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NHS West Yorkshire
Integrated Care Board

Neighbourhood Health in Kirklees

Overview & Scrutiny Committee – July 2026

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National Context:
What is Neighbourhood Health?

WEST YORKSHIRE INTEGRATED NEIGHBOURHOOD HEALTH

Neighbourhood Health Framework

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- 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.

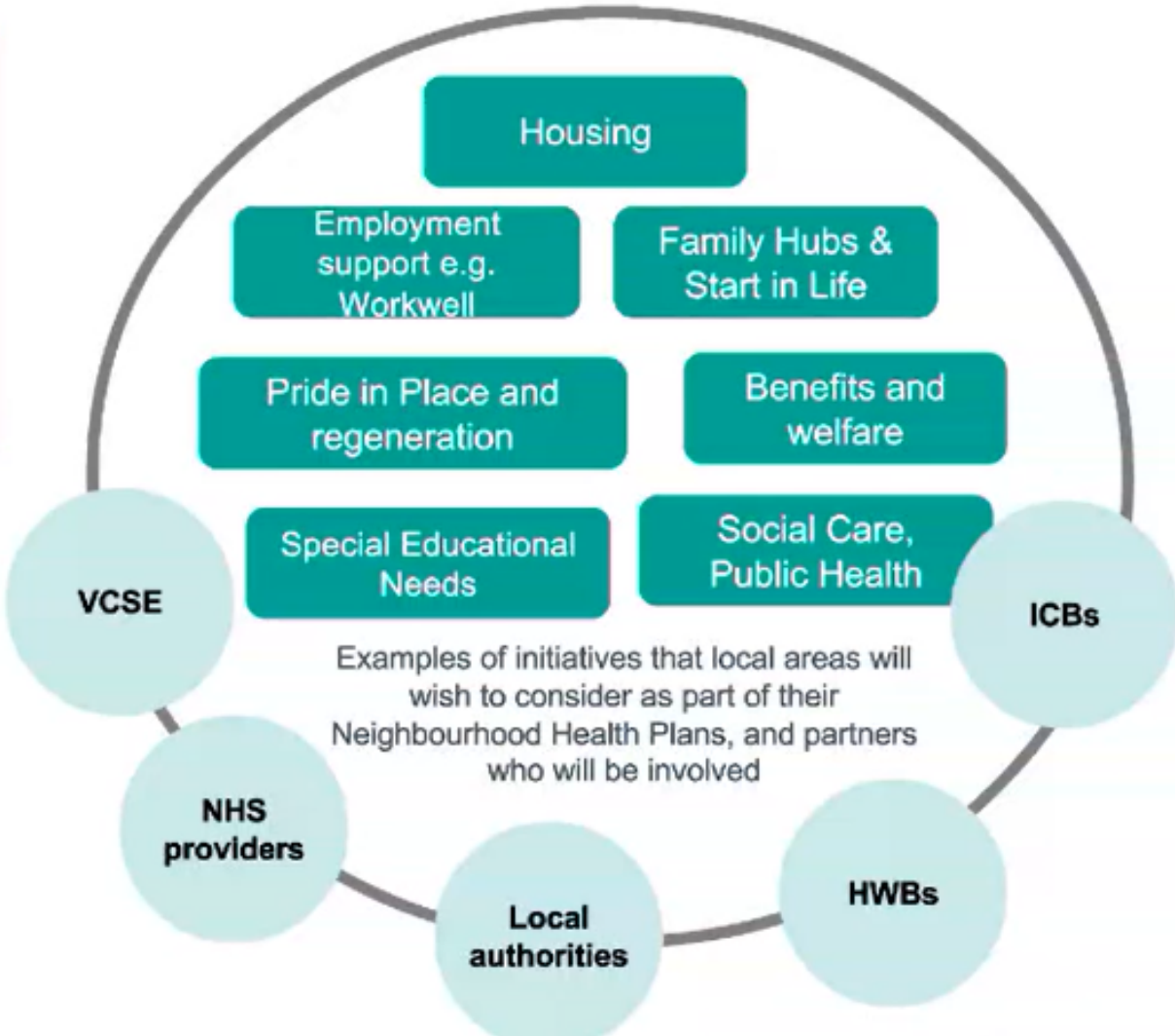
Through Health and Wellbeing Boards, ICBs and local authorities will work in partnership to:

- 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.



Neighbourhood Health Framework - Summary

Next Steps

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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)

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

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Neighbourhood Health in Kirklees

WEST YORKSHIRE INTEGRATED NEIGHBOURHOOD HEALTH

What are we trying to achieve?

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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.

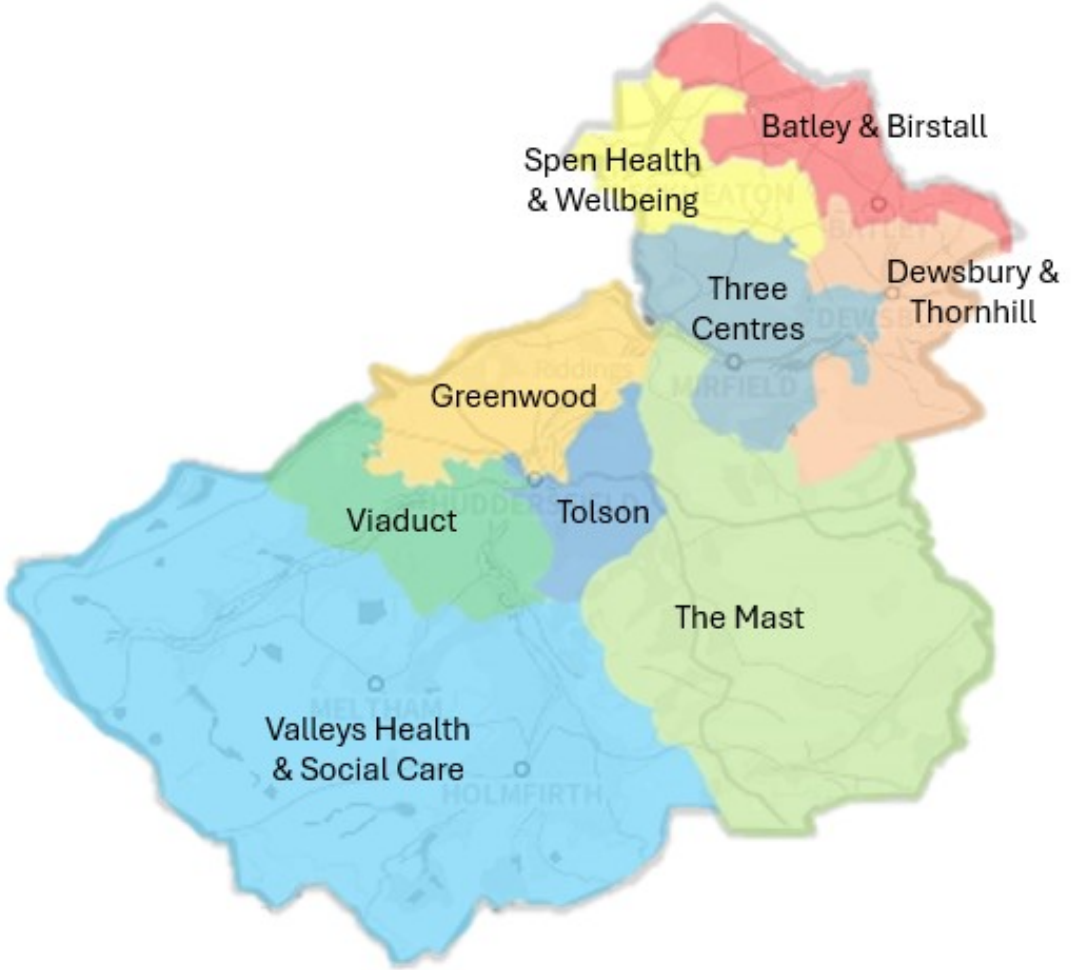
This builds on the West Yorkshire Vision.

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

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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

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- 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

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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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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

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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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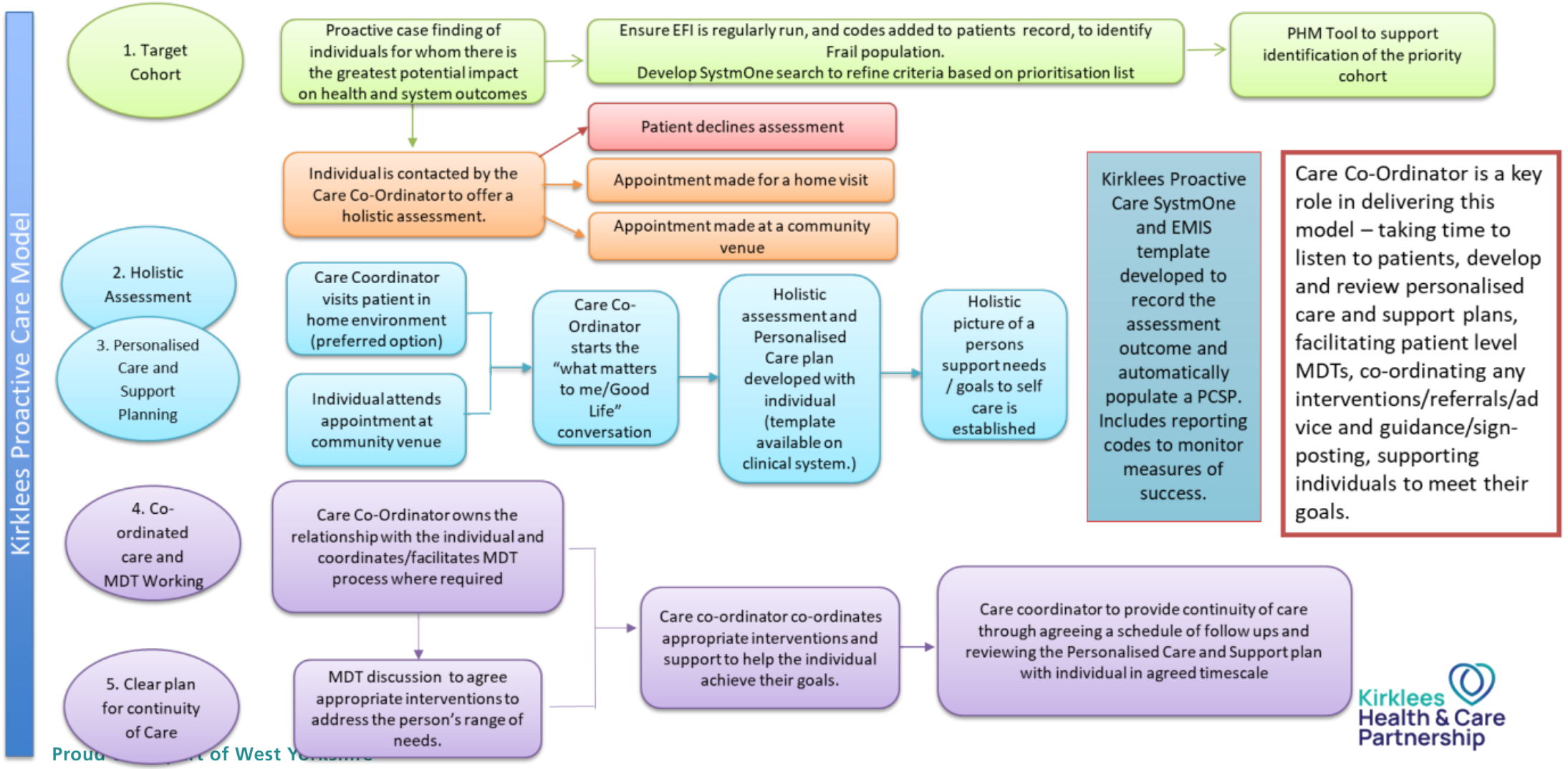

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Population Health Management (PHM)

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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

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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.

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.

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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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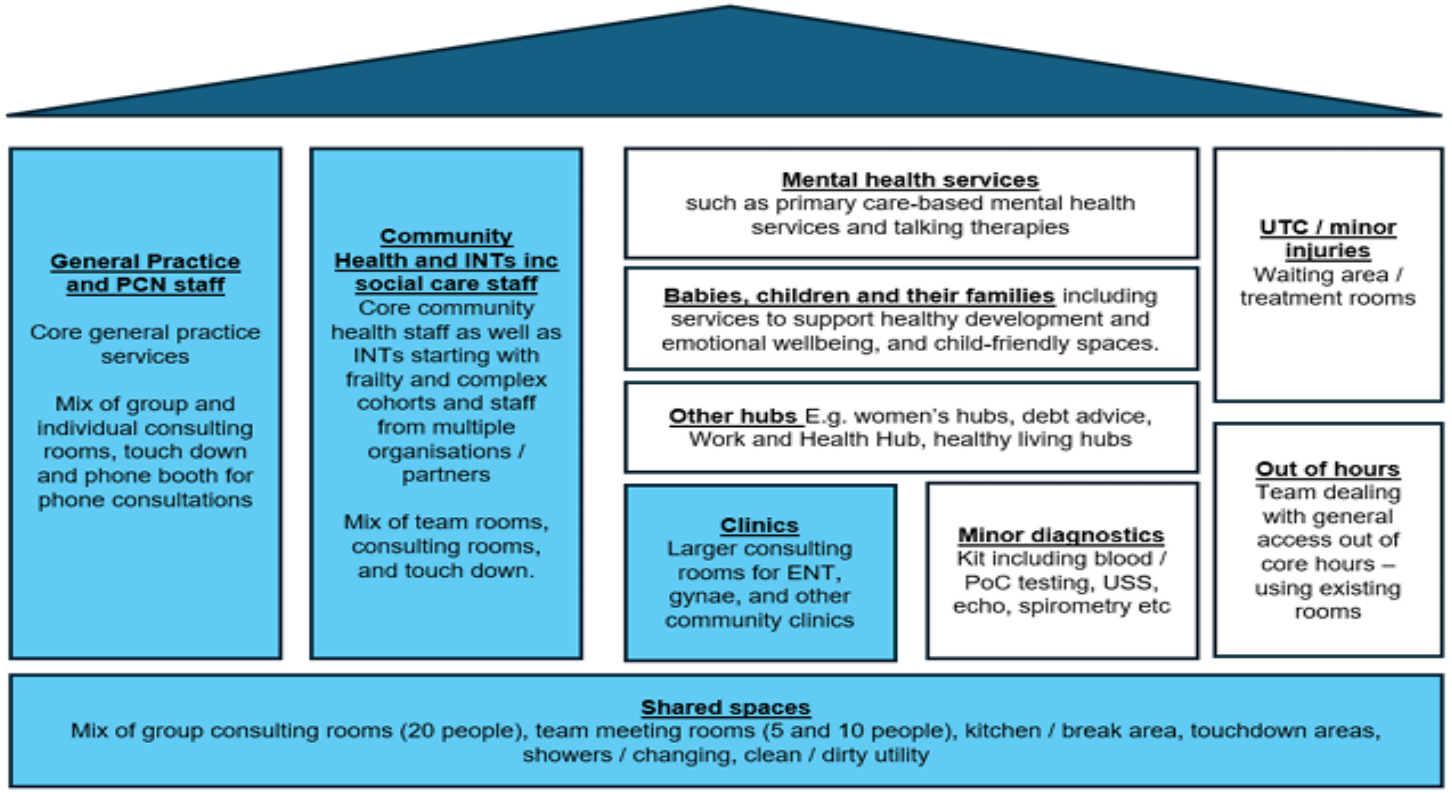

Blue boxes represent the minimum requirements for designation as an NHC. As a minimum, this includes an on-site GP practice and a model capable of operating at scale over time.

Place Submissions

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- 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

- 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.

Refinement and pipeline build:

- 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.

Scheme progression:

- 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

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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

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Governance within Kirklees: Place Provider Partnership (PPP)

WEST YORKSHIRE INTEGRATED NEIGHBOURHOOD HEALTH

Development of the Kirklees Place Provider Partnership Recap

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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

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"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

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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

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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

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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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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

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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

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- 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

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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

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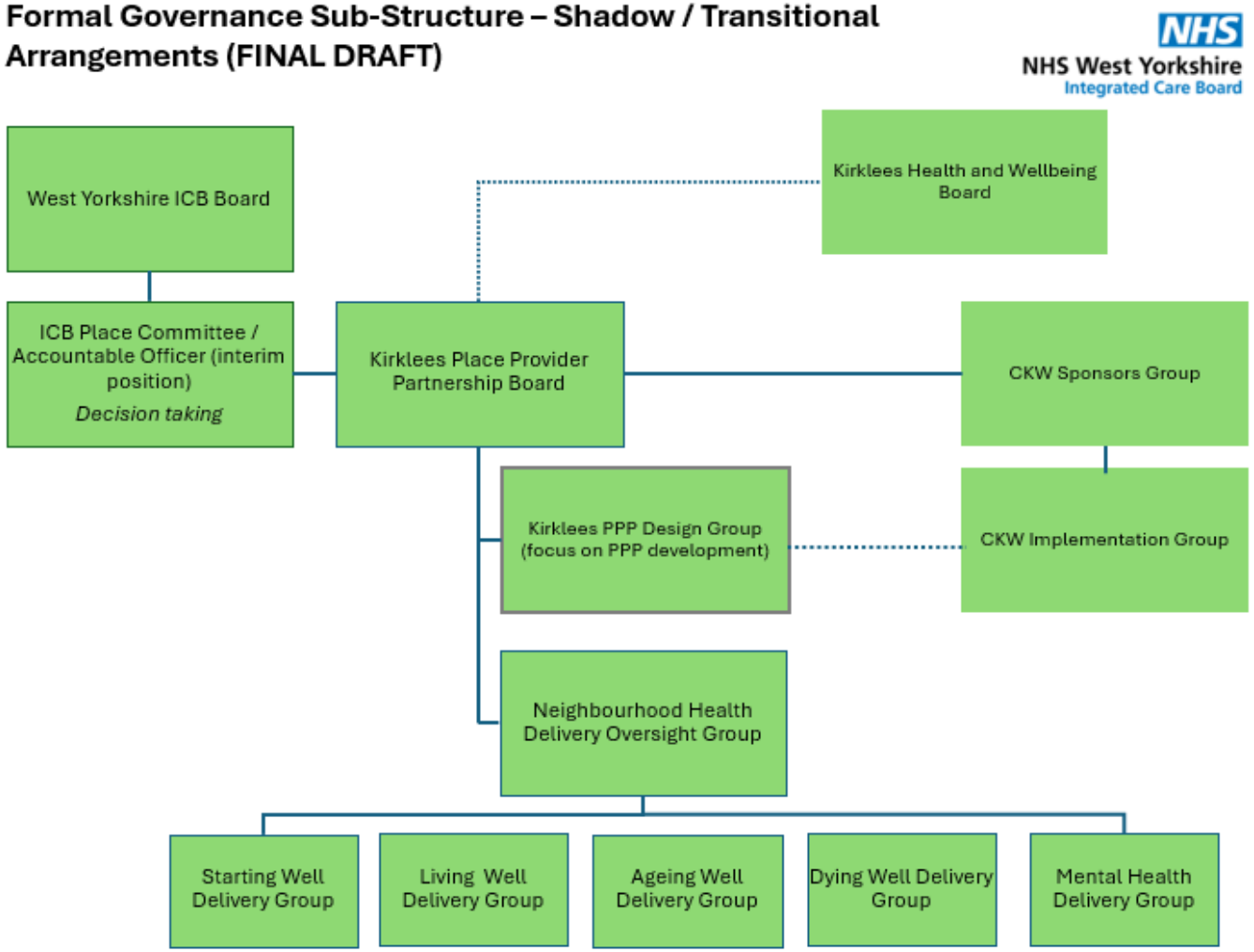
Formal Governance Sub-Structure – Shadow / Transitional Arrangements (FINAL DRAFT)



Kirklees Place Provider Partnership : Design, Development and Maturity

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- 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
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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

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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

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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