Public Document Pack

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Tuesday 14 July 2026

Notice of Meeting

Dear Member

Health and Adult Social Care Scrutiny Panel

The **Health and Adult Social Care Scrutiny Panel** will meet in the **Council Chamber - Town Hall, Huddersfield** at **2.00 pm** on **Wednesday 22 July 2026.**

This meeting will be webcast live and will be available to view via the Council's website.

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

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 Health and Adult Social Care Scrutiny Panel members are:-

Member

Councillor Akhtar Kasia (Chair)
Councillor Bill Armer
Councillor Brian Moughtin
Councillor Michael Simmons
Councillor Mark Smith
Councillor Sarah Wood
Helen Clay (Co-Optee)
Kim Taylor (Co-Optee)

Agenda
Reports or Explanatory Notes Attached

Pages

1: Membership of the Panel

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

2: Minutes of previous meeting

To approve the Minutes of the meeting of the Panel held on the 22nd April 2026.

3: Declaration of Interests

1 - 2

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

4: Admission of the public

Most agenda items take place in public. This only changes where there is a need to consider exempt information, as contained at Schedule 12A of the Local Government Act 1972. You will be informed at this point which items are to be recommended for exclusion and to be resolved by the Panel.

5: Deputations/Petitions

The Panel 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.

6: Public Question Time

To receive any public questions.

In accordance with Council Procedure Rule 11, the period for the asking and answering of public questions shall not exceed 15 minutes.

Any questions must be submitted in writing at least three clear working days in advance of the meeting.

7: Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS)

3 - 26

To receive a report on Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS).

Contact: Nicola Sylvester, Principal Governance and Democratic Engagement Officer.

8: Changes to the Integrated Care Board

27 - 82

To receive a report on changes to the Integrated Care Board (ICB) including Neighbourhood Health in Kirklees.

Members of the Children's Scrutiny Panel will be in attendance to consider this item.

Contact: Nicola Sylvester, Principal Governance & Democratic Engagement Officer.

9: Work Programme and Agenda Plan

83 - 92

To agree the Work Programme and Agenda Plan.

Contact: Nicola Sylvester, Principal Governance and Democratic Engagement Officer.

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KIRKLEES COUNCIL			
COUNCIL/CABINET/COMMITTEE MEETINGS ETC **DECLARATION OF INTERESTS** Health & Adult Social Care Scrutiny Panel			
Name of Councillor			
Item in which you have an interest	**Type of interest (eg a disclosable pecuniary interest or an "Other Interest")**	**Does the nature of the interest require you to withdraw from the meeting while the item in which you have an interest is under consideration? [Y/N]**	**Brief description of your interest**

Signed: …… **Dated:** ……

NOTES

Disclosable Pecuniary Interests

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

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

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

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

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

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

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

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

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

the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Kirklees COUNCIL

Report title: Myalgic Encephalomyelitis (ME)/Chronic Fatigue Syndrome (CFS)

Meeting	**Health and Adult Social Care Scrutiny Panel**
Date	**22 July 2026**
Cabinet Member (if applicable)	
Key Decision **Eligible for Call In**	**Not applicable**

Purpose of Report

To update members of the Health and Adults Social Care Scrutiny Panel on the Department of Health mandate for dedicated care plans for people with ME/CFS and how the 2021 NICE guidelines have been implemented across the ICB, trusts and Kirklees Council.

Recommendations

- To consider the information provided and determine if any further information or action is required,
- To note the current specialist, ME/CFA arrangements available to Kirklees residents,
- To note the January 2026 data identifying 1937 Kirklees residents with a recorded ME/CFS diagnosis or clinical read code,
- To note the actions undertaken to disseminate national guidance, referral information and progressional training resources
- To encourage closer collaboration across primary care, acute, community mental health, adults social care and specialist services to reduce gaps between organisational pathways.

Reasons for Recommendations

- To understand how the 2021 NICE guidelines and 2025 Department of Health and Social Care mandate have been implemented.

Resource Implication: N/A

Date signed off by <u>Executive Director</u> & name	N/A
Is it also signed off by the Service Director for Finance?	N/A
Is it also signed off by the Service Director for Legal and Commissioning (Monitoring Officer)?	N/A

Electoral wards affected: None specific

Ward councillors consulted: Not applicable

Public or private: Public

Has GDPR been considered? Yes. The report does not include any personal data that identifies an individual.

1. Executive Summary

ME/CFS is a complex, chronic and potentially disabling condition. Its severity varies considerably.

In February 2026, the Kirklees Health and Adults Social Care Scrutiny Panel agreed for an informal session with the Kirklees and Calderdale ME Support Group to consider information raising systemic failings.

The Scrutiny Panel agreed to request information to issues raised, and subsequently wrote to the Integrated Care Board requesting detailed information about their protocols for treating and accommodating people with ME along with inviting

A report and appendix has been provided which responds to questions raised, along with an overview of current arrangements for people living with ME/CFS in Kirklees.

2. Information required to take a decision

Not applicable.

3. Implications for the Council

Not applicable.

3.1 Council Plan

No specific implications.

3.2 Financial Implications

No specific implications.

3.3 Legal Implications

No specific implications.

3.4 Other (e.g. Risk, Integrated Impact Assessment or Human Resources)

No specific implications.

Integrated Impact Assessment (IIA)

No specific implications.

4. Consultation

Not applicable.

5. Engagement

Not applicable.

6. Options

Not applicable.

6.1 **Options Considered**

Not applicable.

6.2 **Reasons for recommended Option**

Not applicable.

7. Next steps and timelines

That the Health and Adults Social Care Scrutiny Panel takes account of the information presented and considers the next steps it wishes to take.

8. Contact officer

Nicola Sylvester, Principal Governance and Democratic Engagement Officer
Nicola.sylvester@kirklees.gov.uk

9. Background Papers and History of Decisions

Not applicable

10. Appendices

Attached

11. Service Director responsible

Samantha Lawton – Service Director, Legal, Governance and Commissioning.

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Kirklees Health and Adult Social Care Scrutiny Committee

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS): Local Provision, Implementation of National Guidance and Service Assurance

Report of: NHS West Yorkshire Integrated Care Board and system partners
Date: July 2026
Purpose: For information, assurance and scrutiny

1. Purpose of the Report

This report responds to questions raised by the Kirklees Health and Adult Social Care Scrutiny Committee concerning:

- implementation of the 2021 NICE guideline for ME/CFS and the July 2025 Department of Health and Social Care national plan;
- commissioned specialist ME/CFS provision;
- waiting times for assessment, diagnosis and specialist support;
- the number of Kirklees residents diagnosed with ME/CFS and Long COVID, or awaiting assessment;
- engagement with the Kirklees & Calderdale ME Campaign group;
- workforce training; and
- identification and support of people with severe and very severe ME/CFS.

This report provides an overview of the current arrangements for people living with Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) in Kirklees. It draws together information provided by NHS West Yorkshire Integrated Care Board (ICB), Kirklees place-based commissioning and primary care, local NHS provider organisations, the Leeds and West Yorkshire specialist ME/CFS service and wider public health provision.

ME/CFS is a complex, chronic and potentially disabling condition. Its severity varies considerably. Some people can maintain aspects of daily life with appropriate support, while others with severe or very severe ME/CFS may be substantially housebound or bedbound and require highly individualised and flexible care.

2. Executive Summary

ME/CFS is a complex, chronic and potentially disabling condition. People may experience a wide spectrum of severity, from those able to maintain some daily activities with appropriate support to people with severe or very severe ME/CFS who may be substantially housebound or bedbound.

Kirklees does not have a separately commissioned specialist ME/CFS service located within the district. Kirklees residents have access to the regional Leeds and West Yorkshire specialist ME/CFS service, commissioned for the West Yorkshire population.

Following national guidance updates, information was circulated to primary care and GP practices in Kirklees. This included updated NICE guidance, referral information, required investigations and diagnostic tests, annual review guidance, patient education and support materials, and information about reasonable and practical adjustments.

Kirklees ICB also promoted three NHS England and Royal College of General Practitioners-approved ME/CFS e-learning modules. However, comprehensive data on the proportion of staff completing this training are not currently held.

Data supplied by the place-based ICB data team in January 2026 identified 1,837 Kirklees residents with a recorded diagnosis or clinical read code for Myalgic Encephalomyelitis or Chronic Fatigue Syndrome. There is not currently a comprehensive validated figure for residents diagnosed with Long COVID, people with both conditions, or those awaiting ME/CFS assessment.

Kirklees-specific waiting-time information is not currently available at place level because referrals are made directly to the specialist service. Current waiting-list and waiting-time data should therefore be obtained from the specialist provider.

Engagement has taken place between West Yorkshire representatives, the specialist ME/CFS service and the Kirklees & Calderdale ME Campaign group, with a series of meetings identified between February 2025 and March 2026.

The information gathered demonstrates existing provision and activity but also identifies opportunities to strengthen system-wide assurance, particularly in relation to waiting-time data, workforce training uptake, implementation monitoring, and coordinated support for people with severe and very severe ME/CFS.

3. Response to the Committee's Questions

3.1 Actions taken in response to the 2021 NICE guideline and July 2025 national plan

NHS West Yorkshire ICB commissions services with the expectation that care is delivered in accordance with relevant national guidance, including NICE Guideline NG206, published in October 2021.

Following relevant national updates, the NHS West Yorkshire ICB Medical Director circulated information to acute and mental health trusts. At Kirklees place level, an update and notification was circulated to all primary care and GP practices through established communication routes.

The information provided to primary care included:

- updated NICE guidance for clinicians;
- links to the Leeds and West Yorkshire specialist ME/CFS service;
- referral information, including an updated referral form and details of investigations and diagnostic tests required to support referral;
- annual review guidance for patients with ME/CFS, including management information;
- updated patient education and support information that can be downloaded and shared;
- links to other professional resources and support organisations; and
- information on reasonable and practical adjustments that primary care services can make for people with ME/CFS.

Kirklees ICB also continues to circulate pathway and referral updates received from the specialist service, with referral guidance most recently updated in May 2026.

At Calderdale and Huddersfield NHS Foundation Trust (CHFT), the 2021 NICE guidance was previously reviewed and, given the passage of time and changes in medical personnel, a further review is being undertaken within the Integrated Medical Specialties directorate. The Department of Health and Social Care plan was reviewed by the Trust's Executive Board in July 2025, and CHFT reports that it considers itself well placed in relation to delivery and is progressing relevant work.

Mid Yorkshire Teaching NHS Trust (MYTT) has advised that its Rheumatology and Neurology services do not receive referrals for the diagnosis or management of ME/CFS and do not implement specialist ME/CFS treatment plans. It has therefore not undertaken specific implementation activity relating to specialist service recommendations, with suspected ME/CFS generally managed through primary care and referral to the regional specialist service where appropriate.

The available evidence demonstrates dissemination of guidance and referral information and some organisational review activity.

3.2 Commissioned specialist provision

There is no separately commissioned specialist ME/CFS service located within Kirklees.

Kirklees residents have access to the Leeds and West Yorkshire specialist ME/CFS service commissioned for the West Yorkshire population.

The specialist service provides assessment, clinical advice, personalised management planning, symptom and energy management support and multidisciplinary input where appropriate, for eligible residents across the West Yorkshire ICB area, including Kirklees. It accepts referrals for people across the spectrum of ME/CFS severity.

Primary care clinicians can refer patients directly to the specialist service in accordance with the referral pathway. Kirklees ICB circulates pathway and referral guidance updates to GP practices.

CHFT has also confirmed that where patients require specialist ME/CFS care, its pathway is to refer onwards to the regional specialist service. The Trust notes that ME/CFS can present across multiple specialties and is not owned by one individual hospital specialty.

The commissioned specialist pathway is expected to operate in accordance with NICE NG206

3.3 Waiting times

Kirklees place-based ICB does not directly hold waiting-time information for specialist ME/CFS assessment and support. GP practices and clinicians refer directly to the regional specialist service, and relevant referral and waiting-list information is therefore held by individual practices and/or the specialist service provider.

MYTT similarly does not hold comprehensive information on waiting times because it does not provide or manage the specialist ME/CFS service.

CHFT has advised that it cannot quantify ME/CFS-specific referral information before diagnosis from its available data. Where specialist ME/CFS input is required, patients can be referred to the regional specialist service.

Consequently, the information currently available does not provide Kirklees-specific figures for:

- time from presentation to diagnosis;
- time from referral to specialist assessment;
- the number of people currently waiting;
- median or longest waits; or

3.4 Number of residents diagnosed or awaiting assessment

Data supplied by the place-based ICB data team in January 2026 identified **1,837 people registered in Kirklees with a diagnosis or clinical read code for Myalgic Encephalomyelitis or Chronic Fatigue Syndrome**.

For comparison, the corresponding figures provided were:

- Calderdale: 1,075;
- Kirklees: 1,837;
- Wakefield: 1,517; and
- total across these three areas: 4,429.

The Kirklees figure represents people identified through recorded diagnosis/read-code data and provides a more specific local measure than the earlier prevalence estimate of approximately 940–1,880 residents.

However, this does not necessarily represent every person living with ME/CFS. Differences in coding, people who remain undiagnosed and individuals currently undergoing assessment may affect the total.

The information currently available does not provide a validated figure for:

- Kirklees residents diagnosed with Long COVID;
- people diagnosed with both Long COVID and ME/CFS; or
- people awaiting ME/CFS assessment or diagnosis.

MYTT has confirmed that any ME/CFS figures derived solely from its hospital activity would represent only a subset of the wider population and could therefore be misleading.

CHFT reported 957 inpatient episodes since April 2023 involving patients who had an ME diagnosis recorded, although only three had ME as the primary diagnosis. These are episodes of care rather than a count of unique Kirklees residents and should not be interpreted as prevalence data. CHFT also identified 95 Kirklees patients with an ME diagnosis who had been seen in a Neurology outpatient setting over the period covered by its data.

3.5 Engagement with the Kirklees & Calderdale ME Campaign group

Engagement has taken place between West Yorkshire representatives, the specialist ME/CFS service and representatives of the Kirklees & Calderdale ME Campaign group.

Meetings or discussions were identified on:

- 3 February 2025;
- 14 April 2025;
- 9 June 2025;
- 14 July 2025;
- 13 October 2025;
- 8 December 2025;
- 12 January 2026; and
- 16 March 2026.

An ME/CFS plan was also recorded as completed on 9 June 2025.

Kirklees place-based ICB representatives have not directly held separate engagement sessions with the campaign group. However, through updates at the West Yorkshire Mental Health, Learning Disability and Autism commissioning forum, Kirklees representatives were aware of engagement involving West Yorkshire programme representatives and the specialist service provider.

In communications to GP practices, Kirklees ICB also advised that the Kirklees and Calderdale patient group had offered support and advice to practices undertaking in-house educational activity and provided contact details for this purpose.

CHFT has advised that there are currently no scheduled meetings with the campaign group but that it is open to increasing awareness of ME/CFS within the Trust, including through internal communications and promotion of relevant community awareness activity.

The specialist service also operates a bi-monthly patient forum through which people who have received care from the service can contribute to discussions about service development and future improvement.

3.6 Workforce training

Kirklees ICB promoted three NHS England and Royal College of General Practitioners-approved e-learning modules:

1. Introduction to ME/CFS;
2. Guidance for community-based healthcare practitioners; and
3. Managing severe ME/CFS.

Practices were advised that completion could contribute towards continuing professional development requirements.

Primary care also received updated NICE guidance, referral information, annual review guidance, patient information and advice concerning reasonable and practical adjustments.

In addition, primary care received updated NICE guidance, specialist referral information, annual review guidance, patient information and advice concerning reasonable and practical adjustments for people with ME/CFS.

However, Kirklees ICB does not hold comprehensive completion data and cannot currently provide the proportion of relevant staff who have completed ME/CFS-specific training.

MYTT does not currently provide bespoke ME/CFS training and does not hold completion data for ME/CFS-specific education.

3.7 Severe and very severe ME/CFS

People with severe and very severe ME/CFS may be housebound or bedbound and can experience substantial limitations affecting mobility, communication, self-care and access to healthcare.

The regional specialist service accepts referrals for people across all levels of ME/CFS severity and offers both outpatient and community assessments and if required an inpatient service.

Potential support across the wider system includes specialist advice, remote consultations, coordination with primary care, community support, reasonable adjustments, personalised symptom and energy management and other health and

care support according to individual need. Support across the wider system may include:

- specialist assessment and advice;
- remote or telephone consultations where appropriate;
- coordination with primary care;
- community-based support;
- home visits where clinically appropriate and available;
- reasonable and practical adjustments to accessing primary care;
- personalised symptom and energy management;
- occupational therapy, physiotherapy or other community support where clinically appropriate; and
- support for associated physical or mental health needs.

Kirklees public health provision that may provide wider support includes the Wellness Service, social prescribing and Community Champions.

South West Yorkshire Partnership NHS Foundation Trust supports people in relation to mental health needs and co-morbidities but does not operate an internal ME/CFS diagnostic pathway. It has identified the potential benefit of closer working between physical and mental health pathways to provide more coordinated and holistic care.

MYTT does not operate a dedicated ME/CFS pathway or maintain a register of people with severe or very severe ME/CFS. Its Rheumatology and Neurology services do not routinely diagnose or manage the condition, with suspected cases generally managed in primary care and referred to specialist services where appropriate.

CHFT similarly recognises the regional specialist service as the specialist hub for Kirklees patients requiring dedicated ME/CFS expertise.

4. Recommendations

The Committee is asked to:

1. **Note** the current specialist ME/CFS arrangements available to Kirklees residents.
2. **Note** the January 2026 data identifying 1,837 Kirklees residents with a recorded ME/CFS diagnosis or clinical read code.
3. **Note** the actions undertaken to disseminate national guidance, referral information and professional training resources.
4. **Encourage** closer collaboration across primary care, acute, community, mental health, adult social care and specialist services to reduce gaps between organisational pathways.

5. Conclusion

Kirklees residents have access to a regional specialist ME/CFS service, supported by primary care and wider health, community and public health services. There has been significant dissemination of updated guidance and referral information to

primary care, access to nationally approved professional training, and ongoing engagement between the specialist service, West Yorkshire representatives and the Kirklees & Calderdale ME Campaign group.

The January 2026 primary-care data identifying 1,837 Kirklees residents with an ME/CFS diagnosis or read code provides an important indication of the scale of local need.

A key theme emerging from the information provided is that ME/CFS care crosses organisational and professional boundaries. Continued collaboration between commissioners, primary care, acute and community providers, mental health services, adult social care, the specialist ME/CFS service and people with lived experience will therefore be important in ensuring that Kirklees residents receive accessible, coordinated and person-centred care.

LYPFT

Leeds and West Yorkshire ME/CFS Service - Response to ICB Information Request

(For onward submission to Kirklees Health and Adults Social Care Scrutiny Panel)

Service Overview

Leeds and York Partnership NHS Foundation Trust (LYPFT) host a specialist ME/CFS service covering Leeds and the wider West Yorkshire area. The service provides assessment, diagnosis, and specialist management in line with current NICE guidance.

Question 1: Actions taken regarding the 2021 NICE Guidelines and July 2025 DHSC Delivery Plan

NICE Guideline (NG206, 2021) Implementation

The service undertook a comprehensive review of its compliance with NICE Guideline NG206 (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Diagnosis and Management), reviewing 119 relevant recommendations. We found that 97% of relevant recommendations are fully met, with the remaining recommendations either partially met or not applicable to the service remit.

Areas of strong compliance included holistic assessment, multidisciplinary working, personalised care planning, energy management, symptom management, support for severe ME/CFS, carer involvement, and provision of specialist advice to primary care. The small number of partially achieved recommendations largely relate to areas outside the service's direct responsibility (particularly primary care reviews and investigations), or practical implementation challenges such as providing resources in multiple languages and accessible formats, where a case-by-case approach has been adopted.

Since the previous review, the action tracker has been updated to reflect service developments, including the re-establishment of the severe ME/CFS pathway, updates to guidance and training resources, and the removal or revision of actions relating to COVID-19. Overall, the review demonstrates a high level of alignment with NICE guidance and a strong commitment to continuous service improvement.

Areas of strong compliance included:

- Multidisciplinary care delivery
- Holistic assessment and personalised management approaches
- Energy management (pacing) as a core intervention
- Avoidance of graded exercise therapy in line with NICE guidance
- Provision of flexible, accessible care (including remote consultations and home visits where appropriate)

Evidence:

- Attached

Primary Care Guidance

The service updated its Primary Care Guide, incorporating:

- NICE diagnostic criteria
- Management approaches focused on energy management (pacing)
- Clear guidance on cautions regarding graded exercise therapy

This guidance is publicly available via our website:

https://www.leedsandyorkpft.nhs.uk/our-services/leeds-and-west-yorkshire-myalgic-encephalomyelitis-me-and-chronic-fatigue-syndrome-cfs-service-primary-care-guide/

Dr McKeever, GPwSI working within the LYPFT ME/CFS service contributed directly to the Department of Health and Social Care ME/CFS Delivery Plan.

DHSC Delivery Plan Response

Following publication of the Department of Health and Social Care ME/CFS Delivery Plan (2025), the Leeds and West Yorkshire ME/CFS Service reviewed the plan against current service provision and development priorities. The review identified substantial alignment between the Delivery Plan priorities and existing service activity. While many of the initiatives described below were established prior to publication of the Delivery Plan, they directly support its aims relating to research, education and awareness, service accessibility, co-production, and support for people living with ME/CFS. Future service development work will continue to be informed by the Delivery Plan

The Leeds and West Yorkshire ME/CFS Service supports the aims of the Department of Health and Social Care's 2025 ME/CFS Delivery Plan through ongoing work across the key themes of research, education and awareness, and improving the lives of people living with ME/CFS.

Research

As part of Leeds and York Partnership NHS Foundation Trust, the service contributes to an organisation that has made a strategic commitment to embedding research within clinical practice. The Trust's Research and Development Strategy aims to place research at the center of organisational activity, recognising its role in improving quality of care, patient outcomes and service development. The Trust's stated objective is to develop and deliver high-quality research for the communities it serves.

The ME/CFS team actively supports the development and dissemination of research within the field. Team members regularly attend national conferences and professional events to remain up to date with emerging evidence, including attendance and presentations at the BACME Annual Conference and attendance at the International Post-Infectious Conditions (IPIC) Conference.

The service has recently been approached regarding potential future research into sleep and ME/CFS and is awaiting further information.

One team member is currently undertaking a research internship exploring the lived experience of people with ME/CFS who are also neurodivergent, whilst another is undertaking a Clinical MSc Programme commencing in September 2026 with the intention of developing future research focused on clinical interventions for people with severe and very severe ME/CFS.

Many members of the team are active members of BACME. Team members also contribute to wider professional research and development through membership of professional networks, including Royal College of Occupational Therapists specialist forums relating to long-term conditions and fatigue.

Attitudes and Education

The service is committed to improving understanding of ME/CFS amongst healthcare professionals, support services, patients, carers and the wider community.

The service GPwSI regularly delivers teaching and training sessions both locally and nationally. This includes education for GPs, acute medical teams, neurologists, infectious disease physicians, rehabilitation medicine clinicians, and other healthcare professionals. Recent teaching has included presentations on hormones, hypermobility and ME/CFS to the Yorkshire Family Planning Primary Care Group. The GPwSI has also facilitated peer learning and support groups for doctors working within ME/CFS services.

In addition, the GPwSI is leading BACME's national tube-feeding project for people with ME/CFS, with publication anticipated later this year.

Members of the MDT have delivered teaching sessions to occupational therapists, physiotherapists, and multidisciplinary teams working with people with ME/CFS and related fatigue conditions. The service is currently developing educational links with Leeds Mental Wellbeing Service and Leeds Teaching Hospitals NHS Trust Neurorehabilitation Services to further improve understanding of ME/CFS across healthcare settings.

The service also contributes to workforce development by providing regular placement opportunities for Occupational Therapy and Nursing students. Work is underway to develop a specialist leadership and innovation placement for MSc Occupational Therapy students.

Education and consultation are also provided to care agencies supporting people with severe and very severe ME/CFS.

Living with ME/CFS

Service development is informed through patient feedback and co-production activities. The service has an established patient forum and is developing a co-design subgroup to support service-level improvement projects.

The service maintains an extensive library of written resources and is collaborating with other ME/CFS services to develop accessible video-based resources and workbooks informed by patient feedback.

The service provides specialist ME/CFS support across West Yorkshire. Most assessments and interventions are delivered remotely, reflecting patient preference. Feedback highlights reduced energy expenditure associated with travel, greater flexibility around work and childcare commitments, and easier management of symptoms during appointments. Home visits are available where required.

The service has an established pathway for people with severe and very severe ME/CFS, providing flexible assessment and intervention approaches, including home visits, adapted assessments and extended intervention timeframes.

Supporting participation in education and employment is a routine component of the therapeutic pathway. Vocational rehabilitation approaches are routinely used, and the team regularly provides supporting information regarding reasonable adjustments.

Summary

The service demonstrates strong alignment with the priorities set out in the 2025 ME/CFS Delivery Plan through its commitment to research engagement, professional education, co-production, accessible information, support for severe and very severe ME/CFS, service accessibility, and support for participation in education and employment.

Delivery Plan Theme	Priority Area	Current Service Activity
Research	Research engagement	Conference attendance and presentations at BACME and other related conferences such IPIC.
	Research activity	OT research internship exploring ME/CFS and neurodivergence; Lead OT commencing MSc with plans for future severe ME/CFS research.
	Research culture	Culture is supported and fostered by the wider trust and their commitment to embed this organisational planning. Team members' active participation in professional forms such as BACME and RCOT. On-going service evaluation and quality improvement projects.
Attitudes & Education	Professional education	Teaching provided to GPs, acute medicine, neurology, rehabilitation, AHPs, and primary care teams.
	Supporting wider services	Advice and education provided to care agencies and partner services supporting people with ME/CFS.
	Workforce development	Regular OT and Nursing student placements; development of a specific leadership and

		innovation OT placement to be made available in the service
	Regional and national contribution	Participation in BACME, regional ME/CFS and long covid networks, forums and national specialist interest groups.
Living with ME/CFS	Co-production	Established patient forum, co-production training, mentorship and development of a co-design group.
	Accessible information	Written resources available by post and email; development of video resources and workbooks in response to patient feedback and co-design priorities.
	Access to services	West Yorkshire-wide specialist service; predominantly remote delivery based on patient preference; home visits available on severely affected pathway.
	Severe and Very Severe ME/CFS	Dedicated pathway offering flexible assessment, home visits, adapted approaches and ongoing pathway evaluation.
	Education and employment	Vocational rehabilitation, education support, advice regarding reasonable adjustments, and supporting letters.

Question 2: Details on any commissioned speciality ME services that meet NICE requirements

LYPFT hosts a commissioned specialist ME/CFS service for Leeds and West Yorkshire.

The service is structured to meet NICE NG206 requirements, including:

- Specialist multidisciplinary assessment
- Individualised management plans
- Support for varying severity levels

Full service details are available here:

https://www.leedsandyorkpft.nhs.uk/our-services/leeds-and-west-yorkshire-myalgic-encephalomyelitis-me-and-chronic-fatigue-syndrome-cfs-service-primary-care-guide/

Question 3: Waiting times for assessments, diagnosis, and specialist support – (from Kirklees)

Service Demand (Context)

The ME/CFS service is managing high and sustained referral volumes across West Yorkshire, which is an important factor when considering access and waiting times.

Between November 2025 and June 2026, the service received approximately 95-100 referrals per month on average, with a peak of 137 referrals in March 2026.

Acceptance rates vary month-to-month following clinical triage.

Kirklees-Specific Demand

Referrals from Kirklees are consistently received each month, ranging from:

- 13 to 29 referrals per month in last 6 months

This demonstrates a steady and ongoing demand for specialist ME/CFS provision from the Kirklees population.

Waiting times for assessments, diagnosis, and specialist support

Current Waiting Times

- The current waiting time for initial assessment is approximately 11 months from receipt of referral. Following assessment service users diagnosed with ME/CFS are typically offered a place in therapy pathway within 4 weeks.

Service Context and Improvement Work

- The service is managing high levels of demand across West Yorkshire, with referral numbers remaining consistently high. This demand has contributed to extended waiting times for initial assessment. The service continues to review its pathways and delivery models to ensure available resources are used as effectively as possible, whilst maintaining compliance with NICE guidance and preserving the quality and individualised nature of the specialist support provided. Whilst service improvements may support efficiencies and improvements in patient flow, waiting times are also influenced by the level of demand for specialist ME/CFS services across the region relative to the capacity available within the service.

Summary

Waiting times apply equally across the region, including Kirklees

While there is a long wait for initial assessment, access to therapeutic interventions following assessment is relatively prompt

Question 4: Engagement with Kirklees & Calderdale ME Campaign Group

This question will be primarily addressed by the ICB.

However, locally:

- Members of the LYPFT ME/CFS service have undertaken engagement activity with the Kirklees & Calderdale ME Campaign Group. This has included communication and involvement in discussions relating to service development and patient experience.
- Leeds and West Yorkshire ME/CFS service has had a service user forum for many years. This provided a space for previous service users to catch up with each other, learn and support developments within the service and offer their feedback and support to the service as able. We have many members who attend from all over West Yorkshire. We have several members of the Kirklees and Calderdale ME Support Group who have attended the service user forum for several years.
- Since coming into role, our Lead occupational therapist, Katie Agnew, has been working with the exiting members to develop the forum, with the aim of extending the space to further support lived experience and inform co-design. When the new format was first introduced – we met with the Kirklees and Calderdale support group leaders in Autum 2025, as they wished to discuss a number of specific issues that we felt was not on the agenda and would not be given the time to explore appropriately in the next forum. This was a valuable opportunity to strengthen relationships, answer their questions, provide updates on the service model, and gain a better understanding of the work they have been undertaking within their local communities. During this meeting, we discussed their concerns that patients from Leeds were being prioritised over those living elsewhere in West Yorkshire. We were able to reassure them that this was not the case and explained our service model, including our predominantly remote delivery approach as well equity on service provision and wait times. Feedback from most patients has indicated a preference for remote appointments, as they can be more easily adapted around fluctuating symptoms and reduce the practical challenges associated with travel, work, education, and caring responsibilities. We also discussed the severely affected pathway, which serves patients across the whole of West Yorkshire and includes home visits where clinically required. In addition, they were eager to understand our approaches to ME/CFS and were explained the dysregulation model that underpins our clinical approach, complementing our therapy-led rehab approach.
- We met again in March 2026, where discussions focused on their ongoing engagement with the Integrated Care Board (ICB). We reviewed the NHS England Delivery Plan and the NICE guidelines and discussed how the service is working to align with both. We also discussed the introduction of a co-design element within the patient forum. It was explained that the initial focus would be on service-level developments and improvement projects. At the same time, we recognised and supported the Kirklees and Calderdale group's broader

discussions with the ICB and welcomed opportunities for them to share relevant updates through the forum. One of the of the Kirklees and Calderdale group attended the first co-design forum in April, where a wide range of ideas and potential service improvements were discussed between new and older members. Unfortunately, these forums were temporarily paused due to organisational decisions within the Trust and have not taken place since April. However, we are hopeful that they will recommence in late summer or early autumn.

- We very much welcome continued engagement with the Kirklees and Calderdale ME Support Group. We are keen for the Leeds and West Yorkshire ME/CFS service user Forum to be recognised primarily as a co-design and service development group for current and former service users. Individuals who wish to become involved in broader advocacy activities will be signposted to local support organisations, including the Kirklees and Calderdale ME Support Group, whose leadership team has been highly supportive in facilitating patient involvement across West Yorkshire.

Question 5: Training provided on ME and proportion of staff who have completed

NHSE E-learning Module

The service is aware of the new NHSE ME/CFS e-learning modules

Implementation approach:

- All new staff joining the service are to complete these modules

- Existing staff (with prior expertise and up-to-date knowledge) are encouraged but not required, as we have established staff who are already ahead in terms of the skills and competencies taught in these modules. As this e-learning is designed for general clinicians working with people with ME, not specialists in ME/CFS. We as a specialist team provide training on it ourselves. Despite this some established staff members have completed the training voluntarily.

Internal Staff Training

The service has:

A structured induction programme for all new staff

Weekly educational sessions embedded within team practice

Staff are expected to:

Maintain up-to-date knowledge through continuing professional development (CPD)

Use protected learning time for this purpose. Our team are supported by the service and the Trust to attend external training courses and events with a feedback loop into the education sessions, so learning is up to date and shared across the team.

Training Provided to Non-Specialists

Delivering education externally is a key component of the service's role, aligning with priorities in the DHSC Delivery Plan.

Examples include:

Training delivered by Dr McKeever our service GPwSI to a range of medical and other clinicians, e.g. recent training to Acute Medical Team (St James's University Hospital), to regional network of Neurologists, Infectious Diseases physicians and Rehabilitation Medicine specialists and GP training schemes (VTS).

We have also provided training to care agencies to help them understand severe ME/CFS and how these impacts on people and how to approach working with this service user group.

Dr McKeever is currently Project Lead for a BACME project investigating tube feeding provision in ME/CFS

Question 6: How people with severe and very severe ME identified and supported (from Kirklees)

Patients with severe or very severe ME/CFS are identified through information provided at referral, screening prior to assessment and initial clinical assessment

The service has a specific pathway for patients with severe presentations, including:

- Modified assessment processes
- Flexible approaches to care delivery, including Session timing, Mode (e.g. virtual, telephone) and reduced sensory/cognitive burden

Enhanced Support

- Involvement of family/carers, where appropriate and with patient consent
- Home visits, where clinically indicated and within catchment
- Access to a dedicated MDT forum for discussion of severe cases

This ensures care is tailored to the complexity and vulnerability of this group.

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Appendix 2

Information provided by Healthwatch Kirklees and Calderdale

Kirklees and Calderdale Healthwatch have previously worked with the ME campaign group in Kirklees and Calderdale since approx. 2018 onwards relating to:

- We spoke to the support group about their experiences of services – resulting in their feedback being shared across decision makers and NHS managers in our intelligence reports
- We have hosted surveys that the group wanted to collect data around and provided them with the raw data so they can continue to champion their support group
- We recorded some of their stories so that services could understand the challenges raised
- We supported the group to meet with (at the time) CCG leaders and CHFT leaders to share the concerns they had and also discuss how pathways for treatment might be arranged differently
- We supported them by sharing CPD and training offers about M.E with GP colleagues in Kirklees and Calderdale
- Healthwatch completed a NICE guidance roundtable event on behalf of M.E support groups (this was a partners only event not public) to share what we had learnt from the M.E Group
- We raised their concerns as evidence when the NICE guidance review was completed – this was around graded exercise therapy and the toll it can take getting to the appointments – this has now been reviewed by NICE and removed or the specification has now been amended in NICE guidance
- We connected the M.E group into the university so that their experiences could be shared as part of their health and social care offer to students

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Report title: Changes relating to Integrated Care Board

Meeting	**Health and Adult Social Care Scrutiny Panel**
Date	**22 July 2026**
Cabinet Member (if applicable)	
Key Decision **Eligible for Call In**	**Not applicable**

Purpose of Report

To provide members of the Health and Adults Social Care Scrutiny Panel with an update of the changes that relate to Integrated Care Board (ICB)

Recommendations

- Note the contents of the report provided by representatives of the West Yorkshire Integrated Care Board.
- Consider the implications of the proposed changes for Kirklees residents, patients and stakeholders and identify any areas requiring further scrutiny.
- Recommend to the Overview and Scrutiny Management Committee that a statutory Calderdale, Kirklees and Wakefield Joint Health Overview and Scrutiny Committee be established to scrutinise matters that affect populations across the three local authority areas.
- Recommend that the Chair of the Health and Adults Social Care & Children's Scrutiny Panels are appointed as Kirklees Council's representative as members with necessary expertise in line with Kirklees constitution on the Joint Health Overview and Scrutiny Committee, subject to approval by the Overview and Scrutiny Management Committee.
- Recommend that Calderdale Council and Wakefield Council consider making equivalent arrangements to enable the establishment of a statutory joint scrutiny committee.

Reasons for Recommendations

- Members receive appropriate assurance regarding the proposed changes to Integrated Care Board functions, governance, accountability and funding arrangements
- There is effective democratic oversight of health services and commissioning decisions that affect residents across more than one local authority area.
- Scrutiny arrangements remain proportionate to the scale and complexity of the emerging NHS structures.
- Councils can work collaboratively where decisions, services and outcomes extend beyond local authority boundaries
- The interests of Kirklees residents continue to be represented within future health governance and accountability arrangements.

Resource Implication: N/A

Date signed off by <u>Executive Director</u> & name	N/A

Is it also signed off by the Service Director for Finance?	N/A
Is it also signed off by the Service Director for Legal and Commissioning (Monitoring Officer)?	N/A

Electoral wards affected: None specific

Ward councillors consulted: Not applicable

Public or private: Public

Has GDPR been considered? Yes. The report does not include any personal data that identifies an individual.

1. Executive Summary

The Health and Adults Social Care Scrutiny Panel has requested an update on the significant changes taking place within the NHS, including the reduction in Integrated Care Board (ICB) running costs, changes to governance arrangements, and the emerging operating model for health services across Kirklees. The Panel has previously identified this as a priority area for scrutiny due to the potential implications for local accountability, partnership working, commissioning arrangements, and the delivery of health services within Kirklees.

The report provides Members with an overview of the current position, the proposed future arrangements for the Kirklees Place Provider Partnership and the Integrated Neighbourhood Health Teams, and the implications for Kirklees residents, partners and stakeholders. It also outlines how local influence, oversight and accountability will be maintained as responsibilities and structures evolve.

Members are invited to consider whether enhanced joint scrutiny arrangements should be established with neighbouring authorities to ensure effective democratic oversight of decisions affecting populations across Calderdale, Kirklees and Wakefield

Key areas for consideration include:

- Future governance and decision-making arrangements.
- Accountability for delivery and performance.
- The impact on health inequalities and prevention activity.
- Financial implications and resource allocation.
- Risks associated with organisational change.
- Arrangements for maintaining local influence and place-based working.
- Implications for partnership working across Calderdale, Kirklees and Wakefield

2. Information required to take a decision

Not applicable.

3. Implications for the Council

Changes within the ICB may impact the way health, public health, adult social care and wider council services are planned and delivered collaboratively across the system. The Council will need to understand how resources, programmes and commissioning decisions will continue to support efforts to reduce health inequalities and improve outcomes for Kirklees residents, along with maintaining strong place-based partnerships to ensure the needs of Kirklees residents continue to influence strategic decision-making within the evolving ICB arrangements.

3.1 Council Plan

The report supports the Council's ambitions to improve health outcomes, reduce inequalities and work collaboratively with partners to deliver better outcomes for residents. Effective scrutiny and governance arrangements will assist in ensuring that future NHS changes continue to support these objectives.

3.2 Financial Implications

Any future transfer of responsibilities, commissioning arrangements or place-based functions may have implications for council resources and capacity. Members will wish to understand what impact, if any, changes to NHS funding and operating arrangements may have locally.

3.3 Legal Implications

Any future proposals to establish a Joint Health Overview and Scrutiny Committee would need to comply with the relevant legislation and the Council's Constitution.

3.4 Other (e.g. Risk, Integrated Impact Assessment or Human Resources)

There is a risk that changes to ICB structures and resources could reduce local influence, accountability and understanding of the needs of Kirklees residents if appropriate governance and engagement arrangements are not maintained. The report provides Members with an opportunity to seek assurance regarding governance, accountability, risk management and performance arrangements

Integrated Impact Assessment (IIA)

No specific implications.

4. Consultation

Not applicable.

5. Engagement

Not applicable.

6. Options

Not applicable.

6.1 Options Considered

Not applicable.

6.2 Reasons for recommended Option

Not applicable.

7. Next steps and timelines

That the Health and Adults Social Care Scrutiny Panel takes account of the information presented and considers the next steps it wishes to take.

8. Contact officer

Nicola Sylvester, Principal Governance and Democratic Engagement Officer
Nicola.sylvester@kirklees.gov.uk

9. Background Papers and History of Decisions

Not applicable

10. Appendices

Attached

11. Service Director responsible

Samantha Lawton – Service Director, Legal, Governance and Commissioning.

Kirklees Health and Adult Social Care Scrutiny Committee

update on changes within the ICB

Report of: NHS West Yorkshire Integrated Care Board and system partners
Date: July 2026
Purpose: For information, assurance and scrutiny

1. Purpose of the Report

This report responds to questions raised by the Kirklees Health and Adult Social Care Scrutiny Committee concerning the development and implementation of the Kirklees Place Provider Partnership and the Integrated Neighbourhood Health teams. specifically:

- Shadow year, how this is going
- What the changes mean for Mid Yorkshire Teaching Trust, Calderdale & Huddersfield Trust, SouthWest Yorkshire Trust and Kirklees Council
- Neighbourhood health framework, how goals 1-5 and the NHS reform agendas will be achieved for Kirklees
- How are Integrated Neighbour Teams going to be set up
- Details on Governance, Financial risk, alignment with neighbourhood health, performance ambitions and treatment of core adult social services within Kirklees
- To provide risk assessment with mitigations of changes for Kirklees, including a list of risks and issues (ICB & Kirklees council)
- New timeline of implementation and reviews, including who will be accountable/responsible for sign off and who has been consulted
- To provide a schedule of agreed service level agreement
- To provide a geographical map of C,K,W primary care networks along with what service requirements will be in the new geography, and provide a resource plan to match the map
- What services are currently in scope

2. Executive Summary

Kirklees has established a clear strategic direction for neighbourhood health through the Kirklees Place Provider Partnership (KPPP), which entered a shadow year on 1 April 2026. The partnership brings together NHS providers, primary care, Kirklees Council and wider partners to develop more integrated, preventative and community-based care across nine neighbourhoods aligned to existing Primary Care Network geographies.

Progress during the shadow phase includes establishing partnership governance, refining the Memorandum of Understanding and Terms of Reference, identifying an initial service and financial scope of approximately £127 million, developing sub-governance arrangements and agreeing priorities aligned with the national

Neighbourhood Health Framework. Early evidence is encouraging, including improvements in zero-length-of-stay non-elective admissions and increased proactive care, Home First activity and targeted prevention.

However, the model remains in development and several areas require further assurance before any formal delegation or transfer of responsibilities. These include financial and contractual oversight, quality governance, decision-making and escalation arrangements, workforce and resource capacity, and clarity of accountability between the ICB, Council and provider organisations. During the shadow year, statutory accountability, legal liability and financial risk remain with the West Yorkshire ICB under existing delegation arrangements.

The proposed delivery model of nine Integrated Neighbourhood Teams provides a credible framework for population-based care, but a consistent core operating specification, detailed workforce and resource plan, neighbourhood-level service requirements and geographical mapping are still required.

3. Response to the Committee's Questions

3.1. Shadow year – how this is going

The Kirklees Place Provider Partnership (KPPP) has been operating in shadow form since 1 April 2026. The shadow year is intended to test partnership arrangements, governance, scope, oversight and delivery mechanisms before any formal transfer of responsibilities or contracting arrangements.

Progress to date includes establishing the shadow Board and confirming membership; refining the Memorandum of Understanding and Terms of Reference following previous Scrutiny feedback; further work to identify service budget lines and contracts within the initial scope; agreeing transformation and service-delivery priorities aligned with West Yorkshire strategic commissioning intentions and the national Neighbourhood Health Framework; agreeing a sub-governance approach; assigning owners to due-diligence actions; and progressing work on conflicts of interest, risk management and organisational development.

The presentation(Appendix 1) reports a positive improvement between the baseline and Q1 partnership maturity assessments. However, several matters remain unresolved, particularly financial and contractual oversight, quality surveillance and governance, future decision-making and escalation arrangements, workforce and resource capacity, the effects of organisational change, and short-term concerns relating to Continuing Healthcare and safeguarding.

During the shadow year there is no change to the West Yorkshire ICB Scheme of Delegation, no transfer of legal risk to KPPP partners, and legal accountability and liability remain with the West Yorkshire ICB. The Kirklees ICB Committee continues to provide the formal route for decision-making, assurance and accountability.

3.2. What the changes mean for partner organisations

For Mid Yorkshire Teaching NHS Trust, Calderdale and Huddersfield NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust and Kirklees Council, the immediate change is principally one of greater collaborative planning and delivery, rather than a transfer of statutory accountability during 2026/27.

The organisations will participate in a neighbourhood-enabled provider alliance intended to support integrated leadership, collaborative service planning, pathway transformation, alignment of workforce and digital approaches, and delivery of more care outside hospital and closer to home.

For the NHS trusts, this means increasing involvement in integrated neighbourhood pathways and multidisciplinary working, particularly around community services, mental health, admission avoidance, discharge, long-term conditions and the interface between primary, community and specialist care. SouthWest Yorkshire Partnership's community mental health activity forms part of the initial financial scope.

For Kirklees Council, neighbourhood health creates a stronger interface between NHS services, adult and children's social care, public health and wider local authority services. **Core adult social care is not identified in the presentation as transferring into the KPPP's Phase 1 scope.** Council involvement currently includes partnership governance and services commissioned through Section 75/Better Care Fund and Section 256 arrangements.

3.3. Delivering the Neighbourhood Health Framework goals and NHS reform agendas in Kirklees

Kirklees intends to deliver the national framework through nine neighbourhoods based on existing Primary Care Network geographies, each supported by an Integrated Neighbourhood Team and wider neighbourhood support offer.

The five national goals will be pursued through:

1. **Improved health outcomes** – proactive population health management focused on priority cohorts including frailty, care-home residents, housebound people, end-of-life care and people with major long-term conditions.
2. **Improved access to general practice** – work to reduce unwarranted variation, improve access and strengthen the primary/secondary care interface.
3. **Improved planned-care experience** – closer working between general practice and specialists, pathway redesign and movement of appropriate activity closer to home.
4. **Improved patient and staff experience** – multidisciplinary, personalised care and increased use of personalised care and support plans.
5. **Improved urgent and emergency care** – proactive care, admission avoidance, Home First, reablement, urgent community responses and improved discharge pathways.

This approach supports the three national reform agendas: improving routine healthcare, improving proactive care, and developing better alternatives to hospital care.

The slide deck(appendix 1) reports early evidence of impact, including a 7.8% improvement in zero-length-of-stay non-elective admissions overall and 11.7% in neighbourhoods where INTs were live in May 2026, alongside increased proactive care, Home First activity and targeted prevention.

3.4. How Integrated Neighbourhood Teams will be set up

The intended model is for nine Integrated Neighbourhood Teams, aligned to existing PCN footprints:

- Batley & Birstall – population 61,413
- Dewsbury & Thornhill – 42,814
- Greenwood – 63,228
- Spen Health & Wellbeing – 53,282
- The Mast – 35,934
- Viaduct – 51,970
- Three Centres – 43,582
- Tolson – 50,336
- Valleys Health & Social Care – 59,152

The established Kirklees proactive-care model will be used as a delivery mechanism. Population Health Management will identify priority cohorts, supported by signed GP data-sharing and processing agreements, neighbourhood data packs, segmentation and a local impact dashboard.

The Spen INT provides an existing proof of concept, using tailored patient identification and a multidisciplinary approach involving primary care and wider health and care partners.

3.5. Governance, finance, alignment, performance and adult social care

The Health and Wellbeing Board will be accountable for the Kirklees Neighbourhood Health Plan, with KPPP overseeing delivery. A Neighbourhood Health Oversight Group will report to the KPPP Board, supported by five life-course Delivery Groups.

Approximately £127 million is identified as being within Phase 1 scope, subject to ongoing validation:

- Community services: approximately £84.4m
- Mental health: approximately £36.5m
- Primary care: approximately £6.2m

Financial reporting and assurance arrangements are still being developed. During the shadow phase, no legal financial risk transfers to KPPP.

Performance will be monitored through local Population Health Management arrangements and dashboards, alongside a West Yorkshire dashboard being developed against the national framework goals. Delivery Groups are expected to have defined KPIs and actions.

As noted above, core adult social care is not identified as a wholesale Phase 1 transfer. Adult social care remains a statutory Council responsibility, while relevant integrated and pooled arrangements—including BCF/Section 75 activity—sit within the partnership interface.

3.6. Risk assessment and mitigations

Risk/issue	Proposed/current mitigation
Unclear financial and contractual oversight	Develop formal financial reporting, assurance and contract-management arrangements before formal delegation
No pump-prime funding for transformation	Prioritise invest-to-save opportunities and develop an explicit resource-shift methodology
Quality surveillance arrangements not fully established	Develop a formal quality governance and escalation framework
Future decision-making and dispute escalation unclear	Agree reserved decisions, delegated authority and escalation arrangements during the shadow year
Organisational change may reduce capacity	Maintain named leads, clear ownership and cross-CKW collaboration
CHC and safeguarding capacity, including loss of DCOs	Establish interim continuity and escalation arrangements with explicit executive oversight
Risk of unclear accountability between ICB, Council and providers	Maintain existing statutory accountability during shadow year and document future responsibilities before delegation
Financial risk from widening scope	Require due diligence and formal approval before services or budgets enter scope
INT model may vary between neighbourhoods	Establish a core operating specification while retaining flexibility for local population need
Data-sharing and information-governance risk	Build on existing DSAs/DPAs and establish robust identification and evaluation arrangements
Insufficient evidence that investment shifts from hospital to community	Develop measurable financial and activity trajectories
Adult social care statutory duties becoming blurred	Explicitly protect Council statutory responsibilities and require formal approval for any future scope changes

The areas identified in the above table will be developed into a jointly owned PPP risk register, with named owners, risk ratings, review dates and escalation routes.

3.7. Revised implementation, review and sign-off timeline

The supporting slide deck provides the following plan-development timetable: refinement during **summer 2026**; engagement with Dying Well and Ageing Well groups from **August 2026**; engagement with remaining Well Delivery Groups from **September 2026**; KPPP review and gap analysis in **September 2026**; Health and Wellbeing Board update in **September 2026**; updated KPPP review in **December 2026**; draft to the Health and Wellbeing Board in **January 2027**; KPPP endorsement in **February 2027**; and final Health and Wellbeing Board sign-off in **March 2027**.

The national timetable describes **2026/27** as the development year, with the Neighbourhood Health Plan operational from **2027/28** and longer-term reform continuing through **March 2029**.

The slides(appendix 1) identify the Health and Wellbeing Board as accountable for final plan sign-off and KPPP as responsible for overseeing delivery. The KPPP Design Group holds responsibility for the Development Plan. Consultation and engagement include the Neighbourhood Health Strategic Group, KPPP, Health and Wellbeing Board, Well Delivery Groups and wider partners.

3.8. Schedule of agreed service-level agreements

The PPP has undertaken work to identify service categories and budget scope, including individual agreements, providers, contract values, performance standards, duration and review dates.

Further work is ongoing through the Finance and contracting workstream for a full schedule to be developed, for each PPP agreement.

3.9. Geographic map, service requirements and resource plan

The agreed geography is based on the nine existing PCN footprints listed above.

The requested map included in the supporting pack shows the nine neighbourhood boundaries and key service locations. It should be accompanied by a matrix identifying, for each geography, population need, priority cohorts, core INT services, staffing requirements, current resources, gaps, estates requirements and planned investment.

Three Kirklees proposals have been submitted as potential Neighbourhood Health Centres: Speedwell Surgery, Dewsbury Health & Leisure Centre and the National Health Innovation Campus at the University of Huddersfield.

3.10. Services currently in scope

Phase 1 scope comprises:

- ICB-commissioned general community health services for adults and children;
- current ICB contracts with VCSE services, including adult hospices;

- ICB-commissioned services delivered through Section 75/Better Care Fund and Section 256 arrangements;
- expenditure within community mental health services; and
- general practice discretionary expenditure.

The scope is expected to widen only after the model has been tested and where evidence demonstrates that inclusion would add value.

4. Conclusion

This report and the supporting presentation demonstrates that Kirklees has established a clear direction for neighbourhood health, has moved the KPPP into a controlled shadow phase, and can point to early positive impacts from proactive and integrated neighbourhood working. However, the model is still in development rather than fully implemented.

The shadow year will be treated as a test-and-assure period, with no transfer of statutory or legal risk until governance, finance, quality, workforce and accountability arrangements have been formally demonstrated to be ready and sufficiently robust.

The identified due diligence requirements will be incorporated into the implementation plan and reported through agreed governance arrangements at defined milestones during 2026/27. This will enable the relevant accountable bodies to assess progress against evidence rather than intent and ensure that any future changes proceed only when the necessary safeguards, resources and accountability arrangements are demonstrably in place.

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Proud to be part of West Yorkshire
Health and Care Partnership

NHS West Yorkshire
Integrated Care Board

Neighbourhood Health in Kirklees

Overview & Scrutiny Committee – July 2026

Kirklees
Health & Care
Partnership

Kirklees Health & Care Partnership

NHS West Yorkshire Integrated Care Board

National Context:
What is Neighbourhood Health?

WEST YORKSHIRE INTEGRATED NEIGHBOURHOOD HEALTH

Neighbourhood Health Framework

NHS West Yorkshire Integrated Care Board

- Neighbourhood Health Framework – published 17th March 2026
- Builds on the previous guidance from January 25 and the 10 Year Health Plan's vision for **proactive, community-first model of care**, **moving activity** out of hospitals and into neighbourhood settings.
- Puts the person at the centre of how we deliver their health and care by organising services so they can work together to serve a defined population.
- Includes services such as GPs, community services, and, where appropriate, urgent care, diagnostics and outpatients as well as local authority-commissioned services, such as adult and children's social care and public health services.

Neighbourhood Health Framework - Summary

Principles:

1. Integrate services around people's lives
2. Improve outcomes by focusing on prevention, rather than crisis management
3. Devolve power to local areas, which understand local needs, with services with and for people

Aims:

1. Improve people's health and care outcomes
2. Organise services around the person
3. Reduce pressure on acute services
4. Cut waste and duplication
5. Help the NHS deliver against core targets

Measuring success of neighbourhood health: National NHS goals, objectives and metrics

1. **Improve health outcomes - focus on high priority cohorts***
   - reducing non-elective admissions
   - improving outcomes for long-term conditions improving quality and access to care for children better end of life care
2. **Improve access to general practice**
   - 90% of clinically urgent patients seen the same day
   - faster access to routine GP care
   - improved patient satisfaction
3. **Improve experience of planned care**
   - reducing variation in outpatient referrals
   - improving coordination of outpatient care & reducing secondary care follow-up appointments
4. **Improve urgent and emergency care**
   - Improving co-ordination of care for high priority cohorts (frailty, care homes, end of life)
   - reducing emergency department attendances
   - improving ambulance response times improving hospital discharge processes
5. **Improve patient and staff satisfaction**
   - introducing patient-reported experience and outcome measures
   - Ensuring 95% of people with complex needs have an agreed care plan
   - introducing neighbourhood staff experience measures

***High priority cohorts:**

- Frailty
- Care Home residents
- Housebound patients
- Those receiving end of life care
- those with:
  - CVD
  - diabetes
  - chronic obstructive pulmonary disease (COPD)
  - dementia
  - mental health conditions
- children and young people
- any other cohort identifies by local areas

Neighbourhood Health Framework - Summary

Delivering Neighbourhood Health: Reform Agendas

1: Improve routine healthcare

The NHS will support GP access recovery by:

- Improving GP access targets
- Improving online access
- Ensuring practices open during core hours, and reform out of hours providing faster access to care

GPs will deliver better care through:

- Proactive population health management
- Reduced bureaucracy
- Improved access to specialist advice

2: Improve proactive care

- Develop Integrated Neighbourhood teams to deliver better management of Long-term conditions, frailty, children and young people and cancer
- Grow community services
- Reform outpatients, with closer working between GPs and specialists

3: Better alternatives to hospital care

- Expand urgent community response services
- Increase the capacity of virtual wards
- Increase intermediate care capacity
- **Piloting 24/7 neighbourhood mental health centres**

Contracting Models

Population health contracting to achieve better outcomes through different provider models which aim to strengthen the infrastructure and capability to design and deliver integrated services within and across neighbourhoods, with the potential for more incentive and outcomes-based contracts at greater scale.

- **Single Neighbourhood Providers (SNPs) – pop ~50K:** Deliver neighbourhood services through integrated teams within a defined area; allow primary care to offer services beyond core GP contracts.
- **Multi-Neighbourhood Providers (MNPs) pop 250K+:** Coordinate services across multiple neighbourhoods, supporting consistency, service design and shared risk for the registered population list.
- **Integrated Health Organisations (IHOs):** Hold a whole-population budget, allocate resources across pathways, redesign services and invest in prevention. Initially likely led by high-performing NHS trusts, in partnership with primary and community providers.

Enablers

- **Estates**: Care will be delivered locally, digitally, or at home, with Neighbourhood Health Centres integrating healthcare and community services – targeting 250 NHCs by 2035, of which 120 by 2030.
- **Workforce:** existing staff working differently, supported by new roles, skilled at delivering proactive, preventative and personalised care. 10 Year Workforce Plan in development
- **Finances**: ICBs will lead commissioning and funding, shifting resources from acute care and using flexible, outcome-based contracts to support proactive, population-focused care. The financial framework will be amended from 2026/27.

Neighbourhood health is central to the government's wider agenda of public service reform.

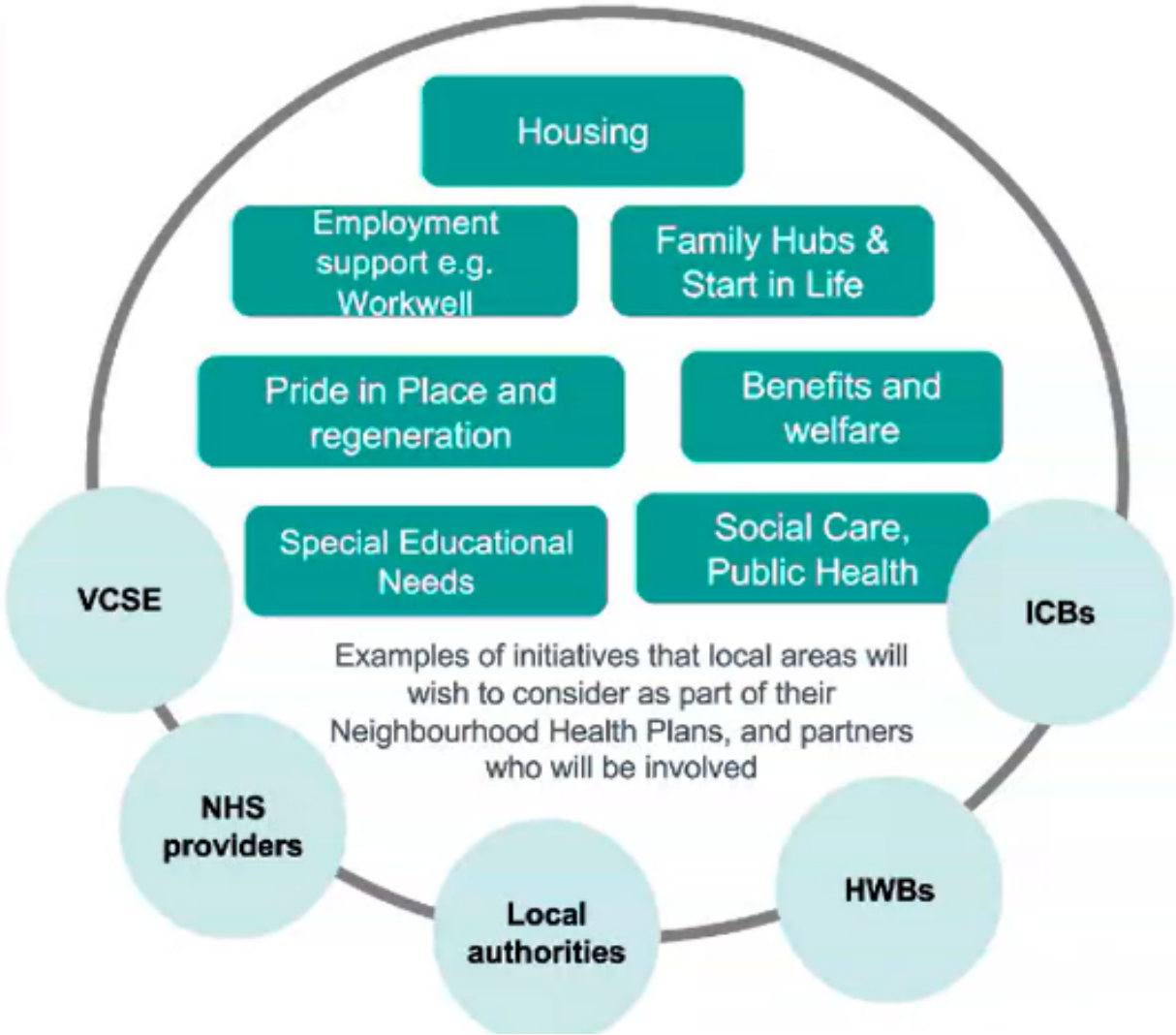
Through Health and Wellbeing Boards, ICBs and local authorities will work in partnership to:

- Plan for their local populations
- Address local priorities and health inequalities set out in their local joint strategic needs assessment
- Agree how neighbourhood health can deliver additional benefits beyond those national minimum goals.

The framework details how systems can establish local metrics

For neighbourhood health to be truly successful, **services must join up across the full spectrum of public services that will impact people's ability to live a happy, healthy life.** This will include housing, employment, education and much, much more.

Health and Wellbeing Boards should build strong links between neighbourhood health and other reforms and consider opportunities for further integration of services. Local authority leaders will play a critical part in this.



Next Steps

Plans will be delivered in 2 stages, which can run in parallel.
- Stage 1: immediate changes in the 2026 to 2027 financial year
- Stage 2: longer-term reform (April 2027 to March 2029)

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Stage 1:
- Agree an initial plan to reduce non-elective admissions and bed days
- Agree a plan for tackling unwarranted variation and improving access to general practice
- Agree neighbourhood footprints
- Agree plans to establish INTs focused on high priority cohorts
- Start to plan for a new neighbourhood approach for elective pathways
- Confirm plans to meet 18-week community waits and eliminate 52-week waits.
- Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund (BCF)
- Continue to improve the primary and secondary care interface in line with the red tape challenge
- Confirm organisational ownership of planned deliverables
- Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation

Stage 2:
- Provide a broad overview of how the national NHS objectives will begin to be delivered through the 3 reform agendas
- Set out how neighbourhood health will support wider local goals
- Set out how local objectives are informed by the JSNA
- Confirm final geographies that partners will then work within
- Confirm which organisations are responsible for different elements of delivery
- Confirm the arrangements to deliver this, including governance and operational partnership arrangements
- Confirm how any other relevant initiatives align with the strategy

Kirklees Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Neighbourhood Health in Kirklees

WEST YORKSHIRE INTEGRATED NEIGHBOURHOOD HEALTH

What are we trying to achieve?

NHS West Yorkshire Integrated Care Board

Our aim for Neighbourhood Working in Kirklees:

To establish x9 Neighbourhoods, each with an Integrated Neighbourhood Team MDT and wider Neighbourhood support offers across Kirklees, to better co-ordinate care, helping people to live independently by staying well for longer, through a joined-up approach to prevention, optimising the use of resources and improving outcomes for people.

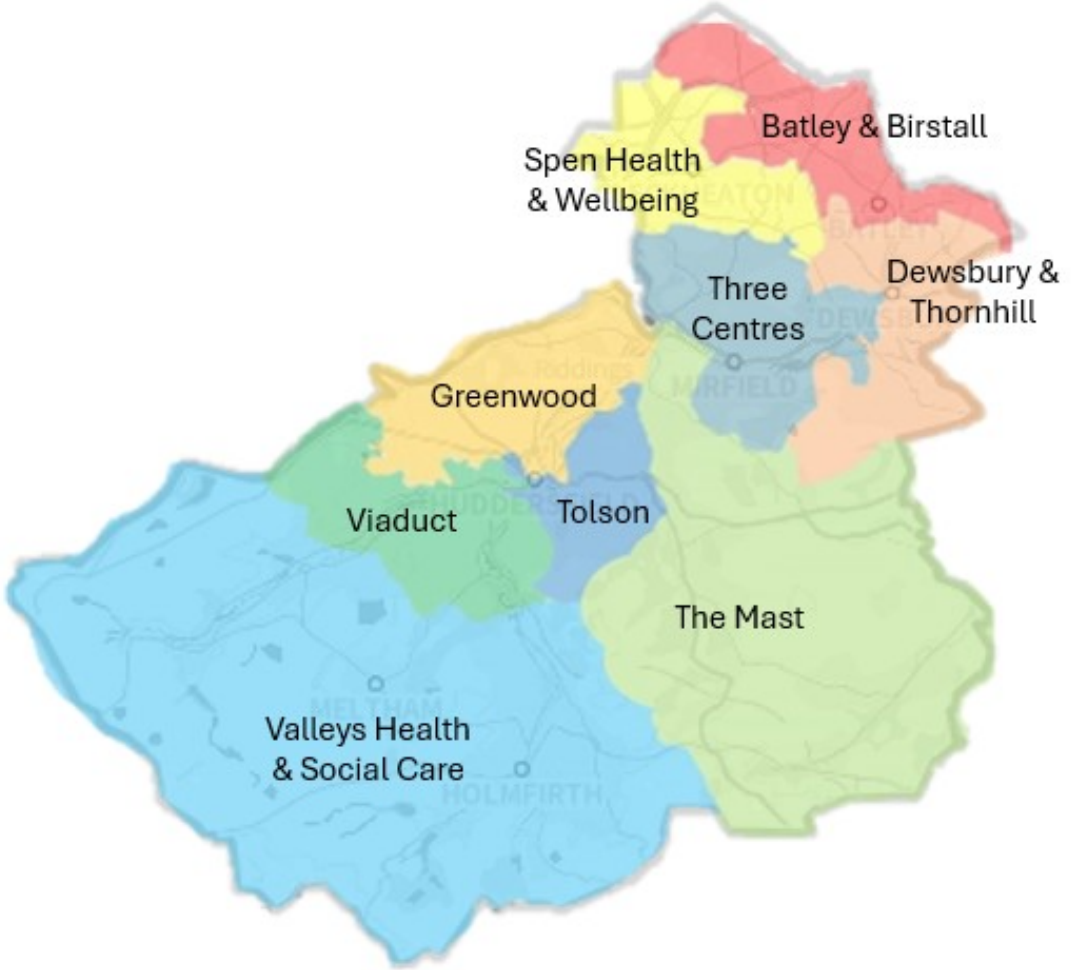
This builds on the West Yorkshire Vision.

West Yorkshire Vision:

To work in partnership with our communities to improve health and wellbeing outcomes through the delivery of person centred, holistic and equitable care and support in local neighbourhoods, addressing physical, psychological, and social health needs. Integrated teams of professionals and organisations will work collaboratively to provide timely, seamless and high-quality services, underpinned by principles of prevention and reducing health inequalities.

Our Neighbourhoods

System agreement that Neighbourhood footprints will form around the existing PCN geographies/boundaries



	INT - Integrated Neighbourhood Team	Population April 2026
Kirklees	Batley & Birstall	61,413
	Dewsbury & Thornhill	42,814
	Greenwood	63,228
	Spen Health & Wellbeing	53,282
	The Mast	35,934
	Viaduct	51,970
	Three Centres	43,582
	Tolson	50,336
	Valleys Health & Social Care	59,152

Kirklees Neighbourhood Health Plan

NHS West Yorkshire
Integrated Care Board

The national requirements for developing Neighbourhood Health Plans are set out Neighbourhood Health Framework published in March 2026. The Framework states a locally owned Neighbourhood Health Plan must be developed in each place.

Plans should be;

- Outcomes-focused, evidence-based, transparent and deliverable.
- Support delivery of Integrated Care Board strategies and national neighbourhood health priorities
- Aligned with local Health and Wellbeing Strategies and Joint Strategic Need Assessments.
- Health and Wellbeing Boards are expected to lead and oversee the development of Neighbourhood Health Plans, convening partners across the NHS, local authorities, voluntary sector and providers, and ensuring joint ownership and accountability

Neighbourhood Health Plans are expected to be in place and operational from 2027/28. 2026/27 is described as the development year to agree footprints, governance and early plans.

Kirklees Neighbourhood Health Plan

NHS West Yorkshire
Integrated Care Board

- Agreed approach in Kirklees is to build the work already in place to delivery neighboourhood health, continuing delivery through the Well Delivery Groups. The neighbourhood health plan will describe the longer term, strategic ambition, for integrated delivery of preventative and proactive health and care services organised around the needs of local communities within Kirklees.
- Working with the existing Neighbourhood Health Strategic Group, a working draft of a plan is in development. The working draft describes the work to date, the proposed governance for delivery, and emerging next steps. It has been agreed that whilst the Health and Wellbeing Board will be accountable for the plan, the Kirklees Place Provider Partnership will oversee delivery.
- Alignment of Better Care Fund schemes to ensure they support delivery of neighbourhood health.
- Updates on progress have also been shared across Calderdale, Wakefield and Kirklees, aiming for consistency in the type of content included where appropriate.
- Engagement with the Health and Wellbeing Board was initiated in December 2025. A further update was provided at the Board meeting in March 2026, with a commitment to engage at future meetings in 2026/27 to facilitate sign off.

Kirklees Neighbourhood Health Plan

NHS West Yorkshire Integrated Care Board

Type of Engagement	Timeframe
Refining and updating working draft to reflect current position (working with members of existing Neighbourhood Health Strategic Group)	Summer 2026
Initiate engagement with Dying Well and Ageing Well Delivery Groups regarding longer term priorities	From August 2026
Initiate engagement with remaining Well Delivery Groups as they are confirmed regarding longer term priorities	From September 2026
Circulation of working draft for feedback (KPPP) Identification of gaps – to agree key actions for resolution, (consider utilising development sessions if required)	September 2026
Reconfirmation of requirements, progress to date and next steps (HWBB)	September 2026
Updated plan shared for feedback (KPPP)	December 2026
Draft plan shared for feedback (HWBB)	January 2027
Final draft shared for endorsement (KPPP)	February 2027
Final draft for sign off (HWBB)	March 2027

Kirklees Neighbourhood Health Offer - Adults

NHS

Local care, connected support – delivering the right care, in the right place, at the right time

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Integrated Care Board

Our neighbourhood and multi-neighbourhood model brings together health, care and community services to support people across Kirklees with joined-up, person-centred care.

WHAT IS A NEIGHBOURHOOD?

A local geographical area where multidisciplinary teams work together to support a defined population.

- Focus on local population needs
- Delivered by integrated teams and partners
- Prevention, early intervention and personalised care
- Strong links with Primary Care Networks (PCNs)

WHAT IS A MULTI-NEIGHBOURHOOD?

A wider footprint that brings together multiple neighbourhoods to deliver services more effectively at scale.

- Supports larger populations
- Provides specialist or shared services
- Enables consistency and efficiency
- Offers additional capacity and expertise

NEIGHBOURHOOD OFFER

Local services focused on day-to-day support and prevention

These services are:

- Delivered close to home
- Focused on prevention, early intervention and ongoing care
- Built around strong local relationships and knowledge of communities

Neighbourhood Health Centre hub and spoke model (future ambition)

Neighbourhood and Multi-Neighbourhood offers are closely connected to provide seamless, integrated care pathways.

MULTI-NEIGHBOURHOOD OFFER

Wider services providing specialist, coordinated or higher-intensity support

These services:

- Support higher acuity and complex needs
- Provide rapid response and specialist interventions
- Ensure consistency and resilience across Kirklees

KEY BENEFITS OF THE MODEL

- Improved access to services closer to home
- Joined-up care across organisations
- Better outcomes through early intervention
- Efficient use of resources at scale
- Consistent service delivery across Kirklees

KEY MESSAGE

The Kirklees Neighbourhood Health Offer ensures that care is delivered locally where possible, specialist support is available when needed, and services are integrated and person-centred.

Integrated Neighbourhood Teams (INTs) in Kirklees

Working together to deliver coordinated, holistic, person-centred care

NHS West Yorkshire Integrated Care Board

What is an Integrated Neighbourhood Team (INT)?

A team of health, care and community professionals working together around an individual to provide coordinated, holistic, person-centred care.

Key features:

- One named Care Coordinator (key point of contact)
- Focus on "What matters to me" conversations
- Holistic assessments & joint care planning
- Weekly multi-disciplinary team (MDT) discussions
- Delivery of proactive, coordinated care

Role of the Care Coordinator

- Owns the relationship with the individual
- Acts as key point of contact
- Carries out holistic assessments
- Develops personalised care & support plans
- Brings the individual's voice into MDT discussions

Where We Are in Kirklees

(May 2026)

- **9** INTs identified
- **6** Operational
- **1** In development
- **2** To be scoped

All operational by April 2027

Current Focus (Phase 1)

People living with:
- Frailty
- Mental health conditions

Targeting those with complex needs

Using local data and neighbourhood insights

What INTs Are Delivering

- Joint holistic assessments
- Case reviews and MDT discussions
- Care coordination and personalised plans
- Medication reviews
- Social prescribing
- Advanced care planning
- Proactive identification of people needing support

How the Team Works

- Team come together on a weekly basis
- Discuss people proactively identified against agreed criteria
- Gain a good understanding of needs and any proactive support required
- Coordinate provision and deliver joined up care

Development & Next Steps

Each INT is supported to:
- Build relationships, trust and encourage a culture change
- Develop organisational development plans
- Strengthen integrated ways of working
- Seek insight from staff working within INTs to identify improvements

Looking Ahead (Phase 2)

Phase 2 will focus on engagement and development of Children and Young People INTs.

The INT model is aligned with the Neighbourhood Health Framework and local data. It supports individuals with complex needs, specifically Frailty and Mental Health – further refined through Population level data.

SystmOne GP Excellence Awards - Innovation in practice and Neighbourhoods

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- SPEN Integrated Neighbourhood Team (INT) has been announced the winner of the SystmOne GP Excellence Awards following a vote by SystmOne users.
- The work undertaken by the INT to support frail patients has won a national Neighbourhoods award
- It follows a presentation on its work with GPs, patients and service providers.
- One in eight of the patients in the PCN have a frailty diagnosis and the PCN engaged with patients to understand more about what affects their health.
- The PCN then collaborated with each of its seven practices to create a tailored patient list and a multidisciplinary team to look holistically at how they can improve the health and care of patients who would benefit most from this approach.
- The engagement process found mental health and social care issues were central to improving the quality of life for these patients in addition to GP led support, physiotherapy/rehabilitation, personalised care plans and medication reviews. Making simple changes resulted in reduced duplication and the need for additional health care appointments.
- The presentation delivered for the award submission by Dr Danielle Nimmons is available on YouTube.

Feedback received

Everyone is so happy. Delighted. It is validation that what we are doing is good.

We've seen positive results with just six months, and we are looking to roll this out across all the PCN's in North Kirklees. I can even see this approach being adopted in other areas of West Yorkshire or may be even further afield

It's beneficial seeing the providers working well together. We all feel equal in what we bring to this work, and we all have a voice. Each partner is an expert in their field, and it is empowering them to improve the lives of our patients

Kirklees Proactive Care Model

As a delivery mechanism, the below established Kirklees proactive care model is being delivered as part of the Integrated Neighbourhood Team way of working.

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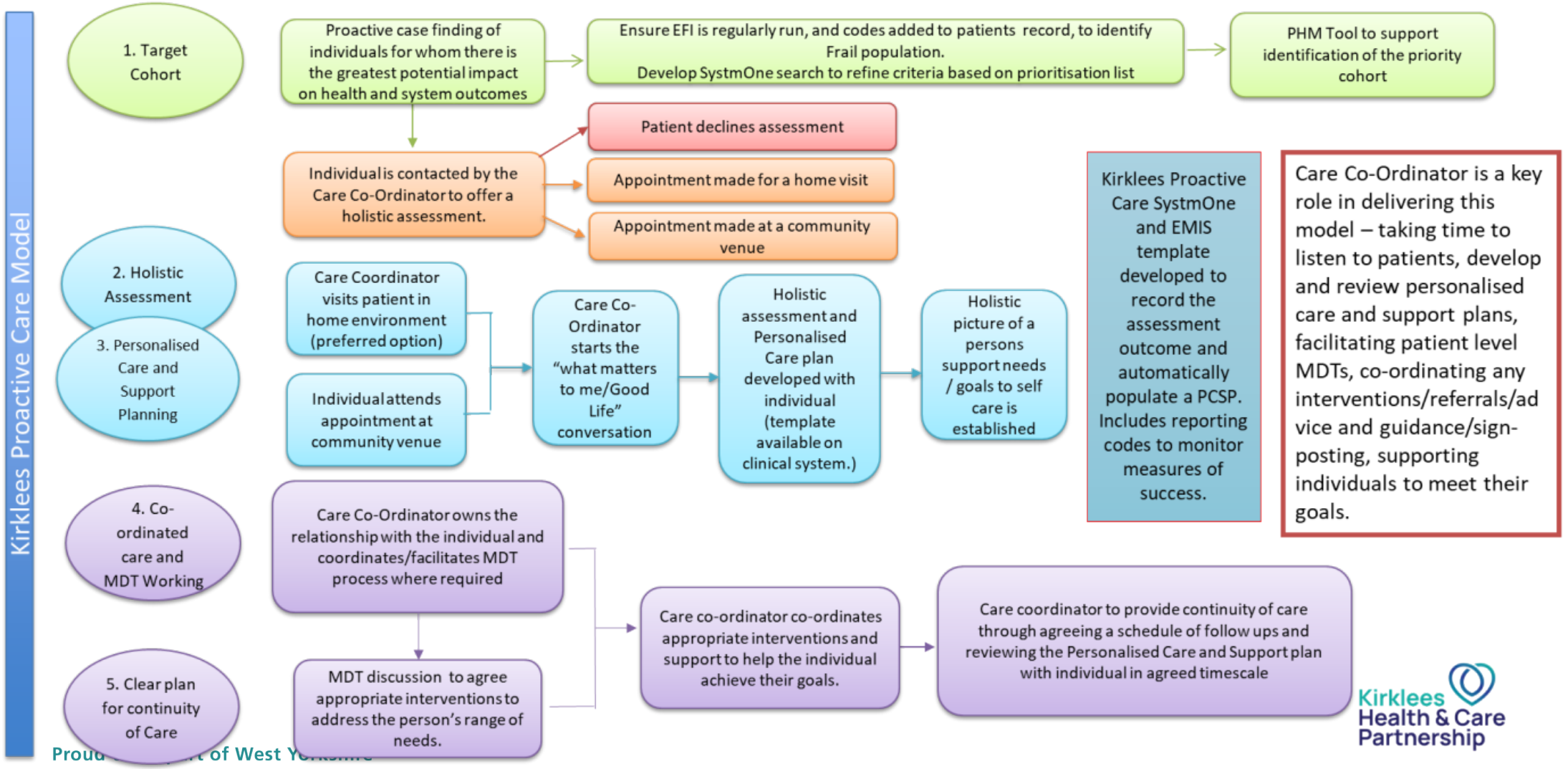

Proud [illegible] of West Yorkshire Health and Care Partnership

Kirklees Health & Care Partnership

Population Health Management (PHM)

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Population Health Management (PHM):

- Data Sharing Agreements: All practices have signed Kirklees Data Sharing Agreements (DSA) & Data Processing Agreements (DPA).
- Data packs developed and shared with INTs –includes utilisation of secondary care data, prevalence of disease registers and deprivation index.
- PHM tool established, and segmentation undertaken across Kirklees and by INT to highlight priority cohorts. Identified top 2% utilisation of secondary care. Re-identification process underway to share with INTs following robust proof of concept.
- PHM Operational Group established November 25, meeting monthly with representation from all partners, Local authority, secondary and community care providers.
- Dashboard developed to monitor local impact.
- West Yorkshire Performance Dashboard in development to track national progress against INH Framework Goals.

People's Voice in Neighbourhood Health (Kirklees)

Working together to deliver coordinated, person-centred care shaped by communities

NHS West Yorkshire Integrated Care Board

What is People's Voice in Neighbourhood Health?

A structured approach to capturing community insight and lived experience to shape neighbourhood health services so they reflect what matters to local people and improve outcomes.

Key Benefits

- One shared understanding of people's needs and priorities
- Builds trust and strengthens community relationships
- Ensures services reflect real experiences, not just data
- Improves access, inclusion and engagement
- Enables more personalised, proactive care

How the Approach Works

- Engagement through community conversations and local activity
- Insight gathered from people, groups and organisations
- Use of consistent questions to understand needs and barriers
- Combining qualitative insight with data
- Shared learning across partners
- Continuous feedback into neighbourhood teams

For Communities

- Services shaped by what matters to people
- Increased trust, confidence and participation
- Improved access and experience of care

For the System

- Insight-led decision making
- Clear understanding of local need and variation
- Stronger partnership working across organisations

For Neighbourhood Teams (INTs)

- Locally meaningful priorities
- Better alignment of data and lived experience
- Improved engagement with individuals
- More responsive, person-centred care delivery

Embedding People's Voice ensures Neighbourhood Health is built with communities—leading to more trusted, effective and integrated care at a local level.

Kirklees Neighbourhood Health: Demonstrating Impact

Impact shown through proactive neighbourhood working, Home First, personalised care, admissions avoidance and targeted population health

Proactive & personalised care

Sustained above target

- the number of people who are in receipt of Proactive care support has been consistently above target for the last 6 months
- Additional care co-ordinator capacity aligned to INTs
- Increase in holistic Personalised Care and Support Plans

Emergency admissions

7.8% improvement overall

11.7% improvement in the neighborhoods where INTs are live

- 2025/26 plan delivered for reducing emergency admissions in over 65s
- 7.8% overall improvement in zero length-of-stay NEL admissions
- 11.7% improvement in neighbourhoods where INTs were live in May 2026

Reablement & independence

66% remained living in the community at 12 weeks

- ASCOF 2D data shows 66% of 65+ people remained living in the community at 12 weeks
- Home First pathways reduce deconditioning and promote recovery at home
- Provider partnership strengthens coordination across discharge, community health, social care and VCSE

IMPACT

Neighbourhood Health in Kirklees

Sustaining independence

Avoidable long-term care admissions fell during 2024/25 from 416 to 354 by September 2025, supported by Home First, domiciliary support, housing-related services and Disabled Facilities Grant interventions.

Personalised care & falls

4,799 referrals in 25-26

- The Personalised Care Team are a key resource for the Kirklees Neighbourhood model. They received a total of 4799 referrals in 25-26.
- Demonstrable impact on the number of falls
- Kirklees Falls Response Tool rolled out within care homes
- Referrals from LTC team, frailty virtual ward, INTs and self-referrals

Home First & discharge

Shift to Home First

- Year-on-year shift from Pathway 2 beds to Pathway 1 Home First
- Integrated front door to community/reablement services developed during 2025
- Shared ambition to access reablement and rehabilitation within 48 hours of discharge readiness

Population health

Targeted prevention gains

- Hypertension treated according to NICE guidance: 70.18%, above WY ICB and England average
- AF anticoagulation: 91.8%, above WY ICB and same as England average
- Type 2 diabetes: 2.8% improvement in care processes and 3.4% improvement in treatment targets

KEY MESSAGE | Kirklees neighbourhood health is demonstrating measurable impact: more proactive personalised support, fewer avoidable admissions, stronger Home First and reablement pathways, and targeted prevention for people with long-term conditions.

All elements are editable PowerPoint shapes/text except the simple NHS-style logo mark.

Kirklees Neighbourhood Health: Demonstrating Impact/DRAFT Trajectories

Kirklees Emerging Strategic Priorities 26/27

Strategic Priorities 26/27	Scheme	Segmentation/ Cohort	Target Population	Baseline Year	Baseline Activity	25/26 outturn	Variance Activity	Variance %	Q4 24/25 v 25/26	2026/27 Ambition	2027/28 Ambition	2028/29 Ambition	2029/30 Ambition
Integrated Neighbourhood Health Approach	Development Of INT	Frailty NEL Admissions	Over 65yrs	24/25	17,867	17,185	-682	-3.8%	-9.29%	4.5% overall reductions from Original Baseline	6% overall reductions from Original Baseline	8% overall reductions from Original Baseline	10% overall reductions from Original Baseline
		Frailty NEL Zero LoS	Over 65yrs	24/25	1,199	1,105	-94	-7.8%		Maintain & Mitagate Growth	Maintain & Mitagate Growth	Maintain & Mitagate Growth	Maintain & Mitagate Growth
		CYP NEL Admissions	0-18 years	24/25	6,017	5812	-205	-3.4%		Under Development as phase 2			
		CYP NEL Admissions	0-4 years	25/26	3,301					Mitigate 1% Growth	1% Improvement on previous Yrs outturn	1% Improvement on previous Yrs outturn	1% Improvement on previous Yrs outturn
		CYP A&E Attendances	0-18 years	24/25	47,970	46652	-1318	-2.7%		Under Development as phase 2			
		MH High Intensity Users ED Attendances	165 Patients	24/25	1,313	509	-804	-61.2%		Maintain & Mitagate Growth	Maintain & Mitagate Growth	Maintain & Mitagate Growth	Maintain & Mitagate Growth
		Substance Care Team ED Attendances	217 Patients	24/25	634	317	-317	-50.0%		Maintain & Mitagate Growth	Maintain & Mitagate Growth	Maintain & Mitagate Growth	Maintain & Mitagate Growth
		Youth Navigators ED Attendances	113 Patients	24/25	215	66	-149	-69.3%		Maintain & Mitagate Growth	Maintain & Mitagate Growth	Maintain & Mitagate Growth	Maintain & Mitagate Growth

To support Kirklees' Integrated Neighbourhood Health priorities, draft trajectories have been developed for identified Population Health Management cohorts. These trajectories utilise demonstrated impact to date as the basis for modelling anticipated activity, outcome and demand impacts in future years. The assumptions and projections are currently being refined.

Kirklees Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Neighbourhood Health Centres – Guidance

Published 16 April 2026

https://www.england.nhs.uk/long-read/neighbourhood-health-centre-guidance-for-regions-and-integrated-care-boards/

WEST YORKSHIRE INTEGRATED NEIGHBOURHOOD HEALTH

National definition of a neighbourhood health centre

- Neighbourhood health centres will be seen as the place to go for most health needs in every community.
- They will bring together general practice services and a mix of community, local authority and voluntary sector services, allowing staff to deliver more co-ordinated and effective care, leading to better patient outcomes and experience.
- They will be open at a minimum of 12 hours a day, 6 days a week.

10 Year Health plan vision for neighbourhood health centres:

- **based in communities** (c.50k population), focused where healthy life expectancy is lowest
- **a 'one stop shop'** for most health needs, offering convenient access to services, particularly for those with more complex needs
- **based around general practices**, also co-locating **community health services** and diagnostics and rehabilitation into the community
- a place from which **multidisciplinary teams** operate
- co-locate **a range of local government and voluntary sector services** to create an offer that meets population need holistically, e.g. social welfare advice or weight management services
- enable move of **outpatient care** from hospitals into the community

NHCs are intended to build on existing community services and infrastructure, rather than operating as standalone clinical facilities.

Core components of a Neighbourhood Health Centre

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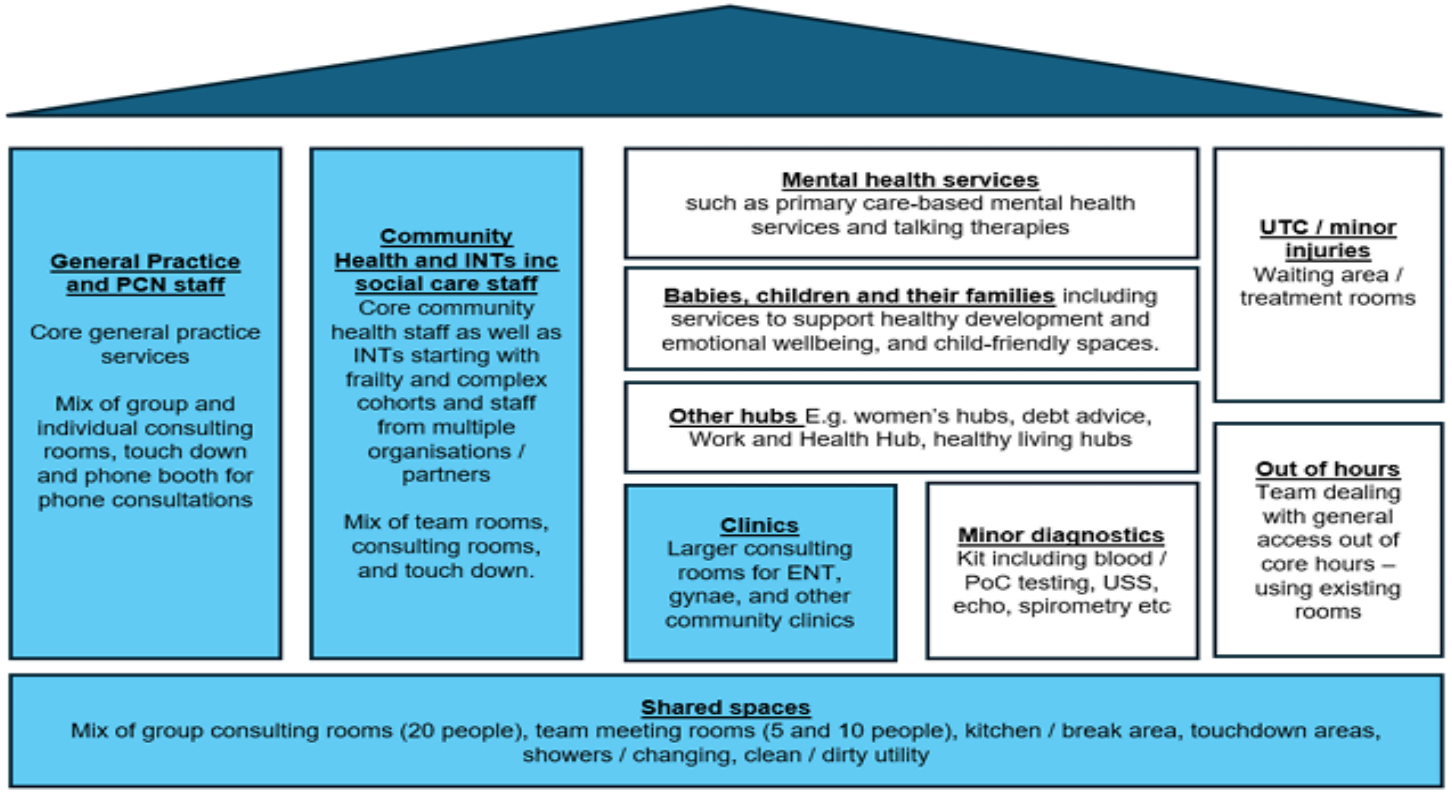

Blue boxes represent the minimum requirements for designation as an NHC. As a minimum, this includes an on-site GP practice and a model capable of operating at scale over time.

Place Submissions

NHS West Yorkshire
Integrated Care Board

- Places had to submit local pipeline, signed off by the Place AO, to the WY team by COP Monday 11th May 2026
- The principal ask of the ICB was to respond with:
  - Neighbourhood geographies within the ICB
  - A coherent pipeline of NHC schemes – both new build and repurposed estate
  - A clear view of how proposals align with the guidance and criteria.
- West Yorkshire team complied the ICB-wide pipeline for EMT sign-off on Wednesday 13th May 2026, ahead of submission to the regional team.
- National deadline for submission was 28 May 2026 as set out in the Guidance

What happens after the 28th May planning deadline

Submission review	Refinement and pipeline build:	Scheme progression:
• Regional and national teams will review submissions and apply a process of challenge, moderation and prioritisation across the pipeline. • Schemes will be assessed against the published criteria.	• Proposals may need to be refined after submission, particularly for new builds and/or where further detail is needed on scope, site, utilisation or affordability.	• This process will help determine which schemes are ready for early progression and which need further development for later waves. • Final wave announcements, approvals and funding decisions will then follow national prioritisation and business case processes.

Neighbourhood Health Centres

NHS West Yorkshire
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- Meetings undertaken with all partners (members of the Strategic Group and Estates) in May to engage on the guidance and national ask, as well as support for the Kirklees submission.
- Sewell Advisory have been supporting work around Primary Care estate:
  - Each PCN has an estates strategy (an output pack) divided into clinical and estate sections to ensure that the clinical strategy is established first which then drives estates requirements
  - One of the main objectives was to understand the utilisation of the estate and provide an overall PCN & Practice prioritisation
- 3 proposals included in the national submission for Neighbourhood Health Centres in Kirklees (awaiting outcome)
  - Speedwell Surgery
  - Dewsbury Health & Leisure Centre
  - National Health Innovation Campus – Huddersfield University

Kirklees Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Governance within Kirklees: Place Provider Partnership (PPP)

WEST YORKSHIRE INTEGRATED NEIGHBOURHOOD HEALTH

Development of the Kirklees Place Provider Partnership Recap

NHS West Yorkshire Integrated Care Board

Function of a Place Provider Partnership

In the future system architecture Provider Alliances will gain **greater autonomy** and **receive the resources** to allow them to **jointly exercise statutory functions and influence commissioning decisions**.

Throughout 2026/27 **ICBs** will adopt a **strategic commissioning approach**, with **provider partnerships** acting as **delivery partners**. This includes:

- Integrated leadership and governance
- Collaborative service planning, driving integration across place and system levels
- Co-producing service models and delivering transformation
- Aligning workforce and digital strategies
- Shaping governance, reporting, and oversight models that could be rolled out at scale across the CKW region.

Each area will have its own Place Provider Partnership. In Kirklees this is called the **Kirklees Place Provider Partnership.**

Kirklees Place Provider Partnership Recap : Vision and Strategic Aims

NHS West Yorkshire
Integrated Care Board

"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."

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.

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.

Kirklees Place Provider Partnership Recap: Strategic Objectives

NHS West Yorkshire
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1. Build on the joint working and collaboration already in place through continuation of good partnership arrangements.

2. Delivery of integrated neighbourhood health

3. Transformation of pathways outside of hospital advocating a shift from hospital to home

Kirklees Place Provider Partnership : Summary of Key Actions

NHS West Yorkshire
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Since the last update at OSC the Kirklees Place Provider Partnership has:

1. Begun working in shadow format, with the establishment of a shadow board from April 2027
2. Confirmation of membership of this board and refinement of MoU and ToR following OSC feedback.
3. Further work undertaken to agree the service budget lines and contracts within initial scope of the PPP (recognising there is no transfer of legal risk to the PPP during shadow phase).
4. Review and confirmation of transformation and service delivery priorities, ensuring alignment to the West Yorkshire strategic commissioning intentions and National Neighbourhood Health Framework.
5. Agreement of sub-governance approach to deliver these priorities.
6. Progression on key area of PPP design including;
   - Due diligence actions identified, and owners assigned
   - Identification and management of conflict of interest
   - Risk management
   - Initial discussions regarding OD approach

Kirklees Place Provider Partnership : Membership

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Organisations who will be represented as members of the Partnership

- South West Yorkshire Partnership Teaching NHS FT
- Calderdale and Huddersfield Foundation Trust
- Mid Yorkshire Teaching Trust
- Kirklees Local Authority
- Locala
- General Practice (representative/s)
- Voluntary and Community Sector (representative/s)
- Public Health
- West Yorkshire ICB

Organisions invited to contribute 'in attendance':

- Kirkwood Hospice
- Independent Care Sector (representative/s)
- Healthwatch

Membership to evolve over time

Kirklees Place Provider Partnership : Confirmation of Scope Phase 1

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Shadow phase scope will cover the following activity;

- ICB commissioned general community health services for adults and children.
- Current ICB contracts with VCSE services including adult hospices
- ICB commissioned services via S75 (BCF) and S256
- Expenditure within community mental health services
- General Practice discretionary spend

The scope will widen over time once the model has been tested and we understand where it adds value

Kirklees Place Provider Partnership : Scope Phase 1

NHS West Yorkshire Integrated Care Board

Total budgets in scope for phase 1: **~ £127m**

Breakdown by service deliver area:

Mental Health: **~ £36.5m** (consisting of SWYPFT community and VCSE services)

Community: **~ £ 84.4m**
Primary Care: **~ £6.2m**

Note: numbers are subject to change due to on-going work with ICB Finance Leads

Work is on-going to identify financial reporting and assurance processes for the KPPP Board.

Kirklees Place Provider Partnership : Priorities

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Why is the 'well' approach important

- Supports the commitment to build on what works well. The 'well' approach is proven to be a structured way of bringing together partners to focus on specific areas of the life-course, ensuring each element of the life-course is prioritised and all relevant stakeholders can be involved.

- Ensures alignment with existing Kirklees Health and Wellbeing Strategy which advocates a life-course approach to improving outcomes in health and wellbeing.

- Ensures alignment to approach outlined in West Yorkshire Strategic Commissioning Plan. Mirroring this way of working will enable efficient flow of information / delegation of tasks from the West Yorkshire strategic commissioning function in the future.

The existing Well Boards will cease and replaced by the Well Delivery Groups

Kirklees Place Provider Partnership : Service Change and Transformation Priorities

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Integrated Care Board

Start Well Delivery Group	Live Well Delivery Group	Age Well Delivery Group	Dying Well Delivery Group	Mental Health Delivery Group
Immediate focus 2627 1. Asthma management (impact on ED attends and NEL) 2. Development of Children's MDT and Neighbourhood Health aligning with MHST and CAMHS support services. Connectivity with existing CYP Clusers (identified as phase 2 for INTs) Work to be undertaken to identify medium / long term priorities for the neighbourhood health plan. **Delivery of NH goals 1 and 3**	**Immediate focus 2627** 1. Continue with primary prevention work Work to be undertaken to re-focus focus areas for secondary prevention (CVD, Diabetes and Respiratory) for the neighbourhood health plan. **Delivery of NH goal 1** **Potential to support delivery of goal 2**	**Immediate focus 2627** 1. Continue to progress Hospital to Community Programme (impact on NEL and LoS) Alignment with delivery of Hospital at Home and UCR changes. Work to be undertaken to identify medium / long term priorities for the neighbourhood health plan. **Delivery of goals 1 and 4**	**Immediate focus 2627** 1. Progress implementation of EoL integrated model (impact on NEL and LoS) Work to be undertaken to clarify later phases of delivery for the neighbourhood health **Delivery of goals 1 and 4**	**Immediate focus 2627** 1. Crisis pathways (impact on NEL and LoS) 2. Neurodiversity all age (impact on planned care WL) Work to be undertaken to identify medium / long term priorities for the neighbourhood health plan **Potential to impact on all NH goals**

Kirklees Place Provider Partnership : Governance

NHS West Yorkshire
Integrated Care Board

As of the **1st April 2026**, the **Kirklees Place Provider Partnership** is **operating in shadow format.**

Working in shadow format – what will / will not change in 2026/27

- No change to the West Yorkshire ICB Scheme of Delegation during Shadow Phase
- All legal accountability and liability remain with West Yorkshire ICB throughout 2026/27
- Place Provider Partnership operates in shadow with no transfer of legal risk to partners
- Kirklees ICB Committee role continues for formal decision making, assurance and accountability
- Formal contracting will begin within the next 2 years, subject to agreed governance

Kirklees Place Provider Partnership : Sub-Governance

NHS West Yorkshire
Integrated Care Board

- The Kirklees Place Provider Partnership Design Group will continue to progress the development of key elements of design work during 2026/27. This will continue to be supported by interfaces across CKW. This group will hold responsibility of the Development Plan.

- A Neighbourhood Health Oversight Group will be established (evolution of the existing Neighbourhood Health Strategic Group) to monitor progress on delivery of the Neighbourhood Health Framework within Kirklees. This will report directly into the Board.

- The Neighbourhood Health Oversight Group will be supported by 5 Delivery Groups across the life course, maintaining the 'well' way of working. These groups will be responsible for delivering against key elements of the Neighbourhood Health Framework and other transformation / service change priorities identified by the Board. They will have defined KPIs and actions.

- Commitment by the Board to continually review this way of working as the Partnership matures, neighbourhood health evolves, and the expectation of Place Provider Partnerships becomes clearer.

Kirklees Place Provider Partnership : Sub-Governance

NHS West Yorkshire
Integrated Care Board

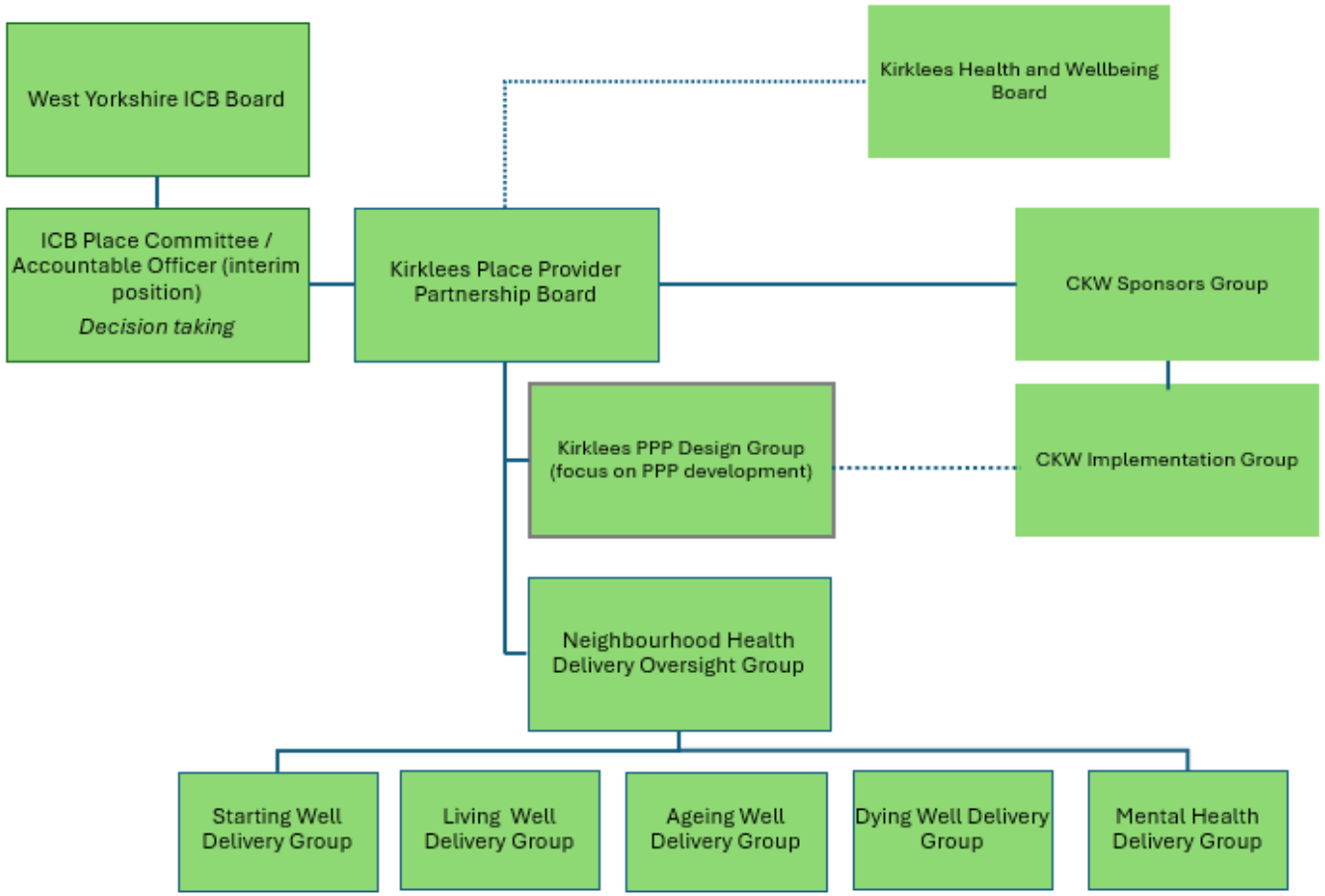
Progress and gaps:

- Mapping of existing delivery mechanisms completed
- Identified existing groups already delivering the priorities identified for ageing well, dying well, primary prevention and elements of mental health. These are system wide groups which are not led by ICB staff (therefore are not impacted by ICB organisational change process).
- Agreement that these groups become the delivery groups for ageing well and dying well. Reporting requirements into the Board are in development. This allows the PPP to test the new ways of working.
- Work to be undertaken to identify resource and leadership to progress the remaining identified delivery groups.

Kirklees Place Provider Partnership : Governance and Sub-Governance

NHS West Yorkshire Integrated Care Board

Formal Governance Sub-Structure – Shadow / Transitional Arrangements (FINAL DRAFT)



Proud to be part of West Yorkshire Health and Care Partnership

Kirklees Health & Care Partnership

Kirklees Place Provider Partnership : Design, Development and Maturity

NHS West Yorkshire Integrated Care Board

- A self-assessment framework has been developed to measure the maturity of Place Provider Partnerships within West Yorkshire, assessing their readiness to take on formal responsibilities.
- All emerging Place Provider Partnerships within West Yorkshire have completed a baseline assessment. It is intended that this exercise is completed on a quarterly basis to track progress.
- Key actions to progress maturity will be documented within a Place Provider Partnership development plan. It is intended that the Design Group will continue to meet to progress the actions within the development plan.

KPPP Baseline Assessment:

Area	Emergent	Developing	Maturing	Mature	Exemplar
Partnership Working and Leadership		✓			
Purpose and Governance	✓				
Population Health Management (PHM)		✓			
Transformation and Delivery	✓				
Stewardship and Resource	✓				
Communications and Involvement		✓			
Capacity and Capability	✓				

Kirklees Health & Care Partnership

Kirklees Place Provider Partnership : Design, Development and Maturity

NHS West Yorkshire
Integrated Care Board

KPPP Q1 Assessment:

Area	Emergent	Developing	Maturing	Mature	Exemplar
Partnership Working and Leadership		✓			
Purpose and Governance		✓			
Population Health Management (PHM)		✓			
Transformation and Delivery		✓			
Stewardship and Resource	✓				
Communications and Involvement		✓			
Capacity and Capability	✓				

- Place Provider Partnerships within West Yorkshire reassessed themselves at the end of Q1. For Kirklees there the re-assessment shows a positive improvement.

Kirklees Place Provider Partnership: Design, Development and Maturity

NHS West Yorkshire
Integrated Care Board

Working together with Wakefield and Calderdale

- Where it makes sense, approaches are being designed once and shared across CKW. This will reduce duplication, use our resources effectively and support colleagues working in Integrator Teams.

- The following workstreams have been identified as opportunities for a joint approach

  - Defining shadow working arrangements
  - Scope, including seeking legal advice
  - Governance products
  - Due diligence
  - OD programme
  - Enablers

Each workstream has a nominated sponsor and connectivity back into the Place Design Groups.

Kirklees Place Provider Partnership Kirklees Place Provider Partnership: Design, Development and Maturity

NHS West Yorkshire Integrated Care Board

Issues and Concerns for Further Resolution

- Systems and processes for oversight of finance and contracts
- Lack of funding to pump prime new ways of working to deliver neighbourhood health and enable shift of resource within the system.
- A robust process for quality surveillance and governance
- How decisions will be made and escalation process for when a decision cannot be reached (post transitional phase)
- People and resources including managing the impact of organisational change in the short term
- CHC and Safeguarding. Specifically relating to loss of DCOs in the short term

Areas identified by the KPPP Board for wider support from the WY ICB

- Clarity on expectation of the PPPs
- Oversight of finance and contracting
- People and resources – access to core team functions in addition to Integrator Teams

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

MEMBERS: Cllr A Kasia, Cllr S Wood, Cllr B Armer, Cllr M Smith, Cllr M Simmons, Helen Clay (Co-optee) Kim Smith (Co-optee).

SUPPORT: Nicola Sylvester, Principal Governance Officer

THEME/ISSUE	APPROACH AND AREAS OF FOCUS	OUTCOMES
• **Changes to the ICB**	• Shadow year, how this is going. • What the changes mean for Mid Yorkshire Teaching Trust, Calderdale & Huddersfield Trust, South West Yorkshire Trust and Kirklees Council. • Neighbourhood health framework, how goals 1-5 and the NHS reform agendas will be achieved for Kirklees. • How are Integrated Neighbour Teams going to be set up. • Details on Governance, Financial risk, alignment with neighbourhood health, performance ambitions and treatment of core adult social services within Kirklees. • To provide risk assessment with mitigations of changes for Kirklees, including a list of risks and issues (ICB & Kirklees council). • New timeline of implementation and reviews, including who will be accountable/responsible for sign off and who has been consulted. • To provide a schedule of agreed service level agreement. • To provide a geographical map of C, K, W primary care networks along with what service requirements will be in the new geography and provide a resource plan to match the map. • What services are currently in scope.	**Panel meeting 22nd July 2026** **Children's Scrutiny Panel in attendance**
• **Myalgic Encephalomyelitis (ME)**	• Details on actions taken regarding the recommendations in the 2021 NICE guidelines for ME and July 2025 Dept of Health Care Plan for ME.	**Panel meeting 22nd July 2026**

	• Details on any commissioned speciality ME services within Kirklees that meet NICE requirements. • Waiting times for assessments, diagnosis, and specialist support within Kirklees. • Number of residents within Kirklees who have a diagnosis of ME and Long Covid or who are currently waiting for assessments. • Details on engagement sessions with the Kirklees & Calderdale ME Campaign group. • Training provided on ME and proportion of staff who have completed. • How people with severe and very severe ME identified and supported within Kirklees.	
• **Health System Financial Overview**	To consider the Health System Financial Overview with an overview of the financial position of the local health and social care system to include • The work that is being carried out to meet current years budgets. • And identify risks. • Recruitment and retention. • Costings for private care home providers. • Details of contracts for private care home providers. • Mid Yorkshire Training Trust Financial Improvement Plan.	**Panel meeting 2nd September 2026**

• **CQC**	• How well is the new model working. • Challenges. • Good news stories. • Number of inspections in Kirklees Council. • Outcomes of inspections. • KPI's used to assess trusts in-between inspections. • Thresholds that trigger inspections. • How services are inspected. • How regulated.	**Panel Meeting 2nd September 2026**
• **Seasonal Pressures and Hospital Discharge (excluding SWYFT)**	• Joined up care between organisations. • Avoiding corridor care. • Seasonal pressure plan for the next 12 months. • Risks across trusts, along with a mitigation plan for the next 12 months. • Discharges in a timely manner along with system flow. • What has been learnt from previous years and what is different. • The number of patients medically fit for discharge but remaining in hospital. • The average length of discharge delays. • The main reasons for delays, including care packages, equipment, housing or assessments. • Readmission rates where available. • What improvements are being made across the system to reduce delays and improve patient outcomes	**Panel Meeting 14th October 2026**
• **Mid Yorkshire Clinical Safety Review**	• Services affected by the clinical safety review. • Reconfigured services in and out of Dewsbury. • Implementation of the new electronic patient record system. • Supporting the Place Based Partnerships. • Maximising the new surgical hub on the Dewsbury District Hospital.	**Panel Meeting 14th October 2026**
• **Kirklees Council CQC Inspection**	• Follow up of actions from the initial CQC Inspection. • Changes to improve services.	**Panel meeting 13th January 2027**

	• Preparing for Phase 2 of the inspection.	
• **Principal Social Worker/Principal Occupational Therapist Annual Report**	• Principal Social worker and Principal Occupational Therapist Annual Report.	**Panel meeting 13th January 2027**
• **Digital Exclusion and Access to Primary Care**	• Current levels of digital and non-digital access across GP practices. • What alternatives are available for residents who cannot or do not wish to use digital services. • Data on telephone waiting times, abandoned calls and appointment access where available. • What measures are in place to support older people, disabled people and those whose first language is not English. • Examples of good practice across Kirklees and areas requiring improvement.	**Panel meeting 13th February 2027**
• **Martha's Law**	• Steps taken to ensure compliance. • Number of cases requiring formal action and their outcomes. • How the law is communicated across the local authority. • Improvements made.	**Panel meeting 17th February 2027**
• **Patients experience at Hospitals**	• Main issues patients raising. • Experiences from vulnerable people.	**Panel meeting 17th February 2027**
• **Mental Health Referral Thresholds**	• The number of referrals declined by CAMHS and adult mental health services. • The most common reasons for declined referrals. • What support is offered to people who do not meet service thresholds. • Waiting times between referral, assessment and alternative support. • Any evidence that people are repeatedly moving between services without receiving appropriate care. • What work is underway to reduce people falling through the gaps.	**Panel meeting 10th March 2027** **Children's Scrutiny Panel in attendance**

• **Seasonal Pressures (SWYFT)**	• Joined up care between organisations. • Avoiding corridor care. • Seasonal pressure plan for the next 12 months. • Risks across trusts, along with a mitigation plan for the next 12 months. • Discharges in a timely manner along with system flow. • What has been learnt from previous years and what is different. • The number of patients medically fit for discharge but remaining in hospital. • The average length of discharge delays. • The main reasons for delays, including care packages, equipment, housing or assessments. • Readmission rates where available. • What improvements are being made across the system to reduce delays and improve patient outcomes	**Panel meeting 10th March 2027**
• **Unpaid carers**	• Overview from Carers Strategy Group. • Breakdown on types of carers. • Challenges for cares. • Support available for carers (including employees of LA). • Contract details with different groups. • Impacts, delivery and costs of carers. • Health Inequalities for carers.	**Panel meeting 10th March 2027**
• **Safeguarding Adults Board**	• Safeguarding within Kirklees as an organisation. • Safeguarding Adults Board Annual report. • Impacts/support for workforce.	**Panel meeting 21st April 2027**
• **Substance Misuse Services**	• Commissioning arrangements and funding. • Performance against contract outcomes. • Number of people accessing services. • Waiting times from referral to treatment. • Successful completion and relapse rates. • Support for people with co-existing mental health needs.	**Panel meeting 21st April 2027**

	• Partnership working with GP, health, social care, housing and the police. • Future challenges and opportunities for improving services.	
• **Visit to Diagnostic Centre**	• To enable Panel members to gain a first-hand understanding of the patient journey, service delivery model, diagnostic capacity, and the centre's contribution to reducing waiting times and improving health outcomes for residents.	**November 2026**
• **Quality of Residential and Domiciliary Care**	• Updated information from the last H&ASC panel meeting. • Timely inspections from CQC. • Operation of the contracts team to ensure quality is maintained. • Complaints followed up and what action taken. • Are there themes of complaints. • How is quality measured. • View of social workers.	**Request Report**
• **Prevention of Suicide**	• What is the work done at each stage of prevention. • Bereavement support after suicide. • Progress made on suicide. • What work is undertaken to prevent suicide (working with groups). • Andy's man club & other organisations to provide an update. • Statistics for Kirklees Council. • Armed forces veterans, number in Kirklees and suicide rate of these.	**Request Report**
• **Dentistry**	• Current access to NHS dentistry in Kirklees, including the number and percentage of adults seen in the last 24 months and children seen in the last 12 months, together with trends over recent years. • Any available data on waiting times for routine NHS dentistry, urgent appointments, Community Dental Services and orthodontic services. If waiting time data is not collected centrally, an explanation of how access is monitored.	**Report requested 29th June 2026**

	• An update on orthodontic provision, including the number of providers in Kirklees, current waiting times, and progress since the previous report. • An overview of NHS dental capacity, including the number of practices, workforce position and whether practices are currently accepting new NHS patients. • An update on oral health inequalities across Kirklees and any targeted work taking place in areas of greatest need. • Progress made since the previous report, including what has improved, what challenges remain and the key priorities going forward. • Any information on alternative approaches to delivering orthodontic services, where clinically appropriate, that could help improve access. • Any significant risks affecting NHS dental provision over the next 12 to 24 months, including workforce, funding and commissioning. • How any of all registered dental practices in Kirklees re currently accepting new NHS patients and if there are any, who or where are they? • What are the average waiting times to be accepted as a newly registered NHS patient? • What are the average waiting times for an already registered patient to receive treatment? • Reasons why waiting times for minors are not published for Orthodonture (like A & E waiting times?) • Reasons why the position of minors is not available to parents for Orthodonture.	
• **Healthwatch Reforms**	• The expected impact on Kirklees. • How independent patient voice will be maintained. • Any risks to scrutiny if Healthwatch functions transfer elsewhere.	**Request Report**

	• How the Council intends to continue receiving independent resident feedback.	

Golden Threads: Workforce recruitment and retention.
Performance data to be included where appropriate to inform the individual strands of work.
Reducing Inequalities.
Digital, the impact for people.

Health & Adult Social Care Scrutiny Panel – Outline Agenda Plan – 2026/27

MEETING DATE	ITEMS FOR DISCUSSION
22 July 2026	1. Changes to ICB 2. Myalgic Encephalomyelitis (ME)
02 September 2026	1. Health System Financial Overview 2. CQC
14 October 2026	1. Seasonal Pressures and Hospital Discharge (Excluding SWYFT) 2. Mid Yorkshire Teaching NHS Trust Clinical Safety Review
13 January 2027	1. CQC Kirklees Council Inspection 2. Principal Social Worker/Principal Occupational Therapist Annual Report 3. Digital Exclusion and Access to Primary Care
17 February 2027	1. Patient Experience at Hospitals 2. Marthas Law
10 March 2027	1. Unpaid Carers 2. Mental Health Referral Thresholds 3. Seasonal Pressures (SWYFT)
21 April 2027	1. Substance Misuse Services 2. Safeguarding Adults Board

All meetings have been scheduled to start at 2:00 pm with a pre-meeting at 1:30 pm

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