Bradford District and Craven
Health and Care Partnership
ACTasONE

Our plans for health, care, and wellbeing in Bradford District and Craven

September 2025

Proud to be part of the West Yorkshire
Health and Care Partnership

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Foreword by our Chair

Bradford District and Craven is full of potential. At the same time, official statistics show that two out of every three residents live in areas that are among the most deprived in the country. Too many people face unfair barriers to good health: poverty, poor housing, low income, and limited access to services or opportunities. People in our most disadvantaged communities live shorter lives and spend more of their later years living with poor health.

Our shared ambition is to change this. We want to increase the number of people in Bradford District and Craven who can live long, healthy lives. We've seen how real progress happens when individuals, communities, and partners from every sector come together with a shared purpose. Improving health and wellbeing is not simply a job for the NHS, it takes individuals, families, communities, and partners from every sector - public, independent, and voluntary - working together.

There are many examples across our place where this is already happening. We have developed creative ways of supporting people with long-term conditions to live as healthily as possible. We have worked alongside communities to develop local solutions that improve people's life chances. We have designed services that prevent ill-health and support early intervention. Integrated teams are helping people avoid unnecessary hospital stays and recover well at home. And we are using technology to offer more care in people's homes and communities.

We have also learned that our health and care system can create wider value, sometimes called social value. The decisions we make can improve wellbeing, create good jobs, support local businesses, strengthen communities, and protect the environment. We know what works. The challenge now is to apply that learning in a more joined-up and systematic way so it can have even greater impact.

This strategy has been developed from that learning. It sets out a new way of working. We will build on the good work already happening and reshape services to meet people's needs more fairly. The next phase is about action. Through a series of design and delivery groups, our partners, communities, and workforce will help shape clear, measurable plans that focus on what matters most.

We know that pressures on local budgets and services will remain intense. Difficult decisions are inevitable. That is why we will apply the principle of proportionate universalism. This means supporting everyone, while focusing the greatest effort where the need is greatest.

By working together with local people, we can make lasting change.

Elaine Appelbee

Chair, Bradford District and Craven Health and Care Partnership

Introduction

Acting to reduce health inequalities and improve the health, care, and wellbeing of our population is at the heart of everything we do. This plan is set out in support of our Health and Care Partnership vision, where we **Act as One** to keep people **Happy, Health, at Home**.

Our plan is informed by our work with **local people** as partners. We have made, and continue to make, significant efforts to reach seldom heard and underserved people and communities, working with trusted partners to achieve this. Our **active citizens** are shaping the future of health and care in Bradford District and Craven. We are connecting through community insight and continuing to take an asset-based approach in our neighbourhoods and localities.

Our plan is shaped by the **opportunities** made available to us through new capital investment, the establishment of provider partnerships, and by our shared understanding of our population. We know where we can work together to tackle inequalities, develop neighbourhood health and care, and thereby improve health now and for generations to come, by using the data and insight we have available to us, to better understand our communities and better allocate resources.

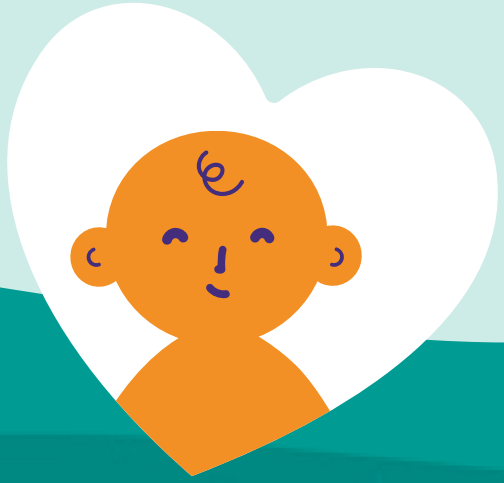
The underlying reason for this plan is the health and wellbeing of our population. While we have a relatively young population, when we look forward to **2040** our population demographic changes significantly. Our use of predictive modelling to **foresee the future** has shown us why we need to transform how we work, where we work, and the simple changes that can make a difference to people's access, experience, and outcomes of care. Without change, the health of our population will continue to deteriorate and our services will be unable to meet the rising and changing needs of local people. **Prevention** – primary, secondary, and tertiary – needs to become life-long, whole system, and at the heart of all that we do.

As partners, we take on the responsibility for the wellbeing of our population. We have a culture of collaboration that is a powerful enabler of change. We are guided by the principle of **subsidiarity**, with decisions taken as close to local communities as possible, and at a larger scale where there are demonstrable benefits or where co-ordination adds value. This requires us all to be leading and directing our organisations to facilitate the ambitions and duties of our Health and Care Partnership.

This plan helps us answer questions and take decisions as a Partnership.

We are not what we do now. Not the past, not tradition.

We are what we do next.



Our Shared Purpose

Our strategic intent

Everyone deserves to expect a long, fulfilling, and healthy life. The health issues facing our population are not caused by any single issue, but a complex mix of environmental, economic, and social factors. We know that up to 80% of individual health outcomes stem from the non-medical drivers of health, many of which are influenced by where we live. Inequity in healthy life expectancy is also partly about how we currently organise our health services, not only social determinants. This connection between the factors that affect everyone's lives is why we have set out our plans for the health, care, and wellbeing in Bradford District and Craven in line with the council plans of Bradford and North Yorkshire.

Whilst we have made good progress in aspects of our Partnership Strategy, there are still many instances where our population experience fragmented and reactive care. We expect our communities to fit their lives around the way we have organised health and care services, rather than the other way round.

Our plan is to create a health and care system across Bradford District and Craven that is increasingly **neighbourhood-focussed**, integrating services to enable people to lead healthier, more independent lives. We will make improvements across the breadth of factors that matter to local people, taking a **whole population** health, care, and wellbeing approach.

As a Health and Care Partnership we work through a distributive leadership model, taking place-based decisions together, taking responsibility for outcomes together, and taking accountability for the health of our population together.

The financial climate within which the partnership operates, and the need to 'live within our means' has created a challenging environment for major service transformation to happen. We know that we will not achieve the aims of this plan without a more fundamental shift in ensuring our resources are community focused. This, in turn, requires us to work differently.

By accelerating workforce transformation, we are increasing our ability to support people to recover from illness or manage multi-morbidity in their own home. A move to more personalised care.

How we organise health services is in our gift. To achieve this, we need to invest in the services and teams that operate in the community, and we need to ensure that there is more consistency (or parity) in access, experience, and outcomes of care for our population. We will plan for change based on predictive modelling to foresee future demand.

Prevention, improving health, and tackling health inequalities guides everything we do.

Our challenge

We cannot meet all the healthcare needs of our population if we continue to do what we do now. As we take decisions about the future we will be open and transparent about why.

People's needs are changing. People are living longer but not in better health. By 2040, there will be a 27% increase in people over the age of 65 and a 38% increase in people living with a long term, life-limiting condition. The major conditions that are collectively the greatest contributors to ill-health and early death are cardio-metabolic disease, MSK (musculoskeletal) disease, cancer, mental health disorders, and dementia. These conditions are not inevitable; they are driven by modifiable risk factors (such as smoking, obesity, physical activity) and living conditions (such as poverty, housing, employment, and the environment).

We are not delivering 'best value' healthcare. One in six hospital admissions are driven by conditions that could have been avoided through timely and coordinated community-based care. One in five primary care encounters are considered non-medical and are driven by social issues like loneliness, housing concerns, debt, or relationship problems. The segment of our population with the most complex needs accounts for two-thirds of non-elective activity. We must use our resources in a way that maximises value, away from reactive care.

The Government has set out '3 Big Shifts' to meet this challenge

- **Analogue to digital:** embracing advances in data and digitally-enabled care to target our resources more effectively, identify patient risk, streamline and simplify communication, and empower citizens.
- **Hospital to community:** keeping people well and independent at home by wrapping the right support around them to avoid escalation of risk, using the full range of assets that exist in communities.
- **Treatment to prevention:** addressing the biological, psychological, and social drivers of ill-health and inequalities, to mitigate risk by intervening earlier and tackling the wider determinants of health.

Optimising our system architecture for delivery of the '3 Big Shifts'

We must build capability and clear delivery structures to enact our plans for integrated neighbourhood care, integrated specialist care, and our integrated approach to population health management.

This plan sets out the **foundations** for our new 'system architecture'. Our system architecture defines how our local system is structured, behaves, and how our component parts interact. It guides our physical and mental models during the design, development, and implementation of our plan. It is our **roadmap** to build a sustainable health and care system.

Our Population

Our population data and future state

Our plans are guided by data and intelligence, analysis, and insight to develop a deep understanding of our local population, their needs, and how these are likely to change over time. Bradford District and Craven Health and Care Partnership serves a GP-registered population of around **670,000 people**, with a mixed urban and rural, and ethnically diverse population. Overall, Bradford District has a relatively young population (compared to the UK). More than a third of our population live in poverty (mainly in wards around central Bradford and Keighley), whereas Craven has an older and further ageing population.

Office for National Statistics population projections predicts by 2040: a reduction of 16% in 0-19 year olds; 6% growth in the working age adult population (20-64 years of age); and a 27% increase in those aged 65plus, of which there will be a 53% increase in those aged 85 years and above (a high healthcare use cohort). When applied to our current population profile, the largest population changes will be seen in Shipley (5.1%), Keighley 5.8%), and Craven 7.6%).

Our population profile

Most of our population are either classified as being healthy (51%) or with long term conditions (LTCs) (38%). Of the remaining 11%, children with complex conditions (4%), and frailty and dementia (3.5%) are the largest groups.

It is inevitable that many people will develop long term conditions, and some will have multiple conditions. We need to support a trend towards a **healthier population** by:

- slowing the rate of transition of people from healthy to long-term conditions (via primary prevention);
- slowing the rate of transition of people with long-term conditions to more complex conditions (via secondary prevention and joined-up care); and
- by improving integrated pathways to better manage the health of people with complex conditions and multi-morbidity.

The **key differences** in the population health profile between **our six localities** are:

- Shipley and Craven have the lowest proportion of healthy population and highest proportion with long term conditions (likely caused by higher life expectancy and more people living with illness into older age);
- The palliative care population is highest in Keighley and Craven, and frailty/dementia highest in Craven (although Bradford South has a high proportion of frailty/dementia in the under 65 years population); and
- Children with complex conditions make up a higher proportion of the population in Bradford East, South, and West.

If our current trends continue, the number of healthy people is predicted to fall by 2.2% by 2040, with those with long term conditions predicted to rise by 9%. Of concern is the large, predicted increase in those requiring palliative care support and treatment (increasing by 38%), and people with frailty and dementia (increasing by 29.4%).

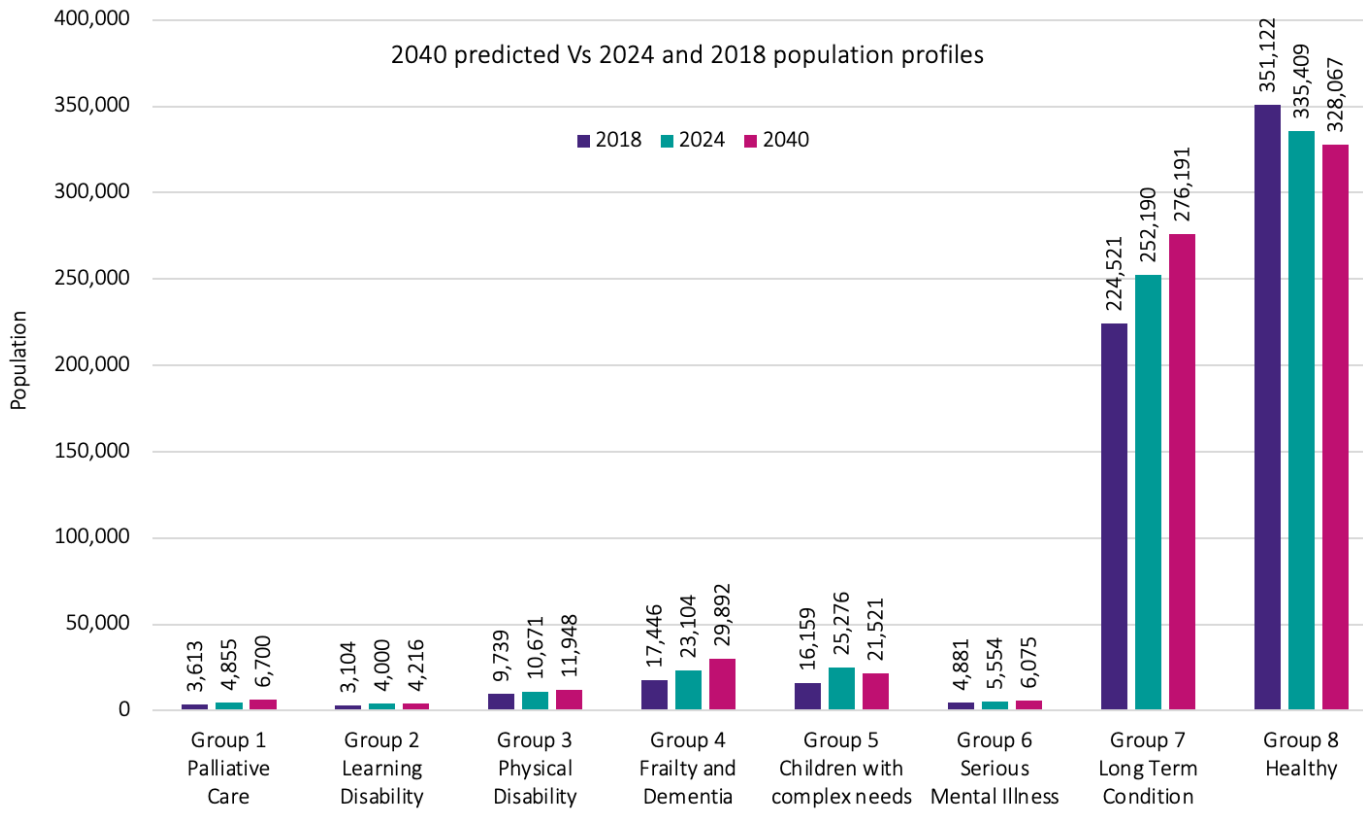


Figure 1: Predicted population profile for Bradford District and Craven 2018, 2024 and 2040

The 'healthy' population make up one third of Emergency Department (ED) visits and 20% of emergency admissions, although some of these people will have undiagnosed illness and not yet be on disease registers. Certain groups account for a much higher proportion of healthcare use, and should be priorities for coordinated care, including:

- People above 65 years with **serious mental illness** (approximately 900 patients), who have emergency admissions three times the average and six times the average bed days;
- **Children with complex conditions** (25,300), who have double the average secondary care use and three times more emergency admissions;
- **Frailty and dementia** patients above 65 years, who account for nine times the average emergency bed days;
- **Palliative care** patients account for ten times the average level of elective care, eight times the emergency admissions, and 22 times emergency bed days than the average; and
- **People with learning disabilities** (4,000 patients) have twice the average levels of ED attendees, and six times the mental health admissions and service bed days.

In deprived parts of our district, 5-10% of primary care lists are accountable for up to 40% of appointments, with a higher proportion of attendance for or caused by non-medical reasons. These reactive patterns leave less capacity for proactive and preventive work.

Key health conditions

The key conditions that **cause ill health** across the life course in our district are for:

- **Children and young people under 20 years:** maternal/neonatal disorders, mental health disorders, and non-communicable causes (e.g. asthma, dermatitis);
- **Adults 20-40 years:** mental health and substance use disorders; increasing musculoskeletal (MSK) conditions with age;
- **Adults 40-70 years:** mental health disorders, MSK, diabetes, kidney conditions; increasing cardiovascular disease (CVD) and respiratory illness with age; and
- **Adults over 70 years:** cancer and CVD; with increasing neurological, sensory conditions, and unintentional injuries with age.

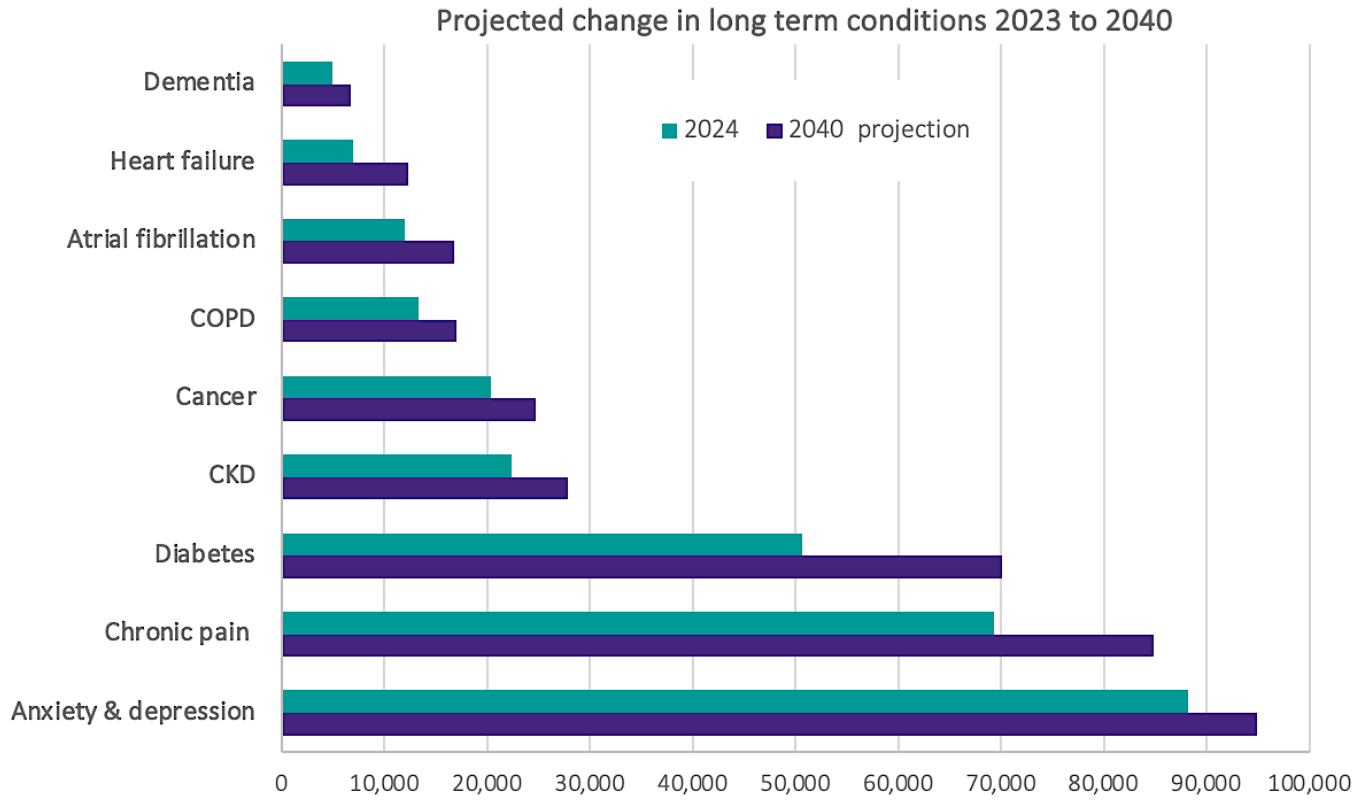


Figure 2: Projected change in long-term conditions 2023 to 2040

An ageing population and projected higher prevalence of some long-term conditions will lead to a sharp increase in demand for healthcare if we do not adopt more radical prevention strategies. From national research, the largest estimated increases in patients by 2040 are for diabetes (49% increase), chronic pain (32%), and heart failure (92%); conditions that tend to be managed in primary care settings.

Multi-morbidity

In the UK, hospital admission costs are four times higher for someone with four LTCs compared to no LTCs. A high proportion of people with **chronic conditions** (e.g. cancer, CVD, respiratory disease, and mental health disorders) also have a recorded musculoskeletal condition (affecting muscles, bones, joints, nerves, and causing pain). The other area of high multi-morbidity is between recorded depression in people who have other long-term conditions. Development work on **multi-morbidity pathways** incorporating pain and mental health treatments is essential.

Our health inequalities

Life expectancy is the average number of years a person is expected to live. Life expectancy varies by 8 years for women and 10 years for men across wards in Bradford District and Craven.

Healthy life expectancy is the average number of years a person is expected to live in good health. Women living in parts of central Bradford can expect 49 years of healthy life expectancy compared to 72 years in Wharfedale, a 23-year difference. For men, healthy life expectancy varies from 51 to 71 years, a 20-year gap.

Deaths from circulatory diseases (heart diseases, stroke, and diabetes) and cancer contribute at least half of the life expectancy gap for people in our district. Over the last 3 years the death rate due to preventable cardiovascular disease has risen.

Across our 13 Community Partnership areas there is **significant variation** in lifestyle, access to healthcare, and long-term conditions including:

- **Lifestyle factors** – smoking varies between 8% and 24% by Community Partnership (overall value 18%);
- **Preventive interventions** – flu vaccinations vary between 22% and 72% (overall value 42%);
- **Healthcare access** – pregnant women's access to maternity care by 10 weeks varies between 35% and 78% (overall 51%); and
- **Long term conditions** – Chronic Obstructive Pulmonary Disease (COPD) prevalence varies between 1.4% and 3.5% (overall 2.3%).

Preventable mortality, that is preventable from public health interventions, is significantly higher than the England average in 17 of 30 council wards in Bradford District.

Lifestyle and prevention

In our district:

- Approximately 30% of the reasons for ill health are due to our **lifestyles** including smoking (14% locally), gambling, our diet and exercise, alcohol intake, substance use, and sexual activity;
- Whilst **smoking** rates have fallen over the last decade, two thirds of adults are overweight/ obese with **obesity** rates above the national average for our children, a key area for prevention activity;
- Cancer, cardiovascular disease, stroke, and diabetes often share **common risk factors**, including obesity, smoking, high blood pressure, and unhealthy dietary choices; and
- Dementia and serious mental illness have common risk factors, including social isolation and limited early access to **mental health** care.

The following graphic demonstrates that in Bradford District many lifestyle factors for children, young people, and working age adults are worse than the England average.

It demonstrates **opportunities** to work on **preventive health** to improve health outcomes across the life course.

Figure 3: Life Course Statistics in Bradford District 2024 (not available for Craven district)

Our nine key areas of action to improve the long-term health of our population

1. **Prioritise and embed prevention into communities and care pathways.** The development and progression of illness can be avoided or delayed through effective prevention. Maximise the uptake of existing prevention offers, and target those who would benefit most, to improve outcomes and manage future health and care demand.

2. **Design pathways with a greater consideration of health literacy.** Increase health literacy by tailoring language and messaging to overcome cultural barriers and stigma; and customise communications to specific population groups.

3. **Shift pathways into communities.** Deliver more interventions in community settings to improves access. Work with partners such as VCSE organisations to help understand community readiness for interventions and tailor health models accordingly.

4. **Improve our invites and appointment processes.** Develop a combination of approaches to improve uptake of services. Recognise that some groups require reasonable adjustments to attend appointments, and develop digital solutions, avoiding a digital by default approach.

5. **Target specific groups and reduce variation.** Tackle unwarranted variation in care access and delivery, from screening to treatment, particularly in inclusion health groups and those with protected characteristics.

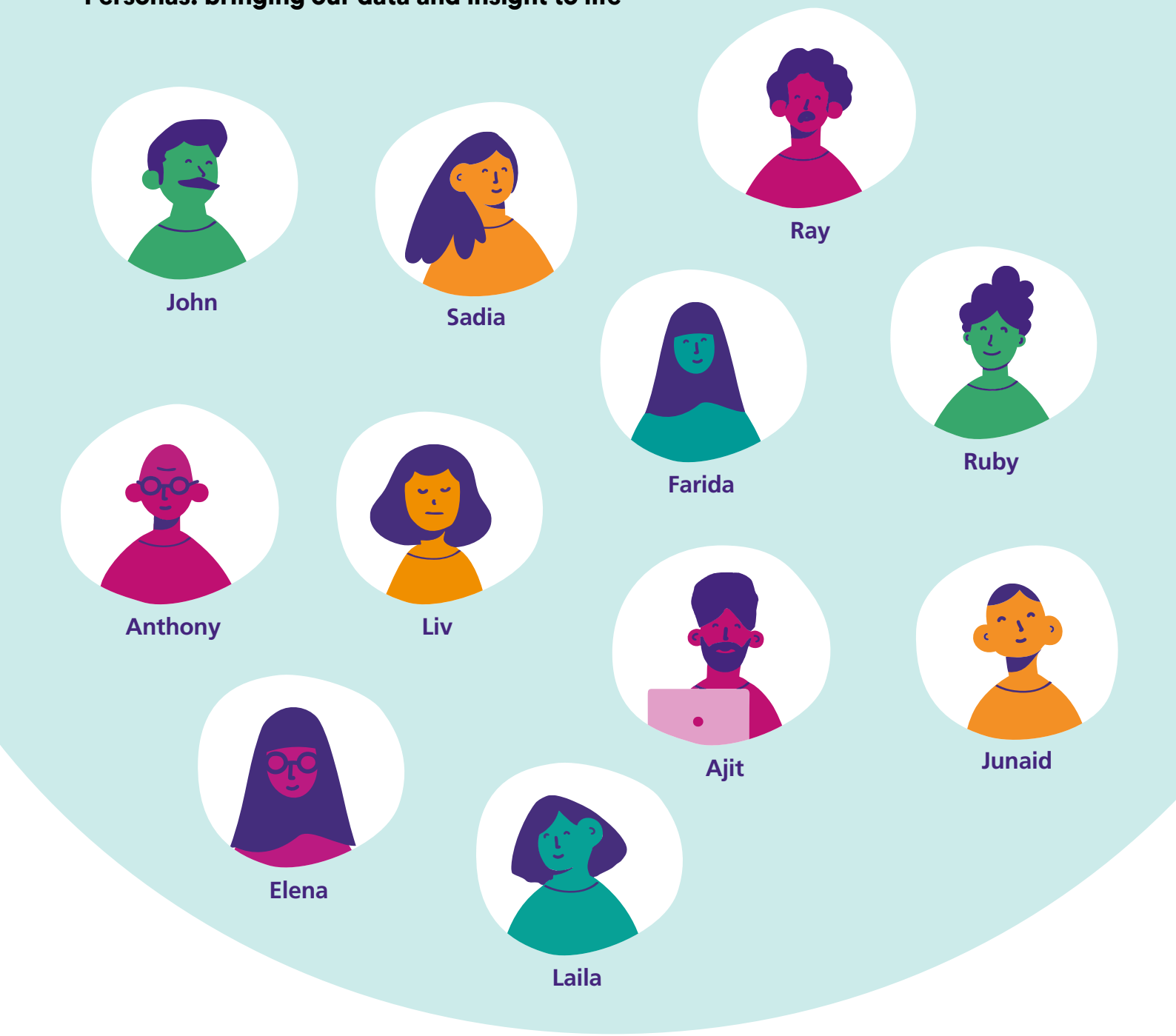
6. **Develop holistic and integrated care approaches to multi-morbidity.** Coordinated care approaches are needed for people with complex long-term conditions and multi-morbidity. Generalist pathways and approaches, with support for single specialty care, using multidisciplinary teams where possible should be used for these cohorts to avoid fragmented care and to integrate mental and physical care needs.

7. **Support self-management.** Increasing the availability of, and access to, support tools will help people to be more actively involved in their care plans and to be more confident in managing symptoms and exacerbations. This includes the use of digital technologies where appropriate. Offers may need to be tailored to meet the needs of individuals, with a range of access options available.

8. **Take a population health management approach.** Use a data driven approach to identify the patients, communities, and conditions that account for the greatest numbers of unplanned and avoidable healthcare use, where greatest health gains can be made.

9. **Target inequalities.** Focus work on health and healthcare inequalities as a 'must do' from a social perspective, a statutory responsibility, and to achieve financial stability and sustainability of our healthcare system.

Personas: bringing our data and insight to life



To bridge insight and action, we have developed a set of population personas – illustrative portraits based on population health segmentation and informed by conversations during our Listen in programme. Each persona reflects real people in our communities – such as adults with learning disabilities, children with complex needs, or healthy working-age adults – and is rooted in real experiences and conversations but anonymised to reflect a wider group.

These personas help us connect strategic decisions to people's lived realities. We will use them to shape the action plan for delivery, challenging services, organisations, and teams to plan from the perspective of those we serve. We will stress-test decisions by asking, for example, *how will this make things better for Ruby? how will Junaid access this service?*

These personas bring data to life and will shape how we tailor plans based on where different population segments live, how their needs are changing, and how they use services.

Our citizen activation, insight, and involvement

As a partnership, we recognise the key role our communities play in meeting our ambitions. Through our strategy we have committed to 'inverting the power to act'. This means devolving and **sharing decision-making with our communities** and supporting active citizenship. Active citizens don't sit around waiting for change to happen – they drive change themselves. They are inspired, motivated, and empowered to make a difference, because change can happen through us, not just to us. Our plans mean working with people as partners, shifting the relationship from passive recipient to active shaper of services.

This chapter draws on the most recent insights gathered through our participatory approaches: our deliberative events and the ongoing 'Listen in' programme.

Understanding what matters to our communities

Through the Listen in programme, we have gone out into communities without an agenda, open to hearing whatever people wanted to share about their lives, experiences, and priorities. Our efforts and resources have been focused on reaching underserved people and working with trusted community partners to achieve **meaningful engagement**.

Alongside this, we have run deliberative events: three large-scale sessions with members of the public and the health and care workforce, and six local events supported by VCSE partners in each locality - convening people, communities, and partners to challenge, critique, and inform our decision-making.

Together, these involvement activities have built a deep and dynamic understanding of our local population needs and wants. **This evidence has directly shaped and informed our strategy**.

What have we heard

Shift from hospital to community

- People are **supportive** of care closer to communities. There was concern about community services completely replacing hospital-based care. People noted issues around timely access to appointments at their GP practice, suggesting that any shift to community should include suitable healthcare staff moving to community services.
- People value the support they receive from VCSE organisations, noting the trust they place in **culturally appropriate** services tailored to meet their specific needs.
- There would need to be assurances that a shift to community-based care is **equitable** to avoid any form of 'postcode lottery' or creating any further inequalities.
- People cited the **variation** they see among services, for example the offer available from pharmacies can vary.
- As well as looking at fixed community assets and buildings, people suggested the use of **targeted** mobile and home clinics. This would help overcome the challenges people regularly feedback on travel and transport issues affecting their ability to access services.

Shift from analogue to digital

- People could see the benefits of shifting to digital to support the health and care system. However, there was issues identified such as an age divide as to who are more likely to adopt digital services and wider **digital literacy/ digital inclusion** issues.
- Throughout our work with communities, we have consistently heard how people can feel lost in a complex system. The move to digital was viewed by some as offering an opportunity for people to take **greater control** of their health and understand the services they are in contact with as well as see their **care journey**.
- People felt that if all services adopted the **same approach** and technology, it would make it easier for services to communicate with each other.

- For those who access other services digitally, there was a strong view that health and care providers could offer more efficient services through **virtual appointments**.
- People want support when using a new digital service, so they can fully understand how they can use the technology to **take control** of their health.

Shift from sickness to prevention

- People understood the benefit of early intervention and **prevention**, although they would not want to see a 'trade off' that sees a reduction in funding to support prevention.
- There was a strong view that more support was needed to help people to manage their **mental health**, avoiding the need to access services where this was preventable and helping people overcome issues such as loneliness and isolation.
- People wanted more being done to address **wider issues** (determinants) that can lead to poor health such as poor housing conditions, lack of employment opportunities, and education.
- There are **mixed views** on different preventive actions people can take with some receiving more support, such as screening programmes, and others having mixed or negative views especially when considering vaccinations.
- More focus should be given to **educating people** about the key actions they can take to stay well. This includes work with schools as well as through other community and VCSE organisations.

Our sessions involved our wider workforce. More specifically we have heard from colleagues working in the VCSE sector that they need stability through longer-term funding agreements to ensure they can provide community-level support.

From insight to action: enabling the shifts

We heard clear messages that to achieve change we must address key enablers:

- **Workforce capacity and retention** – better working conditions and career pathways are needed.
- **Smarter digital systems** – patient records must be shared effectively to prevent delays, duplication, and frustration.
- **Better hospital-to-community links** – smoother discharge planning and faster follow-up care to prevent patients feeling abandoned.
- **Stronger VCSE partnerships** – VCSE organisations are trusted but have highlighted that they need stable funding to deliver health support.
- **Clearer access routes** – people need to know where to go for care, including social prescribing and preventative services.
- **Affordable and accessible transport** – travel costs and poor public transport stop people from accessing healthcare, especially in rural areas.
- **Support for unpaid carers** – practical and emotional support for those looking after family members at home.

Citizen activation

Our work with local communities shows broad support for people to take more active roles in shaping and improving their own health, care, and wellbeing outcomes – to achieve this, we must address persistent challenges:

- Overcoming mistrust – some communities mistrust large organisations. Trusted local groups and leaders can help bridge this gap.
- Health and digital literacy – people want help understanding health and digital tools to participate fully. A structured programme could support this.
- Culturally appropriate support – services must reflect people's identities, languages, and needs.
- Clear articulation of trade-offs – people want honesty about the changes ahead and involvement in tough decisions.
- For our strategy to deliver lasting change, we must move from passive engagement to true activation. This means going beyond consultation, enabling people to be part of decisions and supporting them to lead change in their communities.

Through our approach to citizen activation, we want to create the conditions for people to feel more connected, more confident, and more in control of their health and wellbeing. This means shifting power - enabling communities to shape services, take action locally, and influence how resources are used. We're already seeing this in practice, from participatory budgeting initiatives to community-led delivery models.

Over time, this will help build pride in place, stronger intergenerational links, and a sense of shared responsibility for what matters most. With one of the youngest populations in the UK, we're also looking ahead - working with schools, programmes like Child Friendly Bradford, and cross-sector partners to equip young people with the tools and confidence to shape their own futures.

By combining local insight, data-driven planning, and people-powered change, we aim to build a healthier, fairer future.

Our integrated neighbourhood health and care support

Our model

Our neighbourhood health and care model envisions **healthy communities** equipped with essential infrastructure that reflects local people's needs and makes use of local assets. This is underpinned by social prescribing, universal support, and avenues for citizen engagement, rights, and advocacy.

We know from national and international evidence that around 10% to 20% of people's overall health outcomes are attributed to health care services, whereas the majority are due to wider determinants such as socioeconomic conditions, education, housing and the environment.

Our approach to integrated neighbourhood health and care support in Bradford District and Craven recognises the need to meet people's health and care needs holistically, where our neighbourhood health and care services effectively knit together both clinical diagnosis and treatment for identified health conditions alongside wider care and wellbeing support, such as helping people experiencing social isolation or requiring employment support and debt advice.

Our model is aimed at improving timely access to general practice, improving continuity of care for those with long-term conditions, reducing levels of emergency care and hospital admissions, preventing avoidable long-term admissions to care homes, and that this is connected together alongside wider wellbeing support services. This encompasses all types of care that happens within our communities, whether for relatively straightforward and short-term episodic needs, continuity of care for those with more complex and on-going support needs, and community-based crisis response services for those with urgent needs.

Across each layer, a multidisciplinary team (MDT) approach ensures **'warm handovers'** where, if we identify that a person would benefit from what one team does not provide but that you know others do, we make the referral rather than simply signpost.

Our Partnership values people's **mental health** equally to physical health. We know there needs to be better connections between physical and mental heath services. Our plans must improve the experience of people who require help with mental ill health. We will tackle mental health issues with the same energy and priority as we tackle physical illness, with funding, commissioning, and training on a par with physical health services.

While there will be times when people need elective and emergency mental health care, sometimes with an admission to a hospital setting, we support most people at home. Our neighbourhood health and care offer will strengthen the help given to people to get advice and support, to **recover and live well**, with services available when people are in crisis.

Our integrated neighbourhood teams are not a single team rather a **'team of teams'**, reflecting that our patient cohorts and geographies vary. Our ambition is to ensure universal coverage of multi-agency team-based models within our local communities, where the membership and focus of those teams is **designed with and by the staff** working in those communities. What works best within the inner city and within the more rural areas to the north of the district will, naturally, vary.

The primary goal of our model is to offer comprehensive, **person-centred care** in the community, ensuring that people receive timely, effective treatment closer to home. Our model will focus on preventive care, chronic disease management, mental health support, and early intervention to reduce the risk of people's conditions deteriorating or exacerbating need for hospital admissions. Importantly, it will focus on what is important to the people we support, working with them to **personalise** their care.

For certain aspects of treatment, care, and support within neighbourhoods, these will remain most effectively led and provided by individual organisations (for example for a straightforward consultation for a medical need within general practice). For those who require more wrap-around continuity of care for multiple needs, an essential part of our approach brings together health and care staff from a diversity of backgrounds who can contribute together to help support the **whole needs** of individuals and families.

There is potential for a much greater shift of selected **secondary care** services into community-based settings. We will look to significantly increase the level of services such as rehabilitation, diagnostics, and urgent care through community hubs; helping people recover at home or in familiar environments. These will be delivered in **collaboration** with **primary care and community teams**, and through changing the current model for outpatient services. We will be offering more specialist clinics in the community, with expansion and greater adoption of remote consultations, monitoring, telehealth, and telecare solutions.

Our strong foundations

We need to strike the right balance between **enabling local design** and development of integrated care, ensuring all parts of our system are working broadly together towards the same goals, so that no communities are at risk of being left behind.

We have many good foundations to build upon. We have several multidisciplinary hubs and wellbeing hubs offering comprehensive services that provide a space where general practice teams and community healthcare staff come together, working in shared spaces, providing **holistic care** that addresses the physical and mental needs of patients.

We will continue to transform our **intermediate care** offer aimed at supporting people to get home from hospital in a timely manner or for people to stay at home and avoid going into hospital. Wherever possible, people will be supported to return to their home for assessment to avoid the over prescription of care, and the harm that can be done by increasing dependency on care.

To shift more care from hospital settings to the community we need more initiatives involving community stakeholders to promote better health through social and cultural activities, addressing **social determinants** of health.

Our **voluntary community and social enterprise sector** organisations play an important role in supporting people with wider wellbeing needs. Our partners provide creative therapies, health and wellbeing coaching, alternative crisis services, housing support and debt advice, and transport, linking people to a diversity of local wellbeing services and providing peer support networks. We have well-established models that are valued by local people.

What are the key ingredients and what needs to happen?

At the centre of this is building a 'One Team' approach within neighbourhoods around:

- **A focus on people and outcomes first**, then prevention of ill health, then high quality services, supporting people to adopt healthier lifestyle behaviours to improve their wellbeing and live well for longer.
- **Ease of access** to neighbourhood health and care services where every contact counts, there is no 'wrong front door', people have a range of access options and trust where to go, there is a physical and digital single point of access.
- Care models, pathways and interventions that are informed by a **comprehensive understanding of population health data and need**, that supports optimal targeting of health and care resources, and in a format digestible and actionable for staff working in neighbourhoods. Population health management needs to become the norm.
- **Digital interoperability** for staff from different organisations working together in neighbourhoods to enable better joint-working and seamless flow of information; plus, improved **digital skills** for staff to use data, IT, and wider digital technologies.

- **Self-care Apps** (plus better and more widespread utilisation of the NHS App) that supports individuals and staff with navigating where to go for (how to access readily) the most appropriate support, and to encourage improved self-management, whilst addressing digital exclusion and not exacerbating inequalities.
- **For our workforce** – investment and training for staff working in neighbourhoods. This will be multi-skilled, where staff train together to help further foster working relationships, plus an emphasis on developing coaching skills to support individuals to self-care. Our future estates and infrastructure developments will consider opportunities for greater co-location.
- **Proportionate Universalism** – with greater intensity and scale for those facing the greatest need and poorer health outcomes, aiming to address health inequalities, in district wide programmes but also on a hyperlocal level.
- Building **wider partnerships** beyond the core health and care sector, for example with businesses and schools, that help build approaches to address the wider determinants of health.

Our initial focus

1. Ensuring there is a **shared system approach** and priority for integrated neighbourhood health across the Partnership, working to a shared vision and goals
2. Defining and agreeing the enabling **financial framework** for integrated neighbourhood health that incentivises improvement in health outcomes, proactive care, integration by providers, and where 'returns on investment' from keeping people well at home and in the community flow back to those providers. We will explore ways of moving towards 'one pot' of funding for integrated care.
3. Identifying and agreeing the **set of deliverables**, and what is required to enable the success, for integrated neighbourhood health and care, building on those that are already mandated. Developing our approach to **outcomes based accountability**, thinking and taking action to improve health.
4. Developing and implementing the **workforce transformation** approaches needed to both build sufficient staffing capacity and capability within neighbourhoods, and a 'one team' culture that fosters collaborative behaviours by staff from different employers.

Supported by 'Health on the High Street'

The principles underpinning health on the high street offer us the opportunity to redesign our services with our communities. We have a **generational opportunity** not only to rethink what NHS services could more effectively be delivered on the high street, but to sustainably embed them at the heart of a diverse new community offer. With relatively simple changes, our town centres can become a real driver for **social change** based around wellbeing.

Working with industries and ventures that exist, by bringing access to a range of health and wellbeing activities into the heart of our town centres, we will improve access to health and bring socio-economic benefits through increased activity on our high streets.

Figure 4: Health on the high street

Our acute services of the future

In 2025 we can look back with pride on the last 5 years of transformational service delivery across our partnership. We have designed new pathways, developed new services, secured additional funding, shifted resource into our communities and opened a new diagnostic centre. Our **Act as One ethos** has established a firm footing for the next stage of our collaboration journey. Everyone involved in the design and delivery of care has a role to play.

Our systems of care need to be designed with pathways that indicate clearly why and when a person needs to attend for a face to face encounter. We will minimise the **burden of treatment** for patients and carers where there are costs in terms of time and inconvenience. Our patients often have multiple appointments for tests that could be delivered at one appointment with little bit of thought, difficult journeys to reach distant clinics at inconvenient times, and a lack of consideration for the lives people lead outside of our care.

There are severe problems facing hospitals in the immediate term: financial deficits in trusts, a reliance on locum working, outdated equipment, and a growing maintenance backlog, to name a few. But underlying these problems is a profound set of **structural questions** as to how a hospital operates and whether this is the right model. We need a new approach that moves away from the supply driven model, organised around what clinicians do, towards a patient-centred approach organised around what patients need.

Hospitals within a system reorientated towards prevention and early intervention

The scale of patient access in a hospital is of a different quantum to the rest of the healthcare system. They are deliberately configured to maximise treatment volume in one location. The benefit of the hospital is the range and depth of **specialisms** it offers in one place. This includes both clinical expertise and equipment, enabling the most severe clinical needs to be treated.

The final **unique contribution** of the hospital is the speed at which it is designed to respond to urgent clinical needs. Unlike other parts of the health system, which operate around routine and pre-scheduled appointments often during the working week, hospitals are explicitly designed to respond to urgent care, constantly re-prioritising patients based on the severity of clinical need. Hospitals are open 24 hours a day, 365 days a year and are constantly staffed at a level that enables them to respond adequately to every type of unscheduled medical emergency.

The core logic of hospitals is that they provide a range of services that draw on economies of scale, providing different forms of care to high volumes of patients using the same underlying infrastructure base. But socio-economic inequalities in access are evident in our system. The effect on a patient's health of waiting for treatment is not the same across different groups.

Our hospitals need to work closely with primary and community care to reduce demand at the 'front door' of the hospital, and with social and community care to prevent delays to discharge at the 'back door' of the hospital. Realising the **integration ambition** at both a systemic level and at an operational level has proven difficult. This undermines the overall effectiveness of specialist care in our hospitals.

What will the hospital of the future look like? How will it operate?

Our hospitals of the future will be… More digital. More innovative. More efficient. More accessible. More integrated. More sustainable. More personalised.

Our future will be… **hospitals without walls**.

This shift will augment physical and virtual care in a meaningful and integrated way that delivers a better patient experience and better clinical outcomes. It will also impact the health workforce and reshape what, how, and where work is performed and by whom.

While the future still calls for brick-and-mortar hospitals, all but the **highest acuity and specialist care** and procedures will shift away from this setting and be delivered in the community; whether it is stepped-up/down clinics, retail locations, schools or community facilities, workplaces, or, most often, a patient's home. This move will be enabled through interoperable/joined-up data, digital technologies, remote patient monitoring, value-based payment systems, and by the expectations of our patients and citizens.

Care delivery transformation

People want more **convenient** health care; often delivered to them at home, in local pharmacies, in shopping centres, or at their workplace or school.

Modern hospitals and health systems are turning to cloud computing, artificial intelligence, 5/6G wireless technologies, and **interoperable** data and analytics to address current challenges and build **'digitally powered'** care delivery models.

As we move to **personalised** care and care without walls, our hospital and community providers, and the wider health and care system, will position **virtual** health care as integral to delivery. We need a model that increases access and convenience while reducing the total cost of care.

Digitally powered care will require our health system to embed virtual health within the fabric of our delivery model. Solving for this will require thinking about **virtual care** and the hospital of the future as an essential part of the core business, alongside inpatient care, and not merely a discretionary add-on. This transformation will ensure that the care delivered outside of the hospital is just as safe and reliable, if not more so, than that delivered in person. We need to catch up.

Acute collaboration

There is an assumption that acute collaboration is about doing things differently in a hospital setting, but this is not our intent. There are several areas our teams can work across our hospital trusts in shared teams or more formalised pathways, but it is much more than this. Our neighbourhood health model will bring care closer to our communities and our examples of Rethinking Pain, community mental health transformation, health hubs in schools, and our proactive care team demonstrate the strength and outcomes that can be gained by our clinical and non-clinical services **combining their expertise** to deliver services in alternative venues to health sites.

The West Yorkshire Association of Acute Trust (WYAAT) service review is enabling provider trusts to focus on several areas, in particular what can be done once either as a **geographical partnership** or as part of a networked model.

Through doing this collaboratively across several trusts, there is the potential to do some rapid mobilisation, learn and adapt, and maximise the potential of our fragile and limited services across our West Yorkshire footprint.

Secondary care as a service, not a building

The increasing sophistication of technology is normalising virtual care, and the potential for these to reduce costs while improving care is significant. A **reimagined model** of secondary care involves three core pillars of service delivery: in the hospital, in the community, and in the home.

Rethinking the division of care in a hospital raises questions about economies of scale, as well as logistical concerns about services, facilities, and rotas. This will include how the workforce would need to adapt, the configuration of services, and scale.

As we shift to a more patient-centric model we will reconfigure our 'offer' to include:

- highly accessible **primary care** based in convenient locations delivering care for low acuity patients, and same-day access urgent care;
- **enhanced primary care** focused on patient segments and the chronically ill, in a model tailored to our underlying population and cultural norms. Patients receive 'whole person' care;
- **systemised surgery** models – high efficiency ambulatory surgery focusing on a limited set of interventions. Personalised convenient care pre, during, and post surgery; and
- **specialist-led** integrated, multidisciplinary teams that wrap around the sickest patients across all care settings providing coordinated, comprehensive, highly personalised care.

Our revised model is an opportunity to markedly improve quality, access, and efficiency.

Our guiding principle: what happens in a hospital is that which can only happen in a hospital.

We know there are some **important questions** to consider, including how we go about addressing the following:

1. Our core focus

- Self-assess what should be done in the community to ensure a hospital is for specialised care and emergency care only, with urgent care moved to the community;
- Use this to inform the opportunity for a reconfigured hot/cold site model of care; and
- Transform urgent care, therefore, to be more planned and defined, with better use of appointments for scans, tests etc. that would otherwise be done in a hospital building.

2. Our geographical partnerships

- Learning from our work on stroke and the Community Diagnostic Centre, bring staff together sharing expertise and building resilience in clinical and professional teams;
- Partner with specialist GP services in joint clinics/ MDT approach to skill share – starting with ENT, gynaecology, cardiology, and ophthalmology; and
- Repatriate specialised care to maximise our local potential for example primary percutaneous coronary intervention.

3. Our shared workforce

- Outline our intent towards creating centres of excellence to attract new entrants to the workforce, e.g. joint appointments across areas of high specialism;
- Establish partnering opportunities with the independent sector to maximise estate, capacity, and skills; and
- Use our clinical expertise across Place to provide new service offers, for example neuro-rehabilitation for brain injury to repatriate our out of area patients.

4. Our emerging model

- Moving from single conditions to multi-morbidity clinics, with increasing patient self-management of their chronic condition;
- Expanding virtual appointments in our community hubs – using these trusted venues to enable people to 'Attend Anywhere' so they do not have to travel; and
- Supporting our workforce to work efficiently in a digitally-powered way, addressing capacity and demand challenges, removing duplication and waste, and creating time for care.

Our financial plans

Value and values

'Population healthcare' focuses primarily on segments of the whole population defined by a common need, which may be a symptom such as breathlessness, a condition such as arthritis, or a common characteristic such as frailty in old age, and does not involve institutions, specialities, or technologies. As a Partnership, we accept the social and moral need to reduce health inequalities. Population healthcare is the approach needed to allow a proper debate on **allocative value**, aligning funding and resources strategically with long-term population health outcomes, with value-based approaches to prioritisation.

To optimise allocative value, our budgets need to be expressed not in terms of institutions, such as hospitals or community services, but as they relate to **segments of the population**. Once it has been decided how much to allocate to each **programme budget**, it is necessary to ask how resources should be allocated within each budget. Shifting to a programme budgeting approach that reflects the population segmentation we have set out. Then allowing us to move resources and finances to reflect our **population health goals**.

There is no simple formula to resolve the dilemma in the allocation of finite resources

There is no ideal way to allocate resources. Every solution creates problems and tension between those who see themselves as losers and those who are seen as winners. We agree that the allocation of resources should reflect variations in need. We must ask ourselves:

- Has the money been allocated to different patient groups in a way that is equitable and that will optimise value for the whole population?
- Are the resources that have been allocated being used on the right interventions?
- Are all of the right patients, and only the right patients, being offered the high-value interventions?
- Are we sure that every individual patient is getting the right intervention in a way that is right for them?

Closing the Gap

'Closing the Gap' is our collaborative programme in response to the extreme financial challenges we face. The goal of Closing the Gap remains the same – to deliver a balanced net system financial position.

Our Partnership must go **further and faster** to 'close the gap'. This will mean an increasing focus on large scale transformation, decommissioning of services that do not have the desired impact at the right scale; removing duplication and waste; shifting of services from expensive to less expensive settings; ensuring services are delivered in the right place by the best provider, and consolidating services that can be done once rather than several times. Undoubtedly the new hospital programme in Airedale will give us an opportunity to do this sooner rather than later.

The aims of 'Closing the Gap' are underpinned by the following

- Ensure that our decision-making is led by data and insight;
- Meet core health and care standards including critical safety standards;
- Where possible take preventive approaches to healthcare; and
- Mitigate the impact of health and wider social inequalities.

These aims provide a sound base for our medium-term financial strategy, and we will continue to work with these underlying principles.

There are 'red lines', such as patient safety, but we know that slowing or pausing some of our work may slow our ability to reduce inequalities. By using Quality and Equality Impact Assessments (QEIA), we look to **mitigate risks** – assessing each proposal through the lens of equity and justice. We are approaching this as a whole Health and Care Partnership because no one part of our Partnership can address this alone. We will hold ourselves and each other to account. It is essential that we use our collective resource effectively, ensure efficiency, and build on value.

Collectively we will need to make some difficult decisions, to focus on what is best for our system and not our own organisations. We will need to be brave by committing to the design of a health system for the future.

Each health organisation has already developed a list of **difficult decisions** which we need to work through and implement to make savings. As we work through these, we will need to make bigger decisions for the medium term and commit to the implementation of those changes. There is a pressing need to focus more broadly on **value not simply cost**.

Our significant, finite, funding will need to move with the redesign of our services, and we will need to test that every pound is providing **value**. Our financial strategy might change people's experience or access to services. Proportionate universalism is an approach to reducing health inequalities that recognises everyone should **have access to support and services** but that support should be **tailored and scaled** according to the level of need.

Our current financial planning has further highlighted the significant deficit gap that the health system has. At the time of writing there are no plans on how the system will get back to breakeven and sustain that. A **more radical approach** is required.

Fundamentally, a shift of resources is needed to support the medium-term strategy as hospitals become smaller and more specialist, and out of hospital care needs to expand and work efficiently to keep patients away from the hospital setting.

We will hold ourselves accountable as a Partnership for **financial stewardship**, using the tools and resources at our disposal to improve equity and reduce inequalities, aligning our funding and resources strategically with our aspirations for the long-term health outcomes of our population.

Our plans include:

1. **Agreeing timescales for the difficult decisions we need to make.** Acting through a robust programme and project structure, enact strategic commissioning and ensure we deliver those difficult decisions and the new services that follow to obtain better care. This will mean releasing the funding from a hospital-focused contract to a community-focused contract and delivering savings to close the deficit gap.

2. **Collaboration between different partners.** If one partner can deliver a service better, at scale, in a more cost-effective way, then we must move to that new model.

3. **Choosing the best value option for any change** to services even if it means a loss of income to any service provider.

4. **Using growth funding differently year on year in the medium term**. Reducing growth into the hospital sector by an agreed percentage to invest in care in the community setting. Integrated neighbourhoods, community services, and primary care will need to demonstrate that they are performing well, keeping patients out of hospital, and saving money in the acute sector to enable this shift.

5. **Establishing a community investment standard** so that growth funding in future financial plans can be diverted into integrated neighbourhood health and care.

6. **Being open and transparent** across all health and care partners on the current cost of services so that savings can be realised on a true 'cost out' basis and not on the basis of historic contract value. We may need a set timeline to remove stranded costs, but this will be agreed up front.

7. **There should be no exclusions.** No area is off limits other than statutory requirements and those aspects critical to safety.

Our workforce plans

People's experience of health, care, and wellbeing services are shaped by the interactions they have with our workforce. Ensuring that we have the right number of individuals with the right skills and behaviours, working in the right roles, is central to the delivery of our plans for health, care, and wellbeing. This will require us to **attract, retain, support, and develop** our workforce to meet changing patient and service user need.

There are currently over **40,000 people** working in health and care services across Bradford District and Craven, making us the largest employing sector in the area. Across our place, we employ over 4,000 nurses and midwives, nearly 2,000 doctors and dentists, over 10,000 people providing direct social care, and over 12,000 people working across our VCSE sector.

Over recent years, the number of people employed within our health and care organisations has grown significantly, with our workforce growing by around 22% since 2018. Despite the growth we have seen across the workforce, we know that in many areas our services remain under significant pressure.

We also know that **our workforce is aging**, with 28% of Practice Nurses, 17% of GPs, and 24% of social care staff approaching retirement age. To continue to provide high quality care we will therefore need to recruit, retain and, most importantly, transform our workforce in line with evolving models of care.

Providing health and care services in an environment of workforce shortages, high demand, and high workload is hugely challenging and we know that turnover is currently elevated across the sector. Our employing organisations must therefore **prioritise employee wellbeing** and a healthy work and life balance. This will mean continuing to support our people in working flexibly and creating compassionate, inclusive workplaces across all our employers.

As the biggest employer within the district, we can support both health and economic and social development through the provision of high-quality employment. To do this, we must work closely with our educational institutions, local authorities, and communities more broadly to create clear **pathways to employment** for people living within our place, ensuring that as a sector we are seen to be an employer of choice.

From an employment perspective, associate and support roles as well as an increased use of apprenticeships can help in creating more **entry level opportunities** with clearly defined pathways for progression within our organisations. To support this, we must work with colleagues in education to build a **pipeline of people** equipped to work in the health and care sector, including through the growth of T-levels (a two year qualification for 16-19 year olds designed in collaboration with employers).

Meeting the needs of our **diverse** population means we must continuously improve access, experience, and outcomes. To do this we must ensure our **workforce is representative** of the people we serve. We will actively seek out candidates with a range of life experiences, including focusing on hiring more people with disabilities or long-term health conditions, neurodiversity, and those from different ethnic backgrounds. At the same time, we must make sure that all employees who have protected characteristics receive the support they need.

This strategic plan has shown that health and care services will need to change to meet the growing and evolving needs of patients, service users, and our population, with significant increases in the number of people with multiple long-term conditions. This will require our people to **work differently**, both in terms of the kind of roles they hold and the skills they require. To provide high-quality person-centred integrated care, we will need to work seamlessly across organisational, sectoral, and professional boundaries.

As more services are provided in community settings, a shift in workforce will be required to match. Our staff will increasingly be working in multidisciplinary, integrated neighbourhood teams which **span organisational and sectoral boundaries**. Whilst the last few years have seen a period of significant workforce growth, the vast majority of this has been focussed on the acute sector, which has grown almost twice as quickly as community and primary care.

This process has already started as demonstrated by the increasing number of **new roles** created across our services. The use of these roles to develop multidisciplinary team roles has been prevalent in primary care, with 467 individuals employed under the Additional Roles Reimbursement Scheme (ARRS). These roles will play a key part in the continued move towards integrated community care.

Upskilling our workforce to both drive and adapt to these changes in service provision will be vital to meeting the needs of our population and will require us to work closely with our partners, particularly in the education sector.

As we will see in the digital chapter, digital and technology will play a vital role in how health and care are provided. Therefore, enhancing the skills of our workforce, creating an environment where people are equipped and able to **utilise technology**, with the skills and capacity to respond to changing needs and priorities will be essential.

Meeting the changing need of patients will also require our workforce to demonstrate a range of **new skills**, with professionals increasingly needing to work across systems to care for patients with a range of complex health and care needs. Understanding these needs will require us to develop our population health capacity to ensure that our services continue to **match the changing population**.

Our digital plans

The local context

In 2025, our care delivery matures to a **neighbourhood centric** model where we need to ensure health and care organisations are able to access systems, services, and data seamlessly, from any location.

Our local programme will focus on enabling neighbourhoods to **flourish**. We will do this by fostering a collaborative and, innovative digital culture, delivering improved connectivity and interoperable systems, enabling a Data Driven Intelligent System, ensuring our Digital Infrastructure is **modern, resilient and sustainable**, and providing access to approved tools that empower organisations and communities.

The national drivers

NHS England's national planning guidance for 2025/26 sets out a series of digital principles, requirements, and ambitions. These are key enablers to transform services, cut waiting times, and improve care for patients across England.

In response to the national direction of travel, West Yorkshire ICB has set out a clear vision and ambition for digital and data to underpin, enable, and transform health care delivery for the local population, across the five places it serves.

By the Autumn 2025, a new ICB Digital, Data, and Technology (DDaT) strategy will be published. This is aligned to a revised vision that supports and enables a reduction in health inequalities, proactive and preventative care, seamless access to care, personalised services, and digital inclusion.

During the early stages of development of the DDaT strategy seven key 'pillars' have been identified. They focus on:

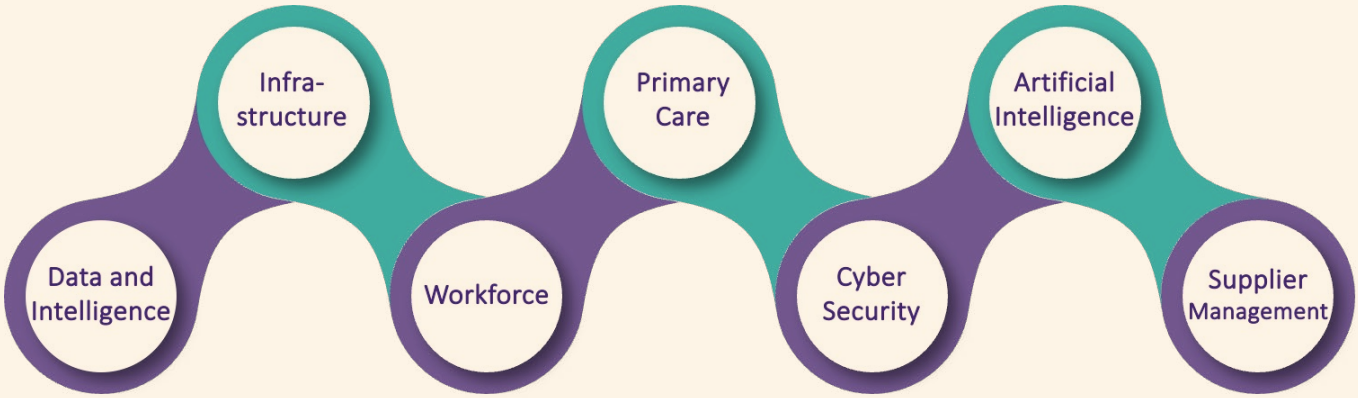


Figure 5: DDaT strategy seven key pillars

Our digital strategic principles

1. **Shared care record:** maintaining and enabling the secure and seamless flow of information between our organisations to support care delivery and transformation, exploiting new opportunities and tools as they emerge.

2. **Infrastructure and interoperability:** continuing to introduce and optimise digital healthcare solutions in an integrated, consistent manner, including getting the most out of the tools we already have.

3. **Workforce:** creating an environment where our workforce is equipped and able to use technology, responding to changing needs and priorities, developing, motivating, and retaining our staff.

4. **Innovation:** making the most of our resources and maximising our investments, aligned with our sustainability priorities through innovation and improvement.

5. **Opportunities presented by new and emerging digital solutions:** especially in the areas of Artificial Intelligence (AI), Rapid Process Automation (RPA) and Predictive Data Analytics (PDA) are exciting opportunities. Expanding and accelerating the adoption of new solutions to increase the efficiency and accuracy of time-consuming administrative tasks, continuing to explore ways of gaining workflow efficiencies. We will shift to predictive analytics, enhancing diagnostics and harnessing artificial intelligence to analyse our data, for personalised care.

6. **Digital empowerment:** when patients have near real-time access to their own health information, they are more empowered to take care of themselves and be more engaged in self-care decisions. Personal technology also provides a closer patient-clinician relationship by allowing easily shared data to help with prevention and broader health decisions.

7. **Digital inclusion:** digital poverty and access are recognised as a significant challenge and barrier to accessing services. We will tailor our approach towards neighbourhoods to increase the use of digital interactions, including but not limited to use of the NHS App.

8. **Clinical safety and cyber security:** Ensuring systems are clinically safe both in their design and deployment is vital in the delivery of digitally enabled care. We will appropriately apply Clinical Safety standards and methods for all relevant systems and assist all our providers to engage and adopt these standards consistently. Cyber Security remains at the heart of our design, delivery and maintenance of all technologies and systems.

9. **Data driven care across our place:** proactively impacting care delivery using data driven intelligence and analytics. Using data to support decision making, service design, and research to improve the health of our population, with the adoption of the Federated Data Platform and the Making Data Count Methodology.

Our infrastructure plans

At the heart of the desired future state is a strong primary and community neighbourhood model of care, that is fully aligned with our acute and mental health hospitals clinical services strategy.

This model of 'home first, strengths based, and digitally enabled' will determine what should be our community offer with our partners and will shape our community and primary care estate. It is key to supporting the shift of services out of the hospital setting and into the community, promoting self-care, and keeping people out of hospital for as long as possible.

Effective utilisation of all our infrastructure is also an important driver for our estates strategy to match our integrated neighbourhood team aspirations. This includes all local assets across Health, Bradford and North Yorkshire Councils, VCSE, and the private sector, building in flexibility to change as services develop with new ways of working and the digital future.

Current position

Our current health estate has been categorised as either 'Core, Flex, or Tail' to inform our strategy for the retention, development, and use of our estate infrastructure. We will work with our system partners to ensure that we take a collective view of our estates infrastructure and look to re-purpose existing estate to support community-based service delivery, provide facilities to support digital service access, and promote integrated team working across health and care.

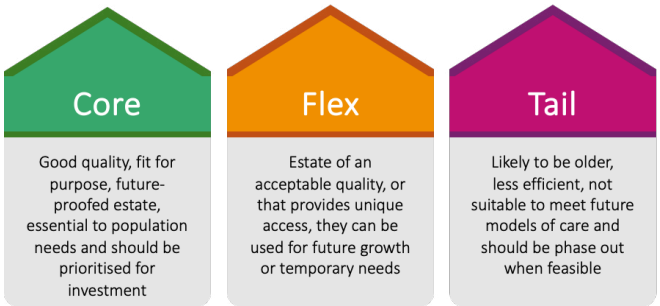


Figure 6: Categorisation of healthcare facilities

This categorisation of our estate reflects a combination of condition and functional suitability. Investment in some 'Flex' estate may result in re-categorisation as 'Core' where this aligns with strategic clinical and estate plans.

Estate categorised as 'Tail' reflects our priorities for estate that needs to be replaced when alternative estate becomes available and includes **Airedale General Hospital** (RAAC site due to be replaced under the New Hospitals Programme), **Lynfield Mount Hospital** (capital secured for partial replacement), and a small number of community health centres that continue to be used beyond their expected useful life.

The relatively high proportion of estate at **Bradford Teaching Hospitals** categorised as 'Flex' includes the parts of the Bradford Royal Infirmary and St Luke's hospital sites that are beyond their intended design life and continue in use, but which can only be modified with a very significant level of investment.

Primary Care 'Core' estate includes the seven LIFT (Local Improvement Finance Trust) sites, from which a range of primary and community services are provided, that have no backlog maintenance liabilities.

Key challenges

The key estate challenges in our Health and Care Partnership include:

- **Aged estate**, a significant proportion of our estate is operating beyond its expected useful life with our hospital estate (acute and mental health) carrying very high levels of backlog maintenance (£740m), of which £618m relates to critical infrastructure risk.
- **Adequacy of estate and workforce** to meet population growth (particularly demographic growth and the impact of additional housing) and the shift of more services into the community.
- **Availability of capital**, both NHS and private capital (the return on investment too low to attract investors, or results in schemes that are unaffordable).

- **Securing core primary and community LIFT estate** (seven sites in the Bradford District) where Lease Plus Agreements (LPA) on LIFT buildings expire starting in 2031. These buildings are modern, purpose-built healthcare facilities with no backlog maintenance that can be used flexibly with the potential for future expansion.
- **Current economic climate** with continuing cost inflation and high interest rates resulting in high capital development costs. Combined with the financial position of local Health and Care partners, this makes it even more challenging to address our infrastructure issues.
- **No common platform for space sharing**, which means that we are not able to make best use of the space that we have.

Where do we want to be?

We want to provide high quality, fit for purpose infrastructure to enable us to deliver care, safely, collaboratively and in an innovative way.

To do this we will:

- Target our infrastructure resources to address the highest need and contribute to reducing health inequalities for our population.
- Ensure our strategic infrastructure planning reflects changing delivery models and aligns with future clinical service strategies to support effective service delivery for our population.
- Put in place a digitally enabled infrastructure that supports the analogue to digital shift and inter-operability across health and care.
- Adopt more flexible use of buildings and other infrastructure assets available to us to support integrated working across all Public Sector Partners, the VCSE, and the private sector.
- Ensure our strategic infrastructure planning supports our strategy to attract and retain our local workforce through the provision of appropriate training facilities.
- Proactively maintain our assets, including rationalisation and backlog maintenance reduction.
- Develop our infrastructure in a sustainable way and delivering our Net Zero Carbon targets.

How will we get there?

We will make optimum use of our existing 'Core' and 'Flex' estate across health and care, re-purposing our estate where possible before adding more capacity, and in particular:

1. **Manage** the demand for space within the acute hospital setting through the shift of services into the community and driving benefits from acute hospitals collaboration. This will include taking the opportunity to use community base sites differently, for example extending our use of space in shopping centres, or VCSE sites to provide easier access to local services;
2. **Retain** non-RAAC estate on the Airedale Hospital site for continued clinical use in line with the Place health, care, and wellbeing plan;
3. **Retain** LIFT sites beyond the end of the initial concession period as key 'Core' community sites to support the development of community hubs; and
4. **Provide** additional primary care and community services capacity where required to respond to the impact of significant housing developments and replacement of estate, which is no longer fit for purpose.

Conclusion

Keeping our focus

At the heart of our plan is a recognition that, over the last decade, **health inequalities** have been driving a shift to reactive hospital based care and away from community based care. We need to **re-balance** this by recognising that health inequalities exist in all our communities and require community-led solutions.

As partners we need to fully embrace **prevention** as a way of both improving the health of local people but crucially reducing demand on much needed planned and emergency care. We know we can do this by improving access to **resources** for preventative health.

Different community approaches to reducing health inequalities are required in localities depending on the local age structure, the main types of illness, social deprivation, the ethnic diversity, and local community assets. This will influence how local communities will access preventive services and support to achieve **optimal care**.

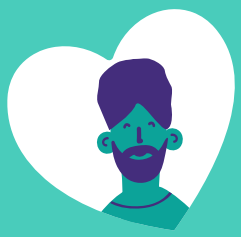
While we must plan on the basis that our population structure is getting older, ill health and disability in older age is not inevitable. Support for **healthy ageing** and dementia friendly communities; lifelong exercise to support independence into older age; and early access to screening programmes to stop or delay onset of disease will all support a more sustainable community health model. The greatest opportunities to influence health and wellbeing lie with the health choices of our children and young people.

In 2022, we set out our Health and Care Partnership **commitments** for our population, our place, and our partnership. As set out in our Plan on a Page below, we remain committed to our shared purpose of:

- Choosing equity as our way to reduce inequality;
- Positioning our collective resources wisely to focus on those with the greatest need;
- Inverting the power to act, for people to become active and engaged partners;
- Empowering our workforce to lead on behalf of the partnership, and
- As a Partnership, tackling the issues no one part of our Partnership can address alone, through public stewardship.

Our plans now will guide how we use our resources to maximise improved health and access to high quality care. Our focus is shifting from institutions to **population outcomes**, and we are targeting health inequalities by improving equity of access, experience, and outcomes.

We are what we do next.



Our Plan on a Page

our Vision

By meeting people where they are, working with them to access the tools and opportunities to enable them to live longer in good health...

we Act as One to keep people Happy, Healthy at Home

our Added Value

Our Population
Our priorities supporting a better experience of health and care for local people

Our Shared Purpose
All working to the same goal, for our population to have more chances to lead healthier lives

Our Partnership
Greater value through the best use of our collective resources, minimising duplication and waste

our Purpose

Narrowing the Gap
Positioning our collective resources to focus on the greatest need to improve health and wellbeing

Our Workforce
Empowered to lead on behalf of the Partnership and the people we serve

Equity and Justice
Choosing equity as our way to reduce inequality because more equal societies benefit everyone

Inverting the Power to Act
Sharing responsibility and power, for people to become active and engaged partners

Our Partnership Plan
Tackling the issues no one part of our Partnership can address alone, through public stewardship

our Commitments

We will all:

- **Prioritise as One** those who have the worst outcomes for health and wellbeing
- **Understand as One** what matters to local people
- **Work as One** with people in our system and our community to achieve what matters
- **Integrate as One** to better enable people to achieve what matters to them

We will all:

- **Commit as One** to our role in making our district a great place to live, work and thrive
- **Plan as One**, taking actions now that create a legacy for future generations
- **Focus as One** on preventing the causes of ill health
- **Measure as One** our impact on health and wellbeing through one data

We will all:

- **Lead as One** in partnership with our population, in their communities
- **Share as One** the power and responsibility to make the best use of our collective assets
- **Grow as One** to strengthen our relationships, trust and our ambition; improving together
- **Deliver as One** through our shared, skilled and trusted workforce

our Population → **our Place** → **our Partnership**

Bradford District and Craven
Health and Care Partnership

ACTasONE

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