delivery mechanism within England's Integrated Care System (ICS) architecture. They support the Integrated Care Systems as they provide a forum for providers to jointly plan and coordinate services, manage shared risks, support workforce sustainability, and contribute to delivery of Health and Wellbeing Strategies within places. This Memorandum of Understanding Agreement (Agreement) sets out the shared intent, principles, and arrangements through which partner organisations will collaborate at place, while retaining their individual statutory duties and organisational autonomy.

Legislative and national policy changes underpin this direction of travel, first laid out within the Health and Care Act 2022 which provided a legal framework for agencies to work together more easily. It placed a duty on the NHS to consider effects of their decisions on better health and wellbeing; quality of care for all patients and the sustainable use of NHS resources (triple aim). As part of these reforms Thriving places: guidance on the development of place-based partnerships defined a "place" as the level at which providers can best understand population need, reduce health inequalities, and design services around people rather than institutions.

The 10 Year Health Plan for England: fit for the future published July 2025 set out the reforms for the NHS operating model, including a significant opportunity for Providers to hold outcome-based contracts for a local population. This direction aligns with the key findings of the Darzi Review, which highlighted the importance of locking in the shift of care closer to home by hardwiring financial flows; simplification and innovative care delivery for neighbourhoods; drive productivity in hospitals; and tilt towards technology.

3. Introduction

3.1 Vision

Working collaboratively as a neighbourhood-enabled provider alliance, we will deliver integrated, person-centred care that, empowers the people of Kirklees to live their best lives, addressing health inequalities. Through stewardship of our collective resources, we will build stronger communities and a sustainable future.

3.2 Aims

- Build on the joint working and collaboration already in place through continuation of good partnership arrangements;
- Delivery of integrated neighbourhood health; and
- Transformation of pathways outside of hospital advocating a shift from hospital to home.

3.3 Objectives

- Improve Outcomes:** deliver better health, care, and wellbeing through integrated, person-centred services that focus on prevention and proactive care.
- Tackle Inequalities & Promote Inclusion:** design services inclusively and in partnership ensuring the voices of people with lived experience helps shape priorities and delivery.
- Drive Efficiency & Stewardship:** make best use of shared workforce, digital, and financial resources, acting as a trusted steward of the Kirklees Pound.
- Strengthen Communities & Neighbourhoods:** enable primary care and community-led neighbourhood models to lead local delivery, supporting resilient communities and stronger partnerships.

~~v. **Contribute to the Wider System:** work at scale with Kirklees partners, aligning with Calderdale, Kirklees & Wakefield (CKW) integration, West Yorkshire priorities, and contributing to regional collaboratives such as WYAAT and the MHLDA.~~

In-scope approx. £112m

- ICB commissioned general community health services for adults and children;
- Current ICB contracts with VCSE services including adult hospices;
- ICB and LA commissioned services via s75 (Better Care Fund) and s256 (relevant budget lines – to be agreed);
- Expenditure within community mental health services; and
- General Practice contracts including discretionary spend.

3.4 Primary functions

- i. **Integrated Leadership & Governance:** provides a leadership forum for NHS, social care, voluntary, and community sector (VCSE) providers in Kirklees. It will help transition local services into an integrated care system that can collectively plan, manage, and deliver health services more efficiently;
- ii. **Collaborative Service Planning:** responsible for overseeing the development and implementation of shared priorities, aligned with national and regional health policies;
- iii. **Operational Transformation:** drives local operational changes, such as co-designing governance and delivery models for future Local Accountable Care Systems (LACS), and identifying ways to reduce duplication in services, improve efficiency, and enhance outcomes;
- iv. **Workforce and Digital Transformation:** by engaging in workforce development and digital transformation, the Alliance will promote a more agile and efficient system. This includes workforce planning, digital infrastructure development, and joint initiatives that improve care delivery across sectors; and
- v. **Improvement of Health Outcomes:** a primary goal is to improve health outcomes by aligning care services and fostering collaboration among providers to meet the health and social needs of the community, with a strong focus on reducing inequalities. and
- vi. ~~**Preparatory Role for CKW Provider Integration:** as a shadow collaborative, the Alliance lays the groundwork for Kirklees' participation in the future CKW Integrated Provider Board, helping to shape governance, reporting, and oversight models that could be rolled out at scale across the CKW region.~~

4. Status of this Agreement

The Parties have agreed to adopt a Memorandum of Understanding as set out in this Agreement.

For the avoidance of doubt this Agreement is not an NHS Contract pursuant to s.9 of the National Health Service Act 2006 and is not intended to be legally binding and no legal obligations or legal rights shall arise between the Parties.

The Parties enter into the Agreement intending to meet the purpose, aims and objectives of this Agreement whilst retaining their own statutory duties, responsibilities and all sovereignties.

A Partner may withdraw from this Agreement by giving not less than 6 months' written notice to each of the other Partners' representatives. A Partner may be excluded from this Agreement on notice from the other Partners (acting in consensus), in the event of:

- the termination of their Services Contract; or

- an event of Insolvency affecting them.

5. Implementation

This Agreement comes into effect on 1 April 2026 and remains in place until 31 March 2027 after which this Agreement will lapse unless reviewed and amended in accordance with Clause 5 (Review and Amend) below.

6. Review and Amendment

The Parties to this Agreement may, at any time on or before 31 March 2027, review and amend this Agreement. Any amendment(s) to this Agreement must be agreed by all Parties.

7. Purpose of this Agreement

The purpose of this Agreement is to improve outcomes for the benefit of patients, residents and service users across the Place.

- i) The Parties working together for and on behalf of the people within the Place Provider Collaborative will work in an integrated way in a manner that embeds collaboration and joint working as the basis for delivery of services;
- ii) Ensuring there is an associated operational work programme adopted that drives forward transformation between Parties to enable collaboration and joint working as the basis for delivery of services;
- iii) Parties working together to reduce health inequalities and implement the England Neighbourhood Health Guidelines 2025/26 – NHS England published on 30 January 2025; and
- iv) Ensuring there is a focus on prevention to support the Place-Based Provider Partnership in managing demand across the wider system in a collaborative and integrated way.

8. Aims and Objectives

8.1 Partnership Working and Leadership

- gain a full understanding of their individual responsibilities and those which require collaboration and co-operation to achieve shared objectives;

- develop and embrace leadership styles that embrace and embody the Values and Behaviors set out in this Agreement and consistently demonstrate the agreed values and behaviors of their Places;
- develop and agree non-clinical and clinical leadership principles and behaviours; and
- agree a contractual structure with general agreement on mutual and individual responsibilities.

8.2 Population and Health Management

- gain a full understanding of the actions that they can take individually and collectively, to address inequalities in service provision;
- agree actions to address inequalities, including prevention, and ensure these are built into transformation design;
- ensure population segmentation is being utilised to plan and deliver services at Place and Neighbourhood levels;
- ensure information governance is in place to ensure de-identified data for care design and re-identified data for clinical purposes;
- ensure VCSE organisations in the Place-Based Provider Partnership are part of both decision making, service delivery and design ensuring sustainability of the sector to support emerging neighbourhood models;
- ensure contracting supports shared accountability for improved patient outcomes;
- ensure costs and performance analysis is patient focused; and
- ensure data and information is clearly directed to support evidence of impact on required outcomes and clear processes to inform strategic commissioning intentions and contract outcomes.

8.3 Transformation and Delivery

To ensure that Transformation Programmes are:

- being scaled within the context of the local neighborhood health model and enabled through changes to the development of financial and people resource between providers within the Provider Alliance;
- enabled through the local implementation of Single Neighbourhood Provider and Multi-Neighbourhood Provider contracts;

And Transformation methodology includes:

- stakeholder engagement and NHS best possible value and LEAN approaches;

- an agreed evaluation methodology, which includes qualitative and quantitative metrics for assessing competing risks (e.g.: capacity and travel further vs access to excellent centre);

And Transformation delivers:

- the objectives and approach of the Place-Based Provider Partnership uphold values and are aligned to the assumptions regarding the impact of possible situations and are rigorously tested;
- providers, services and/or clinical pathways which are designed to ensure adherence with relevant standards and accreditation schemes;
- an operating model which will enable Place-Based Provider Partnership to hold population/pathway-based contracts that span multiple care settings and multi-year time horizons; and
- clarity and agreement regarding the map of services and who is responsible for different elements of delivery which will form the basis of contractual structure and identify any gaps in required provision.

8.4 Financial and risk management principles

- ensure allocated funds for programmes of work are utilised effectively;
- the Place-Based Provider Partnership's operating model enables the Place to hold population, services or pathways-based contracts that span multiple care setting and multi-year time horizons;
- there is clear financial governance in the Place-Based Provider Partnership to support shared decision making/pooled budgets;
- able to demonstrate how financial savings have benefited the Place-Based Provider Partnership with the use of clear robust benefits realisations models;
- work has been undertaken to scope options and implications for existing Local Authority ("LA") commissioning arrangements and options and plans management of joint LA / WY ICB commissioning arrangements and associated pooled budgets;
- there has been formal agreement of each Place-Based Provider Partnership's contractual structure and format, and the role of each Place Based Provider Partnership Member has been identified, and consideration has been given in respect of a process for partners to join or leave the Place Based Provider Partnership;
- a dispute resolution mechanism has been established; and
- there is an understanding of where potential risk/gain share approaches could be utilised to mitigate, remove or reduce identified risks.

8.5 Communication and Engagement

- to review, with the involvement of local communities, the stakeholder map to ensure full representation of diversity of the population of Place;
- for a Place-Based Provider Partnership communications plan which is aligned to the system plan, and which sets out agreed key messages and supports joint messages around NHS provision;
- for Place-Based Provider Partnership Members to demonstrate how communication and engagement has influenced decision making and transformation design;
- data gathered from different stakeholders' sources is distilled and deployed within formal governance arrangements;
- for stakeholders to be involved in making strategic decisions on behalf of communities; and
- for the Place-Based Provider Partnership to have strong relationships within the WY ICB and the Regional Team, ensuring engagement with the development of strategic and operational plans.

8.6 Workforce and Capacity principles

- be on track in the delivery of its capacity and capability maturity plan and to have confirmed capacity and capability arrangements required to safely host, on behalf of the Place-Based Provider Partnership, the contract with the WY ICB;
- enable the operational delivery of the Place-Based Provider Partnership Committee arrangement and undertake commissioning and contracting activities with the LA;
- ensure arrangements are in place for the teams and functions to transfer to the organisation(s) hosting the system and integrator function at the transition date of 1 April 2027;
- secure capacity and capabilities to the System Integrator via this Agreement with the WY ICB and other organisations where there are benefits in sharing existing partnership functions/joint ventures;
- establish a programme to align continuous improvement methodologies across partner organisations; and
- pool clinical governance.

8.7 Quality

In its role to arrange and deliver high quality care, the Place-Based Provider Partnership will ensure improving quality is a key outcome of system transformation through its collaborative arrangements with partners. Quality in a thriving partnership is:

- coordinated, person-centered and grounded in population health need;
- delivered through strong partnership working across NHS, Local Authority, health and care provision and VCSE organisations;
- focused on equitable access, experience, outcomes and reducing health inequalities;
- informed by lived experience insight and community voices triangulated with reliable quantitative data; and
- involves professionals, people and communities in planning, design, decision-making and evaluation to ensure accountability and improve experience of care.

The Place-Based Provider Partnership's approach to quality oversight, assurance and improvement needs to be consistent with the requirements of national guidance. Overarching quality functions will build on existing guidance from the National Quality Board and be set out in the forthcoming National Quality Strategy. There is an expectation, that can apply to the Place-Based Provider Partnership, that Providers will implement a Quality Management System (QMS) approach incorporating four key functions:

- Quality Planning – what do we need?
- Quality Control – what is our performance?
- Quality Improvement – what could be better and how do we get there?
- Quality Assurance – are we meeting standards?

Core responsibilities for each function are being developed for Regions, ICBs and service providers. Once published these will need to be reviewed and adapted for the Place-Based Partnership to identify which could be delegated from an ICB or be a shared responsibility with the ICB.

8.8 Embedding Quality in the Transitional Year

- develop a single understanding of quality, shared and visible across the Place-Based Provider Partnership;
- identify shared quality improvement priorities responding to unwarranted variation or quality concerns;
- redesign specific care pathways using evidence-based models, including relevant modern service frameworks when published, to improve outcomes and drive quality;

- conduct impact assessments in respect of quality, equality and health inequalities where service redesign or reconfiguration may be required;
- develop meaningful approaches to involve residents, communities, staff and stakeholders in shaping how services are designed, delivered and evaluated;
- evaluate impact of redesigned care pathways or reconfigured service delivery collecting relevant patient safety indicators, patient and staff reported experience, outcome measures and wider feedback and intelligence;
- agree and implement a Quality Management System for the Place-Based Provider Partnership which aligns to the WY ICB and NHS England Regional approach, including management of quality issues or concerns; and
- ensure Place Based Provider Partnership governance arrangements enable shared decision-making, transparency, and mutual accountability.

9. Values and Behaviours

The Parties are committed to abide by the following values:

- Honesty
- Integrity
- Ambition
- Mutual respect
- Be bold
- Develop unity
- Deliver what we say

The Parties agree to demonstrate the following behaviours, we:

- are leaders of our organisation, our Place and of West Yorkshire;
- support each other and work collaboratively;
- act with honesty and integrity, and trust each other to do the same;
- challenge constructively when we need to;
- assume good intentions; and
- will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

10. Building Recommendations and Making Decisions

The Place-Based Provider Partnership will meet to develop recommendations for the population and communities across their Place. Every recommendation made by the Place-Based Provider Partnership will be taken through their WY ICB Place Committee as referred to in Clause 12 (Arrangements and Accountability) below.

Each WY ICB Place Committee, established by the ICB have delegated authority to make decisions in accordance with the WY ICB Financial Scheme of Delegation (FSoD), Scheme of Reservation and Delegation (SoRD), Operational Scheme of Delegation (OSoD) and Standing Financial Instructions) SFIs.

11. Conflicts of Interest

Subject to compliance with Law and contractual obligations of confidentiality the Parties agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner. Parties must ensure compliance with the following:

- WY ICB Conflicts of Interest Policy; and
- NHS England Managing Conflicts of Interest in the NHS Guidance for Staff and Organisations (Published 7 February 2017; updated 17 September 2024)

The Parties agree to declare, in line with NHS guidance, any real or potential conflict of interest arising in connection with this Agreement as soon as they become aware of the same.

The Parties will:

- disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the operation of the Partnership governance immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of this Agreement;
- not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and
- use best endeavours to ensure that their appointed members also comply with the requirements of this Clause 10 as relevant when acting in connection with this Agreement.

12. Dispute resolution

The Parties commit at all times, to working cooperatively to identify and resolve issues to their mutual satisfaction to avoid all forms of dispute or conflict in performing their obligations under this Agreement. The Parties believe that by focusing on the Values and Behaviors set out in this Agreement and being

collectively responsible for all risks will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this Agreement. The Parties agree to:

- seek solutions within a shared culture of ‘no fault, no blame’;
- seek to resolve any disputes in an open, amicable and communicative manner;
- treat each other as equal parties; and
- ensure, to the best of their ability, that their representatives on the Place-Based Provider Partnership comply with the terms and spirit of this Agreement above when acting within its remit.

If a problem, issue, concern or complaint comes to the attention of a Partner in relation to any matter in this Agreement such Partner shall notify the other Partners in writing. The Partners shall then try to resolve the issue in a proportionate manner within 20 Operational Days of written notification. If they are not able to do this, the matter will be resolved in accordance with Schedule 1 (*Dispute Resolution Procedure*).

If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this Agreement (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act relating to this Agreement) the receiving Partner will liaise with the other Partners as to the contents of any response before a response is issued.

13. Arrangements and Accountability

The Place-Based Provider Partnership will be supported by the following WY ICB Place Committee, in discharging their purpose:

- Kirklees Provider Alliance: Kirklees Health and Care Partnership Committee

The WY ICB Place Committee remains accountable to WY ICB as set out in Clause 9 (Building Recommendations and Making Decisions) above.

Full details of the Placed-Based Provider Partnership can be found in Schedule 2: the Kirklees Health and Care Place Provider Alliance Terms of Reference.

14. Endorsements

The Parties to this Agreement acknowledge and confirm that they have the necessary authorisation to enter into this Agreement and that its own Board, Cabinet and/or Governing Body has approved the content of this Agreement.

By signing this Agreement, the Place-Based Provider Partnership Members are setting forth their shared understanding and commitment to the values and behaviours set out above. This is not intended to be a legally binding Agreement, but rather a symbolic commitment to the Parties shared vision and a framework for collaborative working during the Transitional Year:

13.1 Signed by Members of the Kirklees Provider Alliance

Organisations	Signatures
Signed by Rob Aitchison CEO on behalf of Calderdale & Huddersfield NHS Foundation Trust	
Signed by GP, on behalf of Kirklees General Practice (representative/s)	
Signed by Steve Mawson, Chief Executive on behalf of Kirklees Metropolitan Borough Council	
Signed by Karen Jackson, Chief Executive on behalf of Locala Health and Wellbeing	
Signed by Brent Kilmurray CEO on behalf of Mid Yorkshire Teaching NHS Trust	
Signed by Mark Brooks CEO on behalf of South West Yorkshire Partnership Teaching NHS Foundation Trust	
Signed by [Job title] on behalf of Kirklees Voluntary and Community Sector	
Signed by Vicky Dutchburn, Accountable Officer for and on behalf of NHS West Yorkshire Integrated Care Board	

15. Definitions

Terms	Definitions
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in Schedule 1 for the resolution of disputes which are not capable of resolution under Clause 11 (Disputes Resolution).
FSoD	WY ICB Financial Scheme of Delegation
OSoD	WY ICB Operational Scheme of Delegation
Parties	Kirklees Provider Alliance
Place	The geographical level at which most of the work to join up health care services happens which is, for the purposes of this Agreement, Kirklees.
Place-Based Provider Partnership	Collaborative arrangements formed by organisations responsible for arranging and delivering care services in Places
SFIs	WY ICB Standing Financial Instructions
SoRD	WY ICB Scheme of Delegation and Reservation
Transitional Year	1 April 2026 to 31 March 2027
WY ICB	NHS West Yorkshire Integrated Care Board
WY ICB Place Committee	Kirklees Health and Care Partnership Committee

SCHEDULE 1: DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 11 (Disputes Resolution) prior to commencing this procedure.

The Partners believe that by focusing on their agreed Objectives and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the Partnership arrangements set out in this Agreement.

The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the Partnership (each a '**Dispute**') when it arises.

In the first instance the relevant Partners' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the relevant Partners. If the Dispute cannot be resolved by the relevant Partners' representatives within 10 Operational Days of the Dispute being referred to them, the Dispute shall be referred to senior officers of the relevant Partners, such senior officers not to have had direct day-to-day involvement in the matter and having the authority to settle the Dispute. The senior officers shall deal proactively with any Dispute on a Best for the Place-Based Provider Partnership basis in accordance with this Agreement so as to seek to reach a unanimous decision.

The Partners agree that the senior officers may, on a Best for the Place-Based Provider Partnership basis, determine whatever action it believes is necessary including the following:

- If the senior officers cannot resolve a Dispute, they may agree by consensus to select an independent facilitator to assist with resolving the Dispute; and
- The independent facilitator shall:
 - (i) be provided with any information he or she requests about the Dispute;
 - (ii) assist the senior officers to work towards a consensus decision in respect of the Dispute;
 - (iii) regulate his or her own procedure;
 - (iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and
 - (v) have its costs and disbursements met by the Partners in Dispute

equally.

- If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 3 and only after such further consideration again fails to resolve the Dispute, the Partners may agree to:
 - (a) terminate this Agreement in accordance with Clause 3 (Status of this Agreement); or
 - (b) agree that the Dispute need not be resolved.

SCHEDULE 2: KIRKLEES PROVIDER ALLIANCE TERMS OF REFERENCE

Terms of reference

Kirklees Provider Partnership Shadow Committee **[Joint Committee / Committee in Common]**

Version control

Version: 0.3
Approved by: Provider Partner Members
Date Approved: **[TBC]**
Responsible Officer: Senior Provider Executive
Date Issued: [1 April 2026]
Date to be reviewed: [1 April 2027]

Change history

Version number	Changes applied	By	Date
0.1	Kirklees Provider Partnership	Sue Baxter, Head of Partnership Governance	10/12/25
0.2	Strengthen Health Inequalities	Sue Baxter, Head of Partnership Governance	22/12/25
0.3	Final changes to the draft ToR	Head of Partnership Governance	02/02/26

1. Purpose

This Committee is established for 2026/27 transitional year, as a shadow Committee of the Kirklees Health and Care Provider Partnership, to enable decisions to be built on Partnership business. With the aim of enabling the emergent Place Provider Partnership, together with all NHS Statutory Provider organisations and other health and care provider organisations to operate within Kirklees from 1 April 2026.

Approximately £112m will be in scope, including the following functions and services:

- ICB commissioned general community health services for adults and children;
- Current ICB contracts with VCSE services including adult hospices;
- ICB and LA commissioned services via s75 (Better Care Fund) and s256 (relevant budget lines – to be agreed);
- Expenditure within community mental health services; and
- General Practice Contracts including discretionary spend

2. Remit and responsibilities

The following responsibilities will fall under the remit of this Shadow Kirklees health and Care Provider Partnership Committee for a transitional year from 1 April 2026 until no later than the 31 March 2027. Shadow arrangements will cease once agreement on the Place Provider Partnership contract is reached and signed.

The remit of this Shadow Committee is to:

a) To make recommendations on behalf of Partners operating as Kirklees Health and Care Provider Partnership, in-line with NHS West Yorkshire ICB delegation of the following key areas of responsibility for the transitional year:

- i. develop recommendations regarding the future Kirklees Health and Care Provider Partnership approach, by no later than 1 April 2027;
- ii. develop joint working arrangements that embed collaboration as the basis for delivery, with NHS statutory provider partners within the place and with other provider partners, as well as the wider West Yorkshire (WY) Integrated Care System;
- iii. develop accountability arrangements and clear lines of report to the Health and Wellbeing Board, member Partner Boards and to the Shadow Committee;
- iv. oversee a structured due diligence exercise which includes a thorough assessment of financial, legal, operational and strategic factors to identify any potential risks or opportunities. Ensuring this exercise provides a robust evaluation and verification of accurate information in relation to the

transferring functions prior to entering into a contract with the ICB for those functions;

- v. collaborate across Kirklees and ensure arrangements for complying with the Provider Self-Assessment Framework / Readiness Checklist across NHS West Yorkshire ICB
- vi. be sighted on evolving arrangements for Integrated Neighbourhood Health services within Kirklees including risk sharing and / or risk pooling with other organisations (for example pooled budget arrangements under section 75 of the NHS Act 2006), for approval by this Shadow Committee;
- vii. arrange for the provision of health services, ensuring a focus on reducing health inequalities in-line with the allocated resources across Kirklees through a range of activities including:
 - a. oversee the agreement of contracts to secure delivery of the strategic goals and operational plans;
 - b. convene and lead major service transformation programmes to achieve agreed strategic outcomes working at scale at place, across Kirklees and across West Yorkshire, as appropriate;
 - c. sponsor the delivery of high quality and effective care shifting care delivering into integrated neighbourhood health services, aimed at tackling health inequalities whilst shifting more service provision out of hospital and into community, shifting from analogue to digital, and shifting from treatment to prevention;
 - d. work together with NHS West Yorkshire ICB **Integrator team** to:
 - work with partners to create the integrated neighbourhood health model;
 - oversee primary care operations and transformation; and
 - develop pathway and service development programmes.
 - e. sponsor new Provider service developments including support of GP practices working towards larger footprints with the development of new neighbourhood provider services (c50k) via single neighbourhood provider contracts. Work with PCNs/GP Federations over larger geographies (c250k population) via multi-neighbourhood provider contracts;
 - f. sponsor work 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; and
 - g. sponsor work with the Providers as a first order priority to move from hospital by default to digital-by-default.

b) To make recommendations on behalf of Partners operating as Kirklees Health and Care Provider Partnership, in line with NHS West Yorkshire ICB

delegation, for the benefit of the patients, service users, carers and population

- i. establish governance arrangements to support collective accountability between partner organisations for Place Provider Partnership's system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations;
- ii. in the pursuit of earned autonomy for NHS providers, support NHS Trust member partners with achieving Foundation Trust (FT) status for a modern integrated health system and / or renewing FT status;
- iii. building on new/renewed FT status and earned autonomy, support NHS Provider Trusts with preparations to agree and sign Integrated Health Organisation (IHOs) contract, capable of receiving the resources (both revenue and capital);
- iv. agree a plan to meet the health and healthcare needs of the population within the Place Provider Partnership, having regard to health and care strategy and planning requirements and health and wellbeing strategy;
- v. allocate resources to deliver the plan, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital); and
- vi. sponsor and draw assurance from Place Provider Partnership's strategic and operational risk management approach.

3. Members

The Members of the Kirklees Place Provider Partnership Shadow Committee are:

- Calderdale and Huddersfield NHS Foundation Trust
- General Practice (representative/s)
- Kirklees Metropolitan Borough Council
- Locala Health and Wellbeing
- Mid Yorkshire Teaching NHS Trust
- South West Yorkshire Partnership Teaching NHS Foundation Trust;
- Voluntary and Community Sector Representative(s)
- NHS West Yorkshire ICB

4. Attendees

The following individuals will be invited to attend each meeting of this Shadow Committee as Attendees. Attendees attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote. The Attendees are:

- a) Kirkwood Hospice

- b) Independent Care Sector (representative/s)
- c) Public Health
- d) Deputy Director of Integration;
- e) Shadow Committee Secretariate;

The Chair may invite such other Attendees to attend any meeting of this Shadow Committee as the Chair considers appropriate.

5. Deputies

Members will nominate a deputy to attend a meeting of the Shadow Committee that the Member is unable to attend. The deputy may speak and vote on their behalf.

6. Chair

The Chair of this Shadow Committee shall be a Senior Provider Executive. If the Chair is unable to attend, then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.

7. Quoracy

The quorum for meetings shall be three members, including at least one Provider Chief Executive and 50% of the membership. Recommendation on decisions to be made to NHS West Yorkshire ICB Board Place Committee will be reached by consensus wherever possible.

8. Frequency of meetings

This Shadow Committee will meet monthly, and papers shall be circulated at least five Working Days before the meeting. Any need for additional meetings at any time will be agreed by the members. Shadow arrangements during the transitional year from 1 April 2026 to 31 March 2027, and will focus on implementation (phase two of development).

9. Urgent decisions

In the case of recommendations for an urgent decisions needed in extraordinary circumstances, every attempt will be made for this Shadow Committee to meet. Where it is not possible for the Shadow Committee to meet, a recommendation for an urgent decisions may be exercised by the Chair, with members, via email, in-line with quoracy section of these Terms of Reference.

10. Declarations of interest

All members are required to declare any actual or potential conflicts of interest in line with NHS guidance. A register of interests will be maintained.

11. Secretariat support

Secretariat support will be provided to this Shadow Committee by **[to be confirmed]**.

This will include:

- agreement of the agenda with the Chair;
- sending out agendas and supporting papers to Members and Attendees at least five Working Days before the meeting;
- taking minutes of the meetings, including an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward;
- drafting minutes for comment and approval by the Chair within five Working Days of the meeting. Following Chair's approval, distributing the minutes to all Members and Attendees within five Working Days of the approval. Updating minutes in accordance with any amendments agreed at subsequent meetings;
- maintaining an on-going list of actions, specifying the Member(s) responsible for each action, due dates, progress and completion;
- maintaining an annual work plan; and
- receiving notifications and requests on behalf of the Chair, including notifications relating to conflicts of interest, requests for meetings and/or nomination of deputies.

Notifications and requests to the Chair must be sent to **[insert email of secretariate support]**

12. Authority

All Members and Attendees will operate within the Kirklees Provider Alliance's Memorandum of Understanding and any other relevant policies or documents agreed by the Shadow Committee.

As the Shadow Committee is not authorised to commit finances on behalf of NHS West Yorkshire ICB, whilst operating in shadow, decisions will be taken by one of five ICB's place committees. Financial decisions can be built by the Shadow Committee and recommended to the relevant NHS West Yorkshire ICB Place Committee. Where the decision required has a value in excess of the place committee's limit of £20m the Shadow Committee shall make a recommendation to the place committee for escalation to the ICB's Board.

Note: decision taking will be carried out in-line with the ICB's Constitution, Scheme of Reservation and Delegation (SoRD), Standing Financial Instructions (SFIs), Financial Scheme of Delegation (FSOD), and Operational Scheme of Delegation (OSoD).

Fora reporting to this Shadow Committee are:

- Wells Programme Board
- Mechanism for representing the public voice are under discussion.

13. Reporting

This Shadow Committee shall submit its minutes to NHS West Yorkshire ICB's place committee in Kirklees; to the Health and Wellbeing Board; and to Partner Member Boards.

This Shadow Committee will receive for approval the minutes of meetings that report into it, as set out in the Authority section.

14. Review date

These terms of reference shall be reviewed by 31 March 2027 and annually thereafter.

15. Implementation

These terms of reference come into effect on 1 April 2026.

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**WAKEFIELD PLACE-BASED PROVIDER PARTNERSHIP
and NHS WY ICB**

MEMORANDUM OF UNDERSTANDING

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1. Parties and Members

The Parties to this Agreement are:

- (1) Wakefield Health and Care Place Provider Partnership (Alliance); and
- (2) NHS West Yorkshire ICB

Provider Partnership Members

- General Practice (nomination to be led by Connexus)
- Healthwatch Wakefield
- Mid Yorkshire NHS Hospital Teaching Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Wakefield Metropolitan District Council (Public Health, ASC, and CSC)
- VCSE (through Nova Wakefield and District)
- NHS West Yorkshire ICB

2. Background

Place-Based Provider Partnerships (Partnership) are set to become a core delivery mechanism within England's Integrated Care System (ICS) architecture. They support the Integrated Care Systems as they provide a forum for providers to jointly plan and coordinate services, manage shared risks, support workforce sustainability, and contribute to delivery of Health and Wellbeing Strategies within places. This Memorandum of Understanding Agreement (Agreement) sets out the shared intent, principles, and arrangements through which partner organisations will collaborate at place, while retaining their individual statutory duties and organisational autonomy.

Legislative and national policy changes underpin this direction of travel, first laid out within the Health and Care Act 2022 which provided a legal framework for agencies to work together more easily. It placed a duty on the NHS to consider effects of their decisions on better health and wellbeing; quality of care for all patients and the sustainable use of NHS resources (triple aim). As part of these reforms Thriving places: guidance on the development of place-based partnerships defined a "place" as the level at which providers can best understand population need, reduce health inequalities, and design services around people rather than institutions.

The 10 Year Health Plan for England: fit for the future published July 2025 set out the reforms for the NHS operating model, including a significant opportunity for Providers to hold outcome-based contracts for a local population. This direction aligns with the key findings of the Darzi Review, which highlighted the importance of locking in the shift of care closer to home by hardwiring financial flows; simplification and innovative care delivery for neighbourhoods; drive productivity in hospitals; and tilt towards technology.

- Ensures a coordinated approach between providers to the achievement of Wakefield District Plan, particularly the health and wellbeing element. In this context, role model a distributed leadership approach;
- The District Plan leadership responsibilities will include functions for example like Social Value leadership as part of an Anchor Institutions approach, contributing to the economy work as the biggest employer in the District, and workforce planning including talent attraction and retention (potentially as part of a more systemic approach which includes offers around key worker housing);
- Ongoing development of a service model(s) that will deliver an integrated care approach (the Alliance as a 'Care Integrator') and fulfil the ambitions of Wakefield's Neighbourhood Health approach;
- Identify the key risks and challenges across the health and care system and work collaboratively to address these;
- Act collaboratively as 'custodians of the Wakefield £', working to ensure 'strong seamed care';
- Oversight of system performance, including transparency of data in this context;
- Represent the voice of the citizen/service user and people with lived experience, and feedback from Healthwatch. In this context, ensure that co-production underpins the Alliance's work and there is evidence of stronger patient relationships; and
- Development of new models of care designed on international best practice.

3.4 Principles

- The foundations of the Wakefield Provider Partnership is that it supports the work that takes place at Neighbourhood level, as it is here that the biggest impact on people's lives is made;
- Provider Partnership oversight of joined up care including:
 - Improved access to services
 - Continuity of care
 - Enhanced coordination between care providers
- The Wakefield Provider Alliance builds on and takes into account the relationships, networks and provider alliances that already exist, providing governance oversight for those Alliances and any new Alliances implemented, including Neighbourhood Health development;
- The members of the Wakefield Provider Alliance recognise they share a responsibility to contribute to the delivery of its objectives/plans, and partner governing bodies own and support the functions, principles, objectives, and workplan of the Provider Alliance;

- Each member has a voice. There is no hierarchy. Each member will be recognised for their own unique and valuable contribution; and
- Members work together to make the biggest improvements possible because we can achieve more together – the whole is greater than the sum of our parts.

4. Status of this Agreement

The Parties have agreed to adopt a Memorandum of Understanding as set out in this Agreement.

For the avoidance of doubt this Agreement is not an NHS Contract pursuant to s.9 of the National Health Service Act 2006 and is not intended to be legally binding and no legal obligations or legal rights shall arise between the Parties.

The Parties enter into the Agreement intending to meet the purpose, aims and objectives of this Agreement whilst retaining their own statutory duties, responsibilities and all sovereignties.

A Partner may withdraw from this Agreement by giving not less than 6 months' written notice to each of the other Partners' representatives. A Partner may be excluded from this Agreement on notice from the other Partners (acting in consensus) in the event of:

- the termination of their Services Contract; or
- an event of Insolvency affecting them.

5. Implementation

This Agreement comes into effect on 1 April 2026 and remains in place until 31 March 2027 after which this Agreement will lapse unless reviewed and amended in accordance with Clause 6 (Review and Amend) below.

6. Review and Amendment

The Parties to this Agreement may, at any time on or before 31 March 2027, review and amend this Agreement. Any amendment(s) to this Agreement must be agreed by all Parties.

7. Purpose of this Agreement

The purpose of this Agreement is to improve outcomes for the benefit of patients, residents and service users across the Place.

- i) The Parties working together for and on behalf of the people within the Place Provider Collaborative will work in an integrated way in a manner that embeds collaboration and joint working as the basis for delivery of services;
- ii) Ensuring there is an associated operational work programme adopted that drives forward transformation between Parties to enable collaboration and joint working as the basis for delivery of services;
- iii) Parties working together to reduce health inequalities and implement the England Neighbourhood Health Guidelines 2025/26 – NHS England published on 30 January 2025; and
- iv) Ensuring there is a focus on prevention to support the Place-Based Provider Partnership in managing demand across the wider system in a collaborative and integrated way.

8. Aims and Objectives

8.1 Partnership Working and Leadership

- gain a full understanding of their individual responsibilities and those which require collaboration and co-operation to achieve shared objectives;
- develop and embrace leadership styles that embrace and embody the Values and Behaviors set out in this Agreement and consistently demonstrate the agreed values and behaviors of their Places;
- develop and agree non-clinical and clinical leadership principles and behaviours; and
- agree a contractual structure with general agreement on mutual and individual responsibilities.

8.2 Population and Health Management

- gain a full understanding of the actions that they can take individually and collectively, to address inequalities in service provision;
- agree actions to address inequalities, including prevention, and ensure these are built into transformation design;
- ensure population segmentation is being utilised to plan and deliver services at Place and Neighbourhood levels;
- ensure information governance is in place to ensure de-identified data for care design and re-identified data for clinical purposes;

- ensure VCSE organisations in the Place-Based Provider Partnership are part of both decision making, service delivery and design ensuring sustainability of the sector to support emerging neighbourhood models;
- ensure contracting supports shared accountability for improved patient outcomes;
- ensure costs and performance analysis is patient focused; and
- ensure data and information is clearly directed to support evidence of impact on required outcomes and clear processes to inform strategic commissioning intentions and contract outcomes.

8.3 Transformation and Delivery

To ensure that Transformation Programmes are:

- being scaled within the context of the local neighborhood health model and enabled through changes to the development of financial and people resource between providers within the Provider Partnership;
- enabled through the local implementation of Single Neighbourhood Provider and Multi-Neighbourhood Provider contracts;

And Transformation methodology includes:

- stakeholder engagement and NHS best possible value and LEAN approaches;
- an agreed evaluation methodology, which includes qualitative and quantitative metrics for assessing competing risks (e.g.: capacity and travel further vs access to excellent centre);

And Transformation delivers:

- the objectives and approach of the Placed-Based Provider Partnership uphold values and are aligned to the assumptions regarding the impact of possible situations and are rigorously tested;
- providers, services and/or clinical pathways which are designed to ensure adherence with relevant standards and accreditation schemes;
- an operating model which will enable Place-Based Provider Partnership to hold population/pathway-based contracts that span multiple care settings and multi-year time horizons; and
- clarity and agreement regarding the map of services and who is responsible for different elements of delivery which will form the basis of contractual structure and identify any gaps in required provision.

8.4 Financial and risk management principles

- ensure allocated funds for programmes of work are utilised effectively;

- the Place-Based Provider Partnership’s operating model enables the Place to hold population, services or pathways-based contracts that span multiple care setting and multi-year time horizons;
- there is clear financial governance in the Place-Based Provider Partnership to support shared decision making/pooled budgets;
- able to demonstrate how financial savings have benefited the Place-Based Provider Partnership with the use of clear robust benefits realisations models;
- work has been undertaken to scope options and implications for existing Local Authority (“LA”) commissioning arrangements and options and plans management of joint LA / WY ICB commissioning arrangements and associated pooled budgets;
- there has been formal agreement of each Place-Based Provider Partnership’s contractual structure and format, and the role of each Place Based Provider Partnership Member has been identified, and consideration has been given in respect of a process for partners to join or leave the Place Based Provider Partnership;
- a dispute resolution mechanism has been established; and
- there is an understanding of where potential risk/gain share approaches could be utilised to mitigate, remove or reduce identified risks.

8.5 Communication and Engagement

- to review, with the involvement of local communities, the stakeholder map to ensure full representation of diversity of the population of Place;
- for a Place-Based Provider Partnership communications plan which is aligned to the system plan, and which sets out agreed key messages and supports joint messages around NHS provision;
- for Place-Based Provider Partnership Members to demonstrate how communication and engagement has influenced decision making and transformation design;
- data gathered from different stakeholders’ sources is distilled and deployed within formal governance arrangements;
- for stakeholders to be involved in making strategic decisions on behalf of communities; and
- for the Place-Based Provider Partnership to have strong relationships within the WY ICB and the Regional Team, ensuring engagement with the development of strategic and operational plans.

8.6 Workforce and Capacity principles

- be on track in the delivery of its capacity and capability maturity plan and to have confirmed capacity and capability arrangements required to safely host, on behalf of the Place-Based Provider Partnership, the contract with the WY ICB;
- enable the operational delivery of the Place-Based Provider Partnership Committee arrangement and undertake commissioning and contracting activities with the LA;
- ensure arrangements are in place for the teams and functions to transfer to the organisation(s) hosting the system and integrator function at the transition date of 1 April 2027;
- secure capacity and capabilities to the System Integrator via this Agreement with the WY ICB and other organisations where there are benefits in sharing existing partnership functions/joint ventures;
- establish a programme to align continuous improvement methodologies across partner organisations; and
- pool clinical governance.

8.7 Quality

In its role to arrange and deliver high quality care, the Place-Based Provider Partnership will ensure improving quality is a key outcome of system transformation through its collaborative arrangements with partners. Quality in a thriving partnership is:

- coordinated, person-centered and grounded in population health need;
- delivered through strong partnership working across NHS, Local Authority, health and care provision and VCSE organisations;
- focused on equitable access, experience, outcomes and reducing health inequalities;
- informed by lived experience insight and community voices triangulated with reliable quantitative data; and
- involves professionals, people and communities in planning, design, decision-making and evaluation to ensure accountability and improve experience of care.

The Place-Based Provider Partnership's approach to quality oversight, assurance and improvement needs to be consistent with the requirements of national guidance. Overarching quality functions will build on existing guidance from the National Quality Board and be set out in the forthcoming National Quality Strategy. There is an expectation, that can apply to the Place-Based Provider Partnership, that Providers will implement a Quality Management System (QMS) approach incorporating four key functions:

- Quality Planning – what do we need?

- Quality Control – what is our performance?
- Quality Improvement – what could be better and how do we get there?
- Quality Assurance – are we meeting standards?

Core responsibilities for each function are being developed for Regions, ICBs and service providers. Once published these will need to be reviewed and adapted for the Place-Based Partnership to identify which could be delegated from an ICB or be a shared responsibility with the ICB.

8.8 Embedding Quality in the Transitional Year

- develop a single understanding of quality, shared and visible across the Place-Based Provider Partnership;
- identify shared quality improvement priorities responding to unwarranted variation or quality concerns;
- redesign specific care pathways using evidence-based models, including relevant modern service frameworks when published, to improve outcomes and drive quality;
- conduct impact assessments in respect of quality, equality and health inequalities where service redesign or reconfiguration may be required;
- develop meaningful approaches to involve residents, communities, staff and stakeholders in shaping how services are designed, delivered and evaluated;
- evaluate impact of redesigned care pathways or reconfigured service delivery collecting relevant patient safety indicators, patient and staff reported experience, outcome measures and wider feedback and intelligence;
- agree and implement a Quality Management System for the Place-Based Provider Partnership which aligns to the WY ICB and NHS England Regional approach, including management of quality issues or concerns; and
- ensure Place Based Provider Partnership governance arrangements enable shared decision-making, transparency, and mutual accountability.

9. Values and Behaviours

The Parties are committed to abide by the following values:

- Honesty
- Integrity
- Ambition
- Mutual respect
- Be bold
- Develop unity
- Deliver what we say

The Parties agree to demonstrate the following behaviours, we:

- are leaders of our organisation, our Place and of West Yorkshire;
- support each other and work collaboratively;
- act with honesty and integrity, and trust each other to do the same;
- challenge constructively when we need to;
- assume good intentions; and
- will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

10. Building Recommendations and Making Decisions

The Place-Based Provided Partnership will meet to develop recommendations for the population and communities across their Place. Every recommendation made by the Place-Based Provider Partnership will be taken through their WY ICB Place Committee as referred to in Clause 13 (Arrangements and Accountability) below.

Each WY ICB Place Committee, established by the ICB have delegated authority to make decisions in accordance with the WY ICB Financial Scheme of Delegation (FSoD), Scheme of Reservation and Delegation (SoRD), Operational Scheme of Delegation (OSoD) and Standing Financial Instructions) SFIs.

11. Conflicts of Interest

Subject to compliance with Law and contractual obligations of confidentiality the Parties agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner. Parties must ensure compliance with the following:

- WY ICB Conflicts of Interest Policy; and
- NHS England Managing Conflicts of Interest in the NHS Guidance for Staff and Organisations (Published 7 February 2017; updated 17 September 2024)

The Parties agree to declare, in line with NHS guidance, any real or potential conflict of interest arising in connection with this Agreement as soon as they become aware of the same.

The Parties will:

- disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the operation of the Partnership governance immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person

employed or retained by them for or in connection with the performance of this Agreement;

- not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and
- use best endeavours to ensure that their appointed members also comply with the requirements of this Clause 11 as relevant when acting in connection with this Agreement.

12. Dispute resolution

The Parties commit at all times, to working cooperatively to identify and resolve issues to their mutual satisfaction to avoid all forms of dispute or conflict in performing their obligations under this Agreement. The Parties believe that by focusing on the Values and Behaviors set out in this Agreement and being collectively responsible for all risks will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this Agreement. The Parties agree to:

- seek solutions within a shared culture of 'no fault, no blame';
- seek to resolve any disputes in an open, amicable and communicative manner;
- treat each other as equal parties; and
- ensure, to the best of their ability, that their representatives on the Place-Based Provider Partnership comply with the terms and spirit of this Agreement above when acting within its remit.

If a problem, issue, concern or complaint comes to the attention of a Partner in relation to any matter in this Agreement such Partner shall notify the other Partners in writing. The Partners shall then try to resolve the issue in a proportionate manner within 20 Operational Days of written notification. If they are not able to do this, the matter will be resolved in accordance with **Schedule 1** (*Dispute Resolution Procedure*).

If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this Agreement (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act relating to this Agreement) the receiving Partner will liaise with the other Partners as to the contents of any response before a response is issued.

13. Arrangements and Accountability

The Place-Based Provider Partnership will be supported by the following WY ICB Place Committee, in discharging their purpose:

- Wakefield Health and Care Place-Based Provider Partnership: Wakefield Health and Care Partnership Committee

The WY ICB Place Committee remains accountable to WY ICB as set out in Clause 10 (Building Recommendations and Making Decisions) above.

Full details of the Placed-Based Provider Partnership can be found in the Terms of Reference set out in Schedule 2 to this MoU.

14. Endorsements

The Parties to this Agreement acknowledge and confirm that they have the necessary authorisation to enter into this Agreement and that its own Board, Cabinet and/or Governing Body has approved the content of this Agreement.

By signing this Agreement, the Place-Based Provider Partnership Members are setting forth their shared understanding and commitment to the values and behaviours set out above. This is not intended to be a legally binding Agreement, but rather a symbolic commitment to the Parties shared vision and a framework for collaborative working during the Transitional Year:

13.3 Signed by Members of the Wakefield Health and Care Provider Partnership

Organisation	Signature
Signed by [Job title] on behalf of General Practice (nomination to be led by Connexus)	
Signed by Lewis Smith-Connell [Job title] on behalf of Healthwatch Wakefield	
Signed by Brent Kilmurray CEO on behalf of Mid Yorkshire Teaching NHS Trust	

Organisation	Signature
Signed by Mark Brooks CEO on behalf of South West Yorkshire Partnership Teaching NHS Foundation Trust	
Signed by Tony Reeves Chief Executive on behalf of Wakefield Council	
Signed by Chief Executive on behalf of VCSE (nomination through Nova)	
Signed by Melanie Brown Accountable Officer for and on behalf of NHS West Yorkshire Integrated Care Board	

15. Definitions

Terms	Definitions
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in Schedule 1 for the resolution of disputes which are not capable of resolution under Clause 11 (Disputes Resolution).
FSoD	WY ICB Financial Scheme of Delegation
OSoD	WY ICB Operational Scheme of Delegation
Parties	Wakefield Health and Care Place Provider Partnership

Terms	Definitions
Place	The geographical level at which most of the work to join up health care services happens which is, for the purposes of this Agreement, Wakefield.
Place-Based Provider Partnership	Collaborative arrangements formed by organisations responsible for arranging and delivering care services in Places
SFIs	WY ICB Standing Financial Instructions
SoRD	WY ICB Scheme of Delegation and Reservation
Transitional Year	1 April 2026 to 31 March 2027
WY ICB	NHS West Yorkshire Integrated Care Board
WY ICB Place Committee	Wakefield Health and Care Partnership Committee

SCHEDULE 1: DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 11 (Dispute Resolution) prior to commencing this procedure.

The Partners believe that by focusing on their agreed Objectives and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the Partnership arrangements set out in this Agreement.

The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the Partnership (each a '**Dispute**') when it arises.

In the first instance the relevant Partners' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the relevant Partners. If the Dispute cannot be resolved by the relevant Partners' representatives within 10 Operational Days of the Dispute being referred to them, the Dispute shall be referred to senior officers of the relevant Partners, such senior officers not to have had direct day-to-day involvement in the matter and having the authority to settle the Dispute. The senior officers shall deal proactively with any Dispute on a Best for the Place-Based Provider Partnership basis in accordance with this Agreement so as to seek to reach a unanimous decision.

The Partners agree that the senior officers may, on a Best for the Place-Based Provider Partnership basis, determine whatever action it believes is necessary including the following:

- If the senior officers cannot resolve a Dispute, they may agree by consensus to select an independent facilitator to assist with resolving the Dispute; and
- The independent facilitator shall:
 - (i) be provided with any information he or she requests about the Dispute;
 - (ii) assist the senior officers to work towards a consensus decision in respect of the Dispute;
 - (iii) regulate his or her own procedure;
 - (iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and
 - (v) have its costs and disbursements met by the Partners in Dispute

equally.

- If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 3 and only after such further consideration again fails to resolve the Dispute, the Partners may agree to:
 - (a) terminate this Agreement in accordance with Clause 4 (Status of this Agreement); or
 - (b) agree that the Dispute need not be resolved.

SCHEDULE 2: WAKEFIELD PROVIDER PARTNERSHIP TERMS OF REFERENCE

Terms of reference

Wakefield Provider Partnership Shadow Committee [Joint Committee / Committee in Common]

Version control

Version: 0.5
Approved by: Provider Partner Members
Date Approved: [TBC]
Responsible Officer: Senior Provider Executive
Date Issued: [1 April 2026]
Date to be reviewed: [1 April 2027]

Change history

Version number	Changes applied	By	Date
0.1	Wakefield Provider Partnership	Sue Baxter, Head of Partnership Governance	10/12/25
0.2	Strengthen Health Inequalities	Mel Brown, Accountable Officer Wakefield Place and Sponsor Group Governance Lead	22/12/25
0.3	Final draft clean copy	Sue Baxter, Head of Partnership Governance	31/12/25
0.4	Inclusion of functions under attendees	Sue Baxter, Head of Partnership Governance	05/01/26
0.5	Final changes to draft ToR	Sue Baxter, Head of Partnership Governance	02/02/26

1. Purpose

This Committee is established for 2026/27 transitional year, as a shadow Committee of the Wakefield Health and Care Provider Partnership, to enable decisions to be built on Partnership business. With the aim of enabling the emergent Place Provider Partnership, together with all NHS Statutory Provider organisations and other health and care provider organisations to operate within Wakefield from 1 April 2026.

Approximately £100m will be in scope, including the following functions and services:

- oversight of mobilisation of Integrated Neighbourhood Health;
- reducing health inequalities;
- out of hospital NHS neighbourhood community services;
- community mental health services; and
- current ICB contracts with VCSE services (including Hospices).

2. Remit and responsibilities

The following responsibilities will fall under the remit of this Shadow Wakefield health and Care Provider Partnership Committee for a transitional year from 1 April 2026 until no later than the 31 March 2027. Shadow arrangements will cease once agreement on the Place Provider Partnership contract is reached and signed.

The remit of this Shadow Committee is to:

a) To make recommendations on behalf of Partners operating as Wakefield Health and Care Provider Partnership, in-line with NHS West Yorkshire ICB delegation of the following key areas of responsibility for the transitional year:

- i. develop recommendations regarding the future Wakefield Health and Care Provider Partnership approach, by no later than 1 April 2027;
- ii. develop joint working arrangements that embed collaboration as the basis for delivery, with NHS statutory provider partners within the place and with other provider partners, as well as the wider West Yorkshire (WY) Integrated Care System;
- iii. develop accountability arrangements and clear lines of report to the Health and Wellbeing Board, member Partner Boards and to the Shadow Committee;
- iv. oversee a structured due diligence exercise which includes a thorough assessment of financial, legal, operational and strategic factors to identify any potential risks or opportunities. Ensuring this exercise provides a robust evaluation and verification of accurate information in relation to the transferring functions prior to entering into a contract with the ICB for those functions;

- v. collaborate across Wakefield and ensure arrangements for complying with the Provider Self Assessment Framework / Readiness Checklist across NHS West Yorkshire ICB
- vi. be sighted on evolving arrangements for Integrated Neighbourhood Health services within Wakefield including risk sharing and / or risk pooling with other organisations (for example pooled budget arrangements under section 75 of the NHS Act 2006), for approval by this Shadow Committee;
- vii. arrange for the provision of health services, ensuring a focus on reducing health inequalities in-line with the allocated resources across Wakefield through a range of activities including:
 - a. oversee the agreement of contracts to secure delivery of the strategic goals and operational plans;
 - b. convene and lead major service transformation programmes to achieve agreed strategic outcomes working at scale at place, across Wakefield and across West Yorkshire, as appropriate;
 - c. sponsor the delivery of high quality and effective care shifting care delivering into integrated neighbourhood health services, aimed at tackling health inequalities whilst shifting more service provision out of hospital and into community, shifting from analogue to digital, and shifting from treatment to prevention;
 - d. work together with NHS West Yorkshire ICB **Integrator team** to:
 - work with partners to create the integrated neighbourhood health model;
 - oversee primary care operations and transformation; and
 - develop pathway and service development programmes.
 - e. sponsor new Provider service developments including support of GP practices working towards larger footprints with the development of new neighbourhood provider services (c50k) via single neighbourhood provider contracts. Work with PCNs/GP Federations over larger geographies (c250k population) via multi-neighbourhood provider contracts;
 - f. sponsor work 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; and
 - g. sponsor work with the Providers as a first order priority to move from hospital by default to digital-by-default.

b) To make recommendations on behalf of Partners operating as Wakefield Health and Care Provider Partnership, in line with NHS West Yorkshire ICB delegation, for the benefit of the patients, service users, carers and population

- i. establish governance arrangements to support collective accountability between partner organisations for Place Provider Partnership's system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations;
- ii. in the pursuit of earned autonomy for NHS providers, support NHS Trust member partners with achieving Foundation Trust (FT) status for a modern integrated health system and / or renewing FT status;
- iii. building on new/renewed FT status and earned autonomy, support NHS Provider Trusts with preparations to agree and sign Integrated Health Organisation (IHOs) contract, capable of receiving the resources (both revenue and capital);
- iv. agree a plan to meet the health and healthcare needs of the population within the Place Provider Partnership, having regard to health and care strategy and planning requirements and health and wellbeing strategy;
- v. allocate resources to deliver the plan, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital); and
- vi. sponsor and draw assurance from Place Provider Partnership's strategic and operational risk management approach.

3. Members

The Members of this Place Provider Partnership Shadow Committee are:

- Mid Yorkshire Teaching NHS Trust;
- NHS West Yorkshire ICB (Wakefield Place)
- Acute: Mid Yorkshire Teaching NHS Trust
- Mental Health: South West Yorkshire Partnership NHS Foundation Trust;
- Community: Mid Yorkshire Teaching NHS Trust
- VCSE * (nomination process to be agreed through Nova as the infrastructure organisation)
- General Practice (nomination process to be led by Connexus)
- Adult services: Adult Social Care, Wakefield Council
- Children's services: Children's Social Care, Family Hubs, Wakefield Council
- Public Health, Wakefield Council
- Healthwatch (alternative arrangements for citizen representation to be developed prior to Healthwatch being dis-established)

4. Attendees

The following individuals will be invited to attend each meeting of this Shadow Committee as Attendees. Attendees attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote. The Attendees are:

- Deputy Director of Integration;
- Shadow Committee Secretariate;
- Governance support;
- Communication support;
- Finance/Contracting support;
- Workforce support; and
- Business Intelligence support.

The Chair may invite such other Attendees to attend any meeting of this Shadow Committee as the Chair considers appropriate.

5. Deputies

Members will nominate a deputy to attend a meeting of the Shadow Committee that the Member is unable to attend. The deputy may speak and vote on their behalf.

6. Chair

The Chair of this Shadow Committee shall be a Senior Provider Executive. If the Chair is unable to attend, then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.

7. Quoracy

The quorum for meetings shall be three members, including at least one Provider Chief Executive and 50% of the membership. Recommendation on decisions to be made to NHS West Yorkshire ICB Board Place Committee will be reached by consensus wherever possible.

8. Frequency of meetings

This Shadow Committee will meet monthly, and papers shall be circulated at least five Working Days before the meeting. Any need for additional meetings at any time will be agreed by the members. Shadow arrangements during the transitional year

from 1 April 2026 to 31 March 2027, and will focus on implementation (phase two of development).

9. Urgent decisions

In the case of recommendations for an urgent decisions needed in extraordinary circumstances, every attempt will be made for this Shadow Committee to meet. Where it is not possible for the Shadow Committee to meet, a recommendation for an urgent decisions may be exercised by the Chair, with members, via email, in-line with quoracy section of these Terms of Reference.

10. Declarations of interest

All members are required to declare any actual or potential conflicts of interest in line with NHS guidance. A register of interests will be maintained.

11. Secretariat support

Secretariat support will be provided to this Shadow Committee by **[to be confirmed]**.

This will include:

- agreement of the agenda with the Chair;
- sending out agendas and supporting papers to Members and Attendees at least five Working Days before the meeting;
- taking minutes of the meetings, including an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward;
- drafting minutes for comment and approval by the Chair within five Working Days of the meeting. Following Chair's approval, distributing the minutes to all Members and Attendees within five Working Days of the approval. Updating minutes in accordance with any amendments agreed at subsequent meetings;
- maintaining an on-going list of actions, specifying the Member(s) responsible for each action, due dates, progress and completion;
- maintaining an annual work plan; and
- receiving notifications and requests on behalf of the Chair, including notifications relating to conflicts of interest, requests for meetings and/or nomination of deputies.

Notifications and requests to the Chair must be sent to [\[insert email of secretariate support\]](#).

12. Authority

All Members and Attendees will operate within the Calderdale, Kirklees and Wakefield Provider Partnership's Memorandum of Understanding and any other relevant policies or documents agreed by the Shadow Committee.

As the Shadow Committee is not authorised to commit finances on behalf of NHS West Yorkshire ICB, whilst operating in shadow, decisions will be taken by one of five ICB's place committees. Financial decisions can be built by the Shadow Committee and recommended to the relevant NHS West Yorkshire ICB Place Committee. Where the decision required has a value in excess of the place committee's limit of £20m the Shadow Committee shall make a recommendation to the place committee for escalation to the ICB's Board.

Note: decision taking will be carried out in-line with the ICB's Constitution, Scheme of Reservation and Delegation (SoRD), Standing Financial Instructions (SFIs), Financial Scheme of Delegation (FSOD), and Operational Scheme of Delegation (OSoD).

Fora reporting to this Shadow Committee are:

- [Alliances]
- [Mechanism for Public Voice]

13. Reporting

This Shadow Committee shall submit its minutes to NHS West Yorkshire ICB's place committee in Wakefield; to the Health and Wellbeing Board; to Wakefield Together Partnership; and to Partner Member Boards.

This Shadow Committee will receive for approval the minutes of meetings that report into it, as set out in the Authority section.

14. Review date

These terms of reference shall be reviewed by 31 March 2027 and annually thereafter.

15. Implementation

These terms of reference come into effect on 1 April 2026.

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