Bradford District and Craven Partnership Board

17 May 2024
10:00 – 13:00
G7/G8, Scorex House, 1 Bolton Road, Bradford

AGENDA

Item	Lead	Purpose	Time	Mins
1. Welcome, introductions and apologies	Chair	Information	10:00	5
2. Conflicts of interest A register of Board members can be found on our website – Declarations (mydeclarations.co.uk)	Chair	Assurance	10:05	0
3. Minutes of the meeting held on 8 March 2024 /action log/matters arising	Chair	Approve and to note	10:05	5
4. Public questions	Chair	Information	10:10	5
5. Listen in	Victoria Simmons/Shak Rafiq	Information	10:15	15
6. Place Lead's update to include: Partnership Board Terms of Reference	Therese Pattern	Information	10:30	15
7. Reports from committees and fora	Committee and Forum Chairs	Information/approval	10.45	10
8. Partnership governance effectiveness & efficiency – proposal for longer-term partnership governance arrangements	Sue Baxter and Carrie Haywood	Assurance/ approval	10.55	15
9. Partnership high level risk update	Carrie Haywood	Assurance	11:10	10
Break 11:20-11:30				
10. Deep dive focus on 'workforce wellbeing' - staff/staff retention	Andrew Milner	Information	11:30	50
11. Financial and Operational Planning Update	Mike Woodhead	Information	12.20	20
12. Better Care Fund – Sign off	Iain Macbeath/ Javeid Karim	Information/approval	12.40	10
13. Any other business	All	Information	12:50	5
14. Reports/escalations to WY ICB and review of meeting	Chair	Information	12:55	5

Date and time of next meeting –
Friday 6 September
10:00 – 13:00
Craven – Venue TBC

For any queries regarding this agenda, please contact: carrie.haywood@bradford.nhs.uk

DRAFT Minutes of the Bradford District and Craven Partnership Board
Friday 8 March 2024
10:00 – 13:00
Belle Vue suite, Belle Vue Square, Broughton Road, Skipton, BD23 1FJ

Present:

Elaine Appelbee	Independent Chair of Bradford District and Craven Health and Care Partnership (BD&C H&CP)
Andrew Gold	Chair of Airedale NHS Foundation Trust
David Crampsey	Chair of Clinical Forum/Executive Medical Director, Airedale NHS Foundation Trust
Andy Withers	Non-executive chair of the Quality Committee of the BD&C H&CP
Therese Patten	Chief Executive, Bradford District Care NHS Foundation Trust
Danielle Hann	Deputy Chair, Bradford and Airedale Branch of YORLMC
Louise Bestwick	Chief Executive, Bradford Care Association
Iain MacBeath	Strategic Director – Health and Wellbeing, City of Bradford MDC (items 1-8)
Jonathan Kerr	Chief Officer, Age UK North Craven
Sam Keighley	CEO, VCS Alliance
Helen Rushworth	Chair of Citizen's Forum/Chief Executive, Healthwatch Bradford District
Ashley Green	Chief Executive, Healthwatch North Yorkshire
Linda Patterson	Chair of Bradford District Care NHS Foundation Trust

In Attendance:

Nancy O'Neill	Chief Operating Officer, BD&C H&CP
Victoria Simmons	Senior Head of Communications and Involvement, BD&C H&CP
Mike Woodhead	Director of Finance, Contracting and Estates, Bradford District Care NHS Foundation Trust/BD&C Partnership lead Finance Director
Amanda Stanford	Chief Nurse, Airedale NHS Foundation Trust
Sue Baxter	Assistant Director of Governance and Assurance, BD&C H&CP
Carrie Haywood	Senior Assurance and Governance Manager, BD&C H&CP
Catherine Smith	Corporate Governance Manager, BD&C H&CP (minutes)

Apologies:

'Foluke Ajayi	Chief Executive of Airedale NHS Foundation Trust
Victoria Turner	Public Health Consultant, North Yorkshire Council (deputising for Louise Wallace)
Karen Siennicki	Assistant Director of Adult Social Care, North Yorkshire Council
Julie Lawreniuk	Non-executive chair of the Finance and Performance Committee of the BD&C H&CP
John Pattinson	Chief Executive, Independent Care Group
Louise Wallace	Director of Public Health, North Yorkshire County Council
Marium Haque	Strategic Director – Children, City of Bradford MDC
Richard Haddad	Chair, Bradford Care Alliance
Richard Webb	Corporate Director, Health and Adult Services, North Yorkshire Council
Karen Dawber	Chief Nurse, Bradford Teaching Hospitals NHS FT/ BD&C Partnership Quality Director
Lesley Tillotson	Associate Director (people, patients & resilience), BD&C H&CP
Lorraine O'Donnell	Chief Executive, City of Bradford MDC
Mel Pickup	Chief Executive, Bradford Teaching Hospitals NHS FT/BD&C Partnership Place Lead
Melanie Hudson	Non-executive chair of the People Committee of the BD&C H&CP

Members of the public: 1

1 Welcome and introductions

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Elaine Appelbee welcomed everyone to the Bradford District and Craven Partnership Board meeting. It was noted that the meeting was not quorate so any decisions would need to be ratified outside of the meeting.

2 Conflicts of Interest

The members register of interest was noted and no further declarations of interest were made.

3 Minutes of the meeting held on 12 January 2024/action log/matters arising

As the meeting was not quorate the Board recommended that the minutes of the meeting held on 12 January 2024 were agreed as a true and accurate record with agreement from absent members needed. It was noted that all of the actions on the action log were complete.

Linda Patterson queried progress since the primary care deep dive that took place in the meeting in July 2023; Elaine agreed that an update on primary care would be brought to a future meeting. **Action – update following the primary care deep dive to be brought to a future meeting**

4 Public questions

There were no questions received for the meeting and the three responses to the questions received for the meeting on 12 January 2024 were noted.

5 Listen in – children and young people cycle

Victoria Simmons presented a report which described the first cycle in the second year of the 'Listen in' programme which focused on children, young people and their families. During the cycle in January and February 2024 a range of meetings, activities or visits to groups took place across Bradford District and Craven to engage with children, young people, their families and staff working with children and young people. Mental health and wellbeing was noted as the main theme from the cycle, with other themes summarised as schools as a source of support, anxiety and pressures; waiting times for mental health; neurodevelopmental diagnosis or support; and the importance of waiting well, such as support and advice when on a waiting list. Other themes included a lack of understanding of the health and care system and considerations for young people as the future workforce and career pathways in health and social care. Other areas raised were a loss of trust in institutions, the importance of the continuity of relationships and of trauma informed approaches when working with vulnerable children and young people.

Victoria highlighted that the cycle involved insight work with special education schools and the development of useful relationships with headteachers who had become involved in the children, young people and families priority. There had also been engagement with children looked after to understand their experiences of being in the social care system. Positive examples of VCS work with children and young people were raised throughout the cycle with opportunities to build confidence in capacity and support. It was noted that the report included insight from children and young people which was gathered during the first year of 'Listen in' and information collected from other partners to complement the 'Listen in' feedback.

Victoria summarised the themes for the future 'Listen in' cycles as racialised communities, inclusion health groups, LGBTQ+ communities, disabled people and their carers, men in insecure employment, and women particularly in areas of deprivation. Victoria welcomed involvement from any Board members interested in these areas.

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Therese Patten provided observations from a visit to SELFA, a charity which supported children and young people in Skipton and Craven, noting that in Settle the support for children and young people included one school and SELFA, and queried how the partnership could support schools to think in a broader sense about how they could support children and young people. Therese added that information from the cycle was also presented at a development session for the children, young people and families priority that took place on 5 March 2024 and it was agreed that it would be used to focus the work for the coming year for the priority. Therese offered to share this information at a future Board meeting or development session.

Ashley Green referred to the importance of the wider determinants of health, such as employment opportunities, schools and leisure, which could also be used as opportunities to make contacts count. David Crampsey noted the important message on the loss of trust in institutions by children and young people and a need to show that the partnership listened with a value in organisations to change things for the better.

Andrew Gold referred to access as also being digital access, such as through websites or social media, and not just traditional access to appointments and queried whether there would be any merit in the Board understanding whether digital access was a determinant of health and whether it was creating health inequalities.

Jonathan Kerr raised the differences in the schools across Bradford District and Craven in terms of size and location, noting very rural areas in Craven, with children in different areas having different mental health needs with the need to consider where support for children and young people was most needed, as well as considering the needs of those outside the educational system.

Andy Withers raised a challenge to the Board on 'you said, we did' approach to show that the Board had listened and could demonstrate the differences made, recognising the financially challenging times.

Helen Rushworth referred to a report that Healthwatch had produced following an audit on mental health in schools in Bradford and District and noted a difference between people who wanted mental health services in schools and those who felt it was inappropriate and did not want to share experiences in school. Helen advised being mindful of children and young people who do not engage with school or other services. Helen also challenged the Board to consider whether the partnership knew what people wanted from health and care services within the challenging financial position and whether the population were being asked the right questions.
Action – Helen Rushworth to circulate the Healthwatch report on mental health in schools in Bradford and District

Sam Keighley agreed on the importance of involving and engaging with communities on the financial position and to listen to what children and young people were saying about the importance of community assets alongside the need to understand Bradford Metropolitan District's Council's (BMDC) budget decisions which affected leisure and sports facilities and libraries. Sam suggested that the partnership worked together to keep some of the assets operational and to consider using the remaining assets in the right ways to make them accessible for everyone in order not to widen health inequalities.

Linda Patterson referred to Born in Bradford as a huge resource of data on children and young people and the relationships formed with other organisations by the Children's Trust, which the system could utilise.

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Victoria Simmons thanked colleagues from across the partnership for their continued support in the 'Listen in' programme as well as Emily Rhodes and other colleagues for their work and support during the current cycle.

The Partnership Board:
1. Considered the ideas and insights from the 'Listen in' cycle and made recommendations for how the place governance and priority boards could take this learning forward.

6 Place Lead's update

Nancy O'Neill presented a report which summarised key activities and points to note arising from the activity of the Bradford District and Craven Place Partnership and the wider West Yorkshire Health and Care Partnership and progress in response to key issues and in pursuit of the strategic goals.

Nancy referred to the recent national budget which was announced on 6 March 2024 and included additional funding of £2.5 billion for health services and £24 billion for capital infrastructure, with further work needed on what this meant for the budget of the local system. The budget included focuses on holistic approaches, sustainability, early intervention and early help, which underpinned the approach of the partnership.

Nancy highlighted work on end of life care in the WY ICB in terms of sustainable funding for hospices in WY and a commitment to develop an end of life care vision with Healthwatch gathering views from people who were receiving end of life care across WY.

Other areas highlighted included changes to the death certification reforms which included regulations which would mean the faster release of bodies for burial. It was noted that work continued on the review of the ICB's operating model with ongoing support for staff affected by changes following the review and the new operating model staffing structures.

Danielle Hann referred to the GP contract offer for 2024/25 which had been rejected by the General Practitioners Committee (GPC England) and all GPs who were members of the British Medical Association had been asked to vote in a referendum on whether they would accept the contract offer.

Iain MacBeath provided an update on the financial position of BMDC noting that exceptional financial support (£220 million over the next two years - £80 million in 2023/24 and £140 million in 2024/25) had been approved by the government but the need for the council to work towards a sustainable budget remained. The additional funding allowed the council to borrow money and sell assets but was also a debt that need to be repaid by the council with work continuing to generate more savings. On 7 March 2024 the council agreed a budget which would see £40 million of cuts to local services and would affect VCS infrastructure, household waste centres, libraries and leisure centres and require savings from adult care.

Ashley referred to the new national Pharmacy First advanced service which aimed to reduce pressure on GP practices and raised concern on the impact on pharmacies and advised caution on how the approach was monitored. Danielle highlighted that work was still needed by GPs in terms of a referral for the service. It was suggested that it was discussed further in a future Board meeting or development session, with involvement from community pharmacy, in the context of unintended consequences or impacts of national approaches and strategies within the whole partnership.
Action – agenda item on the impact of national approaches or strategies within the partnership to be brought to a future Board meeting or development session

The Bradford District and Craven Partnership Board:
1. Received and noted the Place lead's update.

7 Reports from committee and for a

The reports were taken as read with the following highlighted.

David provided an update following an exceptional meeting of the Clinical Forum in February 2024 which considered the place financial challenge, the response required to deliver an improved financial position and the closing the gap programme. Discussions from the meeting had been summarised to the Partnership Leadership Executive in order to shape a common narrative on the financial position. The Forum discussed an approach of balancing finance, quality and performance with some 'red lines' in terms of legal requirements, not broadening health inequalities and safety. The Forum suggested a deliberative event led by the partnership with local communities to discuss the potential impact of the financial position on services.

Andy referred to work to align connectivity between the Quality Committee and the Finance and Performance Committee to ensure the right membership on the committees and to get the right level of assurance for the Partnership Leadership Executive and the Board.

Amanda Stanford referred to the need to be open and transparent with the public on the reality of the financial position. David noted strong support for the NHS from local communities.

Andy referred to a discussion in the Quality Committee on the new guidance on the role of the Medical Examiner and a risk of funding out of hours.

8 Partnership high level risk update

Carrie Haywood presented a report which detailed the high-level risks (scoring 15 and above) on the BD&C Health and Care Partnership risk register during cycle six of 2023/24. The report included the WY ICB risk register, information on the common risks across two or more places in the ICB and an update on the WY ICB Board Assurance Framework (BAF).

Carrie highlighted that the scores for the risks related to BMDC's financial position and the sustainability of the VCS (risks 2173 and 2386) had increased from 20 to 25 during cycle six with a further review of the scores expected in the next cycle as exceptional financial support for BMDC had been approved. Carrie summarised the themes from the review of the risk register by the committees which included a request for further understanding of the risk related to VCS financial sustainability and a suggestion that the narratives of the financial risks considered the impact of the closing the gap programme, such as patient safety and staff morale.

Carrie noted that the paper included a summary of the 20 high level risks on the WY ICB risk register and highlighted links to similar risks on the partnership risk register, in order to encourage considerations for whether the risks on the ICB risk register were being addressed locally and how the partnership could influence the risks. The common risks across the five places were provided to encourage considerations for any potential gaps in the partnership risk register. The paper included the WY ICB BAF which had been reviewed in January and February 2024 in order to have a specific focus on the development of action plans for the risks in the BAF.

Update on VCS sustainability risk

Sam provided an update on the risk related to the sustainability of the VCSE sector (risk 2386) noting that the increase in the risk score aligned with the increase in score of the risk related to

BMDC's financial position (risk 2173). Sam explained that on 7 March the full Council agreed, as part of the budget setting, to reduce funding for VCS infrastructure report from £1.2m to £300-350k. The reduced funding would reduce support to the VCSE sector significantly and particularly grassroots organisations that worked with more marginalised groups as well as affecting employment in the sector with 18 people at risk of redundancy. It was suggested that other employment opportunities in the system were shared and promoted. Sam explained that there was work with council colleagues on the reduced offer to the sector with a commitment to work collaboratively and involve partners in the co-design. Sam formally thanked Iain MacBeath for his flexible and amenable approach which was ensuring a smooth path to the future arrangements. The new support from the sector would focus on taking pressure off front end services in health and care, particularly vulnerable children, young people and families and vulnerable adults.

Sam referred to work by the VCS Alliance to arrange volunteer days where people from other parts of the system could experience work in the sector, noting that VCS organisations needed volunteers with IT, HR or information governance expertise in order to strengthen their arrangements and to support the sustainability of the sector.

David referred to the WY ICB BAF in terms of the place risks not representing the different challenges in the partnership in the context of the place financial position and the balance with quality and safety. He queried the risk scores related to inequalities and infrastructure and suggested further discussion on the calibration of these scores in order to accurately represent the challenges in place, such as RAAC, Lynfield Mount and the primary care estate. Andrew agreed that discussions on the BAF risks should be framed in the context of differences in Bradford District and Craven to the other places, noting a differing demographics and a large geographical area with some very rural communities. Andrew also suggested further discussion on the three high level risks on the partnership risk register that related to ADHD and autism. Elaine explained that there would be an agenda item on risk and the partnership risk register in the development session in April.

The Partnership Board:
1. Received the BDC H&CP cycle six risk report and recommended assurance to be noted at the next board meeting on the critical and serious risks scoring above 15.
2. Discussed any identified risks that were not currently recorded on the risk report and signposted the partnership governance team to the relevant risk owners for liaison in preparation for cycle one.
3. Received the ICB risk register and ICB Board Assurance Framework for consideration and recommended assurance to be noted at the next board meeting on the BDC H&CP risks captured in the ICB risk register.

9 Update on finance/closing the gap programme/2024 operational planning

Mike Woodhead presented a paper which provided an update on the 2024/25 operational planning and the draft submission. It was noted that detailed guidance was still to be published but planning had started based on assumptions and the expectation of few changes. Mike highlighted key updates from the areas of non-elective and flow, elective care, diagnostics and cancer, mental health and learning disabilities, community, finance and workforce. Mike summarised that the BD&C Place financial planning gap for 2024-25 (for NHS organisations) was £80m, after identifying savings plans of £40m. The final planning submission to NHS England was due on 21 March 2024.

Iain MacBeath left the meeting.

Mike referred to check and challenge processes on workforce and productivity in terms of considering how increases in workforce would correlate to improvements in productivity with some

assumptions in the plans of reductions in temporary staffing across the year, no further industrial action in 2024/25 and continued reduction in bank/agency staff. The plan included significant levels of risk including workforce pressures, finance, the delivery of the waste reduction/cost savings targets, issues with reinforced autoclaved aerated concrete (RAAC) and the Electronic Patient Record (EPR) at Airedale, increasing demand for services and financial pressures of the council which could impact on health organisations/services.

Closing the gap programme

Mike provided an update on the closing the gap programme which had been established to support a collective approach to the challenging financial situation affecting all of the individual organisations and to close the gap between the budget available and the current expected spend across all sectors. Mike described the arrangements and structure for the programme which included the establishment of a weekly steering group led by a chief executive with a mandate agreed for the group which included holding each other to account, the recognition that the programme would not close the gap so a review of all services was needed and the need to understand the fragility of each service and the interdependencies between services.

Alongside the programme there was ongoing population health work to look at where money was spent and work to match spend to the priority areas which would better inform decisions in future years and planning rounds. An evaluation process and panel had been established to consider disinvestment and investment decisions with a wide range of representation from across the partnership and an agreed scoring matrix with scores for consideration of effectiveness, impact on health inequalities, impact on prevention, connectedness with other parts of the system, the meeting of local needs, local economic growth, cost savings/effectiveness and innovation. The panel would make recommendations to PLE. There were ongoing check and challenge sessions with the wider ICS with pressure to further close the gap. A meeting had taken place with council colleagues to agree areas which would be improved by working together.

Andrew supported the progress being made and the work undertaken to date by colleagues. He referred to the need to consider short and long term impacts and the importance of investment and capital, including for Lynfield Mount and digital work at Airedale NHS Foundation Trust. He advised being mindful of the narrative which should include a clear understanding of why Bradford District and Craven was different to other areas, such as significant rural areas and health inequalities. Therese explained that communications had been discussed in the steering group, with Shak Rafiq as place communications lead sitting on the group, and agreed on the importance of communications to our organisations and the public.

Linda referred to the responsibility of each organisation to consider their own services, which BDCFT had been undertaking in addition to developing a fulfilled workforce by working on retention, recruitment and looking after staff and suggested engaging or involving staff in the co-design of the changes or decisions to be made.

Amanda Stanford left the meeting.

Andrew referred to the importance of data and suggested that PLE consider data from the three NHS trusts in order to highlight and prioritise services that were outliers or where was the greatest gain. Mike explained that the population health work would involve looking at available data with the closing the gap programme holding members to account on data, benchmarking and metrics.

Therese added that there had been some work on productivity in community and mental health services and offered to bring some information to a future meeting to share any learning on productivity in community mental health.

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David referred to an intention in the planning submission not to increase staff numbers, which was in contrast with the NHS People Plan and the need to ensure that services have safe staffing and suggested that it is the responsibility of the leaders to call out this dissonance in the messaging.

Andrew advised being mindful of the impact and pressure on every partner, such as the care and VCS sectors, and suggested that the wider aspects of the partnership are included in the work being undertaken.

It was agreed that updates on finance and the closing the gap programme would be presented at future Board and development sessions.

10 Any other business

Elaine reminded Board members and attendees to complete the survey for the committee effectiveness review by Friday 22nd March.

11 Reports/escalations to WY ICB and review of the meeting

It was agreed that the financial positions of the Health and Care Partnership and BMDC would be alerted to the WY ICB Board in the 'alert, advise and assure' report to the WY ICB Board.

Date and time of next meeting:
Friday 17th May
10:00-13:00
G7/G8, Scorex House

DRAFT

Ref No	Meeting date	Agenda item	Action Required	Lead	Due Date	Status	Notes
2023/17	8-Mar-24	3 - minutes of the meeting held on 12 January 2024/action log/matters arising	Update following the primary care deepdive to be brought to a future meeting		28-May-24	Open	To be mapped to a development session in planning meeting in May
2023/18	8-Mar-24	5 - Listen in – children and young people cycle	Helen Rushworth to circulate the Healthwatch report on mental health in schools in Bradford and District	Helen Rushworth/Catherine Smith	17-May-24	Complete	
2023/19	8-Mar-24	6 - Place Lead's update	Agenda item on the impact of national approaches or strategies within the partnership to be brought to a future Board meeting or development session	Danielle Hann and Andrew Milner	28-May-24	Open	To be mapped to a development session in planning meeting in May

Partnership Leadership Executive

23 February 2024

9am – 12pm

MS Teams

Present:	
Foluke Ajayi (FA)	CEO, Airedale NHS Foundation Trust (ANHSFT)
Iain Macbeath *(IMB)*	Strategic Director of Health and Wellbeing, City of Bradford Metropolitan District Council (CBMDC)
Sam Keighley, *(SK*)	VCSE Sector Lead and CEO of VCS Alliance
Mike Woodhead *(MW)*	System Lead Director of Finance/Chief Finance Officer (BDCFT)
Louise Bestwick *(LB)*	CEO, Bradford Care Association
David Crampsey *(DC*)	Chair of BdC Clinical Forum
Charlotte Ramsden *(CR)*	CEO Bradford Childrens Trust
Sarah Muckle *(SM)*	Director Public Health, (CBMDC)
Phil Hubbard *(PH)*	Director of Nursing and Quality for BdC HCP (distributed leadership) *(on behalf of Therese Patten)*
Marium Haque *(MH)*	Strategic Director for Children's Services, CBMDC
Richard Haddad *(RH)*	CEO, Bradford Care Alliance
Danielle Hann *(DC)*	Medical Director and Deputy Chair, LMC
Sajid Azeb *(SA)*	Chief Operating Officer, Bradford Teaching Hospitals Foundation Trust (BTHFT*) (on behalf of Mel Pickup)*
In Attendance:	
Nancy O'Neill	Chief Operating Officer/Director of Partnership Delivery, Bradford District and Craven Health and Care Partnership (BdC HCP) ***(Chair)***
Louise Clarke *(LC)*	Director of Strategy, Transformation, Primary and Community (BdC HCP)
Shak Rafiq (*SR)*	Associate Director Communications and Involvement (BdC HCP)
Clare Smart *(CS)*	Associate Director Strategy (BdC HCP) *(item 4)*
Vic Simmons (VS)	Senior head of communications and involvement (BdC HCP) *(item 5)*
Carrie Haywood (CH)	Senior Assurance and Governance Manager *(Item 8)*
Alison Bullock*, (AB)*	PA / Partnership manager (BdC HCP)

1. Welcome and apologies for absence	Apologies were received from, Louise Wallace, Lorraine O Donnell, Mel Pickup, Therese Patten, Richard Webb
Declarations of Interest	Item 4 – Recommendations from the Panel for Financial Decisions (SK, RH, LC, DC, FA). Item 5 - Proposal for Bradford District and Craven VCSE infrastructure funding (SK)
2. Notes from 22 December	The minutes of the last meeting were accepted as an accurate record.
2 (b) Action log	Actions have been updated on the action log.

	Matters Arising: Item 6: Neurodiversity Business case was deferred to the March meeting.
Actions:	***None***
3. Finance (Month 10)	The main challenges for forecast this year continue to be in Airedale, part of this is the EPR system, though it was noted this was not just an Airedale issue it was a system issue. In the latest version of planning figures that were submitted to the ICS, the overall West Yorkshire ICB gap after Cost Improvement plans (CIP) has reduced from around £250m to around £175m. Bradford place as a system make up nearly half of this gap. It was clarified this was just the NHS gap, separately there are also significant issues for the Local Authority finances. Check and challenge sessions have been held locally and with the national team. There has been intense scrutiny and discussion over the decisions individual boards have made or are planning to make, around whether these could have been made differently or could have not been made at all. As agreed in December a Close the gap Task and Finish group has convened (Therese Patten is the SRO), the group will meet weekly until the end of March. Currently there is no PMO or project management support which is a risk, and the group are currently exploring options to mitigate this, possibly use the business support unit at Bradford District Care Trust. Clare Smart is drafting a narrative which tasks the Chief Operating Officers of Trusts and Programme Directors to look at Getting It Right First Time (GIRFT) program opportunities. It was reported that feedback from discussions with BdC clinical forum members has highlighted that some of the most senior clinicians are not fully aware of the of the financial situation and therefore reluctant to consider making any changes that may impact on quality of care. It is important that they understand and recognise the necessity of striking a balance between finance and quality. Recognising that our population, patients, and some clinicians may not recognise the gravity of the financial situation, it is important we have a clear narrative. We need to be clear around the red lines for clinicians e.g., legal requirements, interface with CQC, professional regulation, not widening inequalities. Clinicians will need to be supported through this work. Clinicians need to be supported with their transformation ideas, help them own some of this work. Consider whether there is an opportunity to pause rather than stop services, allowing them to restart should the finance situation improve. It is also important to recognise the impact this is having on other people involved in this work e.g., finance colleagues. There needs to be consistency between the NHS and Local authority messaging. Providing assurance that key and core activities will be

	safe, but the reality is we will be making difficult decisions around other parts of the system. It is important that we can differentiate between quality and safety in the narrative, ensure it is clear patient safety will not be compromised. There will be shared opportunities but there is a danger if we look too much at the short term, we can make a bigger impact with long term plans. It was noted that the West Yorkshire Clinical Forum did not appear to be having the same financial conversations and this could be confusing for clinicians. It was suggested that it would be good to have a narrative around why Bradford has 50% of WY £175m deficit. It was suggested a deliberative event that would be a good space to have conversations about quality and what are the red lines for clinicians and for our populations. It was noted that there is a responsibility on each of us as CEOs to ensure that the messages are getting back to our respective organisations.
Actions:	***Action: a) DC to reach out to James Thomas regarding awareness of situation at a WY level.*** ***Action: b) MW to reach out to Jonathon Webb regarding awareness of situation at a WY level.*** ***Action: c) DC/PH/SR create 'Act as One' narrative, for clinicians.***
4. Recommendations from the Panel for Financial Decisions'	Conflicts of Interest: SK: the VCS Alliance is a contract holder for some Reducing Inequalities (RIC) Programmes and the Wellbeing network (SK is employed by the alliance). RH – BCA deliver some RIC projects. DC – ANHSFT deliver the MyCare24 and support virtual wards. FA – ANHSFT deliver the MyCare24 and support virtual wards. LC works at Bevan House which delivers some of these services but was not involved in the process of decision making for them. It was agreed that all the above could listen to the discussion but not participate in decision making where they had direct involvement. Acknowledging the significant financial challenge, we are facing as a system and recognising the need to address this as a partnership, PLE requested a Panel for Financial Decisions was convened. This panel will make recommendations to the PLE on investment (and disinvestment) proposals. The panel draws from a broad membership and has taken the learning from the evaluation of Reducing Inequalities in Communities projects and built on this. A scoring approach set against our strategic purpose and commitments has been used along with links to our partnership strategy, prioritisation toolkit. Everything discussed has been through the relevant priority boards, the System Finance and Performance Committee and Quality Committee. Decisions are based on least

	impact for our population. It was noted this is only relates to decisions around NHS funds. PLE confirmed its support of the process undertaken and that this process continues for future investment decisions and business cases that are the business of the Health and Care Partnership. Reducing Inequalities in Communities (RIC): The RIC programme was established as the result of an increased allocation to Bradford CCG, specifically to target health inequalities. It was designed to run from 1 April 2019 through to 31 March 2024. Whilst funding remains recurrent, it was agreed that, in the current financial situation, the RIC funding needed to be considered in the context of our wider system investment. It is also recognised that inequalities are wider than the Bradford City area. The panel recommends the decommissioning of: - RIC12 Tier 3 Obesity Service - RIC28 Welfare Benefits Advice - RIC24 Primary Care Workforce - RIC01 CLICS To mitigate the impact of the ending of several RIC projects and further challenges that will impact on communities, it is recommended that £1m of the £2.76m RIC budget savings is invested recurrently in the Wellbeing Hubs (WBH). The WBH model will need to change within a reduced budget to an agreed set of outcomes. The Hubs are also encouraged to find as much match-funding as possible. This results in a total reduction in spend of £1.76m. It was felt that there was a danger we could be disinvesting in something that could make an impact but has not had a robust evaluation due to timescales. This potentially could widen inequalities; it is important we can demonstrate how we will mitigate what has been stopped. Going forward we need to be clear at outset of a project what the evaluation process will be. DH raised concern around how some GP's may be affected by these decisions. LC advised there had been engagement with GPs adding combining general practice and the wellbeing hubs and having new ways of working effectively together would be a way of mitigating impact. It is important that there is an exit strategy in place for established services that will be disinvested in. We also need to consider when stopping services formal engagement may be needed. It is important an Equality Assessment Impact is undertaken before proposals are considered by the panel. MyCare24COPD remote monitoring and clinical support: It was reported there was a relatively low take up and early drop off in engagement, and under-representation of the service even in deprived areas. It was felt that as this was condition-specific, there

	were missed opportunities in terms of moving to a multi-morbidity focus. New 72 Virtual Ward beds: It was felt the limited measures in place meant that outcomes, other than bed days saved, could not be easily considered. The bed days saved is not cash-releasing, which is central to Closing the Gap. The Panel recommend a 12-month managed transition within a reduced budget of £1m, with an end date of 31 March 2025. The transition will be funded from the 2024/25 ICB allocation for virtual services of £1.1m. The service will then cease to be funded. If £1.1m is allocated for virtual services, then we would look to develop a different service which has more involvement in the primary care community services. PLE: 1) supported the de-commissioning of the four RIC projects referenced above. 2) supported the recurrent funding of Wellbeing Hubs with a reduced budget of £1m. 3) supported the de-commissioning of the MyCare24COPD remote monitoring and clinical support and new 72 Virtual Ward beds. Recognising that ANHSFT already have issues with performance and are comprised for space, the outcome of these decisions may have a disproportionate impact. It was agreed that this should be monitored in case further mitigation is needed.
Actions:	***CS to draft letter (on behalf of Mel Pickup) to services that will not be renewed and send to Mel for approval before it is sent out***
5. Proposal for Bradford District and Craven VCSE infrastructure funding	Conflict of interest: SK declared an interest as her role is partly funded by this). SK was not part of the decision making. The Local Authority has announced a proposal to withdraw funding for the VCSE infrastructure contract as part of the wider budget proposals. This will have a direct impact on our ICB at place and impact on VCSE delivery partners. PLE were asked to confirm the ICB ongoing commitment of retain £185,000 per year allocated to the VCSE support and improvement program, which is currently funded recurrently and jointly commissioned with the Local Authority. Alongside this, was a proposal to align the provision of accessible information into this contract, this will make a saving to the partnership of £60,000 per year. The plan is to work through a codesign project with partners including Local Authority colleagues, voluntary sector representatives and priority directors to ensure that the contract aligns with our partnership strategy. This is about engagement with people and communities and bringing them on our journey. There is some urgency around confirming our commitment going forward as this will provide some level of stability for the VCS. Any changes in this contract will require potentially giving notice to people,

	and other contractual issues. SK advised that the VCSE counter proposal to the proposed budget would not be recommended by Council officers to Members. The interdependencies were shared, the support that is offered in terms of reaching into communities and providing a voice and influence from our voluntary sector partners is aligned with our ambition to go further. This is about activation and enabling citizens and grassroots community organizations to really engage and really be active partners in our health and care strategy. There is a danger we will lose the expertise of grassroots organisations who are working with our most vulnerable groups. The alliance also supports the coordination of that voice and influence. The Local Authority Stronger Communities team will be ceasing, they provide a lot of insight around citizen voice which will be lost. Acknowledging the Local Authority's significant financial pressures, it was noted this was about VCSE infrastructure, there is an appetite to collaborate around a new arrangement including other VCSE infrastructures in the Local Authority with a focus on sustainability of the VCSE sector, (particularly on health and care) but also delivering financial savings for the wider partnership. It is important that there will be support for the VCSE to move from an infrastructure type approach to a delivery and activation type of approach. It was noted that the VCSE will continue to actively look for external support. Three options have been considered: Option 1: Do nothing Option 2: Reprofile investment to mitigate risk (with moderate saving) Option 3: Revert to previous model of 'health only' contracts. PLE: - Discussed the options outlined, considered the impact, and approved proceeding with Option 2. - Endorsed the approach to codesign with partners (including VCSE, the Citizen Forum, and priority directors) and supported taking forward relevant contractual processes for the preferred option including establishing S75 agreement if there is scope to do so. - Acknowledged the risk associated with instability and uncertainty for VCSE delivery partners and the impact. - Approved the revised approach to acquiring support for accessible information.
Actions:	***None***
6. Neurodiversity Business case	Item was deferred to a future meeting
7. Estates enabler update	A first draft of our capital infrastructure program was shared for information. It was noted although the focus of the paper was on

	estates the capital infrastructure is not just the estate, it is estate and IT. There are ten draft principles that we will work to. It is important we consider the impact of our demography and what the growth looks like e.g., housing developments, schools and as well as health facilities and the broader leisure type facilities. There are some significant 'fitness for purpose' estates issues such as Lynfield Mount and Skipton Hospital which need to be addressed. Conversations are being held with West Yorkshire to see if there is any support they can offer. It was suggested it would be useful to reflect what our priorities were in order of urgency and reasons why, e.g., Lynfield Mount, as this would be additional evidence if any national funding should become available. It is important to have an Act as One approach and consistent narrative to this. Local Authority asset disposal strategy: Agreed that the Local Authority need to be linked into the strategic estates meeting. There are many opportunities e.g., colocation for agile teams. A recent neighbourhood asset review highlighted that a lot of Health/Local Authority buildings are no longer fit for purpose. We need to agree a blueprint for what our estates requirements will be in the future, taking into account our agile working. It is important we recognise the reducing backlog maintenance reference in the principles for BTHFT is subject to significant amounts of capital investment. Consider using space that is currently unused for short term use e.g. (Squire Lane for additional carparking) It is important we can collectively and collaboratively make best use of our assets to help our population access services local to them.
Actions:	***a) NoN to look at representation at the Strategic Estate meeting to ensure all partners are invited***
8. Partnership risk update (risk report – cycle six of 2023/24)	There are 12 high level risks on the register. The increase in score for risks 2173 and 2386 (to 25) has been agreed for an interim period until more is known about the future financial position of BMDC. The risk related to the VCSE sector (risk 2386) has increased in score in line with the financial position of BMDC (2173) due increased pressure to the sustainability to the VCS sector. Referring to risk 2386, CH advised that Partnership Leadership Team had suggested that this risk was wider than the proposed cuts to the VCS Infrastructure funding, this is being explored. There are some emerging risks relating to the MMR and wider vaccine program, The System Quality Committee have received an update from public health, therefore these maybe become additional risks in the next cycle. Adoption foster, Looked after Children and

	SEND were also noted to be emerging risks. It has been highlighted that Bradford does hold risks relating to CAMHS, this is out of trend with the other places, CH will speak with the leads in this area just to clarify if this is a gap for us. It was suggested that Risk 2337: Enhance productivity and value for money needs to reflect the impact of the financial context on workforce morale, staff engagement, this is currently very focused on reputational damage.
Actions:	***None***
9. Priorities and Enablers update	Report was noted for information, any questions should be directed the relevant leads.
Actions:	***None***
10. Covid and flu uptake 23/2024 Autumn Campaign	Item was discussed in conjunction with item 11
Actions:	***None***
11. NHSE Vaccination Strategy	NHSE published their new Vaccination Strategy in December 2023, this is a national strategy but there is a plan to localise it to our population. The vaccination strategy plans to integrate the Covid-19 vaccination programme with existing and more longstanding vaccination programmes. There will be a focus on the priority areas of inequalities, improving access and targeting the population groups that are least likely to come forward. It had been unclear around whether the COVID vaccination funding which has been received in the past few years would continue, but it has now been announced that there will be some recurrent funding made available. Some thought is now needed around how we manage the vaccination programme locally. The current arrangement will end in June, going forward into 25/26 we will be looking at this been a primary care function with somebody who can coordinate and support. Discussions around the infrastructure to support a new model will need to be undertaken. It was felt that using schools and Family Hubs to support the vaccination campaign could be powerful. This will provide an opportunity to engage with parents, myth bust and look at issues around vaccine hesitancy. DH raised a concern around gaps in commissioning with regards to when outbreaks happen, it was suggested this could be a risk. It was agreed the agreed the responsibility for delivery of the vaccine programme sits with Bradford (not West Yorkshire). It is important there is flexibility to be able to tailor it to our demographic. A workshop will be convened to agree individual system responsibilities around vaccination and come to an agreement around how we can collectively work together to discharge these responsibilities using a local approach.

	The Communication team are undertaking a piece of insight work to inform an infant health campaign.
Actions:	***Action: Representation all partners in the system is needed at vaccination workshop. PH to share date when agreed***
12. Any other business	PLE OD session planned for 1 March: It was noted there was a clash with ANHSFT roundtable discussion re the New Hospital Programme therefore it was agreed to stand down OD session. SK advised that Vicki Beere will be leaving Project 6 VCS but will remain in the system as an independent chair of VCS alliance.
Actions:	***None***
13. Key messages	None
Actions:	***None***
Date and time of next meeting	22 March 2024 MS Teams

Meeting name:	Partnership Board
Agenda item no:	5
Meeting date:	17 May 2024
Report title:	Listen in – what are we hearing?
Report presented by:	Victoria Simmons, Senior head of communications and involvement
Report approved by:	Shak Rafiq, Associate director of communications and involvement
Report prepared by:	Victoria Simmons, Senior head of communications and involvement

Purpose and Action

Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate	Information ☐

Previous considerations:

- Plans for Listen in year two, presented at Partnership Board meeting November 2023
- What are we hearing from children and young people? presented at Partnership Board meeting March 2024

Executive summary and points for discussion:

Listen in is an ongoing programme of involvement, with focused periods of activity to have direct conversations with the public, visiting community groups and public spaces to help us understand what matters most to local people when it comes to health and care.

Our second year of Listen in is focused on reaching into communities of interest and understanding the differing experiences of groups of our population. The second of these cycles was on inclusion health groups. In planning this cycle, we worked closely with the Reducing Inequalities Alliance (RIA), their expertise and insight identified a gap in our understanding of people who are in contact with the justice system and their health needs. During this cycle we have gathered insights that are relevant for all inclusion health groups, with a specific focus on people with experience of the justice system.

The attached ‘What are we hearing’ report describes the themes that surfaced under each of our partnership priorities. We also include a ‘call for evidence’ in each cycle to capture existing insight reports that provide context and additional learning. During this cycle of Listen in, we took part in 16 sessions across Bradford District and Craven between February and May 2024.

Some of these sessions involved our team attending existing meetings or events and literally ‘listening in’ to discussions, others were dedicated workshops with focus-group style activities, and some were visits to existing groups where we got alongside people to have one-to-one conversations.

Key themes covered in the report:

- Mental Health and Substance Use
- Access to Healthcare Services
- Support for Families of Prisoners
- Stability and Consistency in Support Services
- Community Engagement and Peer Support
- Housing and Reintegration Challenges

Insight gathered from this cycle is feeding into a new project to improve cancer screening uptake among inclusion health groups, with an event taking place in May with partners including the wellbeing hub network to develop ideas for inclusive pathways.

Future cycles are being planned for the Listen in programme, providing opportunities for Partnership Board members and other colleagues to get alongside communities and hear first-hand about their experiences:

- May- 21 June, Disabled people, and their carers
- 24 June- 12 July, LGBTQ+ communities
- July-September, Women
- October, Racial minority communities
- November, Men

Outline how this supports our partnership vision and strategy

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

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

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

Recommendation(s)

The ***Partnership Board*** is asked to:

1. **CONSIDER** the ideas and insights from this Listen in cycle and MAKE **RECOMMENDATIONS** for how our place governance and priority boards can take this learning forward.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

n/a

Appendices

1. Listen in - Inclusion Health: what are we hearing?

Acronyms and Abbreviations explained

n/a

What are the implications for?

Residents and Communities	**n/a**
Quality and Safety	**n/a**
Equality, Diversity and Inclusion	**n/a**
Finances and Use of Resources	**n/a**
Regulation and Legal Requirements	The Listen in programme is one way in which we discharge our statutory duty to involve the public.
Conflicts of Interest	**n/a**
Data Protection	**n/a**
Transformation and Innovation	**n/a**
Environmental and Climate Change	**n/a**
Future Decisions and Policy Making	Insight from Listen in will provide citizen voice that can be taken into account in future decision-making.
Citizen and Stakeholder Engagement	The Listen in programme is a core part of our partnership approach to citizen engagement. Local stakeholders are actively involved in planning and taking part in the programme.

Bradford District and Craven
Health and Care Partnership

ACTasONE

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

Listen in

Inclusion Health

What are we hearing?

April 2024

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Listen in – our approach

Listen in is an ongoing programme of involvement, with focused periods of activity to have direct conversations with the public, visiting community groups and public spaces to help us understand what matters most to local people when it comes to health and care.

In our second year of Listen in cycles we are focusing on reaching into communities of interest and understanding the differing experiences of groups of our population.

- We go out to communities and meet them in places they feel safe
- We value the support of community partners and VCSE organisations
- We listen to what matters to people through open conversations, without set questions or a specific agenda
- We invite colleagues from across our partnership to join us, so they hear first-hand from people and communities
- We record and report what we hear to maximise impact across our partnership

Our involvement responsibilities, including legal requirements

The legislation we must work to when delivering any involvement is set out in Appendix A.

Involving people is not just about fulfilling a statutory duty or ticking boxes, it is about understanding and valuing the benefits of listening to people and communities.

The Listen in programme enables us to build relationships and continually listen to our communities; this creates a strong foundation of our partnership's approach to involvement which enables us to meet and exceed our statutory duties.

Inclusion health groups

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

People belonging to inclusion groups, tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities.

Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way healthcare services are delivered.

In planning this cycle, we worked closely with the Reducing Inequalities Alliance (RIA), using their expertise and insight to ensure that we focused our efforts in ways that would deepen our insight without damaging trust with groups who are often both 'over-consulted' and 'easy to ignore'.

RIA's work on a Health Needs Assessment for Inclusion Health groups in Bradford District and Craven identified a gap in our understanding of people who are in contact with the justice system and their health needs (see page 17). This provided a clear focus for this cycle of Listen In activity.

Focusing on people with experience of the justice system

During this cycle we have gathered insights that are relevant for all inclusion health groups, with a specific intention to hear from people with experience of the criminal justice system and to build connections with the groups and organisations that support them.

Taking this specific focus to address an identified gap meant that we were 'starting from scratch' in making links and finding routes to connect with people. This means that the volume of data collected is less than in previous cycles, and that there were fewer opportunities for colleagues to participate in visits due to the sensitive nature of some settings.

What did we hear?

Hot topics

- **Mental health and substance use:** The intersection of mental health and substance use was a prevalent topic, with individuals highlighting the importance of addressing both issues concurrently for holistic care. People described their struggles with focus, anxiety, creating routine, and their need for mental health support to manage their lives.
- **Access to healthcare services:** Challenges in accessing healthcare services, including difficulties in making doctor's appointments, lack of support from GPs and feeling misunderstood or judged by NHS staff, and limited ability to or understanding of how to navigate the healthcare system, were common themes. The need for more accessible and culturally sensitive health services for minority communities and those experiencing complex needs was emphasized.
- **Support for families of prisoners:** Providing support for families of individuals in prison or leaving prison was a key topic of discussion, with individuals expressing the need for more groups and services tailored to their specific needs. Issues such as re-adjusting life post-release, sharing responsibilities, and financial struggles were highlighted.
- **Stability and consistency in support services:** The importance of stability and consistency in support services, such as probation officers, navigators, and mental health support, was a recurring theme. Individuals expressed challenges in building relationships and trust with changing probation officers and the impact of inconsistent support on their well-being. Navigator schemes, such as those run by the Bridge Project, were considered vital, successful, and well-regarded by service users, practitioners, and system partners.
- **Community engagement and peer support:** The value of community engagement, peer support, and informal group settings for sharing experiences, providing advice, and fostering a sense of hope and belonging was a significant topic. People highlighted the importance of peer-to-peer advice and inspiration to help rebuild their lives after setbacks or to recover from addiction.
- **Housing and reintegration challenges:** Issues related to housing, reintegration into society post-release, and navigating the complexities of the outside world after being incarcerated were commonly discussed. People talked about feeling unsafe in housing environments, lack of support from housing management, and challenges in accessing essential services while they are in temporary accommodation or homeless.

Access to care

Dental care

People shared experiences of needing urgent dental care but facing challenges in finding information on where to seek immediate treatment. There was uncertainty about whether to call 111 or how to access out-of-hours dental appointments, indicating a need for clearer guidance on emergency dental services. One worker told us that they had supported someone to get an emergency dentist appointment, but the closest place offered was in Sheffield - due to the cost of travel the service-user was unable to attend and the appointment was cancelled.

Barriers to timely healthcare access

Individuals highlighted barriers to accessing timely healthcare services, particularly in urgent situations. Some people mentioned that if appointments were too overwhelming or if they missed appointments, they would resort to attending A&E.

Some individuals and professionals recognised that people's lifestyles created additional challenges for making and keeping appointments, highlighting very basic assumptions that are often made. For example, if people have no data on their phone or no way to charge their phone due to their living/financial situation, they are unable to keep track of the time/date, let alone set reminders.

Navigating healthcare services

Individuals shared experiences of struggling to navigate healthcare systems post-release, including challenges in booking GP appointments online, unfamiliarity with digital systems, and difficulties in accessing essential services. Lack of confidence or knowledge about available resources and changes in healthcare practices post-release were common concerns, with people describing feeling disconnected and disoriented by changes especially if they had been in prison for a long period. Navigator services can provide a lifeline.

> "*I was unmedicated, going round in circles, I needed meds but I didn't even know how to get a GP to start the ball rolling, this service did that for me and it's the first time in years that my ADHD is under control.*"

Hospital care

People shared experiences related to hospital care, including both positive and negative encounters. Some individuals mentioned good experiences at Airedale Hospital, especially with the in-reach from drug and alcohol services. However, there were also instances where individuals felt dismissed or not adequately supported by hospital staff, such as being told to "just go away and sleep it off". The discussions highlighted the importance of improving healthcare provider understanding of addiction and mental health issues to enhance the quality of care received.

Some people said the hospital staff 'didn't have a clue' about addiction a few years ago but they felt it had improved recently, this was backed up by professionals from

the New Vision service who said more training is being provided for NHS staff and they are seeing benefits from having ASIST and MAST teams working on the wards.

Long-term conditions

We heard about the challenges faced by individuals with long-term conditions in accessing healthcare services. Participants discussed the need for more support and advice from healthcare professionals, particularly in addressing mental health issues alongside substance use. The experiences shared underscored the importance of holistic care that considers the interconnected nature of physical and mental health conditions for individuals with complex needs.

Access to Care: getting it right for people in contact with the justice system

Access to care for inclusion health groups would ideally involve a comprehensive and integrated approach that addresses their unique needs and challenges.

Trauma informed and culturally sensitive approaches

People told us how having a safe, non-judgemental, and supportive environment is essential for building trust. Professionals described the need for more healthcare providers to be trained in trauma-informed care so they can better understand and respond to the experiences of individuals who have been involved in the criminal justice system.

Care should be culturally sensitive and responsive to the diverse backgrounds and experiences of individuals in contact with the justice system. People explained how understanding and respecting cultural differences can enhance the quality of care and promote better outcomes.

Continuity of care and collaboration

Professionals talked about the people they support ‘falling through gaps’, and people we spoke to felt there should be seamless coordination and communication between healthcare providers and other agencies, such as probation services and community support organisations to ensure continuity of care during transitions. Healthcare providers, criminal justice professionals, social workers, and community organisations should work collaboratively to address the complex needs of inclusion health groups – taking a multidisciplinary approach can facilitate comprehensive assessments, treatment planning, and support services.

Navigator schemes, such as those run by the Bridge Project, play a vital role in supporting service users with long-term support and coordination, but these have specific eligibility criteria which means many people do not have this level of support.

Rehabilitation and support services

Hospital care should not only focus on acute medical needs but also incorporate rehabilitation and support services to help individuals address underlying health

issues, develop coping skills, and transition successfully back into the community. This may include mental health support, addiction treatment, relationship counselling or social prescribing services.

At the Together Women project, we had a detailed conversation with a woman who was currently on probation and had a long history of complex needs including domestic abuse, care system experience, mental health, substance use and alcohol addiction. She described how she has been ‘going through the system’ all her life with lots of different agencies supporting her at different points. She told us about her difficulties with alcohol and a pattern of admissions through the emergency department at Bradford Royal Infirmary over the last year - describing how in her most recent admission she received excellent, compassionate care.

“Even though I’d done it to myself they still looked after me like I mattered.”

She is now part of a clinical research trial, which was initiated following her admission. She was kept in hospital for several days, discharged with a full rehabilitation offer and with a breathalyser device which is linked to a smart phone app where she can record and track her recovery. Being part of the research seemed to be a source of pride and satisfaction, she talked about feeling that the NHS was investing in her and not wanting to let it down.

Healthy Communities

Positive experiences with support groups

People expressed positive experiences with community support groups, such as Partners and Families of Prisoners sessions. They found these groups to be valuable in providing support, understanding, and a sense of community for individuals with loved ones in prison or transitioning from custody.

Our conversations and interactions during the visits emphasised the importance of peer support networks and community organisations in providing practical assistance, empathy, and guidance for people with complex needs, including justice system experience.

People appreciated the informal and supportive nature of community groups, where they could engage in purposeful activities, open conversations, share experiences, and receive encouragement from others who had progressed in their journey.

> *"… was referred in by the police after domestic violence and isolation, she was really enjoying the group and looked very comfortable to be there with women who had similar lives and gave each other advice."*

Inspiration from role models

Many people told us that they found inspiration and motivation from role models who had successfully turned their lives around after experiencing the justice system, addiction, or mental health challenges. For example, at the probation open day one man told us about how attending art classes led by a former prisoner who had transformed his life served as a source of hope and encouragement.

Community engagement and trust

People highlighted the significance of building trust and relationships within the community, particularly in accessing support services and resources. Trust in community organisations, healthcare providers, and peer support networks was essential for individuals to feel supported and empowered; this is a significant challenge for people who are often traumatised or may feel stigmatised by their experiences.

> *"Lots of stigma around prison leavers. Even a long time after his sentence and now stable and in a good job, he is cautious about revealing he has been in prison. He talked about being treated as a second-class citizen."*

Collaboration and referral pathways

People emphasised the importance of collaboration between health and social care providers, community organisations, and support groups to ensure seamless referral pathways and coordinated care for individuals with justice system experience. Without this, many people feel left afloat.

> "*You're expected to be able to rebuild your life out of thin air, the 'powers that be' hold the building blocks and you've got to beg for them.*"

This was also highlighted as a source of frustration and challenge for professionals working with marginalised groups such as prison leavers. Barriers to data-sharing or different ways of working between organisations can result in missed opportunities to engage with people in a holistic way; when individuals have chaotic or complex lives 'making every contact count' is vital.

Healthy Communities: getting it right for people in contact with the justice system

Based on the insights from our visits, achieving joined-up support and community-based health for inclusion health groups, especially people with justice system experience would mean taking a comprehensive and integrated approach that addresses their physical, mental, and social well-being.

Care coordination

Implementing a holistic care coordination model that integrates physical health, mental health, substance use treatment, housing, and social support services. This approach ensures that individuals receive comprehensive care that addresses their diverse needs in a coordinated manner. Prioritising person-centred care that recognises the unique experiences, challenges and strengths of people fosters a sense of empowerment, trust, and engagement.

Navigator services have helped service users create structure and routine in their lives, no longer feeling overwhelmed by opening post or attending appointments, they feel they have support in place to help.

> *"I can absolutely imagine why someone would choose to go and get smashed as soon as they walked out the gate instead of trying to be organised and see who you need to see. Sounds strange but release is traumatic."*

Peer support and community networks

Establishing more easily accessible peer support networks and mentorship programs where individuals with lived experience can provide guidance, encouragement, and practical assistance to their peers. Engaging with community organisations, support groups, and local resources to create a network of support that extends beyond formal healthcare settings. Building partnerships with community-based organisations enhances access to social services, employment opportunities, housing support, and other essential resources – this could be embedded into the existing VCSE Wellbeing Hub model.

Supporting people to build or improve self-advocacy skills and providing opportunities for individuals to participate in decision-making processes regarding

their care could enhance their sense of agency, building a network of embedded community knowledge and support that would have long-term benefits.

People recovering from substance use also suggested that GP practices could help promote the recovery offer across Bradford District, including family support groups.

Seamless referral pathways

Establishing seamless referral pathways between healthcare providers, social services, community organisations, and support groups to ensure continuity of care and easy access to resources. Clear communication and collaboration among service providers facilitate efficient and effective support for individuals transitioning from the justice system who are often overwhelmed and have very limited resources (financial, social, emotional, practical) to be able to navigate a complex system and can all-too-easily fall through the gaps.

Healthy Minds

We heard from several people about instances when they struggled to get timely and adequate support for their mental health concerns, facing delays in response from mental health teams and challenges navigating the healthcare system.

Substance use and mental health

Many people have complex needs related to substance use and mental health, people talked about turning to substances as a coping mechanism for underlying mental health issues or a way of 'self-medicating'. Others talked about issues with alcohol or drugs making existing mental health problems worse or being a barrier to getting appropriate care. Addressing mental health concerns alongside substance use is crucial for effective treatment and recovery, however the current services and pathways do not seem to enable this.

People shared experiences where healthcare professionals exhibited outdated attitudes and knowledge of addiction and certain substances, particularly cannabis and spice, highlighting the need for improved training and awareness among healthcare providers.

> *"…many healthcare professionals still have an old-fashioned attitude to cannabis, thinking it's quite harmless and not being up to speed with how cannabis is a lot more potent now than 20 years ago."*

Stigma and mistrust

People with experience in the justice system may face stigma and misunderstanding when seeking mental health support. People transitioning from the justice system may have experienced trauma and trust issues, impacting their ability to engage with mental health services. Our conversations indicate that stability and consistency in support services, are essential for building trust and rapport with individuals seeking mental health support.

Mental health impact of custodial sentences

We heard how being in prison can be a scary and difficult; people may feel ashamed or guilty because of being in prison, and this can affect how they see themselves and their worth. When someone is in prison, they may lose connections with their loved ones and struggle to rebuild these relationships when they are released. After leaving prison, people may find it hard to adjust to life outside and face challenges like finding a job, dealing with stigma, and feeling overwhelmed.

> *"I was a really social and outgoing person, now I can't even go on the bus and busy places make me feel really anxious. My family can see how much of a different person I am now."*

Prison leavers may find it challenging to access talking therapy after their transition back into the community. We heard that the experience of being in prison, including

the lack of mental health support when in prison, meant that people were less open to engaging with talking therapies after release.

> *"I trained hard, got pretty strong, played rugby […] and buried anything I thought would demonstrate weakness. There was no access to talking therapies, no one approached me in the 5 years [in prison] about the fact I had been sentenced to a drug related offence."*

Support for family members

We connected with people whose loved ones have been in prison and heard about the wider impacts on a family's life including poverty, stigma, relationship breakdown and mental health.

> *"When her partner was initially sent to prison, she struggled with her mental health and struggled to get any support, on numerous occasions she contacted her GP, but they would not refer her to mental health services. She finally did her own research by going online […] My Wellbeing College "have been excellent, they helped me understand my life has changed."*

Healthy Minds: getting it right for people in contact with the justice system

Tailored and integrated care

People talked about the potential to implement a more tailored and integrated care approach that considers the unique needs and challenges of individuals with diverse backgrounds. This includes addressing mental health, substance use, trauma, and social support needs in a holistic manner to promote overall well-being and recovery. Many people, including professionals, spoke of the need for an integrated mental health service within the drug & alcohol treatment sector.

Value and promote peer support

Fostering peer support networks and positive role models for individuals with justice system experience would make a lasting impact for communities. Peer support can inspire hope, resilience, and motivation for individuals seeking mental health support and recovery, creating a sense of community, and understanding.

Training and awareness

Provide training and awareness programs for healthcare professionals and service providers to improve understanding of the interconnections between neurodiversity, learning disabilities, substance use, mental health issues, and the justice system. This would address stigma, outdated attitudes, and misconceptions to enhance the quality of care and support provided to individuals with diverse backgrounds and complex lives.

Community engagement and asset-based approaches

Collaboration between healthcare providers, community organisations, and support groups could create a network of care for individuals with complex needs that would make services more accessible and inclusive, maximising the opportunities to connect with people and support them to address their own health needs.

Services should recognise the strengths and capacity within inclusion health communities, including prison-leavers, as well as understanding the complex and chaotic nature of people's lives.

Asset-based approaches could help empower individuals with diverse backgrounds to advocate for their own health and care needs. Encouraging self-advocacy, providing information on available resources, and supporting individuals in navigating the healthcare system would make it more likely that people would reach the necessary support and make best use of services.

No wrong door

It is important to ensure that services commissioned by Healthy Minds are known to local support groups, navigator services, and the NHS England funded RECONNECT service that supports people's healthcare needs in the transition from prison into the community. Making sure that there is 'no wrong door' is vital for people who are less likely to persist in their attempts to access support.

People Development

During our visits we were able to talk to several people who have been in contact with the justice system, overcome substance misuse, or dealt with mental health challenges, and gone on to find meaningful career opportunities. Often this has been achieved through volunteering, helping others, accessing training programs, and being inspired by positive role models. These opportunities not only contribute to personal growth and development but also enable individuals to make a positive impact in their communities.

> *"I'd been working and studying at Uni in the last 15 months of my sentence and really wanted to finish my masters as a bit of a 'f**k you' to the system and to those who judged me and prisoners in general. I'd been volunteering in a needle exchange for the same timeframe and by coincidence I had a job interview for the same organisation literally an hour after being released […] I was offered the role the same afternoon and started on the Monday. That lack of 'empty' time kept me focussed and determined. It was a genuine 'open' prison that offered resettlement to give me that opportunity - they don't offer that now."*

We heard about a campaign to increase opportunities and inclusivity for people with convictions led by Unlock, a charity that works to achieve a fair and inclusive society where people with criminal records can move on positively in their lives. 'Ban the Box' encourages employers to remove the section on application forms asking about previous convictions until later in the recruitment process, enabling employers to consider candidates on merit first. Many big employers have signed up to this approach, and people suggested that the local health and care employers could adopt this approach for some roles to make employment opportunities more accessible.

Who did we hear from?

During this cycle of Listen in, we took part in 16 sessions across Bradford District and Craven between February and May 2024.

Some of these sessions involved our team attending existing meetings or events and literally ‘listening in’ to discussions, others were dedicated workshops with focus-group style activities, and some were visits to existing groups where we got alongside people to have one-to-one conversations.

Thank you to the staff, volunteers, and participants at the following organisations for their support in helping us hear from people during this cycle:

- Bradford Probation Delivery Unit
- LEEP (Lived Experience Evaluation Project, run by Change Strength Group)
- Lotus team (the Bridge Project)
- Equality Together
- Bradford Activity Hub at Fountains Church
- Together Women
- West Yorkshire RECONNECT service
- Ingeus
- North Yorkshire Horizons
- Bradford Council (People Commissioning – Public Health)
- MARRS and DRAM Navigator Services, The Bridge Project
- New Vision Bradford
- Health and Justice team – Yorkshire and Humber Probation Service
- York and North Yorkshire Probation Delivery Unit

We engaged with approximately 35 people during this cycle.

We did not collect equality monitoring data however we targeted our activity to ensure that we heard from our diverse population.

We talked to people:

- aged approximately 25 - 65
- with a broad range of needs and experiences that intersected with their experience of the justice system including SEND, substance use, mental health, long-term conditions, care experience, neurodivergence, LGBTQ+, sex workers and the homeless community
- from diverse backgrounds and ethnicities
- living in different localities from around Bradford and Airedale

We also heard from probation officers, caseworkers, social care staff, and mental health workers, substance use support teams.

What we already know

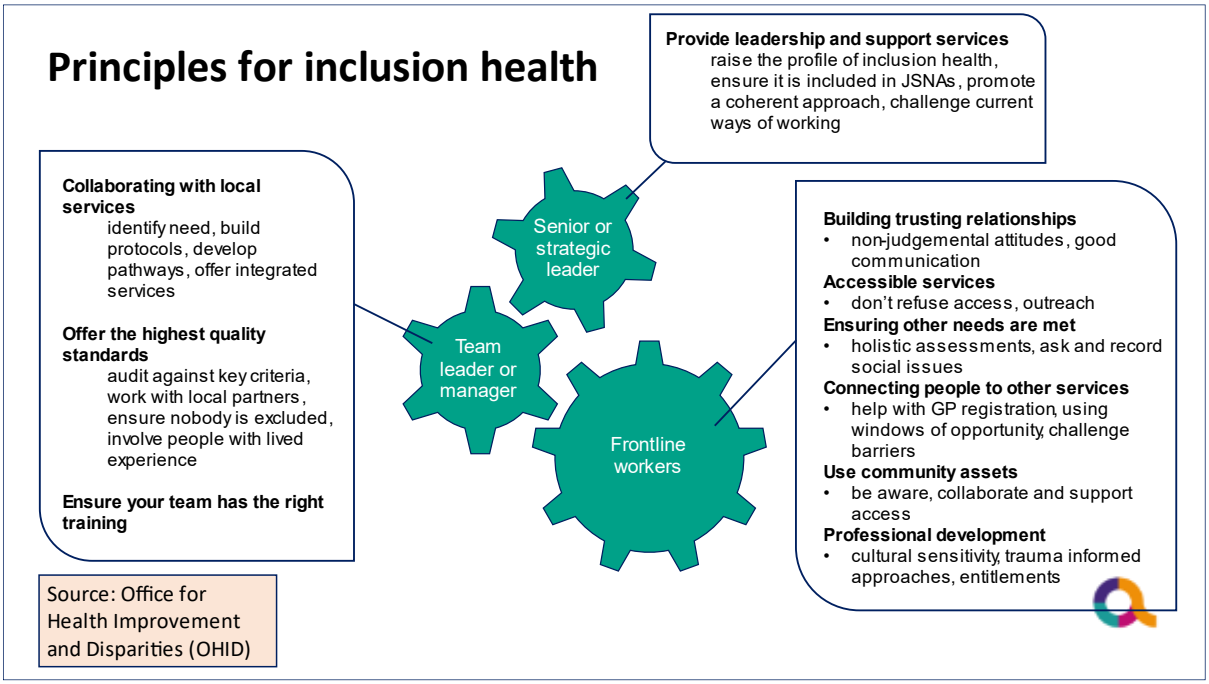
Ahead of each cycle we try to capture recent insight reports and engagement projects relevant to the community of interest. This gives additional context to what we're hearing and over time will enable our partnership to build up a repository of intelligence from our communities that can be shared more effectively across the system.

All the reports referenced below are available to download from our involvement portal www.engagebdc.com/listen-in-call-for-evidence

Key reports and some highlighted findings

Inclusion Health in Bradford District and Craven: Rapid Health Needs Assessment, Myrte Elbers – Reducing Inequalities Alliance, March 2024

> *"There is fragmented knowledge of the health needs of prison leavers, victims of modern slavery, sex workers (except on-street), as this does not get flagged on healthcare systems, nor disclosed due to fear or stigma.*
>
> *"Prison leavers – more detail needed on 60% of people on Probation that self-report a physical or mental health condition…"*



Evaluation project, lived experience of substance use issues within the Bradford Metropolitan District: LEEP report, December 2023

The Lived Experience Evaluation Project (LEEP) engages with people who are in recovery from substance use. The LEEP report highlighted the link between substance use, mental health, and offending: more than half of respondents had served a custodial sentence because of drug-related convictions. In addition, 9 out of 10 respondents had suffered from periods of depression. Anxiety was also common, with 83% of respondents having suffered from anxiety attacks. The report includes data on psychosis, insomnia, and self-harm.

RECONNECT service: NHS England case study, Jan 2023
Changing lives with RECONNECT

Kevin, who's used the RECONNECT service and now works there as a care navigator, tells his story of how he became involved, how it has helped him stay out of prison and how he's using his experience to help others.

Surviving in a revolving door: a study of the evidence about offending
Surviving_in_a_revolving_door_final.pdf (westyorkshire-pcc.gov.uk)

> *"Evidence that shows the effectiveness of the WY-FI Navigator Model, supported by West-Yorkshire-wide leadership that enables multi-agency working to be a valued part of all districts."*

Credits

Report author: Victoria Simmons, Senior head of communications and involvement, Bradford District and Craven Health and Care Partnership

02 May 2024

For more information, please contact communications@bradford.nhs.uk

When planning each cycle of Listen in, we bring together a design group of colleagues from across our partnership to lead and coordinate the activity, ensuring that it is adapted appropriately for the relevant community of interest.

Huge thanks go to colleagues who formed the design group for this cycle and were generous with their time, energy, connections, and expertise:

- Sophie DiMauro, Reducing Inequalities Alliance, BDC HCP Partnership
- Myrte Elbers, Chair of Inclusion Health group, BDC HCP Partnership
- Saeed Khan, Involvement Manager, BDC HCP Partnership
- Grace Mullins, Communications and involvement officer, BD&C Partnership
- Zaynab Nawaz, Equality Together
- Dave Memery, Change Strength Group, Lived Experience Evaluation Project
- Gavin Lee, Bradford Probation Delivery Unit
- Joe Kean, Public Health Commissioning, Bradford Council

Appendix A – our partnership's duties

There are several requirements that must be met when decisions are being made about the development of services, particularly if any of these will impact on the way these services can be accessed by patients.

a. Public involvement legal duties

The legal duties on public involvement require organisations to make arrangements to secure that people are appropriately 'involved' in planning, proposals and decisions regarding NHS services.

NHS England's new statutory guidance provides the detail on these legal duties, when they are likely to apply and how they can be met. Key requirements of Integrated Care Boards (ICBs), trusts and NHS England include that they:

- assess the need for public involvement and plan and carry out involvement activity
- clearly document at all stages how involvement activity has informed decision-making and the rationale for decisions
- have systems to assure themselves that they are meeting their legal duty to involve and report on how they meet it in their annual reports.

Integrated Care Partnerships (ICPs), place-based partnerships and provider collaboratives also have specific responsibilities towards participation. There are statutory requirements for ICBs and ICPs to produce strategies and plans for health and social care, each with minimum requirements for how people and communities should be involved.

A significant change introduced by the Health and Care Act 2022 is that, in respect of NHS England and ICBs, the description of people we must make arrangements to involve has been extended from 'individuals to whom the services are being or may be provided' to also include 'their carers and representatives (if any)'.

b. The triple aim duty

NHS England, ICBs, NHS trusts and NHS foundation trusts are subject to the new 'triple aim' duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively). This requires these bodies to have regard to 'all likely effects' of their decisions in relation to three areas:

1. health and wellbeing for people, including its effects in relation to inequalities
2. quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services
3. the sustainable use of NHS resources.

Effective working with people and communities is essential to deliver the triple aim.

c. Involvement duties on commissioners and providers

To reinforce the importance and positive impact of working with people and communities, NHS England, ICBs and trusts all have legal duties to make arrangements to involve the public in their decision-making about NHS services.

The main duties on NHS bodies to make arrangements to involve the public are all set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022:

- section 13Q for NHS England
- section 14Z45 for ICBs
- section 242(1B) for NHS trusts and NHS foundation trusts.

A requirement to involve the public is also included as a service condition in the NHS Standard Contract for providers.

Each of the organisations listed above is accountable and liable for compliance with their public involvement obligations. However, that does not mean that each organisation should carry out its public involvement activities in isolation from others within the ICS and beyond. Plans, proposals or decisions will often involve more than one organisation, particularly in respect of integration and service reconfiguration, in which case it is usually desirable to carry this out in an joined up and co-ordinated way, reducing the burden on both the public and the organisations themselves.

The legal duties require arrangements to secure that people are 'involved'. This can be achieved by consulting people, providing people with information, or in other ways. This gives organisations a considerable degree of discretion as to how people are involved, subject to the below requirements.

d. The Gunning Principles

Commissioners and trusts must ensure that their arrangements to involve people are fair. The courts have established guiding principles for what constitutes a fair consultation exercise, known as the Gunning principles. These four principles relate to public consultation processes and do not create a binding legal precedent for how other ways of involving the public should be carried out. However, they will still be informative when making arrangements to involve the public, whatever the form of those arrangements.

1. Consultation must take place when the proposal is still at a formative stage.
2. Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response.
3. Adequate time must be given for consideration and response.
4. The product of consultation must be conscientiously taken into account.

e. The Equality Act 2010

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of protected characteristics. These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires public sector organisations to have 'due regard' to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- and foster good relations between people who share a protected characteristic and those who do not.

This is known as the 'public sector equality duty' (section 149 of the Equality Act 2010).

Working with people with characteristics protected under the Act means understanding how decisions or policies can affect them and whether they will be disproportionately affected.

An Equality Impact Assessment (EIA) will need to be undertaken on any proposals for changes to services that are developed, in order to understand any potential impact on protected groups and ensure equality of opportunity. Involvement and consultation must span all protected groups and other groups, and care should be taken to ensure that 'seldom-heard' interests are engaged with and supported to participate, where necessary.

Meeting name:	Bradford District and Craven Health and Care Partnership Board
Agenda item no:	
Meeting date:	17 May 2024
Report title:	Place Lead's Update
Report presented by:	Therese Patten
Report approved by:	Therese Patten
Report prepared by:	Shak Rafiq and Lesley Tillotson

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☒

Previous considerations:

The Place Lead's Update is a regular agenda item at meetings of the Bradford District and Craven Health and Care Partnership Board

Executive summary and points for discussion:

This report summarises key activities and points to note arising from the activity of the Bradford District and Craven place partnership and the wider West Yorkshire Health and Care Partnership. Where relevant, connections are made to national policy developments.

The report seeks to inform the Partnership Board of progress made by the Executive and the whole Partnership in response to our key issues and in pursuit of our strategic goals.

Outline how this supports our partnership vision and strategy

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

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

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

Recommendation(s)

The BD&C Partnership Board is asked to

1) receive and note the Place Lead's Update

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
This report provides an overview of the partnership context, recent highlights, and forthcoming activities. As such it touches on several areas of the BAF but does not seek to provide assurance on any specific risks.
Appendices
n/a
Acronyms and Abbreviations explained
1. ICS integrated care system 2. ICB integrated care board 3. HCP health and care partnership 4. BD&C Bradford District and Craven 5. WY West Yorkshire 6. VCSE voluntary, community and social enterprise sector 7. CQC Care Quality Commission 8. UKHSA United Kingdom Health Security Agency

1. National context and policy development

Death certification reform and the introduction of medical examiners
On Monday 15 April 2024, the Government confirmed that legislation to reform the death certification process will be implemented from September 2024, rather than April 2024, as had originally been proposed.

The legislation means that from 9 September, medical examiners will look at the cause of death in all cases that have not been referred to the coroner. From that date, it will not be possible to register a death without medical examiner scrutiny, unless it has been referred to the coroner.

Medical examiners will look at the care received around the time of death, confirming that the cause of death is valid. They will also consult with families or representatives of the deceased, providing an opportunity for them to raise questions or concerns with a senior doctor not involved in the care of the person who died. This process will help safeguard future patients by learning from death and being supportive to families and healthcare professionals.

We are still awaiting guidance on the details of the legislation. In the meantime, medical examiners in West Yorkshire continue to work with colleagues across health and care to ensure that the new arrangements are working smoothly so as to minimise disruption to bereaved families.

For more information, please see the DHSC announcement.

Overview and scrutiny statutory guidance updated
This statutory guidance for councils, combined authorities and combined county authorities, has been updated to take account of deeper devolution and the creation of combined county authorities through the Levelling Up and Regeneration Act 2023. This guidance was published on 22 April 2024 and replaces guidance published on 7 May 2019.

First ever national clinical director for women's health
The NHS has appointed Dr Sue Mann, a consultant and lead for women's health in City and Hackney, North East London, as its first ever national clinical director for women's health. In her new role, Dr Mann will help implement the Women's Health Strategy alongside supporting the roll out of women's health hubs across England. She will also work on the development of a network of Women's Health Champions, made up of senior leaders in every local care system to drive forward work to improve women's health.

Health Foundation research predicts 700,000 more workers projected to be living with major illness by 2040
The report focuses on inequalities in major illness in England, notably among working-age people. It reveals that growing ill-health will continue to significantly impact people's lives and the economy. On current trends, 3.7 million working-age adults will be living with major illness by 2040—up from 3 million in 2019. The report warns that 80% (540,000) of this increase will be in the more deprived 50% of areas,

further entrenching health inequalities and having considerable implications for local and regional economies.

2. West Yorkshire Health and Care Partnership activity and implications for Bradford District and Craven place partnership

West Yorkshire Health and Care Partnership becomes the first 'Keep it Local' Integrated Care System in the country
The WYHCP has become the first 'Keep it Local' ICS in the country following agreement at the Partnership Board. In the face of pressures on health and social care, this national initiative is focused on how the NHS works with its partners to prioritise supporting, partnering with and commissioning local voluntary, community and social enterprise (VCSE) sector partners.

Find out more on our website or watch this short video featuring Kim Shutler, VCSE Member of the ICB and Senior Responsible Officer for the Power of Communities Programme; Cathy Elliott, ICB Chair and Deputy Chair of the Partnership; and Tony Armstrong, CEO of Locality.

Young people from ethnically diverse backgrounds benefit from £1.7 million boost to tackle workplace discrimination in West Yorkshire
Youth Futures Foundation has awarded the Hamara Centre £1.7 million to support young people from Bangladeshi and Pakistani backgrounds in Leeds and Bradford in seeking employment. The funding will be used to create new employment pathways for young people, drive change with local employers, and strengthen the voices of young people at work. The funding has been awarded in light of new research from Youth Futures Foundation, which found that almost half of young people from ethnic minority backgrounds have experienced discrimination while seeking to enter the workplace. Watch this video for more information.

Let's Connect – new campaign for children and young people's mental health launches
As part of our work supporting young people in crisis, during 2024 -25, the #LetsConnect campaign has been developed to encourage parents, carers, children and young people in West Yorkshire to feel comfortable in talking about mental health and emotional wellbeing with each other. Find out more on our website, watch this video from Consultant Child and Adolescent Psychiatrist Dr Nicola Dawson and look out for our social media posts with a podcast, animations and more to share.

New eye health website for West Yorkshire
The WYHCP's Eye Care Transformation Group worked with Outlookers, a local support group for people with visual impairments, to develop My Eye Health. This new website has details of over 50 different eye conditions, treatments, self-care guidance and post-surgery advice. It includes information about accessing emergency and non-emergency eye care, local support services and eye care charities. There is also a section dedicated to children's eye health, and a

professionals' section for those working in eye care in West Yorkshire. For more details, please see this media release.

Open letter of thanks – responding to winter pressures
It has been recognised how well partners across our system have been working together to deal with the seasonal increases in need for services and the response from colleagues across health and care. Rob Webster (Chief Executive for NHS West Yorkshire ICB), Cathy Elliott (Chair of NHS WY ICB) and Councillor Tim Swift (Chair of WY Partnership Board) wrote an open letter to everyone working within the West Yorkshire health and care system to thank them for all their planning, hard work, care, and commitment over winter.

COVID-19 spring vaccination programme
The COVID-19 spring vaccination campaign started in mid-April to coincide with the re-launch of the National Booking Service (NBS) and the start of visits to older adult care homes and eligible housebound patients from 15 April. The campaign will end on 30 June. By 26 April over 13,500 vaccinations had been administered across West Yorkshire.

Anyone eligible can book a vaccine appointment via the NHS.UK website or by calling 119 for free, with parents or carers able to book a Covid-19 vaccination for children under 16 on their behalf. Eligible people aged 16 and over can also use the NHS App to book an appointment.

Carers hospital discharge toolkit
The ICB's Unpaid Carers Programme has produced a carers hospital discharge toolkit and resources to support NHS trusts to carry out their statutory duty to involve unpaid carers in discharge pathways and to improve unpaid carers' experiences of discharge through increased identification, support, signposting, and referral.

This toolkit and accompanying resources provide practical guidance for implementing the hospital discharge and community support guidance, information for Integrated Care Systems on virtual wards and the recently released statutory guidance for discharge from mental health inpatient settings when it comes to supporting unpaid carers, and sit within the wider context of a 'carer friendly hospital' approach.

This toolkit is intended for all areas of discharge including acute hospitals, mental health hospitals, and virtual wards. Although the term hospital is used throughout the toolkit, the principles in each step are adaptable for virtual wards.

The five West Yorkshire VCSE carer organisations (Carers' Resource, Making Space, Carers Count, Carers Leeds and Carers Wakefield District) will be supporting the launch and introduction of the toolkit and resources over the coming months with stalls, awareness sessions, visiting wards and training sessions.

WYICB annual involvement report published
The West Yorkshire Public Involvement Report 2023-24 describes how people and communities across West Yorkshire have been involved in the work of the partnership over the last year.

The Partnership would like to thank the people, communities and organisations who

have taken part in our involvement and the partners who have worked with us and supported our involvement activity.

3. Bradford District & Craven Partnership progress and issues to note

Ministerial visit to hear more about proactive care
Helen Whately, Minister for Social Care, visited our district on 7 March to hear more about the reducing inequalities programme across Bradford and Craven that proactively targets health inequalities. The Minister heard about three integrated services that bring together specialists across health, care and voluntary organisations, and the positive impact of their work. The Proactive Care Team brings together a wide range of skills and experience to support adults at home and avoid unnecessary GP and hospital appointments. This service is proving successful, showing a 41% reduction in A&E attendances so far.

The Minster also heard about two mental health initiatives from Healthy Minds. The Cultural Adapted Therapies service supports individuals with depression in Muslim communities and is showing positive outcomes for those involved. While the Specialist Early Adaption and Development service – just one of three across the UK – and its multidisciplinary team within CAMHS, is providing therapeutic support for 0–6-year-olds and their families. This is also having a positive impact and showing lasting change for the families involved. Thank you to all those involved in the visit who showcased the innovative work across our place.

Bradford featured in Partnerships for People and Place: learning and evaluation report
The Department for Levelling Up, Housing and Communities has published Partnerships for People and Place: learning and evaluation report which includes learning from case studies from across the country, including Bradford. The Partnerships for People and Place (PfPP) programme was delivered by the Department of Levelling Up, Housing, and Communities between February 2021 and March 2023. The programme aimed to test whether closer working between different parts of central and local government can bring measurable benefits to local communities and people.

Closing the gap: meeting our financial challenge
Our closing the gap programme has been set up to help us - across our Bradford District and Craven Health and Care Partnership - take a collective approach to the incredibly challenging financial situation affecting us. We are involving all sectors of our partnership in an open and transparent way to close the gap we currently have between the budget available and our current expected spending across all sectors.

Visit our webpage to find out more about the work we're doing to meet this challenge, our focus on maintaining our vision to 'Act as One' to keep people happy healthy at home and access all our briefings. We will continue to keep you updated on progress.

Countdown to Bradford 2025 UK City of Culture has begun
On Tuesday 19 March around 400 people from across our district came together at the official countdown event for Bradford 2025 UK City of Culture. The even included some exciting new developments, read on for more information

- A new brand was unveiled including the new logo. Show your love for Bradford District by downloading and displaying the new Love Bradford 2025 logo
- Zayn Malik was announced as the brand ambassador for Bradford 2025. Throughout 2025, Zayn, along with the people of Bradford, will celebrate the district as the UK City of Culture.
- If you can't wait for the Bradford 2025 UK City of Culture to kick off next year, you can get a flavour through three special events announced for 2024.

Stay connected and find out more by visiting the Bradford 2025 website, you can sign up to receive regular updates.

RIC: What works in reducing inequalities
To address inequalities in central Bradford, the Reducing inequalities in communities (RIC) programme was set up in 2019 as a five-year programme to test out various interventions. The programme has been overseeing the delivery of 21 projects, involving a range of partners and has benefitted over 16,000 people. This learning has been captured in a final RIC learning report, there's also a short video, blog and recordings from a RIC Learning Week available from our partnership website www.bdcpartnership.co.uk/RIC

School transforms classroom into flat to teach life skills
A special education needs school has turned one of its classrooms into a furnished flat to teach pupils essential life skills. High Park School in Heaton, Bradford, appealed for donations of furniture and appliances to kit out its flat to help prepare pupils for independent living. Parents, staff and pupils attended the opening of the flat last week. Assistant principal Sarah Tollemache said it was about preparing older students for adulthood.

Students enter the Dragons' Den to pitch for health project
Prototype medical devices created by students at the University of Bradford won praise from a panel of health experts during a Dragons' Den-style assessment.

Seven groups of second-year BSc (Hons) Clinical Sciences students were tasked with inventing a new digital medical device, which they pitched to a group of seven industry and healthcare experts from Pharmacy2U and Health Innovation Yorkshire and Humber.

JogOn to female runner harassment

Safer Bradford is clamping down on the harassment and abuse of female runners by telling perpetrators to JogOn. A national survey by Runner's World magazine has found that 60 per cent of female runners experience some form of harassment, particularly from men in cars. The Safer Bradford partnership (which includes Bradford Council, West Yorkshire Police and the NHS) wants to stamp out the problem. It leaves many women feeling scared and intimidated, looking for alternative running routes or changing the times they go out to avoid cat calling, offensive comments and, occasionally, physical harassment.

Working in partnership to get people Home FAST!

Colleagues within Airedale NHS Foundation Trust and City of Bradford Metropolitan Council have been working in collaboration to deliver a Home First Assessment Support Team (Home FAST) Pilot.

Adapted using the principles from the East Lancs Home First model, the pilot aims to discharge people within 24 hours and undertake an assessment (over a period of up to 3 days) within the individual's own home to determine their ongoing care and support needs.

Starting with a soft launch early March 2024, discharging one person per day, the pilot has already seen 12 people safely return home and remain home with H FAST which equates to approximately 60 bed days saved. The pilot is part of the system wide work taking place to implement our Intermediate Care Blueprint that aims to improve outcomes for our population, maintain flow across the health and care system and ensure everyone has equal access to the right care and support at the right time in the right place. A review of the pilot will take place in July to explore opportunities for wider roll out across Bradford District and Craven. This includes plans for Bradford Teaching Hospitals NHS Foundation Trust.

AWARDS NEWS FROM OUR PARTNERS - congratulations to all

myHappymind Bradford District and Craven shortlisted for the HSJ Digital Awards

Bradford District and Craven's myHappymind project has been shortlisted in two categories at the 2024 HSJ Digital Awards. The awards recognise innovative digital projects across the UK which are transforming care delivery, enhancing efficiency, and improving patient outcomes. The project has been shortlisted for the 'Reducing

Health Inequalities' and 'Moving Towards Net Zero through Digital' award categories. Read more…

Safe Spaces wins Third Sector Care Award for collaboration

The Cellar Trust and Mind in Bradford are delighted Safe Spaces crisis service has been recognised at the Third Sector Care Awards today winning the Collaboration (Integration) Award for our partnership. This award recognises ways of working in partnership with other organisations or services, achieving outcomes that would otherwise not have been achieved.

Staying Put picks up Bronze at the Smiley Awards

Staying Put's 'Grow Your Wings' video has won Bronze at the Smiley Charity Awards. Staying Put would like to thank everyone who has voted for us and shared our story. The Smiley Charity Film Awards is one of the largest charity events of the year, promoting cause-based films. The awards share video campaigns with millions of viewers, highlighting charities tackling the most pressing issues of our time. The ceremony took place on Wednesday 20 March in London.

Airedale healthcare support worker receives national award for her compassion and commitment to care

Cherie Melvin, a healthcare support worker in Airedale NHS Foundation Trust's cardiac rehabilitation team, has been awarded the Chief Nursing Officer for England's Healthcare Support Worker Award. The award recognises the vital contribution of healthcare support workers and their exceptional support of nursing and midwifery practice. Read more on the website.

Hospital colleagues pick up Skills for Health Our Health Heroes awards

Two Bradford hospital workers have scooped 'gold' and 'silver' national Skills for Health Our Health Heroes awards in recognition of their skills. Consultant Rheumatologist at Bradford Teaching Hospitals NHS Foundation Trust, Philip Helliwell, has been presented with a prestigious lifetime achievement award.

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	7
Meeting date:	17 May 2024
Report title:	Sub – Committee and Fora Triple A Reports
Report presented by:	Sub – Committee and Fora Chairs
Report approved by:	Sub – Committee and Fora Chairs
Report prepared by:	Carrie Haywood, Governance Manager, West Yorkshire ICB

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations and any resulting action:			
N/A			
Executive summary and points for discussion:			
Each Sub – Committee and Fora have compiled a Triple A assurance report to be approved at the Bradford District and Craven Partnership Board for Assurance Purposes and to allow committee chairs to alert the Partnership Board to any significant risks and asks.			
Outline how this supports our partnership vision and strategy			
Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives. **Our Population -** Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes. **Our Place -** Making our district a great place to live, work and thrive. **Our Partnership –** Greater value through the best use of our collective resources, minimising duplication and waste.			
Recommendation(s)			
The **BDC Partnership Board** is asked to: 1. **RECEIVE** the Bradford District and Craven Sub – Committee and For a Triple A Reports			
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:			
N/A			

Appendices
1. Clinical Forum Triple A Report
2. Finance and Performance Committee Triple A Report
3. People Committee Triple A Report
4. System Quality Committee Triple A Report
Acronyms and Abbreviations explained
1. BDC: Bradford District and Craven

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven Clinical Forum

Dates of meetings: 13th March & 9th April 2024

Report to: Bradford district and Craven Partnership Board

Report completed by: Mr David Crampsey / John Hartley

Date of Partnership Board: 17th May 2024

Key escalation and discussion points from the meeting
Alert:
There are currently no issues specific to the Clinical Forum to escalate to the Board.
Advise:
A number of items have been discussed at the Forum since the previous update. • An update on impact of Health and Social Care service provision on emergency departments • Human Normal Immunoglobulin (HNIG) in primary care and the current process • Patients Records – Access to records and the impact on GP time to prepare and provide full records. • Patient Safety Research Collaborative - Integration of new starters, including internationally educated workforce. • An update on medicines management including availability of medication / medication shortages. • Forum remains sighted on the difficult financial decisions, and the need to avoid worsening inequality or introducing patient safety risk Future items planned for discussion include. • Regular updates on medicines management. • Born in Bradford and Connected Bradford updates. • Update on the Workforce Programme deliverables • Annual update on the provision of Structured Judgement Reviews Clinical and Professional Leadership development remains a priority for the Forum
Assure:
The Clinical Forum would update the BD&C Partnership Board on the following. • The ongoing discussions regarding representation from ophthalmology and dentistry, and now including the potential for Health Care Scientist representation. • The commitment of the Clinical Forum to provide clinical expertise to the ongoing “Closing the Gap" programme

- The Forum continues to be represented at the ICB Clinical Forum via the chair of the BD&C Forum and with representation from the place Quality and Nursing leadership.

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: System Finance and Performance Committee

Date of meeting: 25 April 2024

Report to: Health and Care Partnership Board

Report completed by: Mike Woodhead/ Julie Lawreniuk

Date: 17 May 2024

Key escalation and discussion points from the meeting
Alert:
• 2024-25 place plans (NHS only) stood at a £53.1m deficit at 25 April, after accounting for an aggregate savings target of £65.3m. • This accounts for around 45% of the total West Yorkshire deficit plan – a disproportionate amount. • An all-day peer challenge and review session is scheduled for 26 April, with a multi-disciplinary panel from partner organisations from across the ICS.
Advise:

• The committee received the usual performance, finance and risk reports. There were no significant new messages compared to recent months.
• The committee focussed on a detailed presentation that had been prepared for the peer challenge and review session scheduled for 26 April. The slides were presented to the committee (and trust chief execs who were also in attendance), with a detailed question and answer session after each section.
• The slides detailed:
  • The improvement in plans already made since February
  • The productivity and efficiency opportunities in each organisation and the extent to which those opportunities are reflected in 24-25 plans
  • Workforce growth in each organisation, with justification for investments/movements and/or further actions to be taken
  • Other options currently being considered to further close the gap
  • The wider system workstreams (collaboration and rationalisation across organisations; development of the population health approach; work with the Council and Children's Trust).
  • Risks and system support requirements

Assure:
• The committee was assured that the presentation fairly reflected BDC Place plans, issues and risks; and that it captured the work that would be done to further close the financial gap beyond the plan submission date of 2 May.

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven HCP People Committee

Date of meeting: 17 April 2024

Report to: BdC Partnership Board

Report completed by: Melanie Hudson (Chair, People Committee)

Date: 19 April 2024

Key escalation and discussion points from the meeting
Alert:
Nothing to Alert
Advise:
Spotlight on Staff Survey and Sector Feedback for 2023/2024: • The committee discussed the staff survey results from each NHS organisation across the domains of the NHS People Promise that were launched in March 2024. • The committee also received information regarding sector workforce feedback from the independent care sector staff well-being surveys and from GPs and Practice Managers workforce planning • The discussion was used as a pre – cursor to shaping an item that has been requested to be received at the BDC Partnership Board on May 17th, focusing on 'How do our staff feel across the BDC system and what more can we be doing to provide a supportive working environment'. • The results of the wider workforce were compared against that of medical and dental in training colleagues to understand whether the experience of Drs in training are reflective of the wider workforce given the level of industrial action within this timeframe which showed that staff group scored lower across each of the domains except 'always learning'. • The committee confirmed that data was not available from across all sectors around staff survey so the picture we are able to present does not reflect the whole partnership. Recognising that a great deal of work happens at organisational level on staff survey. There was a discussion about whether a focus on one area of the people promise may be helpful as an area for collaboration or whether work should be done to get staff survey data that is representative across the partnership including an improved response rate. This will be explored with partnership board further. **BDC Governance Efficiency Review:** • The committee discussed the current position of the governance efficiency review, as a part of this, the disestablishment of the People Committee is being considered • A proposal for how the existing responsibilities of the committee could be distributed across other partnership groups was discussed using the responsibilities from the terms of reference

- The committee agreed that the Finance and Performance Committee would create good triangulation of data through the performance dashboard and saw advantages of the Quality Committee receiving workforce risks due to the linkages of both work.
- The Committee agreed that membership of each of the receiving committees should review their membership to ensure that workforce was represented and could provide the assurance required
- The Committee was in full agreement (although the rationale was clearly understood), that disestablishing the people committee felt like a backwards step in the context of the importance of people to our place, and discussed the options of meeting informally as a collaborative workshop 2-3 times per year to discuss key strategic aims and objectives for workforce for inclusion in the Programme Board.
- The Committee believes that the membership coming together adds value to other workstreams and has been able to create efficiencies
- The Committee recommend that people should be weighted with the same importance as finance and quality and strongly advises to ensure that any changes include the right membership, and intelligence from workforce colleagues across all partners

Assure:

Received BDC Risk Report:

- The Committee received the new format of sub – committee risk report and noted the new risk relating to new immigration changes.
- The Committee agreed that new alignment to risk owners and senior reviewer would be needed due to the change in operating model.

Committee Effectiveness Review:

- The Committee discussed the achievements and strengths from the committee effectiveness results and agreed that any recommended improvements could be used for any future format of the group and for the Workforce Priority Programme Board. It was recommended that this effectiveness review should be considered as part of the governance framework review across the partnership.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven System Quality Committee

Date of SQC meeting: 28th March 2024 (Meeting on 25th April cancelled)

Report to: Bradford district and Craven Partnership Board

Report completed by: John Hartley/Phillipa Hubbard/Andy Withers

Date of Partnership Board: 17th May 2024

Key escalation and discussion points from the meeting

Alert:

It has been noted that the April 2024 meeting was cancelled to enable the change in dat noted below. As at March 2024 therefore, the time of the most recent meeting, the System Quality Committee received updates on;

- The system continues to experience pressures through increased demands, including;
    - At BDCFT a number of younger people being admitted to inpatient beds, pressure on inpatient beds more generally, especially for female acute patients, pressures in unplanned care service relating to workforce capacity. Business Continuity plans are in place so that there is no significant disruption to services.
    - At ANHSFT, increased activity and acuity of patients in ED, low inpatient discharges leading to bed holding in ED, incidents of infection are reducing with no further outbreaks of C.Difficile.
    - At BTHFT, pressures around patient flow and timely placement of patients from accident and emergency due to high volume of patients accessing department with a noticeable rise in incidents of aggression towards staff. Exacerbated by delays in patients leaving hospital due to delays in home care.
- Measles outbreak - A process of obtaining and administering post exposure prophylaxis Human Normal Immunoglobulin (HNIG) post exposure to vulnerable patients needs to be clarified and developed. The local immunisation team have plans in place to run catch up sessions within schools. This issue has also been raised at the Bd&C Clinical Forum.

Advise:

- **SEND Inspection North Yorkshire (Craven)** – North Yorkshire are imminently awaiting their SEND inspection; this is likely to take place in April 2024 (after a deferment request in March by NY Local Authority). Update – the SEND inspection in North Yorkshire has taken place over the period 15th April – 3 May 2024. Further updates to be provided via the future SQC reports to Partnership Board
- **Autism/ADHD Assessment waiting list**. The Autism and ADHD waiting list continue to grow. The business case has now been through the Healthy Minds board, PLE, SQ&F meetings with useful feedback being provided at each stage.
- **Bradford SEND** Written Statement of Action (WSOA) monitoring - 4th monitoring visit took place on the 19th of March. Monitoring visits have now concluded.
- **Closing The Gap** (CTG) – work continues on the CTG programme with ongoing development of process and supporting documentation. The Quality directorate is

represented on the evaluation panel, as part of the development team / steering group. A requirement of the process remains that all proposals have completed an EQIA prior to submission.

- Two **care homes closures** have taken place in February one residential and one nursing home, all residents have been re-located. A further closure of a residential home in Ilkley is taking place this month with partner agencies working together to source alternative accommodation.

Assure:

- Since the previous update the following **QEIAs** have been completed for
  - Thompson Court Intermediate Care facility closure and impacts on Primary Care and General Practice provision.
  - Closure of Norman Lodge Intermediate Care facility
  - An ongoing QEIA process is underway for proposals being considered under the Closing the Gap scheme. Initially this includes an initial high level summary assessment with a view to full QEIA being completed following recommendations and sign off from PLE. This is being utilised in the latest business case being considered for required funding for Children in Care.
- In addition the process for QEIA as agreed at West Yorkshire is being rolled out within the Priority and Enabling programmes within the Health and Care Partnership.

- It has been noted that the **System Finance & Performance Committee** and the **System Quality Committee** planned meeting dates clashed which has caused some issues with attendance from members of both committees. As a result the planned dates for the System Quality Committee have been preliminarily moved to the 2nd Thursday of the month from the 4th Thursday.
  The date of the meeting may need to alter again to account for the dates of other meetings and to allow for full attendance.

Since the last update the Bradford district and Craven **System Quality Committee** has received updates on

- Regular monthly System Quality update - key messages and risks
- Hot Topics/ Urgent Issues that need a view and issues to escalate.

The committee received.

- An update on the role of the Medical Examiner including Primary Care
- An update on the delivery of the Stroke improvement programme - Strategic Vision for Collaboration and Operational Workstreams
- Outcomes and findings of the Voluntary Adoption Agency Ofsted Report
- An update and request for support for a Children in Care Business Case prior to recommendations being considered by the Closing the Gap evaluation panel.
- An update and learning from the LeDeR Learning Event
- The work completed relating to the SQC development workshop and action plan- new ways of working.

In addition, the committee received the following papers and supporting documents for information and review.

- West Yorkshire SQG/ ICB QC Papers
- Bradford district and Craven Clinical & Professional Forum

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	8
Meeting date:	17 May 2024
Report title:	Review of committee effectiveness 2023/24
Report presented by:	Sue Baxter, Head of Partnership Governance, NHS West Yorkshire ICB
Report approved by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB
Report prepared by:	Catherine Smith, Governance Officer, NHS West Yorkshire ICB Carrie Haywood, Governance Manager, NHS West Yorkshire ICB

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations:			
N/A			
Executive summary and points for discussion:			
NHS West Yorkshire Integrated Care Board (WY ICB) and its place committees are required to undertake annual reviews of their effectiveness. In line with good governance practice, it was agreed that an annual review of committee effectiveness would be undertaken with the Partnership Board and all relevant partnership committees and groups. The committee effectiveness includes a review of each committee's achievements and performance, its terms of reference and any associated learning for future arrangements, with the aim to provide assurance that the delegated obligations of each committee have been achieved and to support the shaping of future cycles of business. The report includes a summary of the findings from the review of the effectiveness of the Partnership Board and committees and groups within the governance arrangements of the Bradford District and Craven Health and Care Partnership (BD&C H&CP).			

Outline how this supports our partnership vision and strategy
Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives.

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

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

Recommendation(s)

The Bradford District and Craven Partnership Board is asked to:

1. To **RECEIVE and DISCUSS** the summary of the Bradford District and Craven Health and Care Partnership Board and all relevant partnership committees or group's effectiveness review.
2. To **PROVIDE** any further comments related to the reviews.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

N/A

Appendices

1. Committee effectiveness review - Partnership Board, committees, and groups

Acronyms and Abbreviations explained

WY ICB – NHS West Yorkshire Integrated Care Board

WY ICS – NHS West Yorkshire Integrated Care System

BD&C H&CP - Bradford District and Craven Health and Care Partnership

Bradford District and Craven Health and Care Partnership
Review of committee effectiveness 2023/24

1. Introduction

NHS West Yorkshire Integrated Care Board (WY ICB) and its place committees are required to undertake annual reviews of their effectiveness. In line with good governance practice, it was agreed that an annual review of committee effectiveness would be undertaken with all relevant internal committees and groups. The committee effectiveness includes a review of each committee's achievements and performance, its terms of reference and any associated learning for future arrangements, with the aim to provide assurance that the delegated obligations of each committee have been achieved and to support the shaping of future cycles of business.

In March 2024 members and attendees of the Partnership Board, its three sub-committees (Finance and Performance, Quality and People), Partnership Leadership Executive, Partnership Leadership Team, ICB Leadership Executive, Clinical Forum and the Planning and Commissioning Forum received a link to an online survey which contained a series of questions related to the effectiveness of their group. It was agreed that as the Citizen's Forum Steering Group had recently reviewed their arrangements and would be reforming in a different format from 1st April 2024, they would not be included in the committee effectiveness review.

As response rates for some of the committees and groups were too low to provide meaningful analysis it was agreed that the full committee effectiveness review process for these groups - Finance and Performance Committee (1 out of 17 – 6%), Partnership Leadership Executive (2 out 23 – 9%), ICB Leadership Executive (2 out of 16 – 12%) and the Clinical Forum (1 out 32 – 3%) - would not go ahead.

During April 2024 the board / committees / groups received the feedback from their reviews and were encouraged to consider using the findings to shape the future cycles of business and arrangements and consider any changes to their Terms of Reference following the review. The Partnership Board met to discuss their committee effectiveness review as well as that of the committees / groups in a development session on 25 April 2024.

2. Partnership Board effectiveness summary (15 responses, 45%)

Overall, the responses were positive in relation to the current arrangements. Members commented on the strengths of the Partnership Board noting it as a group where diverse organisations are represented by members covering the breadth of the partnership footprint, with evolved and strong relationships between partners, the

provision of support and challenge to each other and a willingness to engage in the challenges faced by organisations and the wider system.

Members cited successes of the Board in 2023/24 as the 'listen in' programme as a key area of involvement and engagement, the deep dives which provided specific areas of focus, the support for the 'closing the gap' programme and the understanding of the system-wide financial challenges across health and care and the impacts of the financial position, and an increased understanding of health inequalities.

Suggested improvements from members and attendees included the need to actively revisit issues which remain a concern and the need to demonstrate what has happened in response to issues raised through the 'listen in' programme and the deep dives. It was suggested that there was a deeper exploration of specific major risks and clarity on mitigations. More balance towards looking to the future versus the current position was suggested with the Board able to influence the strategic direction of the system. It was suggested that Board members hold each other to account for the delivery of plans that are meaningful and measurable and have a more active role in understanding population health needs and allocating resources to meet needs.

Improved connection was a theme in the suggested improvements, in terms of a better connection between the Partnership Board and the priority boards, further consideration of the role of the sub-committees and the need to avoid duplication or gaps with the role of the ICB committees.

There were suggestions made in connection with the meeting arrangements in terms of the need to give enough time to complete the agenda appropriately and give all items coverage, consider the length of papers and the clarity of the focus or ask, and to consider the content of the Place Lead's report to include key topics of concern from the Place risk register or national issues.

3. Committees / groups effectiveness summary

Below details a summary of the feedback provided throughout the effectiveness review process for the specific committees and groups. For all the committees and groups, members and attendees were overall happy with the current arrangements.

Quality Committee (4 out of 27 – 15%)
Examples of the strengths of the committee were highlighted, such as the level of information received which provides rich discussion alongside challenges which have allow improved delivery of services to the population. It was noted that there is support through the establishment of the System Quality Group which scrutinises the

West Yorkshire Integrated Care System (WY ICS) dashboard and quality metrics and supports discussions at the committee.

Suggested improvements included an increased emphasis on learning and improvement, more strategic oversight of financial plans and the quality impacts, tracking of the strategic achievements and assurance against the Place and WY ICS strategic vision as well as improved links with other committees.

People Committee (9 out of 11 – 81%)
It was highlighted that the committee has evolved very well with system leadership and commitment to collaboration as strengths of the committee. It was thought that it fulfils an important role around agreeing and driving key strategic workforce priorities for the system. The committee has highlighted the importance of 'acting as one' and has got underneath the information available across the whole of Place, identifying gaps and working with the data team to begin to address these.

Members and attendees highlighted a particular achievement of the committee as the provision of oversight of the purpose, focus and delivery of the workforce plans. Other achievements of the committee have included providing recommendations and advice on workforce issues such as recruitment, retention and staff wellbeing. There has been a focus on key areas of risk management.

Suggested areas of improvement include a focus on governance, in terms of simplified and streamlined governance and clarity on the scope of the committee on decision-making. Other areas included the triangulation of data between finance and quality, ensuring the reality of the resource, capacity and capability and continuing to undertake an annual priority review.

Planning and Commissioning Forum (PCF) (7 out of 16 – 44%).
The PCF was cited as providing effective collaboration and engagement between members with the reports supporting jointly commissioned services and facilitating key discussions needed to promote better quality and efficiency in the system. Members and attendees provided specific examples of the achievements of the forum, such as significant process made in reviewing Section 75 and the associated schedules, the focus on the Better Care Fund arrangements, the provision of a clear account of joint commissioning intentions and the increased and improved communications between the City of Bradford District Metropolitan District Council and the WY ICB at Bradford district and Craven place.

Suggestions for improvements focused on membership, such as broadening the membership to include Act as One priority directors, links with North Yorkshire Council and the inclusion of operational colleagues. Other suggestions were focused on the joint commissioning arrangements in terms of alignment of governance and

decision-making, commitment to co-commission, reducing duplication in the system and exploring new opportunities (recognising the financial challenges).

4. Next steps

The chairs of the committees and groups have been encouraged to consider using the feedback from the review to shape the future cycles of business and arrangements and consider any changes to their Terms of Reference. Business planning, agendas and other meeting arrangements are being reviewed to incorporate feedback.

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	8
Meeting date:	17 May 2024
Report title:	Committee Annual Reports as part of Committee Effectiveness
Report presented by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB
Report approved by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB
Report prepared by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐

Previous considerations and any resulting action:

N/A

Executive summary and points for discussion:

As part of the ICB year-end arrangements, each place committee must produce an annual report in a prescribed format for submission to the ICB Board.

In addition to approving its annual report, at its first meeting of the year the committee would normally consider its terms of reference (to be recommended to the ICB Board for approval) and approve the terms of reference of its three sub-committees.

However, due to the proposed changes within the Governance Efficiency Plan in relation to the responsibilities of each sub-committee and the implementation of the consolidated governance function on 1 April, an initiative has been put in place to bring a consistent approach to the production of minutes across all the place committees and their sub-committees and, to achieve this, a further change is recommended to the terms of reference of the committee and the sub-committees. These changes will be implemented with each committee chair and management lead.

Outline how this supports our partnership vision and strategy

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Recommendation(s)

The BDC Partnership Board is asked to:

1. **APPROVE** the committee's Annual Report 2023/24 for submission to the ICB Board
2. **APPROVE** the sub – committee Annual Report
3. **RECEIVE** the committees and its sub - committees Terms of Reference with a view of future changes to be considered

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

N/A

Appendices

1. BDC Partnership Board Annual Report
2. BDC Partnership Board Terms of Reference
3. BDC Finance and Performance Committee Annual Report
4. BDC Finance and Performance Terms of Reference
5. BDC People Committee Annual Report
6. BDC People Committee Terms of Reference
7. BDC Quality Committee Annual Report
8. BDC Quality Committee Terms of Reference
9. BDC Partnership Leadership Executive Annual Report
10. BDC Partnership Leadership Executive Terms of Reference
11. BDC Clinical Forum Annual Report
12. BDC Clinical Forum Terms of Reference

Acronyms and Abbreviations explained

1. BDC: Bradford District and Craven

Bradford District and Craven Partnership Board ANNUAL REPORT 2023-24

INTRODUCTION

The Bradford District and Craven Partnership Board is established as a committee of the NHS West Yorkshire Integrated Care Board (ICB), in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation. The role of the Bradford District and Craven Partnership Board is to lead the Bradford District and Craven place-based partnership in accordance with the BD&C Strategic Partnering Agreement, and in accordance with the Constitution of the West Yorkshire Integrated Care Board.

MEMBERSHIP

- Elaine Applebee, independent chair of the BD&C Partnership Board (Chair)
- Julie Lawreniuk, non-executive chair of the Finance and Performance Committee of the BD&C partnership
- Andrew Withers, non-executive chair of the Quality Committee of the BD&C H&C Partnership
- Melanie Hudson, non-executive chair of the People Committee of the BD&C H&C Partnership
- David Crampsey, chair of the BD&C H&CP Clinical Forum
- Helen Rushworth, chair of the BD&C H&CP Citizens Forum and chief executive of Healthwatch Bradford District
- Mel Pickup, BD&C H&CP Partnership Place Lead (note this role is currently held by the Chief Executive of Bradford Teaching Hospitals NHS FT and is not an additional member of the Board for quoracy purposes)
- Richard Haddad, chair of the Clinical Advisory Board (PCNs)
- Danielle Hann chair of the Local Medical Council
- Andrew Gold, chair of Airedale NHS FT
- 'Foluke Ajayi, chief executive of Airedale NHS FT
- Linda Patterson, chair of Bradford District Care NHS FT
- Therese Pattern, chief executive of Bradford District Care NHS FT
- Sarah Jones, chair of Bradford Teaching Hospitals NHS FT
- Ashley Green, chief executive of Healthwatch North Yorkshire
- Lorraine O'Donnell, chief executive of the City of Bradford Metropolitan District Council

- Iain MacBeath, strategic director adult social care and health of the City of Bradford Metropolitan District Council
- Marium Haque, strategic director children of the City of Bradford Metropolitan District Council
- Sarah Muckle, director of public health of the City of Bradford Metropolitan District Council
- Richard Webb, corporate director health and adult services of North Yorkshire Council
- Louise Wallace, director of public health of North Yorkshire Council
- Louise Bestwick, chief executive of Bradford Care Association
- Jonathan Kerr, chief officer, Age UK North Craven and senior representative of the VCSE sector in Craven
- John Pattinson, chief executive officer of North Yorkshire Independent Care Group
- Sam Keighley, the VCSE sector lead for the Bradford District and Craven Health and Care Partnership
- Marina Bloj, Professor of Health Research, University of Bradford

MEETINGS HELD

- 12 May 2023
- 21 July 2023
- 1 September 2023
- 10 November 2023
- 12 January 2024
- 8 March 2024

ATTENDANCE

Member	**Attendance – number of meetings** **(meetings eligible to attend)**	**Attendance as %**
Elaine Applebee, independent chair	6 (6)	100%
Julie Lawreniuk, non-executive chair of the Finance and Performance Committee	4 (6)	67%
Andrew Withers, non-executive chair of the Quality Committee	5 (6)	83%
Melanie Hudson, non-executive chair of the People Committee	5 (6)	83%
David Crampsey, chair of the BD&C H&CP Clinical Forum	4 (6)	67%

Member	Attendance – number of meetings (meetings eligible to attend)	Attendance as %
Helen Rushworth, chair of the BD&C H&CP Citizens Forum and chief executive of Healthwatch Bradford District	5 (6)	83%
Mel Pickup, BD&C H&CP Partnership Place Lead and Chief Executive of Bradford Teaching Hospitals NHS FT *Deputies John Holden – for BTHFT role Nancy O'Neill – for place lead role	4 (6) 1 (1) 2 (2)	67%
Max Mclean, chair of Bradford Teaching Hospitals NHS FT (until September 2023)	3 (3)	100%
Helen Hirst, chair of Bradford Teaching Hospitals NHS FT (November 2023 – January 2024)	1 (2)	50%
Sarah Jones, chair of Bradford Teaching Hospitals NHS FT (from March 2024)	0 (1)	0%
Richard Haddad, chair of the Clinical Advisory Board	1 (6)	17%
Danielle Hann chair of the Local Medical Council	6 (6)	100%
Andrew Gold, chair of Airedale NHS FT	5 (6)	83%
Foluke Ajayi, chief executive of Airedale NHS FT *Deputy – Stuart Shaw	2 (6) 1 (1)	33%
Linda Patterson, chair of Bradford District Care NHS FT	5 (6)	83%
Therese Pattern, chief executive of Bradford District Care NHS FT *Deputy – Phil Hubbard	5 (6) 1 (1)	83%
Ashley Green, chief executive of Healthwatch North Yorkshire	4 (6)	67%
Kersten England, Chief Executive of the City of Bradford Metropolitan District Council (until September 2023)	1 (3)	33%
Lorraine O'Donnell, Chief Executive of the City of Bradford Metropolitan District Council (from November 2023)	1 (3)	33%

Member	Attendance – number of meetings (meetings eligible to attend)	Attendance as %
Iain MacBeath, strategic director adult social care and health of the City of Bradford Metropolitan District Council *Deputy – Jane Wood	4 (6) 1 (1)	67%
Marium Haque, strategic director children of the City of Bradford Metropolitan District Council	0 (6)	0%
Sarah Muckle, director of public health of the City of Bradford Metropolitan District Council	0 (6)	0%
Richard Webb, corporate director health and adult services of North Yorkshire Council *Deputy - Karen Siennicki	1 (6) 1 (2)	17%
Louise Wallace, director of public health of North Yorkshire Council *Deputy – Victoria Turner	0 (6) 6 (6)	0%
Louise Bestwick, chief executive of Bradford Care Association	6 (6)	100%
Jonathan Kerr, chief officer, Age UK North Craven and senior representative of the VCSE sector in Craven (from July 2023)	5 (5)	100%
Dena Dalton, representative for VCSE sector in Craven (until May 2023)	1 (1)	100%
Sam Keighley, The VCSE sector lead for the Bradford District and Craven Health and Care Partnership *Deputy – Soo Nevison	5 (6) 1 (1)	83%
John Pattinson, chief executive officer of North Yorkshire Independent Care Group *Deputy – Brian Johnson	0 (6) 2 (2)	0%
Marina Bloj, Bradford university representative (from March 2023)	0 (1)	0%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2023 – 24

- Received regular updates from the place lead which summarised key activities and points to note arising from the activity of the Bradford District and Craven Place Partnership and the wider West Yorkshire Health and Care Partnership
- Received regular updates on the development of the partnership priorities

- Received regular updates from the place committees and the forums (Citizen's Forum and Clinical Forum) through the triple A (alert, advise, assure) report
- Received updates on the latest position against national requirements, key constitutional standards, operational planning targets and recovery and local priorities as well as an overview of the NHS oversight framework and current performance
- Regularly received the partnership risk report detailing the serious and critical risks to the partnership and discussed any risks which should be added to the risk register. The Board also regularly received the ICB risk register for information and noted progress with the ICB Board Assurance Framework.
- Received updates from the 'listen in' weeks in localities across Bradford District and Craven (to date Craven, Bradford South and Keighley) with Board members and senior colleagues taking part in engagement and involvement events ahead of each Board meeting in order to have open conversations with local people on what matters to them using the five priority areas to frame the conversations. The Board considered how the insights from the involvement reports following the 'listen in' weeks will inform the delivery of the priorities in each locality and across the place and considered learnings which could be acted upon by the partnership.
- Received regular updates on the financial position of the partnership throughout the financial year as well updates on the performance against ICB resources delegated to the Partnership and summaries of the BDC place financial position and the WY ICS financial position. The Board have been alerted to the critical nature of the underlying financial position going into 2024/25 which has allowed the board to Support the closing the gap financial work to understand the system-wide financial challenges across health and social care with honest discussions on the impact of the challenges
- Supported deep dives into specific areas of focus relating to adult social care, access to services, primary care, health inequalities across the district and children's mental health.
- Supported the implementation of the governance arrangements and the West Yorkshire operating model by having board representation in a BDC governance efficiency steering group and oversight of plans at the board
- All partners supported the successful Airedale NHS FT's bid to join the New Hospital Programme as the Place priority on estates/capital investment

AREAS FOR DEVELOPMENT IN 2024 - 25

- Actively revisit issues which remain a concern, such as primary care/GP access by using a risk informed approach to strengthen the structure of both board and committee agendas which will allow deeper exploration of specific major risks and being clear about mitigations being put in place

- The board is supporting the further development of the ‘listen in’ programme, which is changing from community listen in to priority focused ‘listen in’ which will allow the board to demonstrate what has happened in response to issues raised in ‘listen in’ and the deep dives - the ‘so what’ questions
- The structure of the board deep dive and development sessions to be focused onto strengthening the link to the priority programmes including further work on aligning investment to priorities
- More balance towards looking to the future vs current position – with the Board influencing the strategic direction of the system

Terms of Reference – Bradford District and Craven Health and Care Partnership - Partnership Board

Version control

Version:	1.2
Approved by:	NHS West Yorkshire Integrated Care Board (ICB)
Date Approved:	FINAL
Responsible Officer:	James Drury, Partnership Development Director
Date Issued:	24 July 2023
Date to be reviewed:	Annually - before 31 March each year

Change history

Version number	Changes applied	By	Date
1.0	Approved	ICB	1 July 2022
1.0	Approved	BD&C Partnership Board	12 July 2022
1.1	Membership changes, alignment with Scheme of Reservation and Delegation (SORD) and further minor changes	BD&C Partnership Board and WY ICB Board	21 July 2023 17 July 2023
1.2	Membership changes following discussion at Partnership Board on 21 July 2023	James Drury & Sue Baxter	for ICB approval – approved by WY ICB Board on 19 September 2023

Partnership Board Terms of Reference

1. Introduction

The Bradford District and Craven Partnership Board ('the Committee') is established as a committee of the NHS West Yorkshire Integrated Care Board (ICB), in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation.

2. General

The ICB is part of the West Yorkshire Integrated Care System, which has four core purposes:

- improving population health and healthcare
- tackling unequal outcomes and access
- enhancing productivity and value for money and
- helping the NHS to support broader social and economic development

The ICS has identified a set of guiding principles that shape everything we do:

- we will be ambitious for the people we serve and the staff we employ
- the West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing
- we will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict and
- we will undertake shared analysis of problems and issues as the basis of taking action.
- we will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible

The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values, we:

- are leaders of our organisation, our place and of West Yorkshire
- support each other and work collaboratively
- act with honesty and integrity and trust each other to do the same
- challenge constructively when we need to
- assume good intentions and

- will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Remit and responsibilities

The Partnership Board has no executive powers, other than those specifically delegated in these terms of reference.

The Bradford District and Craven Health and Care Partnership Board will support the ICB in delivering the following statutory and/or corporate functions.

Its role will be to lead the Bradford District and Craven Health and Care Partnership in accordance with the Bradford District and Craven Strategic Partnering Agreement (SPA), and in accordance with the Constitution of the NHS West Yorkshire Integrated Care Board.

Its responsibilities are to:

i. establish governance arrangements to support collective accountability between partner organisations for Bradford District and Craven Health and Care Partnership (Partnership) delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations

ii. agree a plan to meet the health, wellbeing and care needs of the population within Bradford District and Craven, having regard to the partnership's integrated care strategy and health and wellbeing strategies across Bradford District and Craven

iii. allocate resources to deliver the plan in Bradford District and Craven, determining what resources should be available to meet population need and underpinned by the partnership's financial and risk management principles (SPA schedule 5), for how they should be allocated across services and providers (both revenue and capital)

iv. arrange for the provision of health and care services in Bradford District and Craven in line with the resources allocated across the Integrated Care System (ICS), through a range of activities including:

    a) putting contracts and agreements in place to secure delivery of its plan by providers

    b) convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes

    c) support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships, including through investment in PCN management support, data and digital capabilities, workforce development and estates

d) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care

v. approve decisions on the review, planning and procurement of primary medical care services

vi. approve the operating structure for the Bradford District and Craven Health and Care Partnership

vii. agree implementation of the people priorities across the Partnership

viii. agree place action on digital, data, intelligence and insight: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care

ix. agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money in place and support wider goals of development and sustainability

x. develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within NHS West Yorkshire ICB and the Bradford District and Craven Health and Care Partnership plan

xi. develop arrangements for risk sharing and /or risk pooling with other organisations (for example pooled budget arrangements under section 75 of the NHS Act 2006), for approval by the NHS West Yorkshire ICB Board and the Councils

xii. Approve arrangements for senior / executive staff appointments (for PB and sub-PB level posts)

xiii. Agree clinical pathways, clinical thresholds, service specifications and service standards for matters that **do not** meet one or more of the '3 tests' for working at scale

xiv. Approve **partnership**-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.

xv. make arrangements to implement in place NHS West Yorkshire ICB and Partnership risk management arrangements and

xvi. agree implementation in place of the arrangements for complying with the NHS Provider Selection Regime

xvii. Approve place tenders and contracts.

4. Membership

The Members of the Partnership Board are the:

- independent chair of the BD&C Partnership Board
- non-executive chair of the Finance and Performance Committee of the BD&C partnership
- non-executive chair of the Quality Committee of the BD&C H&C Partnership
- non-executive chair of the People Committee of the BD&C H&C Partnership
- chair of the BD&C H&CP Clinical Forum
- chair of the BD&C H&CP Citizens Forum
- BD&C H&CP Partnership Place Lead (note this role is currently held by the Chief Executive of Bradford Teaching Hospitals NHS FT and is not an additional member of the Board for quoracy purposes)
- chair of the Clinical Advisory Board (PCNs)
- chair of the Local Medical Council
- chair of Airedale NHS FT
- chief executive of Airedale NHS FT
- chair of Bradford District Care NHS FT
- chief executive of Bradford District Care NHS FT
- chair of Bradford Teaching Hospitals NHS FT
- chief executive of Bradford Teaching Hospitals NHS FT
- chief executive of Healthwatch Bradford District
- chief executive of Healthwatch North Yorkshire
- chief executive of the City of Bradford Metropolitan District Council
- strategic director adult social care and health of the City of Bradford Metropolitan District Council
- strategic director children of the City of Bradford Metropolitan District Council
- director of public health of the City of Bradford Metropolitan District Council
- corporate director health and adult services of North Yorkshire Council
- director of public health of North Yorkshire Council
- director of children and young people's services of North Yorkshire Council
- chief executive of Bradford Care Association
- the chief executive officer of North Yorkshire Independent Care Group
- The VCSE sector lead for the Bradford District and Craven Health and Care Partnership
- senior representative of the VCSE sector in Craven
- Bradford university representative

5. Required attendees

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

- chief operating officer of the BD&C Health & Care Partnership
- lead finance director for Bradford District & Craven Health & Care Partnership
- director of partnership development of the BD&C Health & Care Partnership
- joint director of quality and nursing of the BD&C Health & Care Partnership (a role shared by the chief nursing officers for the three Trusts) and
- assistant director of governance and assurance of the BD&C Health & Care Partnership
- strategic communications and stakeholder engagement lead of the BD&C Health & Care Partnership

NHS West Yorkshire ICB officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper.

The Chair may invite such other attendees to attend any meeting of the Partnership Board as the Chair considers appropriate.

6. Deputies

With the permission of the Chair, members of the Partnership Board may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.

7. Chair

[See **4. Membership** for selection of the Chair]

The meetings will be run by the chair. In the event of the chair of the Partnership Board being unable to attend all or part of the meeting, another member of the Partnership Board shall chair the meeting

8. Quoracy

No business shall be transacted unless at least 50% of the membership (which equates to 15 individuals) and including the following are present, the:

- independent chair or their nominated replacement as chair for the meeting
- place lead or their nominated deputy for the meeting
- representatives of at least three of the following constituencies: NHS providers, local government, the care sector, the VCSE sector, the primary care sector

For the sake of clarity:

a) no person can act in more than one capacity when determining the quorum

b) an individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum

In exceptional circumstances the chair may choose to hold the partnership board meeting via video conference. Members of the Partnership Board may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

9. Conduct of meetings

In line with NHS West Yorkshire ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each voting member of the Partnership Board will have one vote, the process for which is set out below:

a. all members of the Partnership Board who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the committee are set out at section 4; attendees and observers do not have voting rights.)

b. absent members may not vote by proxy. Absence is defined as not being present at the time of the vote

c. a resolution will be passed if more votes are cast for the resolution than against it

d. if an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the deputy chair presiding over the meeting) will have a second and casting vote and

e. should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting

10. Frequency of meetings

Overtime the Partnership Board will normally meet quarterly, but in the first two year of operation will meet on a bi-monthly basis to support the development of board effectiveness. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to members of the Partnership Board.

One third of the members of the Partnership Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Partnership Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Partnership Board specifying the matters to be considered at the meeting.

In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

11. Urgent decisions

In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Partnership Board to meet virtually. Where this is not possible the following will apply the:

a) powers which are delegated to the Partnership Board, may for an urgent decision be exercised by the Chair of the Partnership Board and the Place Lead for Bradford District and Craven Health and Care Partnership and

b) exercise of such powers shall be reported to the next formal meeting of the Partnership Board for formal ratification, where the Chair will explain the reason for the action taken, and the NHS West Yorkshire ICB's Audit Committee will be notified, for oversight.

12. Admissions of the press and public

Meetings of the Bradford District and Craven Health and Care Partnership Board will be open to the public.

The Partnership Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

The chair of the meeting shall give such directions as they thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Partnership Board's business shall be conducted without interruption or disruption.

As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time, the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Partnership Board.

A public notice of the time and place of the meeting and how to access the meeting shall be given by posting it electronically at least 7 calendar days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

The agenda and papers for meetings will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting not likely to be open to the public.

13. Declarations of interest

If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as early as possible and act in accordance with the NHS West Yorkshire ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

14. Support to the Partnership Board

The Partnership Board's lead manager is the BD&C Partnership Development Director. Administrative support will be provided to the Partnership Board by officers of NHS West Yorkshire ICB. This will include:

- agreement of the agenda with the Chair in consultation with the Lead Manager, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward
- maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions

- sending out agendas and supporting papers to members five working days before the meeting
- drafting minutes for approval by the Chair and ICB Lead Manager within five working days of the meeting and then distribute to all attendees following this approval within 10 working days and
- an annual work plan to be updated and maintained on a quarterly basis
- maintaining a decision log

15. Authority

The Partnership Board is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of the NHS West Yorkshire ICB and they are directed to co-operate with any such request made by the Partnership Board.

The Partnership Board is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations.

The Partnership Board is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing so, the Partnership Board must follow procedures put in place by NHS West Yorkshire ICB for obtaining legal or professional advice.

The Partnership Board is authorised to create sub-committees or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Partnership Board may not delegate executive powers delegated to it within these terms of reference (unless expressly authorised by the NHS West Yorkshire ICB Board as set out within the BD&C HCP Scheme of Reservation and Delegation) and remains accountable for the work of any such group.

16. Reporting

- the Partnership Board shall submit its ratified minutes to each formal NHS West Yorkshire ICB Board meeting
- Report within two weeks of the Partnership Board meeting to the NHS West Yorkshire ICB Board using the committee assurance report framework ‘Triple A’ (alert, advise and assure summarising key items at the meeting)
- Provide the NHS West Yorkshire ICB Board meeting with a copy of the Partnership Board meeting forward plan annually
- the Chair shall draw to the attention of the NHS West Yorkshire ICB Board any significant issues or risks relevant to the ICB

- the Partnership Board's minutes will be published on the NHS West Yorkshire ICB website once ratified
- the Partnership Board shall submit an annual report to the NHS West Yorkshire ICB Audit Committee and the NHS West Yorkshire ICB Board and
- the Partnership Board will receive for information the minutes of other meetings which are captured in the Partnership Board workplan e.g. sub-committees

17. Conduct of the Partnership Board

- All members will have due regard to and operate within the Constitution of the NHS West Yorkshire ICB, standing orders, standing financial instructions and other financial procedures
- Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity
- Members of the Partnership Board will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct
- The Partnership Board shall agree an Annual Work Plan with the NHS West Yorkshire ICB Board
- The Partnership Board shall undertake an annual self-assessment of its own performance against the annual plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from the Partnership Board.
- Any resulting changes to the terms of reference shall be submitted for approval by the NHS West Yorkshire ICB Board

18. Amendments

These terms of reference, which must be published on the NHS West Yorkshire ICB website, set out the remit, responsibilities, membership and reporting arrangements of this Committee (the Bradford District and Craven Health and Care Partnership Board) and may only be changed with the approval of the NHS West Yorkshire ICB Board.

19. Review Date

After 1 year.

Finance and Performance Committee

ANNUAL REPORT 2023-24

INTRODUCTION

The Finance and Performance Committee provides the collective focus on financial and performance outcomes for the Bradford District and Craven Health and Care system. It supports the Partnership Board in delivering its strategic objectives by providing oversight and assurance on the development and delivery of a viable and sustainable Place financial plan; financial and operational robustness of business case proposals and impact on Place partners; performance of the Bradford District and Craven Health and Care System in relation to operational plan delivery, NHS System Oversight Framework requirements and local standards, targets and priorities; and management of risks affecting plan delivery. The Committee is an advisory body and makes recommendations to the Partnership Leadership Executive and the Partnership Board as appropriate.

MEMBERSHIP

- Julie Lawreniuk, Chair – Non-Executive Director, BTHFT
- Maz Ahmed, Vice-Chair – Non-Executive Director, BDCFT
- Leanne Cooper, Chief Operating Officer - Airedale NHSFT
- Mike Savage, Director of Finance – Airedale NHSFT
- Kelly Barker, Chief Operating Officer - BDCFT
- Mike Woodhead, Chief Finance Officer – BDCFT and Place Director of Finance, Bradford District and Craven Health and Care Partnership
- Sajid Azeb, Chief Operating Officer - BTHFT
- Matthew Horner, Director of Finance – BHTFT
- Iain MacBeath, Strategic Director – Adult Social Care and Health, Bradford Metropolitan District Council
- Chris Kinsella - Director of Finance, Bradford Metropolitan District Council
- Steven Mair - Director of Finance, Bradford Metropolitan District Council (from February 2024)
- Nancy O'Neill - Chief Operating Officer, Bradford District and Craven Health and Care Partnership
- Louise Clarke - Director of Strategy, Transformation, Primary and Community Care, Bradford District and Craven Health and Care Partnership
- Robert Maden - Director of Finance, Bradford District and Craven Health and Care Partnership
- Kerry Weir - Associate Director, Planning, Performance & Business Intelligence, Bradford District and Craven Health & Care Partnership
- Stephen Patterson - LMC Chair & GP, Bradford and Airedale Branch of YORLMC
- Julie Crelin - Executive Director, Finance & Resources, Bradford Children and Families Trust

- Claire Risdon, Deputy Director of Finance, BDCFT

MEETINGS HELD

27 April 2023
25 May 2023
22 June 2023
24 August 2023
28 September 2023
26 October 2023
21 December 2023
25 January 2024
29 February 2024
28 March 2024

ATTENDANCE

Member	Attendance – number of meetings (meetings eligible to attend)	Attendance as %
Julie Lawreniuk	10 (10)	100%
Robert Maden *Deputy Amy Paffett	9 (10) 1 (1)	90%
Mike Woodhead	9 (10)	90%
Mike Savage	10 (10)	100%
Matthew Horner *Deputy Chris Smith	9 (10) 1 (1)	90%
Nancy O'Neill	8 (10)	80%
Louise Clarke	4 (10)	40%
Leanne Cooper	9 (10)	90%
Kelly Barker	6 (10)	60%
Claire Risdon (Also deputy for Mike Woodhead)	6 (10)	60%
Kerry Weir	9 (10)	90%
Sajid Azeb *Deputy Chris Stephenson	3 (10) 2 (2)	30%
Stephen Patterson	2 (10)	20%
Iain MacBeath	2 (10)	20%
Maz Ahmed	0 (10)	0%
Chris Kinsella	3 (8)	37%
Steven Mair	1 (2)	50%
Julie Crelin	0 (3)	0%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2023 – 24

- Received regular updates on the latest position against national requirements

(key constitutional standards and operational planning targets and recovery) and local priorities.

- Received regular updates on the financial plans and positions for 2023/24 of the Bradford District and Craven Health and Care Partnership and the Bradford District and Craven Place, alongside considering risks to the financial position and mitigating actions.
- Discussed an approach to address the financial gap for 2023/24 and the underlying deficit position and the development and progress of the closing the gap programme for Bradford District and Craven.
- Received regular updates in relation to operational planning in terms of activity, finance and workforce including details of the submissions to NHS England.
- Made a recommendation to the Partnership Leadership Executive in relation to the establishment of a full in-practice phlebotomy service in WACA and Modality practices from April 2023 in order to support the strategic direction of providing care closer to home and to support equitable service provision to phlebotomy services in general practice across Bradford District and Craven.
- Received an update on the Better Care Fund (BCF) plan for 2023-25 and received further updates on performance against the BCF metrics and the refreshed demand and capacity plans.
- Received an update on the review of the effectiveness of the Committee for 2022/23 which informed a discussion on the development of the Committee.
- Regularly reviewed the Bradford District and Craven Health and Care Partnership risk register, with a specific focus on the risks aligned to the Committee.
- Received an update on the Elective Recovery Fund scheme for 2023/24.
- Received an update on the New Hospital programme from ANHSFT and BDCFT noting next steps in ANHSFT's successful bid and that BDCFT's bid for Lynfield Mount was not successful.
- Received an update on the development of the Keighley Health and Wellbeing Centre and supported the organisational commitment required to engage in the detailed design phase of the Outline Business Case which was expected to be completed by December 2023/January 2024.
- Received an update on the Access to Care programme, its current priorities and considered areas for further detailed update on risks and issues raised.
- Received information on a scheme proposed by the Urgent Care Board for winter spend.
- Received a paper which outlined the process and principles for the formation of the recommendations for the projects within the Reducing Inequalities in Communities RIC programme and agreed that in the context of financial challenges further understanding of the options would be needed before making any recommendations or decisions.
- Considered a number of business cases and agreed that they would be considered during the 2024/25 planning process and within the context of the

financial position – these were in relation to the staffing of the MyCare24 COPD, the virtual ward and diabetes.

- Received an update on the review of the ethnic and cultural diverse communities' specialist mental health support contract, noting that funding was already in place through the Mental Health Investment Standard, and approved the new contract.
- Received an update on direct access pathology pressures at ANHSFT and agreed work to understand and address the significant growth and opportunities to reduce the spend.
- An update was provided on 65 week waits in ANHSFT and the Committee supported the Trust to deliver its recovery plan to clear the 65 week backlog and accepted the risk to the deficit position.
- Reviewed the terms of reference and agreed amendments, such as to reflect the closing the gap programme.
- Received an update on the challenges, risks, financial implications, and business case options for system investment for children and young people's autism and attention deficit disorder (ADHD) provision across Bradford District and Craven noting increasing demand for assessments and associated financial pressures. It was agreed that the preferred option would be presented to the panel for financial decisions.
- Received an update on a review of the partnership governance arrangements and agreed to accept responsibilities in relation to the provision of assurance on the sufficiency of workforce in line with the workforce plan and the management of risk from the People Committee (if disbanded).
- Supported a business case in relation to the gap in nursing capacity needed to provide Review Health Assessments for Children in Care (CIC), with caveats in relation to the development of an Equality Impact Assessment (EQIA) and further benchmarking information, ahead of presentation to the panel for financial decisions for a decision.

AREAS FOR DEVELOPMENT IN 2024 - 25

- Streamlining and strengthening governance and approval processes regarding investment/disinvestment cases.
- Developing closer working and oversight arrangements with the System Quality Committee, particularly regarding investment/disinvestment cases.
- Holding system-wide partners accountable for "closing the gap"; actively challenging partners' appetite for transformation, risk and deeper system collaboration.

Bradford Health and Care Partnership

System Finance and Performance Committee

DRAFT

Terms of Reference

Version control

Version: 0.1 (final approved version to be 1.0)

Approved by: Bradford Health and Care Partnership Board

Date Approved:

Responsible Officer:

Date Issued:

Date to be reviewed: After 1 year

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	Robert Maden	12.05.22

1. Introduction and Context.

1.1 The Bradford District and Craven System Finance and Performance Committee (the Committee) is established by the NHS Bradford District and Craven Health and Care Partnership Board (HCP Board) as part of the Bradford District and Craven Place Based Partnership governance arrangements.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the HCP Board. The Committee has no executive powers, other than those specifically delegated to it under the Scheme of Reservation and Delegation and specified in these terms of reference.

1.3 The Bradford District and Craven health and care system (the system) has agreed to work towards a common vision which is that:

- People will be healthier, happier, and have access to high quality care that is clinically, operationally and financially stable.
- People will take action, and be supported to stay healthy, well and independent through their whole life and will be supported by their families and communities through prevention and early intervention with greater focus on healthy lifestyle choices and self-care.
- When people need access to care and support it will be available to them through a proactive and joined up health, social care and wellbeing service designed around their needs and as close to where they live as possible.

  In short … Happy, Healthy at Home.

1.4 Our partnership is built on the core principles that we should:

- Be ambitious for our people - focused on better outcomes for all – tackling inequalities, and driving the left shift at every point on the pathway;
- Keep our staff and public safe;
- Be clinically and community led change - empowered people, engaged clinical expertise;
- Be agile, fast, iterative change; which is focused on the whole person; and
- Act as one - system by default - bureaucracy light – integrated by design.

1.5 The HCP Board has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisations and of our health and care system.
- We support each other and work collaboratively.
- We act with honesty and integrity, and trust each other to do the same.

- We challenge constructively when we need to.
- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

2. Purpose.

2.1 The Committee provides the collective focus on financial and performance outcomes for the Bradford District and Craven Health and Care system. It will support the HCP Board in delivering its strategic objectives by providing oversight and assurance on the:

- Development and delivery of a viable and sustainable Place financial plan;
- Robustness of business case proposals and impact on Place partners;
- Performance of the Bradford District and Craven Health and Care System in relation to operational plan delivery, NHS System Oversight Framework requirements and local standards, targets and priorities; and
- Management of risks affecting plan delivery.

2.2 The Committee will be an advisory body and make recommendations to the Partnership Leadership Executive and the HCP Board as appropriate.

2.3 The Committee will be supported by the Finance Deputies working group and the Performance Leads working group.

3. Responsibilities.

The Committee will advise and support the HCP Board as follows:

3.1 Financial Planning

- Support the development of an operational finance and activity plan for the Place.
- Support the development of a medium and long-term Place financial plan which demonstrates ongoing value and sustainability.
- Consider business cases (in conjunction with the System Quality Committee) for major investments / disinvestments for material service change or efficiency schemes and make recommendations to the HCP Board.

3.2 **Financial Performance**

- Provide assurance and reporting on the delivery of Place financial plan targets, including the associated efficiency and waste reduction programmes.
- Provide assurance and reporting on the use of Service Development Funding and programme funding to ensure that resources are used efficiently across the Place to deliver the required outcomes.
- Agree and monitor performance against any actions required to address financial performance issues, including the application of any local risk management arrangements.
- Maintain oversight of the underlying organisational run rates and advise on actions to improve.

3.3 **Service Transformation**

- Maintain oversight of Place transformation programmes and provide assurance on business case implementation and delivery of the expected benefits.
- Consider the evaluation of business cases (in conjunction with the System Quality Committee) and make recommendations as appropriate to the HCP Board.
- Make recommendations to the HCP Board on resource shifts to support service change in line with Place Resource Principles and the Place Strategic Partnering Agreement.

3.4 **Performance**

- Provide assurance and reporting on performance against operational plan trajectories and NHS System Oversight Framework requirements.
- To take an overview of Place performance and transformation in relation to ICS objectives and priorities.
- To develop and maintain connections with other Place forums which have a role in performance development and improvement, including the System Quality Committee.

3.5 **Risk**

- Review and monitor those risks on the Place Risk Register which relate to finance and performance.
- Ensure that the HCP Board is kept informed of significant risks and mitigation plans in a timely manner

4 Membership.

4.1 The membership will comprise:

Membership

- **Chair** – Local NHS Trust Non-Executive Director
- **Vice-Chair** – Local NHS Trust Non-Executive Director
- Airedale NHS FT – Chief Operating Officer, Director of Finance
- Bradford District Care NHS FT – Chief Operating Officer, Director of Finance
- Bradford Hospitals NHS FT – Chief Operating Officer, Director of Finance
- Bradford Metropolitan District Council – Director of Adult Social Services, Senior Operational Director, Director of Finance
- Primary Care – Federation / LMC Representative
- Bradford District and Craven Place Based Partnership – Chief Operating Officer, Director of Strategy and Transformation, Director of Finance, Associate Director of Performance.

Attendees

- Finance Deputies Working Group Representative
- Performance Leads Working Group Representative

4.2 The Committee may invite others to attend meetings of the Committee, including attendance for specific agenda items. The Chair shall retain discretion to determine the extent to which additional attendees shall participate in discussions. Additional attendees will not participate in decisions.

5. Arrangements for the conduct of business.

Chairing meetings

The meetings will be run by the chair. In the event of the chair of the committee being unable to attend all or part of the meeting, the vice-chair shall chair the meeting.

Quoracy

5.1 For meetings to be quorate, a minimum of 50% of members is required, including the Chair or Vice-Chair and a member from each organisation.

5.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

5.3 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

5.4 Members of the committee may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf.

Voting

5.5 In line with the ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each voting member of the Committee will have one vote, the process for which is set out below:

a. All members of the committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the committee are set out at paragraph 4.1; attendees and observers do not have voting rights.)

b. Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

c. A resolution will be passed if more votes are cast for the resolution than against it.

d. If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Frequency of meetings

5.6 The Committee will normally meet every two months. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to members of the Committee.

5.7 One third of the members of the Committee may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting, If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Committee members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Committee specifying the matters to be considered at the meeting.

5.8 In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

Declarations of interest

5.9 Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

5.10 Where any Committee member (or any other attendee present) has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member (or attendee) may participate in meetings (or parts of meetings) in which the relevant matter is discussed. The action taken to manage the conflict of interest will be recorded in the minutes.

Support to the Committee

5.11 The Committee's lead manager is the Place Based Partnership Finance Director. Administrative support will be provided to the Committee by officers of the Place Based Partnership. This will include

- Agreement of the agenda with the Chair in consultation with the Lead Manager, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward.
- Maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions.
- Sending out agendas and supporting papers to members five working days before the meeting.
- Drafting minutes for approval by the Chair and ICB Lead Manager within five working days of the meeting and then distribute to all attendees following this approval within 10 working days.
- An annual work plan to be updated and maintained as required.

6. Reporting

6.1 The Committee is accountable to HCP Board, which provides the formal leadership and coordination of the local health and care system. A diagram of these partnership arrangements is set out at Appendix 1.

6.2 The Committee shall submit its minutes to each formal HCP Board meeting.

6.3 The Chair shall draw to the attention of the HCP Board any significant issues or risks relevant to the HCP.

6.4 The Committee shall submit an annual report to the HCP Board.

6.5 The Committee will receive for information the minutes of other meetings which are captured in the Committee work plan.

7. Conduct of the committee

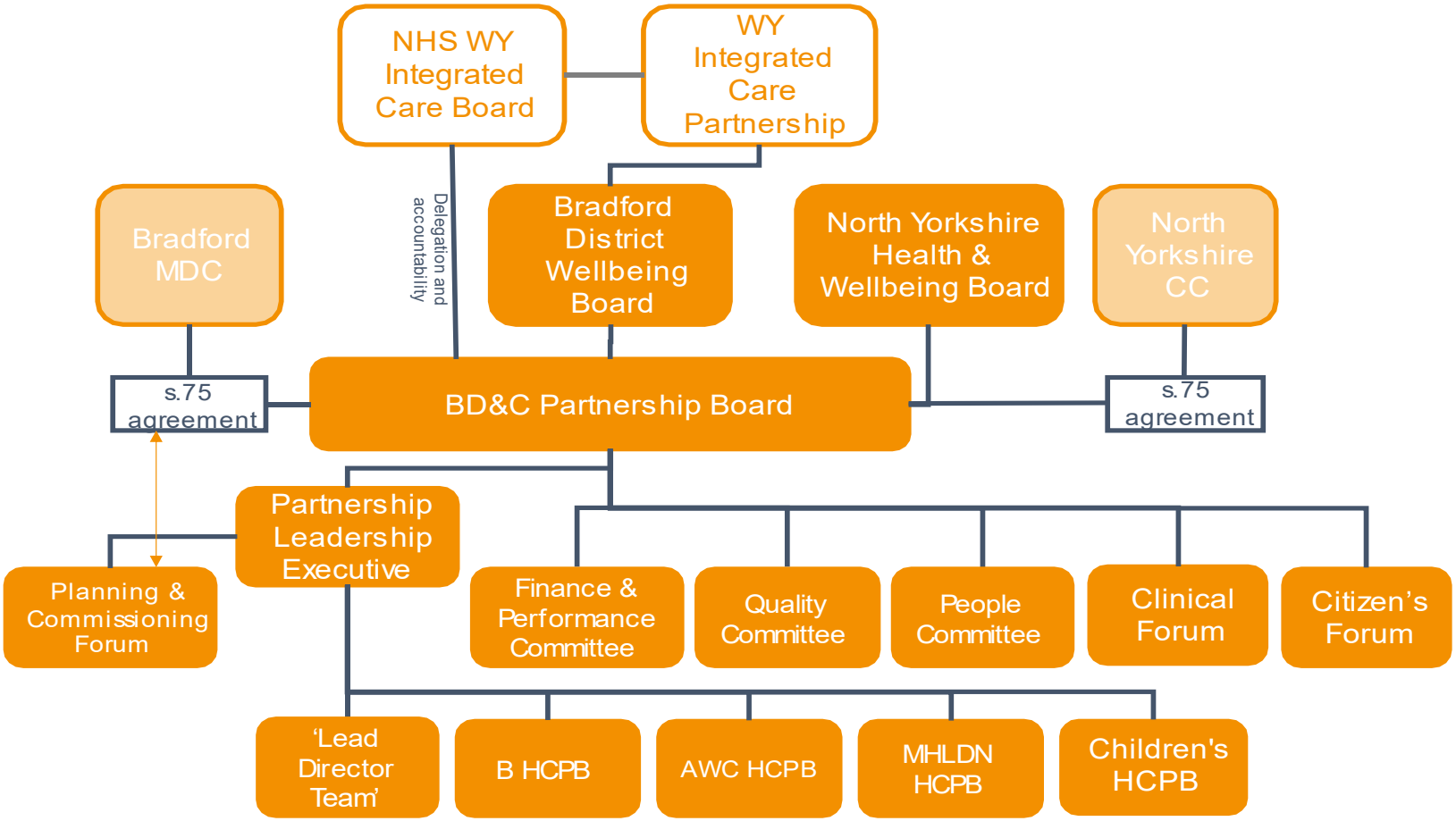
7.1 All Members and Attendees will operate in accordance with the SPA and any other relevant policies or documents agreed by the HCP Board.

7.2 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

7.3 The Committee shall undertake an annual self-assessment of its own performance against the annual plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from the Committee.

7.4 Any resulting changes to the terms of reference shall be submitted for approval by the HCP Board.

Place Governance



BDC People Committee
ANNUAL REPORT 2023-24

INTRODUCTION

The People Committee oversees the BdC People Plan, which is designed to improve our performance on workforce and people metrics so that we can deliver the best outcomes for the people of Bradford district, and Craven This is achieved by:

- Seeking to unblock any barriers to change and mitigate any risks through its collective membership and networks prior to escalating to the Partnership Board
- Identify any areas where there are wider implications/trends of these risks and issues or where additional assurance is required, and escalating to the Partnership Board where appropriate
- Provide oversight and assurance of the workforce elements of the system planning process and associated workforce narrative for the BD&C Place.
- Seek assurance on the connectivity with programmes of work with health and care workforce partners across Place, the ICS and across relevant transformational change programmes; encouraging collective buy in and development of shared programmes of work where it is mutually beneficial.
- Provide the necessary advice and guidance, as required, on specific workforce strategies/plans of other programmes - including supporting workforce redesign
- Engage with key stakeholders to ensure the Integrated People Plan work programmes are inclusive, current and well informed; ensuring effective communication of changing priorities and evaluating the effectiveness of interventions.
- Encourage and seek assurance on the inclusion of horizon scanning and sharing the learning from the wider health, care and education systems, locally, regionally and nationally in order ensure best practice and economies of scale are realised and to maximise funding opportunities.
- Approve the development and submission of Place based workforce bids where appropriate
- Seek and provide assurance on the spending of such funds to achieve agreed programme outcomes and receive associated evaluation reports.

MEMBERSHIP

- Melanie Hudson (Chair) Non-Executive Director of Airedale NHS Foundation Trust

- Karen Walker (vice Chair) Non-Executive Director of Bradford Teaching Hospitals NHS FT
- James Drury, Director of Partnership Development, BDC HCP
- Kez Hayat, Equality, Diversity and Inclusion Lead, BDC HCP and BTHFT
- Amanda Stanford, Chief Nurse, Airedale NHS FT, CTE Board Chair and BD & C Clinical representative
- Joanne Harrison, Director of Workforce and OD, ANHSFT
- Bob Champion Chief People Officer, BDCFT
- Faeem Lal, Interim Director of HR, BTHFT
- Anne Lloyd Director of HR, City of Bradford Metropolitan District Council
- Louise Clarke Director of Strategy Transformation, Primary & Community BDC HCP
- Marie Stout, Chief Operating Officer - Primary Care Workforce & Training Hub
- Peter Horner, Nominated Representative, Bradford and District Voluntary Services Alliance
- Sam Keighley, Chief Executive, VCSE Alliance
- Rachael Ross, Bradford Care Association – Workforce lead
- Denise Baran, Locality Manager, Skills for Care - Yorkshire & Humber/NE
- Andrew Milner, Associate Director of Workforce, BDCHCP
- Carrie Haywood, Senior Governance and Assurance Manager, BDC HCP
- Jean Taylor, Business Support Manager, BDC HCP

MEETINGS HELD

19.04.2023
21.06.2024
16.08.2024
18.10.2024
20.12.2024
21.02.2024

ATTENDANCE

Member	Attendance – number of meetings (Meetings eligible to attend)	Attendance as %
Melanie Hudson (Chair) Non-Executive Director of Airedale NHS Foundation Trust	6 (6)	100%
Karen Walker (vice Chair) Non-Executive Director of Bradford Teaching Hospitals NHS FT	5 (6)	83%

Andrew Milner, Associate Director of Workforce, BDCHCP	6 (6)	100%
James Drury, Director of Partnership Development, BDC HCP (until January 2924)	3 (5)	60%
Kez Hayat Equality, Diversity and Inclusion Lead, BDC HCP and BTHFT	6 (6)	100%
Amanda Stanford Chief Nurse, Airedale NHS FT, CTE Board Chair and BD & C Clinical representative	3 (6)	50%
Joanne Harrison, Director of Workforce and OD, ANHSFT	6 (6)	100%
Bob Champion, Chief People Officer, BDCFT	5 (6)	83%
Faeem Lal, Interim Director of HR, BTHFT	4 (6)	67%
Anne Lloyd, Director of HR, City of Bradford Metropolitan District Council	5 (6)	83%
Louise Clarke, Director of Strategy Transformation, Primary & Community, BDC HCP	4 (6)	67%
Marie Stout, Chief Operating Officer - Primary Care Workforce & Training Hub	5 (6)	83%
Sam Keighley, Chief Executive, VCSE Alliance	3 (6)	50%
Peter Horner, Nominated Representative, Bradford and District Voluntary Services Alliance Deputy: Soo Nevison	3 (5) 1(1)	60% 100%
Rachael Ross, Bradford Care Association – Workforce lead	5 (6)	83%
Denise Baran, Locality Manager, Skills for Care - Yorkshire & Humber/NE	5 (6)	83%
Carrie Haywood, Senior Governance and Assurance Manager, BDC HCP	6 (6)	100%
Jean Taylor, Business Support Manager, BDC HCP	3 (6)	50%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2023 – 24

- The Committee strengthened the assurance role of the committee and supported the definition and development of the Workforce Programme Board
- The Committee help deep dive sessions on specific areas of challenge such as adult social care, clinical placements, data quality, staff survey and sector staff wellbeing and operational planning
- The Committee sought assurance on the partner operational planning round and supported the triangulation of this data to develop a Place – based narrative and plan for submission

- The Committee initiated work on a People dashboard to provide strengthened oversight and assurance on key constitutional standards
- The Committee refreshed its risk management approach and created stronger links to priority areas of concern

AREAS FOR DEVELOPMENT IN 2024 - 25

- Linking to the wider ICB agenda and the people implications of that
- Continue to strengthen the strategic approach and focus on the big, shared people issues
- Create a bi – annual workshop to focus on the wider strategic people issues

Terms of reference – Bradford District and Craven People Committee

Version control

Version: 2.0

Approved by: West Yorkshire Health and Care Integrated Care Board ICB

Date Approved: 15 November 2023

Responsible Officer: James Drury, Partnership Development Director

Date Issued: 12 July 2022

Date to be reviewed: By April 2025

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	James Drury	8 June 2022
1.0	Approved	ICB	1 July 2022
1.0	Approved	BD&C Partnership Board	12 July 2022
1.0	Changes to membership	Maureen Goddard	25 August 2022
1.2	Changes to membership and responsibilities	Andrew Milner	10 October 2023
2.0	Approved	BD&C Partnership Board	15 November 2023

1. General

This BD&C management forum, the ‘People Committee’ is part of the West Yorkshire Integrated Care System, which has four core purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

The ICS has identified a set of guiding principles that shape everything we do:

- We will be ambitious for the people we serve and the staff we employ.
- The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people’s health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake shared analysis of problems and issues as the basis of taking action.
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire.
- We support each other and work collaboratively.
- We act with honesty and integrity, and trust each other to do the same.
- We challenge constructively when we need to.
- We assume good intentions; and

We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

2. Remit and responsibilities

The remit of this BD&C Committee is to:

a) Make the following recommendations on behalf of the ICB, following delegation of this responsibility from the ICB to the Partnership Board and from the Partnership Board to this BD&C Committee:

Agree implementation in place of people priorities (as per SoRD)

b) Provide advice and/or recommendations in the following areas to the Partnership Board, for the benefit of the ICB ((a) and (b) together "ICB Business"); and

c) Provide advice to other members of the Partnership Board "Partnership Business"

The responsibilities of this BD&C Committee are to:

i. Seek and provide assurance on the sufficiency of workforce to in line with the approved workforce plan across place and stated objectives of the BD&C Health and Care Partnership, utilising relevant intelligence sources where appropriate.
ii. Oversee the development and maintenance of a strategic approach to workforce planning, assurance, sharing learning/best practice and collaborative improvement activity across the system.
iii. Seek and provide assurance in relation to place based workforce metric's and identify and escalate any impact on delivery of BD&C priorities
iv. Ensure risks regarding workforce matters within BD&C services are identified, managed and mitigated
v. Consider the BD&C Integrated People Plan; ensuring alignment with national, regional, ICS and place priorities
vi. Request and receive reviews and analysis of Place based workforce issues and make recommendations to the Partnership Board on next steps.

vii. Seek to unblock any barriers to change and mitigate any risks through its collective membership and networks prior to escalating to the Partnership Board.
viii. Identifying any areas where there are wider implications/trends of these risks and

issues or where additional assurance is required, and escalating to the Partnership Board where appropriate

ix. Provide oversight and assurance of the workforce elements of the system planning process and associated workforce narrative for the BD&C Place for recommendation and ratification by the partnership board

x. Provide the necessary advice and guidance, as required, on specific workforce strategies/plans of other programmes - including supporting workforce redesign.

xi. Encourage and seek assurance on the inclusion of horizon scanning and sharing the learning from the wider health, care and education systems, locally, regionally and nationally in order ensure best practice and economies of scale are realised and to maximise funding opportunities.

xii. Support the development of Place based workforce bids where Appropriate for recommendation to partnership board

xiii. Seek and provide assurance on the spending of such funds to achieve agreed programme outcomes and receive associated evaluation reports.

xiv. Champion the importance of workforce within the delivery of service and as a key enabler of service improvement and modernisation.

xv. Investigate any activity within its Terms of Reference and obtain independent specialist advice as it considers necessary.

3. Membership

The Members of this Committee are:

- Two non-executive directors selected by the BD&C Partnership Board, with each director from a different Partner. One of whom will be the Chair of the Committee, and one of whom will be the deputy Chair

Members appointed by virtue of their role:

- The BD & C Assistant Director of Workforce
- The BD & C Director of Partnership Development
- The nominated Equality, Diversity and Inclusion BD&C Place Lead

- Chief Nurse, Airedale NHS FT as H & SC CTE Board Chair and BD & C Clinical representative
- The SRO for programmes in the Integrated People Plan (as per Directors of Workforce below)

One person from each provider organisation and/or sector selected by the BD&C Partnership Board:

- The Director of Workforce and OD ('HRD') of Airedale NHS FT
- The Director of Workforce and OD ('HRD') of Bradford District Care NHS FT
- The Director of Workforce and OD ('HRD') of Bradford Teaching Hospitals NHS FT
- The Director of Workforce and OD ('HRD') of City of Bradford Metropolitan District Council
- Chief Operating Officer - Primary Care Workforce & Training Hub
- Nominated Representative, Bradford and District Voluntary Services Alliance
- Bradford Care Association – Workforce lead
- Adult Social Care workforce representative
- BD & C Locality Manager – Representing Skills for Care
- Nominated representative of North Yorkshire Voluntary Services

When Available:

- Representative of North Yorkshire County Council

4. Required attendees

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

- Business Administration Support
- Programme Manager Support
- Governance Manager BD & C HCP

- Nominated Deputies as identified (deputies can be acting in a partner capacity and/or a Pillar lead capacity)

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

5. Deputies

Members may nominate a deputy to attend a meeting of the Committee that the Member is unable to attend. The deputy may speak and vote on their behalf. The decision of the meeting Chair regarding acceptance of nominated deputies is final.

Any requests for a deputy to be appointed should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

Any reference to Member in these terms of reference includes a deputy appointed in accordance with this paragraph.

6. Chair

The Chair of this BD&C Committee shall be one of the non-executive directors from a Partner that is a Member and selected as follows.

- The first Chair of this BD&C Committee shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.
- Subsequent Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by the BD&C Partnership Board.

One person may not serve more than three consecutive terms as Chair.
If the Chair is unable to attend a meeting or carry out the role of the Chair between meetings this shall be taken on by the Deputy Chair.

The Deputy Chair of this BD&C Committee shall be one of the non-executive directors from an a Partner that is a Member and selected as follows.

The first Deputy Chair of this BD&C Committee shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months. Subsequent Deputy Chairs shall be appointed for a term of eighteen months. Such Deputy Chairs shall be appointed by the BD&C Partnership Board.

One person may not serve more than three consecutive terms as Deputy Chair.
If both the Chair and the Deputy Chair are absent then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.

References to Chair shall be read accordingly.

7. Quoracy

No recommendations shall be made unless at least half the Members are present and at least one Member representing each of the ICB and the three NHS Foundation Trusts within the BD&C Partnership.

If a meeting is or becomes inquorate, this will be minuted. Members may discuss matters but no formal recommendations will be made. Any discussions will be summarised at the start of the next meeting of this BD&C Committee.

The expectation of the Partners is that this BD&C Committee will meet regularly as scheduled. The Partners recognise that even if a meeting is not quorate, useful discussions may take place. However, if the Chair has received apologies for a meeting in advance that indicate that a quorum will not present, the Chair may cancel the meeting if they are satisfied that this is the more appropriate use of Members' time.

An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

8. Conduct of meetings

Meetings of this BD&C Committee will be run by the Chair.
The expectation is that Members will attend meetings in person.

However, in accordance with Standing Order [4.8], the Chair shall have discretion to permit a Member or Attendee to participate in a meeting by telephone, video or by other electronic means where they are available and the Chair is satisfied that there is good reason for the request, such as clinical commitments. Participation by any of these means shall be constitute presence in person at the meeting provided all Members and Attendees in attendance can be heard and hear one another.

Any request to participate in a meeting by telephone, video or by other electronic means should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

The Chair may also require that a meeting take place entirely by telephone, video or by other electronic means where there is good reason to do so, for example the difficulties of managing hybrid meetings or public health concerns.

In line with the Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each Member will have one vote, the process for which is set out in the section below:

a. All Members of this BD&C Committee who are present at the meeting will be eligible to cast one vote each.
b. Absent members may not vote by proxy. Absence is defined as being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. However, they are able to appoint a deputy in accordance with paragraph
c. A resolution will be passed if more votes are cast for the resolution than against it.
d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote.
e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

If the Chair considers it appropriate, recommendations may also be taken through the Written Resolution Procedure set out below:

a. The Chair will arrange for an email to be written that:

- confirms the resolution(s) that the Members are being asked to approve;
- includes, by way of an attachment, all of the relevant information to enable the Member to reach a decision on the proposal(s);
- contains the deadline (date and time) for response that shall be at least ten Working Days from the date of the email; and
- confirms the email address to which the Member's vote should be sent.

b. The Chair will arrange for the email and accompanying documents to be sent by e-mail to all Members on the same date.

c. Each Member shall reply to the designated email address by the deadline given setting out whether they accept, reject or abstain in relation to each resolution set out in the email. Once a Member has responded stating they accept, reject or abstain in relation to a resolution they may not amend or retract their vote.

If the Chair considers it appropriate, recommendations may also be taken through the Written Resolution Procedure set out below:

a) The Chair will arrange for an email to be written that:

- confirms the resolution(s) that the Members are being asked to approve;
- includes, by way of an attachment, all of the relevant information to enable the Member to reach a decision on the proposal(s);
- contains the deadline (date and time) for response that shall be at least ten Working Days from the date of the email; and
- confirms the email address to which the Member's vote should be sent.

b) The Chair will arrange for the email and accompanying documents to be sent by e-mail to all Members on the same date.

c) Each Member shall reply to the designated email address by the deadline given setting out whether they accept, reject or abstain in relation to each resolution set out in the email. Once a Member has responded stating they accept, reject or abstain in relation to a resolution they may not amend or retract their vote.

Exceptions:

d. The following recommendations may not be taken by way of the Written Resolution Procedure:

N/A

Passing the written resolution:

e. In order for the written resolution to be passed the quorum rules must be complied with. If any Member does not respond to a resolution proposed by the Written Resolution Procedure by the deadline given, they are not present for the purpose of the quorum. Responses received after the deadline will be disregarded.
f. Provided the quorum requirements have been complied with a resolution will be passed if the majority of Members responding by the deadline approve the resolution.
g. The Chair will arrange for Members to be notified of the outcome of the Written Resolution Procedure within five Working Days of the deadline.
h. The outcome of all uses of the Written Resolution Procedure will be recorded in the papers for the next meeting. This will include details of votes approving or rejecting each resolution, any abstentions and details of any Member that did not respond by the deadline.

9. Frequency of meetings

This BD&C Committee will meet formally at least once in any two-month period initially to align with the BD&C Partnership Board meeting frequency.

The Chair may call an additional meeting at any time by giving not less than 10 Working Days' notice in writing to all Members and Attendees.

The Partnership Board may require that this BD&C Committee meet within a reasonable timeframe to discuss a particular matter. Such requests should be submitted to the Chair.

Members and Attendees shall be given at least ten Working Days' notice of any meeting save that in emergency situations the Chair may call a meeting with three Working Days' notice by setting out the reason for the urgency and the decision to be taken. Papers shall be circulated at least two Working Days before the meeting.

10. Urgent decisions

In the case of urgent decisions needed in extraordinary circumstances, every attempt will be made for this BD&C Committee to meet. Where this is not possible the following will apply:

i. The decision-making responsibilities which are delegated to this BD&C Committee, may for an urgent decision be exercised by the Chair, a member of the ICB and the HRDs of the three Foundation Trusts within the BD & C Partnership (or where not available a representative of that Trust).
j. The exercise of such powers shall be reported to Members by email within 2 Working Days.
k. The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification, where the Chair will explain the reason for the action taken and report the decision to the Partnership Board for oversight.

Extraordinary circumstances will usually be unforeseen and be such that either calling an extraordinary meeting or using the Written Resolution Procedure will not be appropriate.

11. Admission of the press and public

Not relevant - This BD&C Committee will be advisory and will not take any decisions on behalf of the ICB and will meet in private.

12. Declarations of interest

If any Member or Attendee has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible before the meeting and act in accordance with the Conflicts of Interests Policy.

The Chair will determine how a conflict of interest should be managed in accordance with the Conflicts of Interests Policy, taking into account any previously agreed arrangements for managing a conflict of interest. The Chair may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

13. Support to the committee

Administrative support will be provided to this BD&C Committee by the BD&C place-based team of the ICB. This will include:

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

It is the responsibility of Members and Attendees to ensure that they provide their contact details to the Chair (email and direct dial telephone number) and keep these up to date.
Papers will be circulated electronically. Members or Attendees wishing to receive the papers in a particular format (e.g., large print, hard copy) should make a request to the Chair. The Chair has discretion as to whether to meet the request.

14. Authority

This BD&C Committee is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires within its remit, from any member of staff of a Place Partner and Place Partners will ensure that their staff are directed to co-operate with any such request made by this BD&C Committee.

This BD&C Committee is authorised to commission any reports or surveys it considers necessary to help it fulfil its obligations. In doing, so, this BD&C Committee must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, this BD&C Committee must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Committee is authorised to create and dissolve time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, this BD&C Committee must set clear a clear scope of work and deadline for completion for such groups. Such groups shall not be able to take decisions on behalf of this BD&C Committee.

This BD&C Committee may not create any formal sub-committees, delegate any of its recommending responsibilities or establish any permanent working groups unless

expressly authorised by the Partnership Board. Even if any delegation is approved, this BD&C Committee remains accountable for the work that is delegated.

15. Reporting

This BD&C Committee shall submit a triple A assurance report to each Partnership Board meeting. These shall be published by the Partnership Board as part of its meeting papers.

The Chair shall draw to the attention of the Partnership Board any significant issues or risks relevant to the Place Partnership or the ICB.

This BD&C Committee shall submit an annual report to the Partnership Board.
This BD&C Committee shall propose an annual work plan to the Partnership Board for approval by the Partnership Board. The Partnership Board may make such changes to the annual work plan as it considers appropriate in consultation with the Chair.

This BD&C Committee will receive for information the minutes of other meetings which are captured in the Committee's work plan e.g., minutes of its working groups.

16. Conduct of the Committee

All Members and Attendees will operate within the Constitution of the ICB, standing orders, standing financial instructions, other financial procedures and ICB Policies provided always that this requirement may be disapplied by the Partnership Board in relation to Partnership Business, such authorisation to be given in advance and in writing.

All Members and Attendees will operate in accordance with the SPA and any other relevant policies or documents agreed by the Place Board.

All Members and Attendees will attend and complete any training required by the Chair or the Partnership Board.

Members and Attendees must demonstrably consider the equality and diversity implications of recommendations they make and consider whether any new recommended approach achieves positive change around inclusion, equality and diversity.

Members and Attendees will abide by the 'Principles of Public Life' (The Nolan Principles).

The requirements listed above in relation to conduct of Members and Attendees shall also apply to members of any working groups or task and finish groups reporting to this BD&C Committee.

The Committee shall undertake an annual self-assessment of its own performance against the annual work plan, these terms of reference and the SPA. This self-assessment shall form the basis of the annual report from this BD&C Committee to the Partnership Board.

The Partnership Board may remove an individual Member from this BD&C Committee if:

- That individual fails to comply with these terms of reference;
- That individual has behaved in a way, or is threatening to behave in a way, that is likely to bring this BD&C Committee, the Partnership Board and/or the ICB into disrepute;
- That individual has attended less than 75% of the meetings of this BD&C Committee in any 12-month period;
- The individual no longer meets the relevant membership requirement set out at paragraph, for example because they no longer hold a particular post or work for a particular organisation; or
- They qualify for membership of this BD&C Committee through their host organisation and that host organisation leaves the Place Partnership

17. Amendments

This BD&C Committee may propose changes to its terms of reference to the Partnership Board.

Any changes to these terms of reference must be approved by the Partnership Board.

18. Review date

These terms of reference shall be reviewed annually.

Bradford District & Craven- System Quality Committee
ANNUAL REPORT 2023-24

INTRODUCTION

This BD&C committee, the Quality Committee is part of the West Yorkshire Integrated Care System, which has four core purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

MEMBERSHIP

- Andy Withers (Chair) Non-executive director
- Carol Panteli- (Deputy Chair April24-August 24) Non-executive director
- Sally Napper- (Deputy Chair September24 - onwards) Non-executive director
- Amanda Stanford, Karen Dawber, Philippa Hubbard- BD&C Partnership Director of Quality and Nursing (currently piloting a distributed leadership model which is covered by system chief nurses)
- Amanda Stanford- The Chief Nurse of Airedale NHS FT
- Philippa Hubbard- The Chief Nurse of Bradford District Care NHS FT
- Karen Dawber- The Chief Nurse of Bradford Teaching Hospitals NHS FT
- David Crampsey- The Medical Director of Airedale NHS FT
- David Simms- The Medical Director of Bradford District Care NHS FT
- Ray Smith- The Medical Director of Bradford Teaching Hospitals NHS FT
- Sarah Muckle- A Consultant in Public Health - City of Bradford MDC
- Iain McBeath- The Director of Health and Wellbeing- City of Bradford MDC
- Helen Rushworth- Chief Executive of Healthwatch Bradford District
- Soo Nevison- Chief Executive of The VCS Alliance

- Louise Bestwick- Chief Executive of Bradford Care Association
- Danielle Hann- Medical Director Local Medical Committee
- Helen Rushworth- Chair of Citizen's Forum
- James Drury- Director of Partnerships (April 24- Dec 24)

In addition – attendees (including deputies attending on behalf of members):

- Grainne Eloi- Associate Director of Quality and Nursing – BD&C Partnership
- John Hartley- Assistant Director Quality Improvement – BD&C Partnership
- Beverley Fearnley- Deputy Director of Patient Safety, Compliance and Risk – Bradford District Care NHS Foundation Trust
- Judith Connor- Associate Director of Quality – Bradford Teaching Hospitals NHS Foundation Trust
- Deborah Fox- Assistant Chief Nurse, Patient Safety- Airedale NHS Foundation Trust
- John Bolton- Deputy Medical Director, Bradford Teaching Hospitals NHS FT
- Iram Amin, Programme Manager, BD&C Partnership
- Carrie Haywood, Senior Governance Manager, BD&C Partnership
- Bev Denton, Governance Officer, BD&C Partnership
- Sharonjit Kaur, PA, BD&C Partnership
- Jorge Zepeda, Head of Public Health, Health Protection & Health Improvement BMDC
- Jane Wood, Assistant Director, Commissioning and Integration, BMDC

MEETINGS HELD

27th April 2023
22nd June 2023
27th July 2023
28th September 2023
26th October 2023
23rd November 2023
25th January 2024
22nd February 2024
29th March 2024
A development session was held on 25th May 2023

ATTENDANCE

Member	Job Title	Attendance (number of meetings attended)	Attendance (% out of 9 meetings)
Parveen Akhtar	Associate Director, Primary Care & Transformation, BDC	**4**	44%
Iram Amin	Project Manager, Project & Programme Management,	**8**	89%
John Bolton	Deputy Medical Director, BTHFT	**3**	33%
Judith Connor	Associate Director of Quality, BTHFT	**5**	56%
David Crampsey	Medical Director, ANHSFT	**4**	44%
Karen Dawber	Chief Nurse, BTHFT/ BD&C Partnership Director of Quality and Nursing	**1**	11%
Bev Denton	Governance Manager BD&C HCP	**7**	78%
James Drury	Director, Partnership Development, BD&C HCP	**4**	66%
Grainne Eloi	Interim Deputy Director of Quality & Nursing,	**6**	67%
Bev Fearnley	Deputy Director of Patient Safety, Compliance &	**4**	44%
Deborah Fox	Assistant Chief Nurse, ANHSFT	**6**	67%
Danielle Hann	GP and Deputy Chair of BDC LMC	**6**	67%
John Hartley	Assistant Director Quality Improvement, BD&C HCP	**9**	100%
Carrie Haywood	Senior Assurance and Governance Manager,	**3**	33%
Jo Hilton	Director of Nursing / Deputy Chief Nurse, BTHFT	**2**	22%
Philippa Hubbard	Director of Nursing, Professions and Care Standards BDCFT, BD&C Partnership Director of Quality and Nursing	**6**	67%
Sharonjit Kaur	PA (Minute Taker)	**5**	56%
Sally Napper	Deputy Chair, Non Exec Director	**5**	56%
Carole Panteli	Deputy Chair, Non Exec Director	**2**	22%
Maria Pedley	Senior Strategic Head of Primary Care and Transformation	**3**	33%
Helen Rushworth	Lead Officer, Healthwatch Bradford & Chair of Citizens Forum	**1**	11%
David Simms	Medical Director, BDCFT	**5**	56%
Ray Smith	Chief Medical Officer, BTHFT	**4**	44%
Amanda Stanford	Chief Nurse, ANHSFT, BD&C Partnership Director of Quality and Nursing	**9**	100%
Andy Withers	(Chair) Non-Executive Director, ANHSFT	**8**	89%

Jane Wood	Assistant Director, Commissioning and Integration, BMDC	**7**	78%
Jorge Zepeda	Head of Public Health, Health Protection & Health Improvement BMDC	**7**	78%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2023 – 24

Highlights from the committee's work in 2023-2024 included:

- Deep dives into specific areas which gave insight into the identified areas. This enabled support from the system and an opportunity for learning and sharing.
- Information sharing from other meetings as papers from the WY ICB Quality Committee, WY ICB Clinical Forum, BDC Clinical Forum and BDC System, finance & performance were circulated within the pack.
- Providing regular assurance to the Partnership Board and WY ICB Quality Committee in relation to activities and items within the committees remit via the AAA updates.
- Updates from and support to Priority areas, enablers and workstreams including: Healthy Communities Priority programme, Access to Care Bd&C Health and Care Partnership priority programme, The Better Care Fund plan 2023 – 2025; and an update on the role of the Medical Examiner in Bradford District and Craven.
- Committee received updates on:
    - Adult Autism update
    - Enhanced Surveillance procedure for NHS funded care homes
    - In Hospital Mortality data
    - Experience of Care
    - Specialist mental health support for ethnic and culturally diverse communities' specification
    - Tong Park Incident update
    - Reducing Inequalities in Communities (RIC): Recommendations for future commissioning intentions
    - Virtual Ward proposal
    - WY ICB Harmonised Commissioning Policies
    - DXA Service Alignment to National Osteoporosis Society (NOGG) Guidelines
    - Stroke update
    - Children in Care Business Case
    - Annual reports: CDOP, Children Looked After, Safeguarding, Research & Development and Health Protection.

AREAS FOR DEVELOPMENT IN 2024 - 25

- Ongoing development on establishing the role of the SQIAIG sub-group which will be the key group for SQC
- Planned development session to take place July 2024 and December 2024.
- Review of membership and terms of reference following development sessions and agreement to move meetings date to accommodate attendance from other committees (SFPC)
- Future planned areas of review include:
    - 5 priority areas: Healthy communities, Access to care, Healthy minds, Workforce development, Children & Young people.
    - 4 enables: Reducing health inequalities, Living well, Research & Development, Digital & Information intelligence.
    - SEND inspection and compliance (North Yorks)
    - Closing the gap
- SQC continue to receive annual reports from: CDOP, Children Looked After, Safeguarding, Research & Development and Health Protection

Terms of reference – Bradford District and Craven quality committee

Version control

Version: 2.0 (final approved version to be 2.0)

Approved by: West Yorkshire Health and Care Integrated Care Board ICB

Date Approved: 1 July 2022

Responsible Officer: James Drury, Partnership Development Director

Date Issued: 12 July 2022

Date to be reviewed: 1st April 2025

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	James Drury	8 June 2022
1.0	Approved	ICB	1 July 2022
1.0	Approved	BD&C Partnership Board	12 July 2022
2.0	Final draft	SQC	October 2023
2.0	Approved	BD&C Partnership Board	10th November 2023

1. General

This BD&C committee, the Quality Committee is part of the West Yorkshire Integrated Care System, which has four core purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

The ICS has identified a set of guiding principles that shape everything we do:

- We will be ambitious for the people we serve and the staff we employ.
- The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake shared analysis of problems and issues as the basis of taking action.
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire.
- We support each other and work collaboratively.
- We act with honesty and integrity, and trust each other to do the same.
- We challenge constructively when we need to.
- We assume good intentions; and

We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

In these Terms of Reference the following capitalised terms are given the meaning set out in the NHS West Yorkshire Integrated Care Board Constitution as updated from time to time, unless the context otherwise requires:

- Conflict of Interest Policy
- Constitution
- Standing Order or Standing Orders

Other capitalised terms have the meaning set out below:

- “Attendee” refers to a participant of this BD&C Committee as listed in paragraph 7
- “BD&C Committee” refers to this Committee
- “Chair” means the chair of this BD&C Committee
- “ICB” means the NHS West Yorkshire Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated
- “ICB Business” has the meaning given to it at paragraph **Error! Reference source not found.**“ICB Committee” means a committee of the ICB
- “ICB Policies” means any policy, process or procedure formally adopted by the ICB
- “Member” refers to a member of this BD&C Committee as listed in paragraph 6
- “NHS Foundation Trust Partner” means Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and/or Bradford Teaching Hospitals NHS Foundation Trust
- “Partner” refers to a partner organisation in the Place Partnership which is also a party to the SPA
- “Partnership Business” has the meaning given to it at paragraph **Error! Reference source not found.**
- “Partnership Board” means the Bradford District and Craven ICB Committee as described in the Constitution
- “Place Lead” means that individual appointed by the ICB to oversee and help develop the Place Partnership
- “Place Partnership” means the partnership of organisations described in the SPA
- “SPA” means the Strategic Partnering Agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Bradford District and Craven

- “Working Days” means a weekday that is not a bank holiday in England
- “Written Resolution Procedure” is the written resolution procedure described at
- paragraph **Error! Reference source not found.**.

This BD&C Committee shall operate in accordance with the vision, objectives and principles set out in the terms of reference of the BD&C Partnership Board. When advising or making decisions on behalf of the ICB, it will comply with relevant ICB policies.

The ICB Standing Orders shall apply to this BD&C Committee unless these Terms of Reference expressly make alternative provision that they do not.

2. Reports to

This BD&C Committee reports to the BD&C Partnership Board and the ICB Quality Committee. Members and Attendees may also report back to their respective Partner organisations.

3. Purpose

This BD&C Committee has been established to provide the Partnership Board with assurance that is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the Partnership Board, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

The Committee will provide regular assurance updates to the Partnership Board in relation to activities and items within its remit”

This BD&C Committee has two roles:

- The first is to support the ICB on issues within its remit. If this BD&C Committee makes decisions on behalf of the ICB (see section **Error! Reference source not found.** below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this BD&C Committee.

- The second is to support the wider Place Partnership, which comprises the ICB and various other organisations, on issues within the BD&C Committee’s remit. This support is provided by advising and working collaboratively with all members of the BD&C Partnership, who come from these other organisations.

If this BD&C Committee considers that there is or may be a conflict between these two roles then the Chair shall notify the Place Lead.

In practice, this BD&C Committee carries out both roles by reporting to the Partnership Board, which comprises senior leaders from the Place Partnership and is a committee of the ICB.

How we work across the Place, what the System Quality Committee will offer:

1. Provide challenge and guidance on quality governance and internal control to support effective delivery of strategic objectives and the delivery of sustainable, high-quality care.
2. Ensure risks, issues and concerns regarding quality and clinical outcomes within BD&C service provision, service transformation and improvements are identified and managed and that wider implications and trends are addressed
3. Ensure that services, service transformation and improvements are reflective of and responsive to local populations and people’s experiences.

4. Test, challenge, inquire and explore intelligence evidencing the quality, safety, effectiveness and impact on clinical health outcomes of services and service transformation and improvements.
5. To provide support to the creation, maintenance and development of a patient-focused culture within the BD&C Partnership

How we work across the Place – our Quality principles

1. What contribution is the programme making to help reduce health inequalities?
2. Does the programme promote quality + safety and mitigate any risks, are these risks shared at place and are there appropriate metrics to determine the impact on quality of service provision and patient safety?
3. Are there any concerns from a regulatory perspective and if so how are they being addressed & measured & how are they being shared at Place?
4. What are the key outcomes for the priority area? How will the programme measure whether it is a making demonstrable difference to outcomes – clinical and non clinical?
5. What role is there for citizens and patient voices in the programme and how do you know that you are improving their experiences?
6. Have Quality and Equality Impact Assessments (QEIA) been completed and are there plans to review them throughout the programme life span?
7. Does the programme utilise known best practice and how far is it evidence based?
8. Does the programme encourage training and development of the work force?
9. How will the programme impact on and support 'recovery' and 'reset' requirements?
10. How will the programme be evaluated and to what extent will this be independent of programme governance?

4. Remit and Responsibilities

The remit of this BD&C Committee is to:

a) **Make the following decisions on behalf of the ICB, following delegation of this responsibility from the ICB to the Partnership Board and from the Partnership Board to this BD&C Committee:**

This BD&C Committee has an assurance role and will not be making decisions on behalf of the ICB.

b) Provide advice and/or recommendations in the areas listed below to the Partnership Board, for the benefit of the ICB ("ICB Business"); and

c) Provide advice and/or recommendations in the areas listed below to other members of the Partnership Board ("Partnership Business")

There is a significant overlap between the work that the BD&C Committee will carry out as ICB Business and the work it will carry out as Partnership Business. Any business conducted by this BD&C Committee will be both ICB Business and Partnership Business unless expressly stated otherwise in writing (for example in the agenda and/or minutes),

i. Provide assurance to the Partnership Board of the quality, safety, and effectiveness of services for BD&C, and the contribution services make to improving health outcomes for local people.

ii. The development and maintenance of a strategic approach to quality assurance, reporting and monitoring, sharing learning and improvement activity across the system.

iii. Ensure concerns regarding clinical outcomes within BD&C services are identified and managed and that wider implications and trends are addressed.

iv. Ensure that services are reflective of and responsive to local populations and people's experiences via committee relationship with Citizens Forum and Healthwatch

v. Advise the Partnership Board in the formulation of overall clinical strategy including how decisions are made and the scrutiny of subsequent plans to ensure quality is not compromised by financial imperatives. This will include quality impact assessments.

vi. Test, challenge, inquire and explore intelligence evidencing the quality, safety, effectiveness and impact on clinical health outcomes of services. Commission and approve action plans and other initiatives in relation to areas of concern.

vii. Oversee and monitor delivery of the key statutory requirements relating to quality and patient safety and the Partnership's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g.

CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained. This will include the Patient Safety Incident Response Framework (PSIRF).

viii. Ensure effective communication with regulators and maintain an overview of changes in the methodology employed and changes in legislation/regulation, and assure the Partnership Board that these are disseminated and implemented across all sites.

ix. Receive assurance that the Partnership identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.

x. Identify issues relating to data quality, completeness or accuracy of intelligence in all forms, and commission improvements.

xi. Undertake such quality surveillance activity for commissioned services as from time to time required by the West Yorkshire Quality Group.

xii. To support at all times the creation, maintenance and development of a patient-focused culture within the BD&C Partnership.

xiii. Review and monitor the Partnership Risk Register in respect of quality and safety risks. Request action by accountable individuals to manage aforementioned risks and variation in performance, ensuring plans are put in place to address the achievement of objectives and targets. Ensure that variance against target performance levels is reflected in the Risk Register reports and Partnership Assurance Framework as appropriate.

xiv. Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into this Committee.

5. Members

Members contribute to discussion, participate in decision making and are accountable for decisions made. If a matter goes to a vote, then each Member has one vote save that the Chair shall have a casting vote, as set out in paragraph **Error! Reference source not found.**.

The Members of this Committee are:

- Two non-executive directors to be selected by the BD&C Partnership Board, with each director to be from a different NHS Foundation Trust Partner. One of whom will be the Chair of the Committee, and one of whom will be the deputy Chair.
- The BD&C Partnership Director of Quality and Nursing (currently piloting a distributed leadership model which is covered by system chief nurses)
- The Chief Nurse of Airedale NHS FT
- The Chief Nurse of Bradford District Care NHS FT
- The Chief Nurse of Bradford Teaching Hospitals NHS FT
- The Medical Director of Airedale NHS FT
- The Medical Director of Bradford District Care NHS FT
- The Medical Director of Bradford Teaching Hospitals NHS FT
- A Consultant in Public Health - City of Bradford MDC
- The Director of Health and Wellbeing- City of Bradford MDC
- Chief Executive of Healthwatch Bradford District
- Chief Executive of The VCS Alliance
- Chief Executive of Bradford Care Association
- Medical Director Local Medical Committee
- Chair of Citizen's Forum
- Director of Partnerships

6. Attendees

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

- Associate Director of Quality and Nursing – BD&C Partnership
- Assistant Director Quality Improvement – BD&C Partnership
- Deputy Director of Patient Safety, Compliance and Risk – Bradford District Care NHS Foundation Trust
- Associate Director of Quality – Bradford Teaching Hospitals NHS Foundation Trust
- Assistant Chief Nurse, Patient Safety- Airedale NHS Foundation Trust

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

Any individual wishing to attend a meeting of this BD&C Committee should make request to the Chair by writing to the committee administrator, to be received at least three Working Days to the meeting. Attendance is at the Chair's discretion.

7. Deputies

In accordance with the Standing Orders, with the permission of the Chair, a Member may nominate a deputy to attend a meeting of the Committee that the Member is unable to attend. The deputy may speak and vote on their behalf. The decision of the meeting Chair regarding acceptance of nominated deputies is final.

Any requests for a deputy to be appointed should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

Any reference to Member in these terms of reference includes a deputy appointed in accordance with this paragraph.

8. Chair

The Chair of this BD&C Committee shall be one of the non-executive directors from an NHS Foundation Trust Partner that is a Member and selected as follows.

The first Chair of this BD&C Committee shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.

Subsequent Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by the BD&C Partnership Board.

One person may not serve more than three consecutive terms as Chair. If the Chair is unable to attend a meeting or carry out the role of the Chair between meetings this shall be taken on by the Deputy Chair.

The Deputy Chair of this BD&C Committee shall be one of the non-executive directors from an NHS Foundation Trust Partner that is a Member and selected as follows.

The first Deputy Chair of this BD&C Committee shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.

Subsequent Deputy Chairs shall be appointed for a term of eighteen months. Such Deputy Chairs shall be appointed by the BD&C Partnership Board.

One person may not serve more than three consecutive terms as Deputy Chair.
If both the Chair and the Deputy Chair are absent then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.
References to Chair shall be read accordingly.

9. Quoracy

No decisions shall be made unless at least 50% of the Members are present and at least one Member representing each of the ICB and at least one of the three NHS Foundation Trusts within the BD&C Partnership

If a meeting is or becomes inquorate, this will be minuted. Members may discuss matters but no formal decisions will be made. Any discussions will be summarised at the start of the next meeting of this BD&C Committee.

The expectation of the Partners is that this BD&C Committee will meet regularly as scheduled. The Partners recognise that even if a meeting is not quorate, useful discussions may take place. However, if the Chair has received apologies for a meeting in

advance that indicate that a quorum will not present, the Chair may cancel the meeting if they are satisfied that this is the more appropriate use of Members' time.

10. Conduct of meetings

Meetings of this BD&C Committee will be run by the Chair. The expectation is that Members will attend meetings in person. However, in accordance with the Standing Orders, the Chair shall have discretion to permit a Member or Attendee to participate in a meeting by telephone, video or by other electronic means where they are available and the Chair is satisfied that there is good reason for the request, such as clinical commitments. Participation by any of these means shall be constitute presence in person at the meeting provided all Members and Attendees in attendance can be heard and hear one another. Any request to participate in a meeting by telephone, video or by other electronic means should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

The Chair may also require that a meeting take place entirely by telephone, video or by other electronic means where there is good reason to do so, for example the difficulties of managing hybrid meetings or public health concerns.

In line with the Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each Member will have one vote, the process for which is set out in the section below:

a. All Members of this BD&C Committee who are present at the meeting will be eligible to cast one vote each.
b. Absent members may not vote by proxy. Absence is defined as being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. However, they are able to appoint a deputy in accordance with paragraph **Error! Reference source not found.**.
c. A resolution will be passed if more votes are cast for the resolution than against it.
d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote.

e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

If the Chair considers it appropriate, decisions may also be taken through the Written Resolution Procedure set out below:

a. The Chair will arrange for an email to be written that:

- confirms the resolution(s) that the Members are being asked to approve;
- includes, by way of an attachment, all of the relevant information to enable the Member to reach a decision on the proposal(s);
- contains the deadline (date and time) for response that shall be at least ten Working Days from the date of the email; and
- confirms the email address to which the Member's vote should be sent.

b. The Chair will arrange for the email and accompanying documents to be sent by e-mail to all Members on the same date.

c. Each Member shall reply to the designated email address by the deadline given setting out whether they accept, reject or abstain in relation to each resolution set out in the email. Once a Member has responded stating they accept, reject or abstain in relation to a resolution they may not amend or retract their vote.

Exceptions:

d. The following decisions may not be taken by way of the Written Resolution Procedure:

Passing the written resolution:

e. In order for the written resolution to be passed the quorum rules must be complied with. If any Member does not respond to a resolution proposed by the Written Resolution Procedure by the deadline given they are not present for the purpose of the quorum. Responses received after the deadline will be disregarded.

f. Provided the quorum requirements have been complied with a resolution will be passed if the majority of Members responding by the deadline approve the resolution.

g. The Chair will arrange for Members to be notified of the outcome of the Written Resolution Procedure within five Working Days of the deadline.

h. The outcome of all uses of the Written Resolution Procedure will be recorded in the papers for the next meeting. This will include details of votes approving or rejecting each resolution, any abstentions and details of any Member that did not respond by the deadline.

11. Frequency of meetings

This BD&C Committee will meet at least once in any three month period.

The Chair may call an additional meeting at any time by giving not less than 10 Working Days' notice in writing to all Members and Attendees.

The Partnership Board may require that this BD&C Committee meet within a reasonable timeframe to discuss a particular matter. Such requests should be submitted to the Chair. Members and Attendees shall be given at least ten Working Days' notice of any meeting save that in emergency situations the Chair may call a meeting with three Working Days' notice by setting out the reason for the urgency and the decision to be taken. Papers shall be circulated at least two Working Days before the meeting.

12. Urgent decisions

In the case of urgent decisions needed in extraordinary circumstances, every attempt will be made for this BD&C Committee to meet. Where this is not possible the following will apply:

a) The decision-making responsibilities which are delegated to this BD&C Committee, may for an urgent decision be exercised by the Chair and the BD&C Partnership Director of Quality and Nursing. The Chair shall also consult the Deputy Chair.

b) The exercise of such powers shall be reported to Members by email within 2 Working Days.

c) The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification, where the Chair will explain the reason for the action taken, and report the decision to the Partnership Board for oversight.

Extraordinary circumstances will usually be unforeseen and be such that either calling an extraordinary meeting or using the Written Resolution Procedure will not be appropriate.

13. Declarations of Interest

If any Member or Attendee has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible before the meeting and act in accordance with the Conflicts of Interests Policy.

The Chair will determine how a conflict of interest should be managed in accordance with the Conflicts of Interests Policy, taking into account any previously agreed arrangements for managing a conflict of interest. The Chair may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

14. Support to the Committee

Administrative support will be provided to this BD&C Committee by the BD&C place based team of the ICB. This will include:

- Agreement of the agenda with the Chair
- Sending out agendas and supporting papers to Members and Attendees at least five Working Days before the meeting.

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

Notifications and requests to the Chair must be sent to the committee administrator. It is the responsibility of Members and Attendees to ensure that they provide their contact details to the Chair (email and direct dial telephone number) and keep these up to date.

Papers will be circulated electronically. Members or Attendees wishing to receive the papers in a particular format (e.g. large print, hard copy) should make a request to the Chair. The Chair has discretion as to whether to meet the request.

15. Authority

This BD&C Committee is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires within its remit, from any member of staff of a Place Partner and Place Partners will ensure that their staff are directed to co-operate with any such request made by this BD&C Committee.

This BD&C Committee is authorised to commission any reports or surveys it considers necessary to help it fulfil its obligations. In doing, so, this BD&C Committee must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, this BD&C Committee must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Committee is authorised to create and dissolve time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, this BD&C Committee must set clear a clear scope of work and deadline for completion for such groups. Such groups shall not be able to take decisions on behalf of this BD&C Committee.

This BD&C Committee may not create any formal sub-committees, delegate any of its advisory responsibilities or establish any permanent working groups unless expressly authorised by the Partnership Board. Even if any delegation is approved, this BD&C Committee remains accountable for the work that is delegated.

16. Reporting

This BD&C Committee shall submit its approved minutes to each Partnership Board meeting. These shall be published by the Partnership Board as part of its meeting papers.

The Chair shall draw to the attention of the Partnership Board any significant issues or risks relevant to the Place Partnership or the ICB.

This BD&C Committee shall submit an annual report to the Partnership Board.
This BD&C Committee shall propose an annual work plan to the Partnership Board for approval by the Partnership Board. The Partnership Board may make such changes to the annual work plan as it considers appropriate in consultation with the Chair.

This BD&C Committee will receive for information the minutes of other meetings which are captured in the Committee's work plan e.g. minutes of its working groups.

17. Conduct of the Committee

All Members and Attendees will operate within the Constitution of the ICB, standing orders, standing financial instructions, other financial procedures and ICB Policies provided always that this requirement may be disapplied by the Partnership Board in relation to Partnership Business, such authorisation to be given in advance and in writing.

All Members and Attendees will operate in accordance with the SPA and any other relevant policies or documents agreed by the Place Board.

All Members and Attendees will attend and complete any training required by the Chair or the Partnership Board.

Members and Attendees must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new decision or recommended approach achieves positive change around inclusion, equality and diversity.

Members and Attendees will abide by the 'Principles of Public Life' (The Nolan Principles).

The requirements listed above in relation to conduct of Members and Attendees shall also apply to members of any working groups or task and finish groups reporting to this BD&C Committee.

The Committee shall undertake an annual self-assessment of its own performance against the annual work plan, these terms of reference and the SPA. This self-assessment shall form the basis of the annual report from this BD&C Committee to the Partnership Board.

The Partnership Board may remove an individual Member from this BD&C Committee if:

- That individual fails to comply with these terms of reference;
- That individual has behaved in a way, or is threatening to behave in a way, that is likely to bring this BD&C Committee, the Partnership Board and/or the ICB into disrepute;
- That individual has attended less than [75%] of the meetings of this BD&C Committee in any [12 month] period;
- The individual no longer meets the relevant membership requirement set out at paragraph **Error! Reference source not found.**, for example because they no longer hold a particular post or work for a particular organisation; or

- They qualify for membership of this BD&C Committee through their host organisation and that host organisation leaves the Place Partnership.

18. Amendments

This BD&C Committee may propose changes to its terms of reference to the Partnership Board.

Any changes to these terms of reference must be approved by the Partnership Board.

19. Review date

These terms of reference shall be reviewed annually.

20. Implementation

These terms of reference come into effect on 01/07/2022

ANNUAL REPORT 2023-24

Partnership Leadership Executive

INTRODUCTION

This Bradford District and Craven (BdC) management forum, the 'Partnership Leadership Executive' (PLE) is part of the West Yorkshire Integrated Care System,

The PLE has two roles:
The first is to support the ICB on issues within its remit. If this Partnership Management Forum makes decisions on behalf of the ICB (see section 4 below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this Partnership Management Forum.

The second is to support the wider Place Partnership, which comprises the ICB and various other organisations, on issues within the Partnership Management Forum's remit. This support is provided by advising and working collaboratively with all members of the Partnership, who come from these other organisations.

MEMBERSHIP

Member	
Mel Pickup	Place Based Lead, CEO BTHFT (Chair)
Therese Patten	CEO BDCFT
Richard Haddad	Chair, Clinical Advisory Board.
Iain MacBeath	Strategic Director of Health and Wellbeing (CBMDC)
Sam Keighley	VCSE Sector Lead and CEO of VCS Alliance
David Crampsey	Chair of BdC Clinical Forum/ Deputy CEO (ANHSFT)
Charlotte Ramsden	CEO Bradford Children and Families Trust
Louise Bestwick	CEO Bradford Care Association Ltd
Kersten England	CEO, (CBMDC) until June 2023
Lorraine O' Donnell	CEO, (CBMDC) From July 2023
Foluke Ajayi	CEO, Airedale NHS Foundation Trust
Marium Haque	Strategic Director - Children's Services (CBMDC)
Sarah Muckle	Director Public Health
Dannielle Hann	Medical Director and Deputy Chair, LMC
Richard Webb Louise Wallace	North Yorkshire Council (Only 1 person needs to attend)
Phil Hubbard Karen Dawber Amanda Stanford	Directors of Quality and Nursing (Distributed leadership) (only 1 person needs to attend)
Mike Woodhead	System Finance Director

In addition, regular attendees (not members) include:

Nancy O'Neill	Director partnership delivery/COO, BdC HCP
James Drury	Director partnership development, BdC HCP
Robert Maden	Director system finance, BdC HCP

Dr Louise Clarke	Director strategy and transformation, Primary & Community, BdC HCP
Sue Baxter	Assistant Director, Governance and Assurance, BdC HCP
Shak Rafiq	Associate Director Communications and Involvement, BdC HCP
Alison Bullock	PA/Partnership Manager, BdC HCP

MEETINGS HELD

28/04/23	25/08/23	22/12/23
26/05/23	22/09/23	26/01/24
23/06/23	27/10/23	23/02/24
28/07/23	24/11/23	22/03/24

ATTENDANCE

Member		meetings eligible to attend	% Meetings attended (out of 12 meetings)
Mel Pickup	Place Based Lead, CEO BTHFT (Chair)	12	66%
Therese Patten	CEO BDCFT	12	66%
Richard Haddad	Chair, Clinical Advisory Board.	12	50%
Iain MacBeath	Strategic Director of Health and Wellbeing (CBMDC)	12	91%
Sam Keighley	VCSE Sector Lead and CEO of VCS Alliance	12	100%
David Crampsey	Chair of BdC Clinical Forum/ Deputy CEO (ANHSFT)	12	75%
Charlotte Ramsden	CEO Bradford Children and Families Trust	12	58%
Louise Bestwick	CEO Bradford Care Association Ltd	12	100%
Kersten England	CEO, (CBMDC) until June 2023	3	0%
Lorraine O' Donnell	CEO, (CBMDC) From July 2023	9	22%
Foluke Ajayi	CEO, Airedale NHS Foundation Trust	12	66%
Marium Haque	Strategic Director - Children's Services (CBMDC)	12	66%
Sarah Muckle	Director Public Health	12	58%
Dannielle Hann	Medical Director and Deputy Chair, LMC	12	75%
Richard Webb Louise Wallace	North Yorkshire Council (Only 1 person needs to attend)	6	66%
Phil Hubbard Karen Dawber Amanda Stanford	Directors of Quality and Nursing (Distributed leadership) (only 1 person needs to attend)	10	100%
Mike Woodhead	System Finance Director	12	91%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2023 – 24

- Commented on a business cases proposals for Wellbeing Hubs, Virtual Ward, Trusted Care Assessors
- Received an update on Primary Care services, the challenges faced by them and the work underway to transform services. PLE gave commitment to support this work.

- Received updates on the NHS Operational plan and budget 2023/24 final submission.
- Received regular updates from the Priorities and Enables
- Received regular updates on the Partnership Risk Register
- Received regular updates on Finance and subsequently setting up a dedicated Close the Gap group to focus on how we can reduce our financial deficit.
- Supported a proposal from the Diabetes Transformation Programme around a PCN Model of Care
- Supported the Better Care Fund plan for 2023-24
- Approved the Planning and Commissioning Forum Terms of Reference
- Supported an Independent review by Centre for Mental Health
- Commented on the Intermediate Care Services Review
- Requested a Task and Finish approach to address Digital and Data issues
- Received and update on the Care Quality Commission Assurance Process of Councils – and adult social care 3-year plan
- Invited North Yorkshire to become a member
- Invited Directors of Quality to become members
- Commented on the System response to CQC inspections of maternity services
- Discussed the Special Education Needs and or Disabilities (SEND) Legislation and responsibilities.
- Supported an extension of 12 months to the reducing inequalities projects contracts
- Discussed VCSE Sector Sustainability and how they can be supported
- Received an update on Care Quality Commission (CQC) approach to systems, social care, Local Authorities
- Supported a proposal for continue Distributed leadership (for Director of Quality) for a further 12 months.
- approved the award of the contract for Specialist Mental Health Support to Ethnically & Culturally Diverse Communities
- supported the development of a new model of wellbeing, counselling and therapeutic support for children, young people.
- Approved the recommendations from the Panel for Financial Decisions around Reducing Inequalities in Communities projects, MyCare24COPD, Virtual Ward beds and Wellbeing Hubs.
- Supported a proposal to reprofile investment of Bradford District and Craven VCSE infrastructure funding.
- Requested a workshop was held to clarify responsibilities around delivery of the vaccine programme.
- supported a proposal to work collaboratively with partners to produce the District Strategy 2025-2035.

AREAS FOR DEVELOPMENT IN 2024 – 25

- Terms Of Reference will be reviewed to ensure strengthened oversight on the ‘Closing the Gap’ work/Business case approval process.
- Invite the Director Population Health and Inequalities to become a member to strengthen links with inequalities and Equality, diversity and inclusion
- Continue to develop the relationship between PLE and the Priorities and Enablers
- Further refine the metrics and information that PLE regularly receives to enable it to be well informed in leading the delivery of our partnership plan.

Terms of reference – Bradford District and Craven Partnership Leadership Executive

Version control

Version:	2.0
Approved by:	Bradford District and Craven Health and Care Partnership Board
Date Approved:	1 September 2023
Responsible Officer:	James Drury, Partnership Development Director
Date Issued:	25 August 2023
Date to be reviewed:	by 1 September 2024

Change history

Version number	Changes applied	By	Date
1.0	Approved	Partnership Board	12 July 2022
1.1	Draft - addition to membership of PLE	PLE	01 November 2022
1.2	Membership, reporting in Groups, alignment with the SORD and other minor changes	Sue Baxter	30 May 2023
1.3	For PLE review	PLE	23 June 2023
2.0	For PB approval	PB	25 August 2023

1. General

This Bradford District and Craven Health and Care Partnership ("the Partnership") management forum, the 'Partnership Leadership Executive' is part of the West Yorkshire Integrated Care System, which has four core purposes:

- improving population health and healthcare
- tackling unequal outcomes and access
- enhancing productivity and value for money and
- helping the NHS to support broader social and economic development

The ICS has identified a set of guiding principles that shape everything we do:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible

The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire
- We support each other and work collaboratively
- We act with honesty and integrity, and trust each other to do the same
- We challenge constructively when we need to and
- We assume good intentions

We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

In these Terms of Reference the following capitalised terms are given the meaning set out in the NHS West Yorkshire Integrated Care Board Constitution as updated from time to time, unless the context otherwise requires:

- Conflict of Interest Policy
- Constitution
- Standing Order or Standing Orders

Other capitalised terms have the meaning set out below:

- “Attendee” refers to a participant of this Partnership Management Forum as listed in section 6
- “Chair” means the chair of this Partnership management forum
- “ICB” means the NHS West Yorkshire Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated
- “ICB Business” has the meaning given to it at section 4
- “ICB Policies” means any policy, process or procedure formally adopted by the ICB
- “Member” refers to a member of this Partnership Management Forum as listed in section 5
- “NHS Foundation Trust Partner” means Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and/or Bradford Teaching Hospitals NHS Foundation Trust
- “Partner” refers to a partner organisation in the Place Partnership which is also a party to the SPA
- “Partnership Business” has the meaning given to it at section 4
- “Partnership Board” means the Bradford District and Craven ICB Committee as described in the Constitution
- “Place Lead” means that individual appointed by the ICB to oversee and help develop the Place Partnership
- “Place Partnership” means the partnership of organisations described in the SPA
- “SPA” means the Strategic Partnering Agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Bradford district and Craven
- “Working Days” means a weekday that is not a bank holiday in England
  “Written Resolution Procedure” is the written resolution procedure described at section 10

This Partnership Management Forum shall operate in accordance with the vision, objectives and principles set out in the terms of reference of the Partnership Board. When advising or making decisions on behalf of the ICB, it will comply with relevant ICB policies.

The ICB Standing Orders shall apply to this Partnership Management Forum unless these Terms of Reference expressly make alternative provision that they do not.

2. Reports to

This Partnership Management Forum reports to the Partnership Board. Members and Attendees may also report back to their respective Partner organisations.

3. Purpose

This Partnership Management Forum has two roles.

The first is to support the ICB on issues within its remit. If this Partnership Management Forum makes decisions on behalf of the ICB (see section 4 below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this Partnership Management Forum.

The second is to support the wider Place Partnership, which comprises the ICB and various other organisations, on issues within the Partnership Management Forum's remit. This support is provided by advising and working collaboratively with all members of the Partnership, who come from these other organisations.

If this Partnership Management Forum considers that there is or may be a conflict between these two roles then the Chair shall notify the Partnership Board Chair.
In practice, this Partnership Management Forum carries out both roles by reporting to the Partnership Board, which comprises senior leaders from the Place Partnership and is a committee of the ICB.

4. Remit and responsibilities

The remit of this Partnership Management Forum is to:

a) Make the following decisions on behalf of the ICB, following delegation of this responsibility from the ICB to the Partnership Board and from the Partnership Board to this Partnership Management Forum:

   i. Approve the place operating structure
   ii. Agree place action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
   iii. Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money in place and support wider goals of development and sustainability
   iv. Develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within the ICB and place plan
   v. Develop arrangements for risk sharing and /or risk pooling with other organisations (for example pooled budget arrangements under section 75 of the NHS Act 2006), for approval by the ICB Board
   vi. Agree implementation in place of the arrangements for complying with the NHS Provider Selection Regime

vii. Arrange for the provision of health services in line with the allocated resources across the ICS through a range of activities including:
   a. putting contracts and agreements in place to secure delivery of its plan by providers
   b. convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes.
   c. support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships, including through investment in PCN management support, data and digital capabilities, workforce development and estates.
   d. working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care

viii. Commission services that the Partnership Board agrees require acting on to deliver on the Partnership's priorities and ambitions for people, including putting contracts and agreements in place to secure delivery of its plan by providers

ix. Agree clinical pathways, clinical thresholds, service specifications and service standards for matters that **do not** meet one or more of the '3 tests' for working at scale.

x. approve decisions on the review, planning and procurement of primary medical care services (to reflect the terms of the delegation agreement with NHS England).

b) Provide advice and/or recommendations in the following areas to the Partnership Board, for the benefit of the ICB ((a) and (b) together "ICB Business"):
   i. establish governance arrangements to support collective accountability between partner organisations for place-based system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations
   ii. agree a plan to meet the health and healthcare needs of the population within each place, having regard to the Partnership integrated care strategy and place health and wellbeing strategies
   iii. allocate resources to deliver the plan in each place, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital)
   iv. Make arrangements to implement in place ICB risk management arrangements.

5. Members

Members contribute to discussion, participate in decision making and are accountable for decisions made. If a matter goes to a vote, then each Member has one vote save that the Chair shall have a casting vote, as set out in section 10.

The Members of this Management Forum are:

- The Bradford District and Craven Health and Care Partnership place lead, who shall be the chair of the Partnership Leadership Executive (note the current place lead is also the chief executive of Bradford Teaching Hospitals NHS FT)
- The chief executive of Airedale NHS FT
- The chief executive of Bradford District Care NHS FT
- The chief executive of City of Bradford Metropolitan District Council
- The strategic director of adult social care and health of City of Bradford Metropolitan District Council
- The director of public health of City of Bradford Metropolitan District Council
- The director of children's services of City of Bradford Metropolitan District Council
- The chair of the Partnership Clinical Advisory Board
- The medical director of the Local Medical Committee
- The chair of the Clinical Forum
- The chief executive of the Bradford Care Association
- The Voluntary, Community, and Social Enterprise Sector System Lead
- The chief executive of Bradford Children and Families Trust

6. Attendees

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

The Attendees are:

- The Chief Operating Officer of the Partnership
- The lead primary care director for the Partnership (currently the director of strategy and transformation of the Partnership)
- The lead finance director of the Partnership
- joint director of quality and nursing of the BD&C Health & Care Partnership (a role shared by the chief nursing officers for the three Trusts)
- The Director of Partnership Development of the Partnership
- The Strategic Communications and Engagement Lead of the Partnership

- PLE Administrative Support

The Chair may invite such other Attendees to attend any meeting of this Partnership Management Forum as the Chair considers appropriate.

Any individual wishing to attend a meeting of this Partnership Management Forum should make a request to the Chair by writing to alison.bullock2@bradford.nhs.uk, to be received at least three Working Days to the meeting. Attendance is at the Chair's discretion.

7. Deputies

With the permission of the Chair, a Member may nominate a deputy to attend a meeting of the Management Forum that the Member is unable to attend. The deputy may speak and vote on their behalf. The decision of the meeting Chair regarding acceptance of nominated deputies is final.

Any requests for a deputy to be appointed should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

Any reference to Member in these terms of reference includes a deputy appointed in accordance with this paragraph.

8. Chair

The Chair of this Partnership Management Forum shall be the Place Leader.

If the Chair is unable to attend a meeting or carry out the role of the Chair between meetings then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.

References to Chair shall be read accordingly.

9. Quoracy

No decisions shall be made unless at least 50% of the Members are present.

If a meeting is or becomes inquorate, this will be minuted. Members may discuss matters but no formal decisions will be made. Any discussions will be summarised at the start of the next meeting of this Partnership Management Forum.

The expectation of the Partners is that this Partnership Management Forum will meet regularly as scheduled. The Partners recognise that even if a meeting is not quorate, useful discussions may take place. However, if the Chair has received apologies for a meeting in advance that indicate that a quorum will not present, the Chair may cancel the meeting if they are satisfied that this is the more appropriate use of Members' time.

An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

10. Conduct of meetings

Meetings of this Partnership Management Forum will be run by the Chair.

Meetings may be conducted via video conferencing, or face to face, to be determined by the Chair on a case by case basis.

Where a meeting is held face to face the expectation is that Members will attend the meeting in person. However, the Chair shall have discretion to permit a Member or Attendee to participate in a meeting by telephone, video or by other electronic means where they are available and the Chair is satisfied that there is good reason for the request, such as clinical commitments. Participation by any of these means shall be constitute presence in person at the meeting provided all Members and Attendees in attendance can be heard and hear one another.

Any request to participate in a meeting by telephone, video or by other electronic means should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

It is expected that decisions will be reached by consensus. Should this not be possible, each Member will have one vote, the process for which is set out in the section below:

a. All Members of this Partnership Management Forum who are present at the meeting will be eligible to cast one vote each
b. Absent members may not vote by proxy. Absence is defined as being present at the time of the vote but this does not preclude anyone attending by

teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. However, they are able to appoint a deputy in accordance with section 7

c. A resolution will be passed if more votes are cast for the resolution than against it
d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote
e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting

If the Chair considers it appropriate, decisions may also be taken through the Written Resolution Procedure set out below:

a. The Chair will arrange for an email to be written that:
    - confirms the resolution(s) that the Members are being asked to approve
    - includes, by way of an attachment, all of the relevant information to enable the Member to reach a decision on the proposal(s)
    - contains the deadline (date and time) for response that shall be at least ten Working Days from the date of the email and
    - confirms the email address to which the Member's vote should be sent.
b. The Chair will arrange for the email and accompanying documents to be sent by e-mail to all Members on the same date
c. Each Member shall reply to the designated email address by the deadline given setting out whether they accept, reject or abstain in relation to each resolution set out in the email. Once a Member has responded stating they accept, reject or abstain in relation to a resolution they may not amend or retract their vote

The Chair may also require that a meeting take place entirely by telephone, video or by other electronic means where there is good reason to do so, for example the difficulties of managing hybrid meetings or public health concerns.

Exceptions:

d. The following decisions may not be taken by way of the Written Resolution Procedure: none

Passing the written resolution:

e. In order for the written resolution to be passed the quorum rules must be complied with. If any Member does not respond to a resolution proposed by the Written Resolution Procedure by the deadline given they are not present for the purpose of the quorum. Responses received after the deadline will be disregarded

f. Provided the quorum requirements have been complied with a resolution will be passed if the majority of Members responding by the deadline approve the resolution.

g. The Chair will arrange for Members to be notified of the outcome of the Written Resolution Procedure within five Working Days of the deadline

h. The outcome of all uses of the Written Resolution Procedure will be recorded in the papers for the next meeting. This will include details of votes approving or rejecting each resolution, any abstentions and details of any Member that did not respond by the deadline

11. Frequency of meetings

This Partnership Management Forum will meet at least ten times per year. Usually, it will meet on a monthly basis on the fourth Friday of each month.

The Chair may call an additional meeting at any time by giving not less than 10 Working Days' notice in writing to all Members and Attendees.

The Partnership Board may require that this Partnership Management Forum meet within a reasonable timeframe to discuss a particular matter. Such requests should be submitted to the Chair.

Members and Attendees shall be given at least ten Working Days' notice of any meeting save that in emergency situations the Chair may call a meeting with three Working Days' notice by setting out the reason for the urgency and the decision to be taken. Papers shall be circulated at least two Working Days before the meeting.

12. Urgent decisions

In the case of urgent decisions needed in extraordinary circumstances, every attempt will be made for this Partnership Management Forum to meet. Where this is not possible the following will apply:

a. The decision-making responsibilities which are delegated to this Partnership Management Forum, may for an urgent decision be exercised by the Place Lead. The Chair shall also consult the Chair of the Partnership Board.

b. The exercise of such powers shall be reported to Members by email within 2 Working Days.

c. The exercise of such powers shall be reported to the next formal meeting of this Partnership Management Forum for formal ratification, where the Chair will explain the reason for the action taken, and report the decision to the Partnership Board for oversight.

Extraordinary circumstances will usually be unforeseen and be such that either calling an extraordinary meeting or using the Written Resolution Procedure will not be appropriate.

13. Admission of the press and public

This Partnership Management Forum shall meet in private. Minutes of its proceedings will be reported to the Partnership Board.

14. Declarations of interest

If any Member or Attendee has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible before the meeting and act in accordance with the ICB Conflicts of Interests Policy.

The Chair will determine how a conflict of interest should be managed in accordance with the Conflicts of Interests Policy, taking into account any previously agreed arrangements for managing a conflict of interest. The Chair may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

15. Support to the Management Forum

Administrative support will be provided to this Partnership Management Forum by the place team of the NHS West Yorkshire ICB. This will include:

- Agreement of the agenda with the Chair
- Sending out agendas and supporting papers to Members and Attendees at least five Working Days before the meeting
- Taking minutes of the meetings, including an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward.
- Drafting minutes for comment and approval by the Chair within five Working Days of the meeting. Following Chair's approval, distributing the minutes to all

Members and Attendees within five Working Days of the approval. Updating minutes in accordance with any amendments agreed at subsequent meetings

- Maintaining an on-going list of actions, specifying the Member(s) responsible for each action, due dates, progress and completion
- Maintaining an annual work plan and
- Receiving notifications and requests on behalf of the Chair, including notifications relating to conflicts of interest, requests for meetings and/or nomination of deputies

Notifications and requests to the Chair must be sent to Alison.Bullock2@bradford.nhs.uk

It is the responsibility of Members and Attendees to ensure that they provide their contact details to the Chair (email and direct dial telephone number) and keep these up to date.

Papers will be circulated electronically. Members or Attendees wishing to receive the papers in a particular format (e.g. large print, hard copy) should make a request to the Chair. The Chair has discretion as to whether to meet the request.

16. Authority

The Partnership Leadership Executive is authorised to commit finances of the Partnership up to the value prescribed in the Standing Financial Instructions (SFIs). Financial decisions taken by the Partnership Leadership Executive shall be reported to the Partnership Board at least annually.

Where decisions are required on values in excess of the limit set out in the SFIs, the Partnership Leadership Executive shall make a recommendation to the Partnership Board, and the Partnership Board shall take the decision.

This Partnership Management Forum is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires within its remit, from any member of staff of a Place Partner and Place Partners will ensure that their staff are directed to co-operate with any such request made by this Partnership Management Forum.

This Partnership Management Forum is authorised to commission any reports or surveys it considers necessary to help it fulfil its obligations. In doing, so, this Partnership Management Forum must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This Partnership Management Forum is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, this Partnership Management Forum must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This Partnership Management Forum is authorised to create and dissolve time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, this Partnership Management Forum must set clear a clear scope of work and deadline for completion for such groups. Such groups shall not be able to take decisions on behalf of this Partnership Management Forum.

This Partnership Management Forum has the working groups listed below, which report to it. These working groups exist to support this Partnership Management Forum and are not time-limited. This Partnership Management Forum shall determine their membership, scope and work programme and ensure that these are recorded in writing, regularly reviewed and understood by all participants. A working group may be created or dissolved by this Partnership Management Forum.

Groups reporting to this Partnership Management Forum are:

- Planning and Commissioning Forum
- Partnership Leadership Team
- Primary Care Assurance Group

Priority groups

- Healthy Communities
- Access to Care
- Healthy Minds
- People Development
- Children, Young People and Families

Enablers

- Reducing Inequalities alliance (reducing inequalities)
- Digital information and intelligence programme board (digital, Data Intelligence and insight)
- Living well
- Research and innovation
- Estates

17. Reporting

This Partnership Management Forum shall submit its minutes to each Partnership Board meeting. These shall be published by the Partnership Board as part of its meeting papers.

The Chair shall draw to the attention of the Partnership Board any significant issues or risks relevant to the Place Partnership or the ICB.

This Partnership Management Forum shall submit an annual report to the Partnership Board.

This Partnership Management Forum shall propose an annual work plan to the Partnership Board for approval by the Partnership Board. The Partnership Board may make such changes to the annual work plan as it considers appropriate in consultation with the Chair.

This Partnership Management Forum will receive for information the minutes of other meetings which are captured in the Management Forum's work plan e.g. minutes of its working groups.

For reporting to PLE from all 13 groups:

- quarterly progress reports and annual deep dives from priorities and enablers
- annual reports from PLT, PCF and PCAG

18. Conduct of the Committee

All Members and Attendees will operate within the Constitution of the ICB, standing orders, standing financial instructions, other financial procedures and ICB Policies provided always that this requirement may be disapplied by the Partnership Board in relation to Partnership Business, such authorisation to be given in advance and in writing.

All Members and Attendees will operate in accordance with the SPA and any other relevant policies or documents agreed by the Partnership Board.

All Members and Attendees will attend and complete any training required by the Chair or the Partnership Board

Members and Attendees must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new decision or recommended approach achieves positive change around inclusion, equality and diversity.

Members and Attendees will abide by the 'Principles of Public Life' (The Nolan Principles)

The requirements listed above in relation to conduct of Members and Attendees shall also apply to members of any working groups or task and finish groups reporting to this Partnership Management Forum.

The Management Forum shall undertake an annual self-assessment of its own performance against the annual work plan, these terms of reference and the Strategic Partnering Agreement (SPA). This self-assessment shall form the basis of the annual report from this Partnership Management Forum to the Partnership Board.

The Partnership Board may remove an individual Member from this Partnership Management Forum if:

- That individual fails to comply with these terms of reference
- That individual has behaved in a way, or is threatening to behave in a way, that is likely to bring this Partnership Management Forum, the Partnership Board and/or the ICB into disrepute
- That individual has attended less than [75%] of the meetings of this Partnership Management Forum in any [12 month] period
- The individual no longer meets the relevant membership requirement set out at section 5, for example because they no longer hold a particular post or work for a particular organisation or
- They qualify for membership of this Partnership Management Forum through their host organisation and that host organisation leaves the Place Partnership

19. Amendments

This Partnership Management Forum may propose changes to its terms of reference to the Partnership Board.

Any changes to these terms of reference must be approved by the Partnership Board.

20. Review date

These terms of reference shall be reviewed annually.

21. Implementation

These terms of reference come into effect on 01/09/2023

Bradford District & Craven- Clinical Forum

ANNUAL REPORT 2023-24

INTRODUCTION

The Bradford District & Craven Clinical Forum has two roles.

The first is to support the ICB on issues within its remit. If this BD&C Forum makes recommendations on behalf of the ICB (see section 5 below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this BD&C Forum.

The second is to support the wider Place Partnership, which comprises the ICB and various other organisations, on issues within the BD&C Forum's remit. This support is provided by advising and working collaboratively with all members of the Partnership Board, who come from these other organisations.

If this BD&C Forum considers that there is or may be a conflict between these two roles, then the Chair shall notify the Place Lead.

In practice, this BD&C Forum carries out both roles by reporting to the Partnership Board, which comprises senior leaders from the Place Partnership and is a Forum of the ICB and the ICB Clinical Forum.

MEMBERSHIP

The membership of the forum comprises:

- David Crampsey (Chair) - Deputy Chief Executive | Executive Medical Director ANHSFT
- David Sims - Medical Director & representative from BDCT
- Ray Smith - Chief Medical Officer & representative from BTHT
- Louise Clarke - Clinical commissioner representative
- Sohail Abbas - - Clinical commissioner representative and Deputy MD (ICB)
- Phillipa Hubbard – CNO and Nursing & Quality Lead from BDCT
- Amanda Stanford – CNO and Nursing & Quality Lead from ANHSFT
- Karen Dawber – CNO and Nursing & Quality Lead from BHFT
- One Allied Health Professional representative from each Trust - TBC

- Richard Haddad (BCA), Danielle Hann (LMC), Sara Humphrey, & Stephen Patterson (LMC) - representatives of GP at scale practice
- Sarah Muckle - Director of Public Health
- Iain Macbeath - Strategic Director, Health and Wellbeing (BMDC)- Bradford Metropolitan District Council – Social Care
- TBC - Representative Community Pharmacy West Yorkshire
- Sohail Abbas - representative the Inequalities Alliance
- From April 2023 has included representatives from Optometry and Dental

In addition – attendees include

- John Hartley – Assistant Director Quality Improvement - BdC Health and Care Partnership
- James Drury Programme Director Executive Board - BdC Health and Care Partnership (Up to December 2023)
- Michael McCooe - Associate Medical Director BTHFT, Improvement Academy
- Claire Kilburn - Head of Medicines Optimisation - BdC Health and Care Partnership
- Himanshu Garg - Associate medical director/ consultant psychiatrist (BDCFT)
- Ciaran O'Neill - Leadership fellow - Improvement academy
- Raj Billoo - Optometry
- Chris Davey - Optometry, Secretary of LOC
- Victoria Turner - Public health representative - NYCC
- Jaspreet Sohal - Chief Pharmacist BDCFT
- Carrie Haywood - Senior Governance Manager BdC Health and Care Partnership
- Natalie Cooper Illingworth - Principal Social Worker - NYCC
- Iram Amin Quality Team - BdC Health and Care Partnership
- Alison Bullock - PA/Partnership Manager BdC Health and Care Partnership

MEETINGS HELD

11th April 2023
10th May 2023
13th June 2023
8th August 2023
13th September 2023
10th October 2023
8th November 2023
10th January 2024
13th February 2024
13th March 2024

ATTENDANCE

Member	Job Title	Attendance (number of meetings attended)	Attendance (% out of 10 meetings)
Bev Denton	Governance Manager (BdC P'Ship)	5	50%
Carrie Haywood	Senior Governance Manager (BdC)	9	90%
Chris Davey	Optometry, Secretary of LOC	0	0%
Ciaran O'Neill	Leadership fellow at Improvement academy	2	20%
Claire Kilburn	Head of Medicines Optimisation (BdC P'Ship)	2	20%
Dannielle Hann	GP and Deputy Chair of Bfd YORLMC Ltd	7	70%
David Crampsey	Deputy CEO Medical Director (ANHSFT) **(Chair)**	8	80%
David Simms	Medical Director (BDCFT)	8	80%
Himanshu Garg	Associate medical director/ consultant psychiatrist (BDCFT)	4	40%
Iain Macbeath	Strategic Director, Health, and Wellbeing (BMDC)	0	0%
Iram Amin	Quality Team (BdC P'Ship)	6	60%
James Drury	Programme Director Executive Board (BdC P'Ship)	0	0%
Jaspreet Sohal	Chief Pharmacist (BDCFT)	7	70%
Jo Hilton	Deputy Chief Nurse, BTHFT	1	10%
John Hartley	Assistant Director of Quality Improvement (BdC P'Ship)	8	80%
Jon Lee	AHP (ANHSFT)	0	0%
Karen Dawber	Chief Nurse, BTHFT	0	0%
Louise Clark	GP/Strategic Clinical Director (BdC P'Ship)	0	0%
Martin Flint-Johnson	Armed Forces Advocate	0	0%
Michael McCooe	Associate Medical Director BTHFT, (BHIR)	5	50%
Natalie cooper Illingworth	Principal Social Worker (N Yorks)	0	0%
Nicola Goodberry Kenneally		2	20%
Phil Hubbard	Associate Director of Quality (BdC P'Ship)	1	10%
Prabdheep Sidhu		1	10%
Raj Billoo	Optometry	0	0%
Ray Smith	Medical Director (BTHFT) (BdC P'Ship)	2	20%
Richard Haddad	CEO CAB (GP)	1	10%

Sara Humphrey	GP/ACD/frailty, dementia, and LD	6	60%
Sharonjit Kaur	PA, BDC	4	40%
Sohail Abbas	Deputy Clinical Chair and Strategic Clinical Director Population Health & Wellbeing (BdC P'Ship)	5	50%
Steve Patterson	Chair of Bfd YORLMC Ltd	5	50%
Victoria Turner	Public health N Yorks	2	20%
Jorge Zepeda	Head of Public Health, Health Protection & Health Improvement BMDC	1	10%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2023 – 24

A number of areas of work have been received, discussed and supported within 2023/2024. These include.

- Learning From Medication Related Deaths
- Training on Learning Disability and Autism - The Oliver McGowan Mandatory training
- Health Equity Fellows - their story, the projects they worked on individually, and how their skill sets might be utilised.
- Listen In feedback and how this might be used to inform improvements in service provision.
- Deep dives into specific areas which gave insight into the identified areas. This enabled support from the system and an opportunity for learning and sharing.
- Information sharing from other meetings as papers from the WY ICB Clinical Forum were circulated within the pack.
- Providing regular updates to the Partnership Board in relation to activities and items within the forums remit via the AAA updates.
- Supporting a clinically led approach to Closing the Gap work

AREAS FOR DEVELOPMENT IN 2024 - 25

- Ongoing discussions regarding representation from ophthalmology and dentistry, and now including the potential for Health Care Scientist representation.
- To provide clinical expertise to the upcoming "closing the gap" work
- Future planned areas of review include:
    - Medicines management
    - Born in Bradford and Connected Bradford
    - Workforce update
    - Structured Judgement reviews (annual update)
    - Update on impact of Health and Social Care service provision on emergency departments
    - Update on Shared care

Terms of Reference: Bradford District and Craven Clinical Forum

Version control

Version: 2

Approved by: BdC Partnership Board

Date Approved: TBC

Responsible Officer: John Hartley, Assistant Director Quality Improvement

Date Issued: 1 August 2022

Date to be reviewed: 1 April 2025

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	John Hartley	02 August 2022
0.2	Transfer to Accessible version	Carrie Haywood	14 September 2022
03.	Updated with final feedback	John Hartley	10 October 2022
1	Approved	Bd&C Partnership Board	
1.2	Annual Review 2023 - draft	John Hartley	27 September 2023
2	Approved	Bd&C Partnership Board	10th November 2023

Bradford District and Craven Clinical Forum Terms of Reference

1. Introduction

The Bradford District and Craven Health and Care Partnership Clinical Forum ('the Forum) is established as a group of the NHS West Yorkshire Integrated Care Board (ICB), in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation.

2. General

In these Terms of Reference the following capitalised terms are given the meaning set out in the NHS West Yorkshire Integrated Care Board Constitution as updated from time to time, unless the context otherwise requires:

- West Yorkshire ICB Conflict of Interest Policy
- West Yorkshire ICB Constitution
- West Yorkshire Standing Order or Standing Orders

Other capitalised terms have the meaning set out below:

- "Attendee" refers to a participant of this BD&C Committee as listed in paragraph 7
- "BD&C Forum" refers to this Forum.
- "Chair" means the chair of this BD&C Forum
- "ICB" means the NHS West Yorkshire Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated.

- “ICB Business” has the meaning given to it at paragraph 5 below - “ICB Committee” means a committee of the ICB.
- “ICB Policies” means any policy, process or procedure formally adopted by the ICB.
- “Member” refers to a member of this BD&C Forum as listed in paragraph 6.
- “NHS Foundation Trust Partner” means Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and/or Bradford Teaching Hospitals NHS Foundation Trust
- “Partner” refers to a partner organisation in the Place Partnership which is also a party to the SPA.
- “Partnership Business” has the meaning given to it at paragraph 5 below.
- “Partnership Board” means the Bradford District and Craven ICB Committee as described in the Constitution.
- “Place Lead” means that individual appointed by the ICB to oversee and help develop the Place Partnership
- “Place Partnership” means the partnership of organisations described in the SPA
- “SPA” means the Strategic Partnering Agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Bradford District and Craven
- “Working Days” means a weekday that is not a bank holiday in England
- “Written Resolution Procedure” is the written resolution procedure described at paragraph 11 below.
- This BD&C Forum shall operate in accordance with the vision, objectives and principles set out in the terms of reference of the BD&C Partnership Board. When advising or making recommendations on behalf of the ICB, it will comply with relevant ICB policies.
- The ICB Standing Orders shall apply to this BD&C Forum unless these Terms of Reference expressly make alternative provision that they do not

3. Reports to

This BD&C Committee reports to BD&C Partnership Board and the ICB Clinical Forum.

Members and attendees may also report back to their respective Partner organisations.

4. Purpose

This BD&C Forum has two roles.

The first is to support the ICB on issues within its remit. If this BD&C Forum makes recommendations on behalf of the ICB (see section 5 below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this BD&C Forum.

The second is to support the wider Place Partnership, which comprises the ICB and various other organisations, on issues within the BD&C Forum's remit. This support is provided by advising and working collaboratively with all members of the Partnership Board, who come from these other organisations.

If this BD&C Forum considers that there is or may be a conflict between these two roles, then the Chair shall notify the Place Lead.

In practice, this BD&C Forum carries out both roles by reporting to the Partnership Board, which comprises senior leaders from the Place Partnership and is a Forum of the ICB and the ICB Clinical Forum.

5. Remit and responsibilities

The remit of this BD&C Forum is to:

a) Make the following decisions on behalf of the ICB, following delegation of this responsibility from the ICB to the Partnership Board and from the Partnership Board to this BD&C Forum: None currently delegated.
b) Provide advice and/or recommendations in the following areas to the Partnership Board, for the benefit of the ICB ((a) and (b) together "ICB Business"):

- Actively participating in the development of a clinical strategy and associated narrative for Bradford District and Craven
- Ensuring that all plans within the Bradford District and Craven are clinically led, evidence based, and configured to improve patient and population outcomes.
- Ensuring the voice of the patients, service users and citizens is heard and reflected in all clinical forum discussions.
- Maintaining and embedding clinical co-production as a core principle of the partnership.
- Supporting collaboration and strengthening partnerships between clinical colleagues.
- Exhibiting clinical leadership and galvanising professional colleagues and partner organisations to agree models of care which support delivery to close the three gaps (health, care and finance) in Bradford District and Craven.
- Championing change and evidence-based innovation within organisations and at Place.
- Supporting the transition to new models of care, where appropriate.
- Providing oversight and alignment of all clinical initiatives across Bradford District and Craven and across West Yorkshire ICS.
- Supporting regular communication and engagement with all stakeholders
- Supporting through review the evaluation and impact of all workstreams and plans
- Providing innovative solutions to system-wide challenges, particularly where there are interdependencies between workstreams (including enablers) and local plans.
- Providing input and support to the clinical representation on each of the workstreams.
- Providing a clinical lens on system performance on the quality of health and care services and providing a mechanism for partner organisations to hold each other to account on quality, making appropriate links with other committees in place to support the work of the partnership.

c) Provide advice to other members of the Partnership Board “Partnership Business”:

6. Members

Members contribute to discussion, participate in making recommendations and are accountable for the dissemination of information back into their host organisation as required.

The Members of this Forum are:

Senior clinicians (normally clinical commissioners, GPs, medical directors, directors of nursing, senior allied health professionals) nominated by the relevant organisation or partnership group.

The membership will comprise:

- A Chair
- Medical Director /representative from BDCT
- Medical Director /representative from AFT
- Medical Director /representative from BTHT
- Clinical commissioner representative
- One Nursing / Quality Lead from BDCT
- One Nursing / Quality Lead from AFT
- One Nursing / Quality Lead from BHFT
- One Allied Health Professional representative from each Trust
- 1-4 representatives of GP at scale practice (e.g., GP at scale practices/ federation /Locality CDs)
- One Director of Public Health
- One representative from Bradford Metropolitan District Council – Social Care
- One representative from Community Pharmacy West Yorkshire & one pharmacist representing provider Trusts.
- One representative from Local Medical Committee
- One representative from the Inequalities Alliance
- One representative from Optometry and one representative Dental
- One representative – Healthcare Scientist

A deputy Chair will be agreed from among nominated members.

The first Members of this BD&C Forum shall be appointed by the BD&C Partnership Board. There is no specific term of membership for this forum, any terms will be agreed on an individual basis should this be required.

7. Attendees

The following individuals will be invited to attend each meeting of this BD&C Forum as Attendees. Attendees attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote.

The Attendees of this Forum are:

- Assistant Director Quality Improvement - BD&C Health and Care Partnership
- Head of Research – West Yorkshire Integrated Care System

The Chair may invite such other Attendees to attend any meeting of this BD&C Forum as the Chair considers appropriate.

Any individual wishing to attend a meeting of this BD&C Forum should make a request to the Chair by writing to Assistant Director Quality Improvement or member of the partnership administration team (administrators to the Forum) to be received at least three Working Days prior to the meeting. Attendance is at the Chair's discretion.

8. Deputies

In accordance with Standing Order [4.7], with the permission of the Chair, a member may nominate a deputy to attend a meeting of the Forum that the Member is unable to attend. The deputy may speak on their behalf. The decision of the meeting Chair regarding acceptance of nominated deputies is final.

Any requests for a deputy to be appointed should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

Any reference to Member in these terms of reference includes a deputy appointed in accordance with this paragraph.

9. Chair

The Chair of this BD&C Forum shall be selected as follows.

The first Chair of this BD&C Forum shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.

Subsequent Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by this BD&C Forum, for the avoidance of doubt candidates are permitted to vote in such selections.

One person may not serve more than three consecutive terms as Chair.

If the Chair is unable to attend a meeting or carry out the role of the Chair between meetings this shall be taken on by the Deputy Chair.

The Deputy Chair of this BD&C Forum shall be selected as follows.

The first Deputy Chair of this BD&C Forum shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.

Subsequent Deputy Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by this BD&C Forum, for the avoidance of doubt candidates are permitted to vote in such selections.

One person may not serve more than three consecutive terms as Deputy Chair.

If both the Chair and the Deputy Chair are absent then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.

10. Quoracy

No recommendations shall be made unless at least half the members are present.

If a meeting is or becomes inquorate, this will be minuted. Members may discuss matters, but no formal recommendations will be made. Any discussions will be summarised at the start of the next meeting of this BD&C Forum.

The expectation of the Partners is that this BD&C Forum will meet regularly as scheduled. The Partners recognise that even if a meeting is not quorate, useful discussions may take place. However, if the Chair has received apologies for a meeting in advance that indicate that a quorum will not present, the Chair may cancel the meeting if they are satisfied that this is the more appropriate use of Members' time.

An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

11. Conduct of meetings

Meetings of this BD&C Forum will be run by the Chair.

The expectation is that Members will attend meetings in person.

However, in accordance with Standing Order 4.8, the Chair shall have discretion to permit a Member or Attendee to participate in a meeting by telephone, video or by other electronic means where they are available and the Chair is satisfied that there is good reason for the request, such as clinical commitments. Participation by any of these means shall be constitute presence in person at the meeting provided all Members and Attendees in attendance can be heard and hear one another.

Any request to participate in a meeting by telephone, video or by other electronic means should be made to the Chair at least five working days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

The Chair may also require that a meeting take place entirely by telephone, video or by other electronic means where there is good reason to do so, for example the difficulties of managing hybrid meetings or public health concerns.

In line with the Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each Member will have one vote, the process for which is set out in the section below:

a. All Members of this BD&C Forum who are present at the meeting will be eligible to cast one vote each.
b. Absent members may not vote by proxy. Absence is defined as being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. However, they are able to appoint a deputy in accordance with paragraph 8.
c. A resolution will be passed if more votes are cast for the resolution than against it.
d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote.
e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

If the Chair considers it appropriate, recommendations may also be made through the Written Resolution Procedure set out below:

a. The Chair will arrange for an email to be written that:

- confirms the resolution(s) that the Members are being asked to approve;
- includes, by way of an attachment, all of the relevant information to enable the Member to reach a decision on the proposal(s);
- contains the deadline (date and time) for response that shall be at least ten Working Days from the date of the email; and
- confirms the email address to which the Member's vote should be sent.

b. The Chair will arrange for the email and accompanying documents to be sent by e-mail to all Members on the same date.

c. Each Member shall reply to the designated email address by the deadline given setting out whether they accept, reject or abstain in relation to each resolution set

out in the email. Once a Member has responded stating they accept, reject or abstain in relation to a resolution they may not amend or retract their vote.

Exceptions:

d. The following decisions may not be taken by way of the Written Resolution Procedure:
None

Passing the written resolution:

a. In order for the written resolution to be passed the quorum rules must be complied with. If any Member does not respond to a resolution proposed by the Written Resolution Procedure by the deadline given they are not present for the purpose of the quorum. Responses received after the deadline will be disregarded.
b. Provided the quorum requirements have been complied with a resolution will be passed if the majority of Members responding or all Members who responded by the deadline approve the resolution.
c. The Chair will arrange for Members to be notified of the outcome of the Written Resolution Procedure within five Working Days of the deadline.
d. The outcome of all uses of the Written Resolution Procedure will be recorded in the papers for the next meeting. This will include details of votes approving or rejecting each resolution, any abstentions and details of any Member that did not respond by the deadline.

12. Frequency of meetings

This BD&C Forum will meet at least once in any three-month period.

The Chair may call an additional meeting at any time by giving not less than 10 Working Days' notice in writing to all Members and Attendees.

The Partnership Board may request or require that this BD&C Forum meet within a reasonable timeframe to discuss a particular matter. Such requests should be submitted to the Chair.

Members and Attendees shall be given at least ten Working Days' notice of any meeting save that in emergency situations the Chair may call a meeting with three Working Days' notice by setting out the reason for the urgency and the decision to be taken. Papers shall be circulated at least two Working Days before the meeting.

13. Urgent decisions

Not applicable

14. Admissions of the press and public

Not applicable

15. Declarations of interest

If any Member or Attendee has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible before the meeting and act in accordance with the Conflicts of Interests Policy.

The Chair will determine how a conflict of interest should be managed in accordance with the Conflicts of Interests Policy, taking into account any previously agreed arrangements for managing a conflict of interest. The Chair may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

16. Support to the committee

Administrative support will be provided to this BD&C Forum by the Assistant Director Quality Improvement or nominated member of the partnership administration team. This will include:

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

Notifications and requests to the Chair must be sent to either john.hartley@bradford.nhs.uk or Beverley.Denton@bradford.nhs.uk

It is the responsibility of Members and Attendees to ensure that they provide their contact details to the Chair (email and direct dial telephone number) and keep these up to date.

Papers will be circulated electronically. Members or Attendees wishing to receive the papers in a particular format (e.g. large print, hard copy) should make a request to the Chair. The Chair has discretion as to whether to meet the request.

17. Authority

This BD&C Forum is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires within its remit, from any member of staff or a Place Partner and Place Partners will ensure that their staff are directed to co-operate with any such request made by this BD&C Forum.

This BD&C Forum is authorised to commission any reports or surveys it considers necessary to help it fulfil its obligations. In doing, so, this BD&C Forum must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Forum is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, this BD&C Forum must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Forum is authorised to create and dissolve time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, this BD&C Forum must set clear a clear scope of work and deadline for completion for such groups. Such groups shall not be able to take decisions on behalf of this BD&C Forum.

This BD&C Forum has no working groups, which report to it. Should specific working groups be required to support this BD&C Forum they will not be time-limited. This BD&C Forum shall determine their membership, scope and work programme and ensure that these are recorded in writing, regularly reviewed and understood by all participants. A working group may be dissolved by the BD&C Forum but permanent working groups cannot be created by this BD&C Forum without the agreement of the Partnership Board, as outlined below.

This BD&C Forum may not create any formal sub-Forums, delegate any of its responsibilities or establish any permanent working groups unless expressly authorised by the Partnership Board. Even if any delegation is approved, this BD&C Forum remains accountable for the work that is delegated.

18. Reporting

This BD&C Forum shall provide an update as required to agreed Partnership Board meetings. These shall be published by the Partnership Board as part of its meeting.

The Chair shall draw to the attention of the Partnership Board any significant issues or risks relevant to the Place Partnership or the ICB.

This BD&C Forum shall submit an annual report to the Partnership Board.

This BD&C Forum shall propose an annual work plan to the Partnership Board for approval by the Partnership Board. The Partnership Board may make such changes to the annual work plan as it considers appropriate in consultation with the Chair.

This BD&C Forum will receive for information the minutes of other meetings which are captured in the Forum's work plan e.g. minutes of its working groups.

19. Conduct of the Forum

All Members and Attendees will operate within the Constitution of the ICB, standing orders, standing financial instructions, other financial procedures and ICB Policies provided always that this requirement may be disapplied by the Partnership Board in relation to Partnership Business, such authorisation to be given in advance and in writing.

All Members and Attendees will operate in accordance with the SPA and any other relevant policies or documents agreed by the Place Board.

All Members and Attendees will attend and complete any training required by the Chair or the Partnership Board

Members and Attendees must demonstrably consider the equality and diversity implications of recommendations they make and consider whether any new recommended approach achieves positive change around inclusion, equality and diversity.

Members and Attendees will abide by the 'Principles of Public Life' (The Nolan Principles)

The requirements listed above in relation to conduct of Members and Attendees shall also apply to members of any working groups or task and finish groups reporting to this BD&C Forum.

The Forum shall undertake an annual self-assessment of its own performance against the annual work plan, these terms of reference and the SPA. This self-assessment shall form the basis of the annual report from this BD&C Forum to the Partnership Board.

The Partnership Board may remove an individual Member from this BD&C Forum if:

- That individual fails to comply with these terms of reference;
- That individual has behaved in a way, or is threatening to behave in a way, that is likely to bring this BD&C Forum, the Partnership Board and/or the ICB into disrepute;
- That individual has attended less than 75% of the meetings of this BD&C Forum in any 12 month period;
- The individual no longer meets the relevant membership requirement set out at paragraph 6, for example because they no longer hold a particular post or work for a particular organisation; or
- They qualify for membership of this BD&C Forum through their host organisation and that host organisation leaves the Place Partnership

20. Amendments

This BD&C Forum may propose changes to its terms of reference to the Partnership Board.

Any changes to these terms of reference must be approved by the Partnership Board.

21. Review date

These terms of reference shall be reviewed annually.

22. Implementation

These terms of reference come into effect on 01 August 2022

Meeting name:	Partnership Board
Agenda item no:	
Meeting date:	17 May 2024
Report title:	Partnership governance effectiveness & efficiency – proposal for longer-term partnership governance arrangements
Report presented by:	Sue Baxter, Head of Partnership Governance
Report approved by:	Nancy O'Neill, Director of Partnership Delivery
Report prepared by:	Sue Baxter, Head of Partnership Governance

Purpose and Action			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate	Information ☐

Previous considerations:

- PLE scoping partnership governance efficiency work - 27 October 2023
- PB Development Session – partnership governance efficiency and effectiveness – 12 December 2023
- ICB Executive – partnership governance efficiency – progress update 28 February 2024
- PB Development Session – leaders as one acting as one 25 April 2024

Executive summary and points for discussion:

Bradford District and Craven Health and Care Partnership (BDC HCP) governance arrangements have been established since July 2022, building on local partnership arrangements since the introduction of sustainability and transformation partnerships in 2016, integrated care systems in 2018 and the signing of the BDC HCP Strategic Partnering Agreement in 2019.

In the course of the current ICB operating model review it has been highlighted that in addition to reviewing the optimum size of our local ICB staff teams, we should take the opportunity to drive efficiencies in the way our local partnership governance arrangements operate. The scope of this review was to:

i. develop a proposal for longer term partnership governance arrangements

ii. streamline BDC Health and Care Partnership meeting arrangements

iii. explore the ambition of delegation of budgets and decision making to two of the five Priority Programme Boards: healthy minds and healthy communities

iv. explore joined up partnership support for integration

v. ensure necessary capacity and support for our Distributed Leadership model

The partnership governance effectiveness and efficiency action plan **(Appendix 1)** provides detailed description of progress to-date. This action plan was overseen by a time limited task and finish group, and the group met monthly from January 2024 to June 2024.

Recommendations from the action plan and work carried out to-date:

1. to consider and agree the preferred option as option 2 stand down the People Committee and re-distribute responsibilities to other boards, committees and groups
2. be advised that Sarah Jones (chair of BTHFT) will become the Partnership Board 'chief listening officer'
3. Note the timeline for the new CoBMDC district plan and the delayed review for the PLE and WBE
4. Note the interim arrangement to proactively manage the PLE and WBE meeting forward planners, to mitigate overlap where it is appropriate to do so
5. Be advised of the development of the Adults Joint Commissioning Group and the shared learning with CoBMDC colleagues
6. Note further work to explore equivalent mechanism for NYC childrens' to be taken forward into 2024/25
7. Be advised of the additional Closing the Gap Programme Board (management group), which will report into the Partnership Leadership Executive and
8. Note the changes to the Strategic Partnering Agreement Financial Governance Framework, reflecting the new closing the gap programme board responsibilities in relation to business cases
9. Note the changes to the decision flowchart
10. Be advised of the reform and re-establishment of the Primary Care Strategy and Assurance Group
11. Reduction of Trust Non-Executives from six down to two and alignment of tenure with individuals Trust tenure, and tenure of independent chair to 30 June 2025

12. Note the refreshed Strategic Partnering Agreement and update Governance Handbook will be submitted for approval in September 2024 Partnership Board meeting
13. All future roles to be overseen by the reconstituted partnership vacancy control panel
14. bring learning back from Welsh Health Board and liaise with WY Governance arrangements and partnership governance leads to inform improvements in connectivity with audit and assurance
15. Associate Director of Communications and Involvement to lead the publication on act-as-one partnership website the partnership's contribution to the NHS West Yorkshire ICB annual report for 2023/24
16. Note the Quality Committee approach to the Thirwall inquiry
17. Note the pausing of the ambition to delegate budget and decision making to priority boards and
18. Consider lessons learnt from the review of distributed leadership

Outline how this supports our partnership vision and strategy

Our Purpose - all working to the same goal, for our population to have more chances to lead healthier lives.

Our Population - supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - making our district a great place to live, work and thrive.

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

Recommendation(s)

The Partnership Board is asked to:

1. Receive and note the partnership governance effectiveness and efficiency steering group action plan, note progress to-date and give consideration to the eighteen recommendations outlined above.

In particular, take decisions on

2. People Committee - to consider and agree the preferred option as option 2 stand down the People Committee and re-distribute responsibilities to other boards, committees and groups
3. Reduction of Trust Non-Executives from six down to two and alignment of tenure with individuals Trust tenure, and tenure of independent chair to 30 June 2025

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Risk Register? If yes, please detail which:
N/A
Appendices
1. Governance effectiveness and efficiency action plan v5.0 – 2 May 2024 2. Partnership Governance – Committee structure proposed changes 3. People Committee – proposal (supporting evidence for option 2) 4. SPA financial governance framework – changes to accommodate closing the gap 5. Decision flowchart – changes to accommodate closing the gap

Partnership governance effectiveness & efficiency, a proposal for longer-term partnership governance arrangements

1.0 Introduction

Bradford District and Craven Health and Care Partnership (BDC HCP) governance arrangements have been established and fully operational since July 2022. Building on local partnership arrangements since the introduction of sustainability and transformation partnerships in 2016, integrated care systems in 2018 and the signing of the BDC HCP Strategic Partnering Agreement in 2019.

During the course of the current ICB operating model review it was highlighted that in addition to reviewing the optimum size of our local ICB staff teams, we could take the opportunity to drive efficiencies in the way our local partnership governance arrangements operate. Therefore, the primary purpose of the partnership governance effectiveness and efficiency work is to identify and implement these efficiencies. In addition, in the course of discussing these opportunities with colleagues several other pertinent points were suggested which broadened the scope, to encompass:

The scope of this review included:

i. develop a proposal for longer term partnership governance arrangements
ii. streamline BDC Health and Care Partnership meeting arrangements
iii. explore the ambition of delegation of budgets and decision making to two of the five Priority Programme Boards: healthy minds and healthy communities
iv. explore joined up partnership support for integration and
v. ensure necessary capacity and support for our Distributed Leadership model

The partnership governance effectiveness and efficiency action plan **(Appendix 1)** provides a detailed description of progress to-date against each objective, setting out actions taken. This work was overseen by a time limited task and finish group, and the group has been meeting monthly from January 2024 to June 2024.

2.0 Streamline partnership governance arrangements (Appendix 2)

2.1 Governance structure changes

2.1.1 **Partnership Board** (place committee of the ICB Board)

The Partnership Board will reduce its meetings in public from six per year (bi-monthly) to four per year (quarterly). There will be six development sessions per annum. In total

partnership board will come together ten times per annum (August and December no meeting or development session).

2.1.2 People Committee

There are two options for consideration,
Option 1: reduce the number of people committees to quarterly
Option 2: stand down the - People committee and redistribute it's responsibilities **(Appendix 3)**, as follows:

- Quality committee * (responsibilities: iv & xv)
- Finance and performance committee # (responsibilities: i, iv, viii, ix & xv)
- People development priority programme board (responsibilities: ii, iii, v, vi, xi, xii, xiii, xiv & xv)
- PLT (responsibilities: vii)
- HRDs informal Monday meetings (responsibilities: x)

Notes:

* Quality committee: would require membership to change to include as a minimum an HR Director and Priority Programme Board Assistant Director

Finance and performance committee: discharge people committee responsibilities quarterly with meeting forward planner tailored to include people committee responsibilities, and would require membership to change to include as a minimum an HR Director and Priority Programme Board Assistant Director

The two options were explored at the development session on the 25 April, where there was a clear acknowledgement that the People Committee had made great strides and undertaken some fantastic work. The Partnership Board would not wish to lose the momentum that has built, however, there was acceptance that the Finance and Performance Committee and Quality Committee, along with the People Development Priority Board would be well placed to continue the legacy left by the People Committee. The People Committee chair described how NEDs would join the People Priority Board deep-dive workshops at least twice, but up to four times each year. Therefore, tacit agreement was that the People Committee could cease.

Recommendation:

- **to consider and agree the preferred option as option 2 stand down the People Committee and re-distribute responsibilities to other boards, committees and groups.**

2.1.3 Clinical Forum

Will remain meeting at the same frequency (monthly) with a change of name to the **Clinical and Professional Forum**.

2.1.4 Citizens' Forum

Will reduce frequency from monthly to quarterly and a change of name to the **Citizens' Voice Forum** (involve patients and the public, under section 13Q of the National Health Service Act 2006).

The board-level 'chief listening officer' will be Sarah Jones, Chair of Bradford Teaching Hospitals NHS Trust (BTHFT) who will champion for patient and public involvement on the Partnership Board.

Recommendation:

- **be advised that Sarah Jones (chair of BTHFT) will become the Partnership Board 'chief listening officer'**

2.1.5 Partnership Leadership Executive and Wellbeing Executive

Discussion to clarify the intended remit and scope of the Wellbeing Executive (WBE), BDC HCP Partnership Board, and Partnership Leadership Executive (PLE), in response to feedback of overlap between these groups. In addition, consideration of potential for integrated committee secretariat support arrangements for these groups, with the intention of delivering efficiency and coherence. It was recognised that although there is overlap, there is significant difference is the scope, accountabilities and responsibilities of these decision making fora.

With CoBMDC development of the new district plan phase 1: January to November 2024 and phase 2: November 2024 to April 2025, CoBMDC will review Wellbeing Executive to fit with this timeline. In the interim, a proactive approach to utilisation of the PLE and WBE meeting forward planners will be compared (monthly), to mitigate overlap, where appropriate, during this time.

Recommendations:

- **Note the timeline for the new CoBMDC district plan and the delayed review for the PLE and WBE**
- **Note the interim arrangement to proactively manage the PLE and WBE meeting forward planners, to mitigate overlap where it is appropriate to do so**

2.1.6 North Yorkshire Council (NYC)

On 1 April 2023 a new **unitary council** was formed for North Yorkshire, replacing the county council and seven former district and borough councils (Craven, Harrogate, Hambleton, Scarborough, Richmondshire, Ryedale and Selby). The newly established Adults Joint Commissioning Group is overseeing the Better Care Fund and development of the section 75 agreement membership from partnership includes two Priority Programme Board Directors Finance. Shared learning with the CoBMDC and NYC has been facilitated in relation to the section 75 agreement and approach to the Planning and Commissioning Forum. Discussion with NYC colleagues that have responsibilities for Childrens has yet to take place.

Recommendations:

- **Be advised of the development of the Adults Joint Commissioning Group and the shared learning with CoBMDC colleagues**
- **Note further work to explore equivalent mechanism for childrens' to be taken forward into 2024/25**

2.1.7 Financial challenge – closing the gap

The role of the 'Closing the Gap Programme Board', is a collaborative programme in response to the extreme financial challenges that face the health and care system in Bradford District and Craven. Our goal is to deliver a balanced net system financial position. The deficit plan at Place is £71million (April 2024). In summary, this Programme Board will be the assurance mechanism to demonstrate that every opportunity and action to move to a balanced financial position has been taken.

In order to streamline the process, membership is drawn from the partnership including members of the Finance and Performance Committee (FPC) and Quality Committee (QC). This programme board will take full responsibility for prioritising and assessing business cases and make recommendations to the Partnership Leadership Executive and / or Partnership Board. Although the FPC and QC have role in monitoring, they will not have a role in prioritisation or making recommendations to the PLE and / or PB in relation to business cases. Underpinning work such as quality and equality impact assessments will be undertaken and reviewed as part of the closing the gap programme board approach.

Recommendations:

- **Be advised of the additional Closing the Gap Programme Board (management group), which will report into the Partnership Leadership Executive and**

- **Note the changes to the Strategic Partnering Agreement Financial Governance Framework, reflecting the new closing the gap programme board responsibilities in relation to business cases – Appendix 4**
- **Note the changes to the decision flowchart – Appendix 5**

2.1.8 Primary Care Assurance Group

From 1 July 2022 a Primary Care Assurance Group had been meeting and although this meeting had paused, the requirement to oversee primary care (primary medical services, dentistry, community pharmacy and optometry is delegated by NHS England to the Integrated Care Board). Therefore, the proposal is to reform and re-establish a group locally to discharge this responsibility. With a name change to **Primary Care Strategy and Assurance Group** and meetings reducing to quarterly.

Recommendation

- **Be advised of the reform and re-establishment of the Primary Care Strategy and Assurance Group**

2.2 Trust Non-Executive Directors

Tenure of the six Trust NEDs was extended to the 31 July 2024 to afford the time to undertake the review of partnership governance arrangements.

In the five places across the West Yorkshire Integrated Care System the majority of places have two non-executive members and one independent chair. With six we are an outlier, the proposal is to harmonise with the other places and to stand down the deputy for each of the place committees, thereby reducing the number of non-executives to the chair's of the place committees. Further, should option 2 for the people committee be the preferred option then this would reduce the requirement for a chair. Thereby, reducing the number of Trust Non-Executives from six to two.

Upon agreement then alignment of committee chair's tenure will move to in-line with individual' Trust tenure. Tenure of the independent chair to be extended to align with other place chairs' tenure to 30 June 2025.

Recommendation

- **Reduction of Trust Non-Executives and alignment of tenure with individuals Trust tenure, and tenure of independent chair to 30 June 2025.**

2.2 Strategic Partnering Agreement (SPA) and the Partnership Governance Handbook

Following on from this review the SPA and the Governance Handbook will be refreshed/updated and submitted to the September 2024 Partnership Board meeting.

1. Partnership governance diagram - updated
2. Wider governance partnership arrangements inc priorities and enablers diagrams - developed
3. Scheme of reservation and delegation – underway
4. Decisions function map – updated
5. Decision flowchart – updated
6. Management guide explaining the partnership governance arrangements – drafted
7. Terms of reference updated/developed to take account of changes - underway

Recommendation:

- **Note the refreshed Strategic Partnering Agreement and update Governance Handbook will be submitted for approval in September 2024 Partnership Board meeting**

2.3 Strengthening governance arrangements:

2.3.1 Nominations

Strengthening partnership governance arrangements in relation to nomination to partnership job roles, establish partnership nomination committee to oversee appointment process for key roles of non-executives, executives and place lead. Going forward the ICB staff vacancy control panel to be re-constitute in-line with code of governance principals to become the partnership's vacancy control panel.

Recommendation:

- **All future roles to be overseen by the reconstituted partnership vacancy control panel.**

2.3.2 audit and assurance

Strengthening partnership governance arrangements in relation to assurance, in the absence of a partnership Audit Committee. Also give consideration to links with Provider Audit & Risk / Governance Committees. Head of Partnership Governance to observe a Welsh Health Board Audit Committee 20 June 2024 with the aim of improving communication between WY groups and BDC HCP.

Recommendation:

- **bring learning back from Welsh Health Board and liaise with WY Governance arrangements and partnership governance leads to inform improvements in connectivity with audit and assurance.**

2.3.3. transparency – annual report and accounts

In the absence of a requirement for annual report, accounts and Annual General Meeting and to strengthen transparency with the public regarding the activities of the partnership. We aim to publish the place contribute to the NHS West Yorkshire ICB's annual report and accounts. This is being led by the partnership's Associate Director Communications and Involvement.

Recommendation:

- **Associate Director of Communications and Involvement to lead the publication on act-as-one partnership website the partnership's contribution to the NHS West Yorkshire ICB annual report for 2023/24**

2.3.4 Thirwall inquiry

The partnership's system quality committee (SQC) have given due consideration to local learning from the Thirlwall Inquiry. On the 25 January 2024 the SQC discussed local maternity services under "Hot Topics / Urgent Issues". It was highlighted there had been Local Maternity and Neonatal Services (LMNS) and Care Quality Commission (CQC) visits within partner organisations. The three-year Maternity and Neonatal Services Delivery Plan roll out was also noted and has been discussed within Chief Nurse and Medical Director meetings. The SQC agreed to a future deep dive on maternity services to discuss the challenges, shared learning and opportunities of the new three-year Maternity and Neonatal Services Delivery Plan. This LMNS deep dive will involve peer review colleagues.

Recommendation:

- **Note the Quality Committee approach to the Thirwall inquiry**

3.0 delegation of budget and decision making to priority boards

A stated ambition of the partnership governance effectiveness and efficiency work was an ambition to explore further delegation to Priority Boards in line with our aim of making the Priorities the engines of our collaboration. This ambition initially set

explored two of the five Priority Programme Boards: healthy minds and healthy communities.

Given the financial challenge and the proposal to establish the Closing the Gap Programme Board, this ambition has been paused.

Recommendation

- **Note the pausing of the ambition to delegate budget and decision making to priority boards.**

4.0 Joined up partnership support for integration

In relation to the issue of overlap between Partnership Leadership Executive and Wellbeing Executive and consideration of potential for integrated committee secretariat support arrangements for these groups. This objective has been covered in more detail under section 2.1.5.

During 2023/24 North Yorkshire Council have established an Adults Joint Commissioning Group whose responsibility it is to oversee the Better Care Fund and development of the section 75 agreement. Discussion with NYC colleagues that have responsibilities for Childrens has yet to take place. This objective has been covered in more detail under section 2.1.6.

5.0 Review of distributed leadership

On 1 July 22 we established our partnership governance arrangements and adopted a distributed leadership approach, with an agreement to review within two years. The key question of our shared leadership approach is do we have sufficient capacity and support to deliver our collective and shared ambition of acting as one to keep people happy, healthy at home. With delegation of over £1b annually to our partnership this delegation is based on the delivery against our four primary purposes:

- Improving outcomes in population health, healthcare and wellbeing;
- Tackling inequalities in outcomes, experience and access;
- Enhancing productivity and value for money; and
- Supporting broader social and economic development.

5.1 Place leader

Place leader who is also one of the Chief Executives - Mel Pickup sat on the NHS West Yorkshire Integrated Care Board and took delegated responsibility for Bradford District and Craven Health and Care Partnership. The Place leader has direct

accountability to the CEO of the ICB Rob Webster and supports individual partnership directors as follows:

- leadership and direction on behalf of the Partnership of their individual area of work
- personal support of an individual – coaching, mentoring, guiding, supporting, advocating, developing and
- holding an individual to account for the delivery of their objectives on behalf of the partnership through an individual performance management process and ensuring they do likewise with their teams.

From the 1 May 2024 Mel Pickup will step down as place lead and Therese Pattern will pick up this leadership role.

5.2 Partner members – leading

Leaders from across our partner organisations have taken responsibilities for partnership business including functions, priorities and enablers.

5.3 Distributed leadership review – method

Due to the explorative nature of this evaluation a qualitative semi-structured interview with senior leaders is the approach. Interviews took place via Microsoft Teams, these interviews included open appreciative inquiry questions to illicit key insights, and themes. A sample of 20 individuals were invited to participate from a total of 59 leaders, with 10 selected from the PB/PLE membership and 10 selected from regular attendance at PB/PLE. 17 / 20 (85%) response rate.

5.3.1 Meaning of the partnership's leadership approach

In Bradford District and Craven

Our leadership spirit offers autonomy, empowerment, and responsibility at all levels.

Our leadership practice means seeing others' perspectives, developing supportive relationships, and bringing people together.

Our people have permission to contribute the best of their knowledge, their skills, and their ideas.

By offering equal partnership, we foster innovation, collaboration, and agility.

It's how we do things around here.

#ActAsOne

5.3.1 Key themes

A summary visualising themes and setting out key messages and detailed extracts was shared with PLE and PB members at the Partnership Board development session on the 25 April 2024.

5.3.3 our partnership's vision

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.

5.3.4 key messages from the review

- **Citizens' voice:** "Listen in, has been a good example", of one of the partnership's key strengths
- **The chair facilitating and setting the tone of the Partnership Board**: at the beginning of the Partnership Board meetings, you meet somebody new and understand something and you have something in common. That's established teams and networks (collaboration and improved relationships and understanding)
- **Leadership**: it's about investing in our leadership, developing the distributed leadership approach, considering the capacity of our leaders and investing in our future leaders at all levels for now and the future. Seeking greater transparency in relation to processes for nomination into leadership roles within the partnership

- **Partners coming together**: gaining greater perspective from different lenses and developing a deeper understanding of one another and the collaboration, creativity, shared opportunities and challenges we have
- **How we make decisions:** recognition of the complexity of governance within three levels West Yorkshire, places and sovereign organisations and seeking to improve effective information flow throughout our governance arrangements. Streamlined governance arrangement to support robust decision making, inclusive of all partners is important to us. Our partnership has dual decision making: **Partnership Board** sets and gathers assurance on the partnership strategy and **Partnership Leadership Executive** delivers the strategy.
- **Our focus is set to change due to our financial challenge**: acting as one in the delivery our strategy, recognising the focus has shifted to address the burning platform and the importance of closing the financial gap and moving to a burning ambition. This change may lead to a reframing of focus and activity within our five priority programmes and five enabler programmes
- **New leaders & new operating model**: take some time for a partnership reset as a period of stability is needed, due to changes in both key leadership roles within the partnership and changes resulting from the new operating model and
- **An accountable and responsible partnership:** Recognising the role of the regulators in holding the system and the partners to account and strengthening the partnership's approach to mutual accountability and peer to peer challenge

5.3.5 key messages in a little more detail under each appreciative inquiry question

- **What's working well**
  - act as one is really something that unites us, our relationships are strong
  - you get a much broader understanding of the challenges to each of the other organisations that we work collaboratively with and you're no longer just part of an organisation, being part of a system in a different way
  - actually the distributed leadership model is slightly different in that you are accountable for what's going on at place as well as in your organisation
  - how we listen to our populations
- **Strengths of the model**
  - Bradford district and Craven is very collaborative, the ways that we've worked here in bringing partners together and that it's just the way that we do things here

- Accepting that a good leadership team, is not just about nodding and agreeing with everything. It's being able to have that critical tension where we can have meaningful debates and dialogue with the common purpose in mind
- putting patients at the heart of what we do because we're able to address problems collectively rather than individually

- **Things to make it stronger**
  - the physical capacity of leaders is stretched more than we've ever really encountered it before
  - We want to make sure that where we do have to do things differently and make cuts or efficiencies, we absolutely do not do that to the detriment of our most vulnerable people and communities
  - Understanding how we are going to make the difficult decisions that we have to make to achieve the necessary impact that's going to make a difference quickly. In order to achieve this, we need to be more challenging of each other, and have a tougher accountability framework
  - Turn commitments in to actions / change
  - Recognise the benefits of the partnership and power of doing things together even when organisation pressures are high
- **Right people, with right jobs and permission to act**
  - the more distributed leadership filters through our organisations and particularly those that hold patient or public facing roles, the more that we will empower people to be able to step out of organisational silos. That should enable a huge step change in how that feels for our population's experience of our services because we will then naturally get much more integration of services.
  - first of all, that's the bit that's quite liberating then for colleagues at all levels in the organisation to know that they've got the permission to work in what is a very different way than they might have worked historically
  - bringing in an approach similar to the North Yorkshire Council team sheet concept – whereby we know "who", our distributed leaders are and information smoothly flows in and out of the system (West Yorkshire), the partnership (Bradford District and Craven) and our sovereign organisations.
- **Open feedback**
  - the overwhelming thing for me say it's we can't survive on our own. We don't think we can do that without being part of and very much integrated in the partnership model. Not from a financial perspective or from a service

perspective and therefore partnering is very much for the benefit of our population as an organisation; we very much have to be part of the partnership

- We think there's a real benefit about having health and care together as they're so interlinked and they will be going forward, for everyone involved with the partnership, that's been a really exciting part of what we've been doing
- The crucial bit that the distributed leadership model will only work if we are really challenging one another. It's important that we're still very comfortable with it, you know, a good degree of respectful challenge

Recommendation

- **Consider lessons learnt from the review of distributed leadership**

6.0 Recommendations

1. to consider and agree the preferred option as option 2 stand down the People Committee and re-distribute responsibilities to other boards, committees and groups
2. be advised that Sarah Jones (chair of BTHFT) will become the Partnership Board 'chief listening officer'
3. note the timeline for the new CoBMDC district plan and the delayed review for the PLE and WBE
4. note the interim arrangement to proactively manage the PLE and WBE meeting forward planners, to mitigate overlap where it is appropriate to do so
5. be advised of the development of the Adults Joint Commissioning Group and the shared learning with CoBMDC colleagues
6. note further work to explore equivalent mechanism for childrens to be taken forward into 2024/25
7. be advised of the additional Closing the Gap Programme Board (management group), which will report into the Partnership Leadership Executive
8. note the changes to the Strategic Partnering Agreement Financial Governance Framework, reflecting the new closing the gap programme board responsibilities in relation to business cases – Appendix 4
9. note the changes to the decision flowchart – Appendix 5
10. be advised of the reform and re-establishment of the Primary Care Strategy and Assurance Group

11. reduction of Trust Non-Executives and alignment of tenure with individuals Trust tenure, and tenure of independent chair to 30 June 2025
12. note the refreshed Strategic Partnering Agreement and update Governance Handbook will be submitted for approval in September 2024 Partnership Board meeting
13. all future roles to be overseen by the reconstituted partnership vacancy control panel
14. bring learning back from Welsh Health Board and liaise with WY Governance arrangements and partnership governance leads to inform improvements in connectivity with audit and assurance
15. associate Director of Communications and Involvement to lead the publication on act-as-one partnership website the partnership's contribution to the NHS West Yorkshire ICB annual report for 2023/24
16. note the Quality Committee approach to the Thirwall inquiry
17. note the pausing of the ambition to delegate budget and decision making to priority boards and
18. consider lessons learnt from the review of distributed leadership

Appendix 1: Bradford District and Craven Health and Care Partnership governance effectiveness & efficiency action plan

2 May 2024 v5.0

Owner: Sue Baxter, Assistant Director of Governance and Assurance and Lesley Tillotson, Associate Director (people, patients & resilience)
Senior Responsible Owner: Nancy O'Neill, Chief Operating Officer

The following SPA principles will act as a guide for how we will work together to deliver on the partnership governance efficiency action plan. Partners will work together in good faith and will behave consistently as leaders in ways which model and promote the following shared values:

- exercise leadership for the whole of our Place Partnership, as well as for our individual organisations and for West Yorkshire; behaving in ways which model our shared values;
- understand that we are stewards of the health and care system on behalf of our citizens, now and for future generations; so we will build constructive relationships with communities, groups and organisations for the long term to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing;
- do the work once – duplication of systems, processes and work should be avoided as a wasteful and potential source of conflict; and
- the people named in this partnership governance efficiency plan are representing the partnership and not individual organisations and are expected to act in the best interest of the partnership's population

action plan progress RAG rating key:			
In place/complete	On track - needs monitoring	Off track – close monitoring	Lack assurance/not yet started

GOVERNANCE EFFECIENCY PLAN January – June 2024				
Objective/target	Action	Responsibility	Timescales	Progress
Streamline Partnership Governance arrangements - proposal				
1. Streamline Partnership Governance arrangements – proposal (and progress reporting	1.1 Develop a proposal for PLE and PB setting out options for any major changes to partnership governance arrangements, based on the review of partnership governance arrangements	Nancy O'Neill & Sue Baxter (lead)	May 2024 complete	Proposal will be written for any longer-term changes following review stage – 17 May PB and 24 May PLE.
	1.2 Reporting on progress from the steering group to the ICB Leadership Team	Nancy O'Neill & Sue Baxter	28 February 2 May 2024 25 June 2024 in-progress	bi-monthly reporting on steering group progress will be made to the ICB Executive team
Board and committee meetings efficiency & effectiveness				
2 Bradford District and Craven Health and Care Partnership (BDC HCP) meeting efficiency and effectiveness review supported by annual partnership committee effectiveness review based on CQC Well-led self-assessment (Catherine Smith operational lead) and review of EDS2 and WRES (Kez Hayat)	2.1 Frequency of Partnership Board and committee meetings (agreed quarterly)	Sue Baxter, Laura Ellis & Elaine Appelbee (lead)	1 February 2024 complete	17 January Planning for 2024/25 Committee cycle held. Confirmed the Partnership Board will be Quarterly from 1 April 2024.
	2.2 Membership of Partnership Board (inclusion of University (member) and Quality Executive (attender)	Nancy O'Neill (lead) & Catherine Smith	January - March 2024 complete	CNOs attend on rotation and Marina Bloj approached regarding University member
	2.3 Frequency of Partnership Board development sessions – consider partnership development programme to improve equality of voice and influence from all partners	Elaine Appelbee (lead) & Ash Alom	25 April 2024 complete	Number of development sessions proposal is 6 - agreed

GOVERNANCE EFFECIENCY PLAN January – June 2024				
Objective/target	Action	Responsibility	Timescales	Progress
leadership standards PB, PLE and HWB)	2.4 Role / number of Partnership non-executives linked to Partnership Board and assurance committees • Numbers of Trust NEDs engaged will reduce, with changes to the partnership governance structure and to align with the number of non-execs in other places. Proposal is to reduce from 6 to 2 Trust NEDs.	Nancy O'Neill (lead), Sue Baxter, Ian Corbishley/Laura Ellis	January - April 2024 Complete - subject to proposal paper	Reduce the number of Trust Non-Executives from six to two. Chair of the place assurance committees - Quality Committee - Finance & Performance Committee
	2.5 Number and scope of assurance committees • Quality Committee • Finance and Performance Committee • People Committee • Clinical Forum • Citizens' Voice Forum • Primary Care Strategy & Assurance Group • Closing the Gap Programme Board	Committee/group/ forum chairs and Management lead with Sue Baxter (lead) & Carrie Haywood	Feb / Mar 24 QC 16 Feb FPC 28 Mar PC 22 Feb ClinF 15 Feb CitF 27 Feb PCAG TBC	Structures re-drafted to reflect changes in: frequency, proposal to reduce assurance committees to two and inc. closing the gap programme board, and primary care strategy & assurance group.

GOVERNANCE EFFECIENCY PLAN January – June 2024				
Objective/target	Action	Responsibility	Timescales	Progress
	2.6 Clarification of accountability to place and to ICB (NHS Constitution, NHS Mandate, NHS Long Term Plan and WY 10 ambitions) • WY SORD and BDCHCP SORD to be updated to reflect any changes resulting from new ways of working/operating model • Decision flowchart and Financial Governance Framework refreshed • Partnership Committee structure drafted • Developed a partnership governance management guide	Sue Baxter & Laura Ellis	April - June 2024 to review updated updated developed	SORD, decision flowchart and committee structure have been refreshed following partnership governance changes and will be included in the next version of the Partnership Governance Handbook
	2.7 Board and Committee agenda, forward planners, papers, minutes and triple A's – clarification of scope to avoid duplication – assessment of quality, compliance with accessibility standard – flow of information (internal and external) – Annual review and report on Triple A reports	Lesley Tillotson (lead BDC HCP admin) and Sue Baxter (lead consolidated governance)	Feb – Mar review complete	Conversation held regarding approach to checking the quality of papers for PLE, PB and sub-committees / groups and forums
	2.8 All partners to consider adopting the NYC "team sheet" approach looking at which boards, committees and groups their representatives are members or attendees of	Sue Baxter, Louise Wallace & Carrie Haywood	25 April 2024 complete	Louise Wallace shared the NYC team sheet – will share as part of PB development session

GOVERNANCE EFFECIENCY PLAN January – June 2024				
Objective/target	Action	Responsibility	Timescales	Progress
	2.9 Strengthening partnership governance arrangements in relation to assurance, nomination and remuneration – in the absence of a partnership Audit Committee and remuneration and nomination committee • consider links with Provider Audit & Risk / Governance Committee • Consider a strengthening of transparency of the process for appointment to senior roles, give consideration to establishment of a Nomination Committee / or equivalent scope group for the partnership	Lesley Tillotson (lead vacancy control panel) & Sue Baxter (lead WY liaison)	Unable to attend in March – re-arranged attendance for the June 2024 Welsh Health Board	Sue Baxter to observe a Welsh Health Board Audit Committee 20 June 2024 and feedback on observations with insights for WY and places forms part of the effectiveness and efficiency proposal paper to PB 17 May
	2.10 Strengthening partnership transparency arrangements – in the absence of a requirement for annual report, accounts and Annual General Meeting	Shak Rafiq (lead), Karen Parkin / Mike Woodhead & Carrie Haywood	draft by end of April and final by June 2024 produce report, September 2024 AGM	Contribution to WY annual report and accounts to be reported on at Partnership Board. Carrie overseeing end of year governance processes.

GOVERNANCE EFFECIENCY PLAN January – June 2024				
Objective/target	Action	Responsibility	Timescales	Progress
	2.11 Application of local learning from the application of the Thirlwall Inquiry 'tests': i. whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her ii. the responses to concerns raised about Lucy Letby from those with management responsibilities within the Trust iii. whether the trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby	Andy Withers (lead), Amanda Stanford, Grainne Eloi, Lesley Tillotson & John Hartley	April 2024 complete	The partnership's system quality committee (SQC) have given due consideration to local learning from the Thirlwall Inquiry. On the 25 January 2024 the SQC discussed local maternity services under "Hot Topics / Urgent Issues
	2.12 annual Board effectiveness to consider an evaluation of diversity • Percentage of BME staff in bands 8-9, VSM (inc executive Board members and senior medical staff) compared with the percentage of BME staff, in the overall workforce • Boards are expected to be broadly representative of the population they serve	Kez Hayat, Carrie Haywood & Sue Baxter/Lesley Tillotson	by end of June 2024 underway	Review being undertaken by Kez Hayat, follow-up meeting on the 9 May 2024

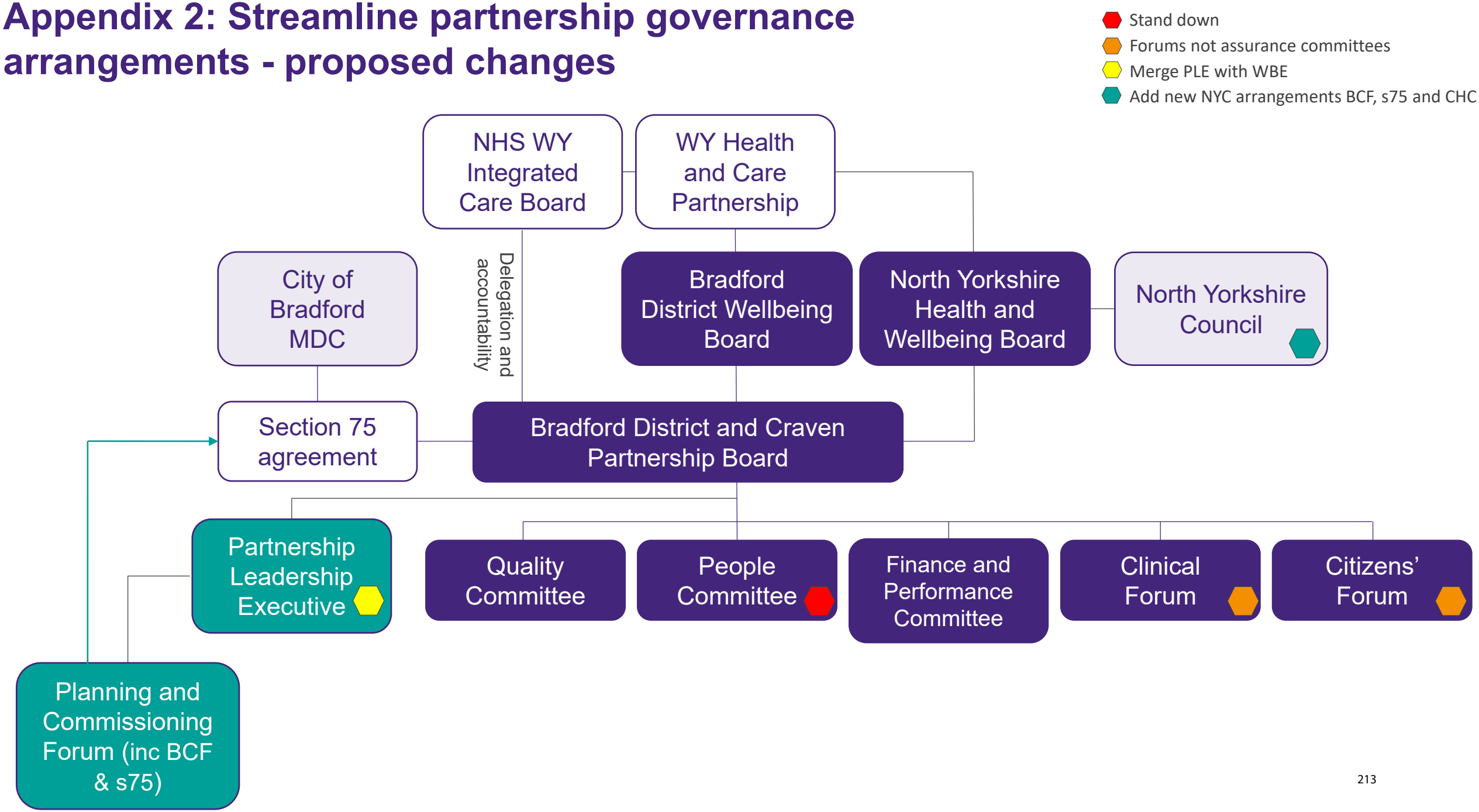
delegation of budget and decision making to Priority Boards				
Objective/target	Action	Responsibility	Timescales	Progress
3 Delegation of decision making to Priority Boards	3.1 Align with the work underway in relation to system finance and Healthy Communities, to guide the ambition. This work is about enabling those intentions.	Louise Clarke (Lead), Foluke Ajayi, Mike Woodhead / Karen Parkin, Esther Venning & Carrie Haywood	From June 2024 not started	this is an ambition for our partnership, however given the financial challenge, not something to pursue at this time
	3.2 Align with the work in Healthy Minds to learn from the Wakefield alliancing model and develop options for a local BD&C Healthy Minds Alliance, or alternative solution	Sasha Bhat (Lead), Iain MacBeath, Fran Stead, Mike Woodhead, Karen Parkin, Kelly Barker, Esther Venning & Carrie Haywood	From June 2024 Not started	this is an ambition for our partnership, however given the financial challenge, not something to pursue at this time

Joined up partnership support for integration				
Objective/target	Action	Responsibility	Timescales	Progress
4 Joined up partnership support arrangements	4.1 Clarify the intended remit and scope of the Wellbeing Executive, BD&C Partnership Board, and PLE, in response to feedback of overlap between these groups. Consider options for integrated support arrangements for these groups, with the intention of delivering efficiency and coherence	Ruth Davison, NYC rep, Sue Baxter (lead), Carrie Haywood & Esther Venning	April 2024 paused to align with timeline for the district plan	Agreed to align potential changes to fit with BMDC district plan timeline. Interim action, proactive management of key meetings forward planners (inc. PLE, PB, WBE & WBB), to support what items are best placed to go where.
	5 Consider options for integrated support arrangements for these groups, with the intention of delivering efficiency and coherence.	Ruth Davison, Sue Baxter & Lesley Tillotson	April 2024	• PB and assurance committees – consolidated Governance team • PLE ICB admin • WBE & WBB CoBMDC

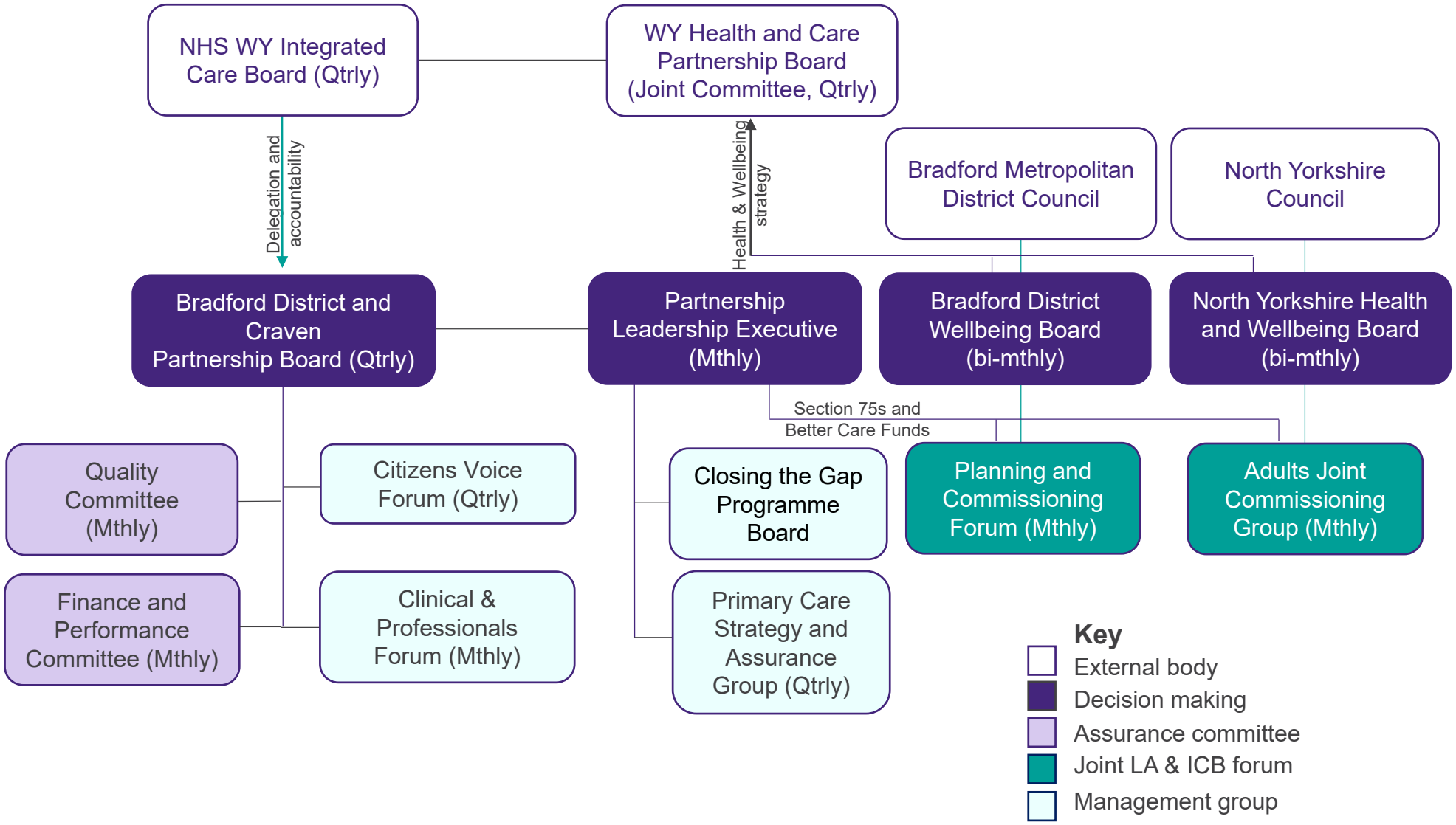
Joined up partnership support for integration				
Objective/target	Action	Responsibility	Timescales	Progress
	5.1 Bring North Yorkshire Council perspective to this partnership effectiveness and efficiency work (regarding Craven)	Karen Seneiki, Sue Baxter/Lesley Tillotson & Ruth Davison	April 2024	Introductory meeting 20 February to discuss this work. Karen agreed to join steering group (from March to June). Sue to set up meeting for Sue/Lesley, Karen & Ruth (May 2024)
	5.2 Consider the impact of the NHS West Yorkshire ICB consolidated model for Corporate Affairs	Laura Ellis (lead), Sue Baxter, Mel Pickup, Nancy O'Neill & Lesley Tillotson	1 April 2024 consolidated Corporate Affairs (inc. Governance) in place	Carrie Haywood, BDC place Governance Manager; and Catherine Smith, Governance Officer. Sue Baxter, Head of Partnership Governance West Yorkshire wide and Bev Denton, governance officer aligned to Calderdale, Kirklees & Wakefield.

review of distributed leadership model				
Objective/target	Action	Responsibility	Timescales	Progress
5. Ensure necessary capacity and support for our Distributed Leadership model	5.3 Listen to the views of those involved in the BD&C Distributed Leadership model (role holders, their employing organisations, their teams, and the partnership)	Sue Baxter (lead), Elaine Appelbee, Nancy O'Neill & Lesley Tillotson	January - April 2024	17 / 20 (85%) participation with distributed leadership review. Interviews completed, transcripts collated and review completed. Key messages prepared for PB Development session 25 April
	5.4 Consider lessons learnt and implement adjustments to the approach if required, including sufficiency of capacity, and availability of support required for success.	Nancy O'Neill, Lesley Tillotson & Sue Baxter (lead)	25 April 2024 Partnership Board Development session	Feedback on proposals around distributed leadership into the PB Development session in April and include relevant learning within PLE & PB proposal see action 1. Detailed report being prepared for 21 May steering group meeting.

Appendix 2: Streamline partnership governance arrangements - proposed changes



Appendix 2: Streamline partnership governance arrangements – *new partnership governance structure



Appendix 2: Option 2 evidence - proposal to align People Committee responsibilities to other boards, committees or groups and stand down the People Committee

The responsibilities of the People Committee are:	draft proposed change	to where/whom
i. Seek and provide assurance on the sufficiency of workforce to in line with the approved workforce plan across place and stated objectives of the BD&C Health and Care Partnership, utilising relevant intelligence sources where appropriate.	tracking progress with workforce plans could move to BDC HCP Finance and Performance Committee System dashboard to include workforce metrics from annual planning round. For performance management (Note: also linked to this responsibility are (ii); (iii); (vi); (viii); and (ix))	FPC would need to consider Workforce / People Committee rep joining FPC from our distributed leadership
ii. Oversee the development and maintenance of a strategic approach to workforce planning, assurance, sharing learning/best practice and collaborative improvement activity across the system.	Taking a helicopter view of the total BDC HCP workforce, however there is a lack of data available outside NHS data sets and a BI tool for partnership workforce NHS data is not yet in place. Recommend 2x deep-dive workshops per annum into workforce sufficiency	People Development Priority Board
iii. Seek and provide assurance in relation to place based workforce metric's and identify and escalate any impact on delivery of BD&C priorities	Use of workforce data for insight to be used to inform the People Development Priority Board (finding the measures that matter to the partnership and developing insight to enable us collectively to know our numbers, is being discussed and is not yet finalised)	People Development Priority Board
iv. Ensure risks regarding workforce matters within BD&C services are identified, managed and mitigated	Workforce risks could transfer to the System Quality Committee for oversight and assurance.	SQC and / or FPC would need to consider Workforce / People Committee

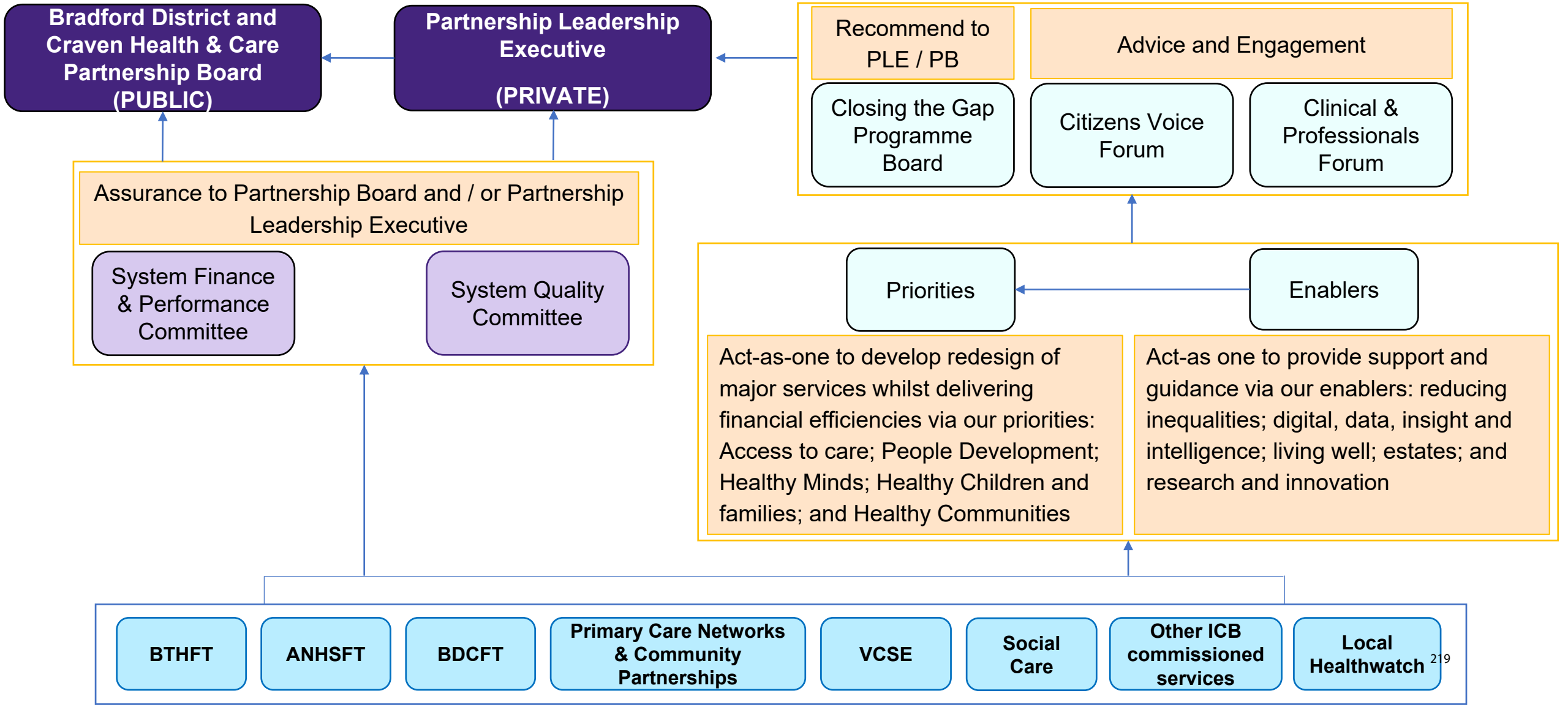
The responsibilities of the People Committee are:		draft proposed change	to where/whom
			rep joining SQC from our distributed leadership
v.	Consider the BD&C Integrated People Plan; ensuring alignment with national, regional, ICS and place priorities	Development arising from the people plan is already covered by the People Development Priority Programme Board.	People Priority Programme Board
vi.	Request and receive reviews and analysis of Place based workforce issues and make recommendations to the ~~Partnership Board~~ PLE on next steps	There are a number of reference groups/task and finish groups that work within the workforce/people currently reporting through the People Committee. These are informal management meetings, and could link to the People Priority Programme Board instead.	People Development Priority Programme Board
vii.	Seek to unblock any barriers to change and mitigate any risks through its collective membership and networks prior to escalating to the ~~Partnership Board~~ PLE.	HRD discussions on a weekly basis on Monday afternoon and also could be escalated, if appropriate, on the People Development Priority Board agenda	Informal HRDs Monday afternoon meeting and/or People Development Priority Programme Board
viii.	Identifying any areas where there are wider implications/trends of these risks and issues or where additional assurance is required, and escalating to the Partnership Board where appropriate	this describes trends in data which is overseen by FPC and could link to (i) above	see (i)
ix.	Provide oversight and assurance of the workforce elements of the system planning process and associated workforce narrative	this describes operational planning which is overseen by FPC and could link to (i) above	see (i)

The responsibilities of the People Committee are:		draft proposed change	to where/whom
	for the BD&C Place for recommendation and ratification by the partnership board		
x.	Provide the necessary advice and guidance, as required, on specific workforce strategies/plans of other programmes - including supporting workforce redesign.	this describes PLT activity of shared learning and interdependencies across Priorities and Enablers	PLT
xi.	Encourage and seek assurance on the inclusion of horizon scanning and sharing the learning from the wider health, care and education systems, locally, regionally and nationally in order ensure best practice and economies of scale are realised and to maximise funding opportunities.	This could be covered by the People Development Priority Programme Board	People Development Priority Programme Board
xii.	Support the development of Place based workforce bids where Appropriate for recommendation ~~to partnership board~~ PLE	This could be covered by the People Development Priority Programme Board	People Development Priority Programme Board
xiii.	programme outcomes and receive associated evaluation reports. To PLE	This could be covered by the People Development Priority Programme Board	People Development Priority Programme Board
xiv.	Champion the importance of workforce within the delivery of service and as a key enabler of service improvement and modernisation.	Exec sponsor to champion with both PLE and PB and AD – workforce to champion championing the delivery, service improvement and modernisation also falls within scope of the People Development Priority Programme Board	Exec Sponsor & AD - workforce People Development Priority Programme Board

The responsibilities of the People Committee are:	draft proposed change	to where/whom
xv. Investigate any activity within its Terms of Reference and obtain independent specialist advice as it considers necessary	This responsibility could transfer to the receiving committees FPC, SQC and People Development Priority Programme Board	FPC, SQC and People Development Priority Programme Board

Appendix 3: Strategic Partnering Agreement: Financial Governance Framework

Priority leads will lead the priorities to oversee and ensure the development of high-quality safe services that meet the partnership's strategy, thereby meeting the needs of our population at all life stages, within the available financial resources



Bradford District and Craven Health and Care Partnership - Decision Flowchart

ACTasONE

Step 1: idea

The idea/proposal(s) goes through the prioritisation toolkit process. The prioritisation toolkit is designed around the BDC H&CP strategy and aligns to our 4p's: our people; our population; our place and our partnership

Desk top review

does the proposal address one of our priorities and enablers or is it aimed at addressing one or more statutory requirement

Prioritisation process

Closing the Gap Programme Board and / or Priority Programme Board apply the prioritisation framework or use an alternate prioritisation approach

As there is no new money, this factor requires consideration

Prioritised and ranked proposals set out within our prioritisation framework – under the 4 p's

Any agreed proposal(s) has an executive sponsor assigned

Step 2: convene & work up

The proposal has been identified and prioritised and is considered to be an important matter in accordance with our strategy, priorities and enablers; or meets one or more statutory requirement

Support team includes but is not limited to involvement of the Clinical & Professional Forum and the Citizens' Voice Forum and relevant Priority aligned Deputy DOF

Lead(s) and support team identification

Where possible existing group(s), under priority programme board, will be used to support, however if there isn't a clear group then a time limited task and finish group could be convened

Work up proposal / business case with relevant forum (s) and stakeholders (identify all stakeholders)

The group / support team together with relevant stakeholders work up a proposal / business case etc. Development of Proposal/Business Case Quality, Equality, Impact Assessment to be completed

The Partnership Executive Lead(s) signs off the proposal / business case ensuring it addresses partnership priorities with a focus on delivery of desired outcomes

Each proposal / business case must consider QEIA and other statutory duties at the outset and throughout development

The lead(s) and support team agree a road map for assurance, scrutiny and decision

Step 3: assurance & scrutiny

At this stage the lead(s) and / or support team will have mapped out the route to gaining proportionate assurance and independent scrutiny as appropriate to the proposal / business case

Internal Assurance

Closing the Gap Programme Board, and WY ICB Audit Committee

External Scrutiny

Overview & Scrutiny (over £2m)
Healthwatch
Public engagement / consultation

Revisions are made to the proposal / business case and QEIA based on assurance process feedback

Sound decision making, tested by a robust process of assurance and where required independently scrutinised

Bradford District and Craven Health and Care Partnership - Decision Flowchart

ACTasONE

Step 4: decision

Robust decisions is supported by a proposals / business cases, that has been informed by all relevant stakeholders and tested via our internal and / or external assurance process; as appropriate to the matter

Discharged in-line with scheme of reservation and delegation (SORD), financial scheme of delegation (FSD) and standing financial instructions (SFIs)

The lead(s) and / or members of the group take the proposal / business case to the relevant decision-making body

Decision making body

Partnership Leadership Executive (private)
Partnership Board (held in public)

Next step: the Lead(s) and support team take forward the decision reached

Step 5: monitoring, assurance & scrutiny

Once a decision has been reached – evaluation and / or on-going monitoring to track progress with mobilisation of decision takes place

As part of the work up of the proposal / business case aligning the measures that matters most together with the level of ambition (i.e. the desired trajectory, target or standard) to inform monitoring, assurance & scrutiny

For the majority of decisions on-going monitoring should be met by the BDC H&CP system dashboard. Alternatively, a specific business intelligence tool capable of tracking should be developed

QEIA to be refreshed bi-annually (could be less frequently dependent upon the proposal / business case timeframe)

Internal monitoring

Closing the Gap Programme Board, Quality Committee, Finance and Performance Committee, and WY ICB Audit Committee

External Transparency

Act as One website

Monitoring and assurance of progress via system dashboard, and/ or specific business intelligence report, or service evaluation and to be complimented as required by deep dives

Next step: with satisfactory progress this is monitored and reviewed for a defined period

Step 6: exit and return to business as usual

This step is concerned with closure of the proposal / business case from the partnership focus and return to business as usual.

Exit partnership scrutiny

The service area or function impacted by the proposal / business has completed the cycle of change and exits from the partnership governance scrutiny

Return to business as usual

The service area or function impacted by the proposal / business will return to business-as-usual governance arrangements within the related service or function area of the relevant statutory organisation

Exit

V10 2 May 2024

Meeting name:	BDCH&CP Partnership Board
Agenda item no:	9
Meeting date:	17 May 2024
Report title:	Partnership risk update (risk report – cycle 1)
Report presented by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB
Report approved by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB
Report prepared by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate	Information ☐

Previous considerations:

Partnership Leadership Team: 17.04.2024
People Committee: 17.04.2024
Finance and Performance Committee: 25.04.2024 – via email
Partnership Leadership Executive – 26.04.2024 – via email

Executive summary and points for discussion:

Effective risk management processes are central to providing the Bradford District and Craven Health and Care Partnership with assurance that all required activities are taking place to ensure the delivery of the Partnerships strategic priorities and compliance with all legislation, regulatory frameworks and risk management standards.

BDCH&CP Risk Register

This report provides details of all high-level risks (scoring 15 or above, or risks escalated from committee review) on the BDCH&CP Health and Care Partnership Risk Register, together with details of risks aligned to each committee.

ICB Risk Register

The ICB risk register is included in this report for consideration, including common risks across 2 or more places in the ICB

Outline how this supports our partnership vision and strategy

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

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

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

Recommendation(s)

The BDCH&CP Partnership Board is asked to:

1. To **RECEIVE** the BDCH&CP cycle 1 risk report and confirm assurance on the critical and serious risks scoring above 15.
2. To **DISCUSS** any identified risks that are not currently recorded on the risk report and signpost the partnership governance team to the relevant risk owners for liaison in preparation of cycle 2
3. To **RECEIVE** the ICB risk register for consideration and confirm assurance on the BDCH&CP risks captured in the ICB Risk Register

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

The report includes details of the current risks on the partnership risk register and those on the ICB corporate risk register for information

Appendices

1. Risk scoring matrices
2. Bradford District and Craven Health and Care Partnership risk register report
3. BdC Risks on a Page Report
4. West Yorkshire ICB risk log
5. West Yorkshire ICB mapped common risks

Acronyms and Abbreviations explained

1. H&CP – Bradford District and Craven Health and Care Partnership
2. ICB – NHS West Yorkshire Integrated Care Board
3. BAF – Board Assurance Framework

What are the implications for?

Residents and Communities	Any implications relating to specific risks are set out within the risk register
Quality and Safety	Any implications relating to specific risks are set out within the risk register

Equality, Diversity and Inclusion	Any implications relating to specific risks are set out within the risk register
Finances and Use of Resources	Any implications relating to specific risks are set out within the risk register
Regulation and Legal Requirements	Any implications relating to specific risks are set out within the risk register
Conflicts of Interest	Any implications relating to specific risks are set out within the risk register
Data Protection	Any implications relating to specific risks are set out within the risk register
Transformation and Innovation	Any implications relating to specific risks are set out within the risk register
Environmental and Climate Change	Any implications relating to specific risks are set out within the risk register
Future Decisions and Policy Making	Any implications relating to specific risks are set out within the risk register
Citizen and Stakeholder Engagement	Any implications relating to specific risks are set out within the risk register

Partnership Risk Register Cycle 1 2024 – 2025 (20.03.2024 – 26.06.2024)

1. Introduction

1.1 The Bradford District and Craven Health and Care Partnership (the Partnership) via the West Yorkshire Integrated Care Board (as a publicly accountable organisation), needs to take many informed, transparent and complex decisions and manage the risks associated with these decisions. As part of this risk management arrangement Partnership therefore needs to engage with this overarching approach and thereby ensure that the partnership has a sound system of internal control.

1.2 Effective risk management processes are central to providing assurance that all required activities are taking place to ensure the delivery of the Partnership's priorities and compliance with all legislation, regulatory frameworks and risk management standards.

2. BDC H&CP risk register

2.1 Effective risk management processes are central to providing assurance that all required activities are taking place to ensure the delivery of the Partnership's priorities and compliance with all legislation, regulatory frameworks and risk management standards.

2.2 To support the reporting throughout the Partnership, all risks are aligned to appropriate BDC H&CP Committees for oversight – with risks categorised as People, Primary Care, Quality, Finance, and Performance, or a combination.

2.3 There are 11 high level risks for review (Appendix two). Of these:

- 4 (36%) are identified as only finance and performance risks
- 0 (0%) are identified as only quality risks
- 6 (54%) are identified as being both finance, investment, performance and quality risks
- 0 (0%) are identified as only workforce risks
- 0 (0%) are identified as only primary care risks
- 1 (9%) are identified as risks to the priority programmes

The below table shows a summary of these risks along with any associated actions. Full risk details can be found in appendix 2.

Ref	Committee	Risk Description	Current Score	Target Score
0008	FPC	**NEW:** IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes	**25 (I5XL5)**	**16 (I4XL4)**
2173	FPC	**Decreased:** BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures.	**20 (I5XL4)**	**12 (I4XL3)**
2337	FPC	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	**20 (I4XL5)**	**9 (I3XL3)**
2314	FPC/QC/PC/PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL There is a risk of long-term disruption of service provision at Airedale General Hospital due to building component failure,	**20 (I5XL4)**	**15 (I3XL5)**

Ref	Committee	Risk Description	Current Score	Target Score
		as the majority of the floors, ceilings and walls (83% of the building) are built of Reinforced Autoclave Aerated Concrete (RAAC) and linked infrastructure including flow of supply of electricity and other utilities (known as daisy chain) throughout the site OR the emergency plan outlines circumstances which trigger an earlier date from which services at Airedale General Hospital may no longer operate beyond 2030. Deterioration of the RAAC and/or structural framework of the building could lead to catastrophic failure of the building with partial or full collapse, despite a comprehensive programme of remedial works. This could result in the closure of substantive or all hospital facilities at the Airedale General Hospital site and a transfer for the continuing provision of services without this facility for months or years. In the event of catastrophic failure of the AGH could result in damage to the partnership's reputation, legal proceedings, claims for compensation and regulatory intervention (implications for AFT and also the NHS WY ICB due to vicarious liability). This links to risk number 2312 (risk that AFT is unsuccessful in securing funding from the new hospitals programme).		
2312	FPC/QC/PC/PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - Although Airedale NHS Foundation Trust has been successful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030, there is a risk that the funds do not flow as quickly as required, resulting in a failure to open the new hospital before the current one ceases to be viable (engineers estimate 2030) (or earlier if a significant	**20 (I5XL4)**	**15 (I3XL5)**

Ref	Committee	Risk Description	Current Score	Target Score
		RAAC incident occurs - see related risk number 2314). Further, Airedale NHS Foundation Trust must submit a new application for funds in 2024/25, relating to the next Comprehensive Spending Review and there is a risk that this process may result in a hiatus mid-programme.		
2215	FPC/QC	LYNFIELD MOUNT HOSPITAL - There is a risk of delivering poor quality health care with a negative impact on patient safety including infection prevention and control, service user experience including privacy and dignity, additional costs for out of area bed usage and negative impact on staff wellbeing, recruitment and retention and on the organisation's reputation. This is due to the deteriorating and failing physical condition of Lynfield Mount Hospital building with £68m backlog maintenance as well being an estate requiring redevelopment this out-of-date estate has insufficient therapeutic space, large ward sizes and a lack of ensuite bathrooms. This is resulting in poor quality environment of care, issues with sewage flooding, heating systems, escalating maintenance costs and impacts on recovery leading to an increased average LOS consistently 60 days which is double than the national average of 30 days.	**20 (I4XL5)**	**2 (I2XL1)**
2386	FPC/QC/PC/PLE/PB	**Decreased:** There is a strong and increasing risk to the sustainability of the VCSE sector. This includes the risk of VCSE organisations and services across Bradford District and Craven closing or reducing their delivery or activities. The risks centre around financial sustainability, ability to recruit and retain staff (especially due to employment	**16 (I4XL4)**	**12 (I4XL3)**

Ref	Committee	Risk Description	Current Score	Target Score
		uncertainty and cost of living) and the decision to withdraw the VCSE infrastructure contract due to local authority budget pressures. All these issues ultimately decrease the sector's resilience and sustainability and would decrease its capacity to engage with the system. This in turn has a knock-on effect on the wider health and care system, both in terms of increase usage of statutory services and a reduction in proactive preventative work to tackle inequalities.		
2266	BDC PLT	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GPs can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two-tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	**16 (I4xL4)**	**4 (I2XL2)**
2039	FPC/QC	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the	**16 (I4XL4)**	**6 (I3XL2)**

Ref	Committee	Risk Description	Current Score	Target Score
		Ofsted/CQC local area SEND inspection held in March 2022. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.		
2227	FPC/QC	Adult ADHD Pathway; There is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service. The gap between demand and capacity within BDCFT BANDS continues to grow month on month and referrals increase and capacity remains static. There is inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider. Concerns exist between differences in service quality and outcomes between NHS and IS providers of ADHD Assessment/Diagnosis services.	**15 (I3XL5)**	**6 (I3XL2)**
2168	FPC	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place-based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	**15 (I3XL5)**	**4 (I2XL2)**

2.4 Of the 11 risks, there are:

- 1 newly identified risk
- 1 Closed risks: this risk related to 2023 – 2024 in year financial performance and has been closed develop the risk for 2024-2025 as shown above
- 0 risks increasing in score

- 2 risks decreasing in score

2.5 Risk 2386 has decreased in score as a result of a proportionality review against the risk register as a whole, the risk still remains high to the sustainability of the VCSE sector and will have the same level of oversight and management from both risk owners, reviewers and the Partnership Board as its previous score.

2.6 Of the 11 Risks:

- 10 were reviewed by the risk owner
- 10 were reviewed by senior risk managers
- 8 have had a static score for more than 2 cycles

3. Emerging risks

3.1 The following risks were identified as emerging risks throughout the current from the sub committees.

3.2 The following risks were previously reported in cycle 6 for 2023 - 2024 as emerging risks from the sub committees, progress on each risk is below:

Increase in the number of cases of measles which relates to concern on the uptake of the MMR vaccine and reduction in the uptake in the wider vaccine programme:
This risk is being developed with Public Health and will be focused on low uptake of vaccines, in particular MMR, COVID-19 and flu alongside community circulation of pathogens including new variants of respiratory viruses and is aggravated by unclear responsibility for commissioning infection control functions like mass vaccination, community swabbing, and clinical assessment of exposed individuals
The risk is currently being scored and senior reviewer being identified, all assurance and controls have been developed.

Reduction of intermediate care beds:
This risk is being managed via the Intermediate Care Programme with oversight by the Health Communities Programme Board. No escalation to the BDC HCP risk register is currently appropriate.

Adoption foster:
Although the area remains challenging, no appropriate risks have been identified

Looked after Children
Although the area remains challenging, no appropriate risks have been identified

SEND
Although the area remains challenging, no appropriate risks have been identified

4. Feedback from committee risk review

4.1 The Partnership Board sub-committees: Quality, Finance and Performance and People Committee have received risk reports and have had the opportunity to review the risks assigned to each BDCH&CP committee, as noted above some committees shared a small number of risks and assurance was sought on progress with mitigating actions.

4.2 Key points from the discussion included:

- The People Committee discussed the transfer of oversight of workforce risks to be under the remit of the Quality Committee should it be disestablished and has requested that any operational risks be managed via the Workforce Priority Programme
- The Partnership Leadership Team supported the re- alignment of risk owners due to the changes imposed by the West Yorkshire ICB operating model

5. ICB Risk log

5.1 The ICB corporate risk log has been provided for assurance of what is being reported to the ICB Board on behalf of each place. The ICB Board report includes risks with a score of 15 plus and place risks with a residual score of 15 plus that have been identified as being common to more than one place, having the potential to impact multiple places, or requiring active management by a number of organisations.

5.2 Reporting for cycle 1 of the ICB risk register is currently taking place. To summarise:

- In cycle 1 there were 17 risks scoring 15 and above on the ICB risk register

Ref	Committee	Risk Description	Current Score	Target Score
2309	QC	There is a risk that demand for CYPMH services outstrips capacity, due to a lack of available community services, leading to increased use of inpatient beds at Red Kite View, out of area placements or CYP being placed in paediatric hospital beds for longer than clinically indicated, resulting in	**20 (I4xL5)**	**9 (I3xL3)**

Ref	Committee	Risk Description	Current Score	Target Score
		poorer experience and outcomes for CYP and their families		
2308	QC	There is a risk that the Neurodivergent population of West Yorkshire do not get the appropriate diagnosis or support from services, due to lack of capacity within existing services and an inability to redesign our whole system to be more needs led, resulting in distress for people and their families and reducing the ability of people to lead fulfilling, healthy lives and make positive contributions to our society across West Yorkshire.	**20 (I4xL5)**	**12 (I4xL3)**
2202	FIPC	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures.	**20 (I4xL5)**	**6 (I3xL2)**
2166	FIPC	There is a risk of a successful cyber-attack, hack and data breach. Due to the escalating threat of cyber-crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	**20 (I4xL5)**	**12 (I4xL3)**

Ref	Committee	Risk Description	Current Score	Target Score
2036	QC	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - there is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital. There is also a risk of a collapse (which could cause injuries to patients and/or staff) and would result in an unplanned evacuation.	**20 (I4xL5)**	**9 (I3xL3)**
2400	QC	There is a risk that initial health assessments and review health assessments will not be completed within the statutory time frames due to resource issues, increased demand and complexity within the Children in Care (CIC) Teams across West Yorkshire. This could result in health needs assessments of CiC being delayed and out of area children placed in West Yorkshire area being significantly delayed. This could result in the health needs of these vulnerable children not being met.	**16 (I4xL4)**	**6 (I3xL2)**
2399	FIPC/QC	There is a risk that incidence of respiratory viruses and urgent and emergency care pressures will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	**16 (I4xL4)**	**12 (I4xL3)**
2398	FIPC/QC	There is a risk that continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce. This will lead to reduced elective capacity,	**16 (I4xL4)**	**12 (I4xL3)**

Ref	Committee	Risk Description	Current Score	Target Score
		increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.		
2391	QC	There is a risk that increasing numbers of people seeking asylum placed in WY and the Home Office Policy decision to implement double occupancy for contingency accommodation, will place significant demand on services and add additional pressure onto service providers. This could result in an increased risk safety and safeguarding concerns, potentially resulting in poor experience, increased harm and poor outcomes.	**16 (I4xL4)**	**9 (I3xL3)**
2232	FIPC/QC	There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available from HMT / DHSC / NHS England. Resulting in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.	**16 (I4xL4)**	**9 (I3xL3)**
2176	QC	Non-surgical oncology - there is a risk that service delivery cannot be sustained before a new model is implemented due to the time required to implement a new model. This would lead to severe capacity pressures within the system and an inability to treat patients in a timely manner.	**16 (I4xL4)**	**12 (I4xL3)**
2175	FIPC/QC	There is a risk that the increasing number of patients in WYAAT hospitals who are ready to be discharged but unable to leave due to capacity issues in social care and community services, will add extra pressure on the workforce and reduce	**16 (I4xL4)**	**12 (I4xL3)**

Ref	Committee	Risk Description	Current Score	Target Score
		elective activity due to inadequate bed capacity. This could result in increased backlogs, delays to patient care, reduced functioning / deconditioning of patients, and reputational damage across WYAAT members.		
2120	FIPC/QC	There is an increasing risk of widening health inequalities and poorer health outcomes across West Yorkshire due to the reduction or loss of VCSE services and closure of VCSE organisations- including infrastructure organisations - in the current economic and financial context. Loss of VCSE services will result in increased demand on already overstretched mainstream NHS services.	**16 (I4xL4)**	**12 (I4xL3)**
2109	FIPC/QC	There is a risk that the ambition to deliver the national ambition in early stage cancer diagnosis (reflected in ICS Ambition 3) will not be achieved due to workforce, capacity, technological, and other resourcing constraints - including the direct impacts of the Covid-19 pandemic, secondary mortality factors and delays to new asset investments such as Community Diagnostic Centres. This would mean that one and five year survival rates for patients affected by cancer would not improve at the pace expected towards European comparators.	**16 (I4xL4)**	**4 (I2xL2)**
2102	QC	There is a risk to the delivery of safer maternity and neonatal care due to staffing levels ,recruitment and retention issues, sickness and absence levels, resulting in reduced capacity to provide clinical care, delays in care, bed/cot closures,, birth centre closures, reduced ability to roll out midwifery continuity of carer (MCoC), reduced choice for women impacting on experience , reduced ability to train staff, reduced ability to implement quality	**16 (I4xL4)**	**4 (I4xL1)**

Ref	Committee	Risk Description	Current Score	Target Score
		improvements, increased pressures on existing staff that may impact on the morale within the workforce.		
2313	FIPC/QC	There is a risk that the Right to Choose agenda in neurodiversity leads to significant additional activity, due to more people accessing private providers outside of plan, resulting in significant and unfunded financial pressure on place commissioning budgets.	**15 (I3xL5)**	**6 (I2xL3)**
2194	FIPC	There is a risk of disruption to current service delivery and a delay in future service transformation programmes due to the imminent commencement of a period of industrial action across the Health Service, resulting in colleagues participating in strike action and therefore not being available to undertake their normal work and for other colleagues in terms of their priority focus on planning for and responding to service critical requirements around strike days.	**15 (I3xL5)**	**6 (I3xL2)**

6. West Yorkshire ICB Common Risks

6.1 The West Yorkshire Risk Operational Group meets to identify common risks emerging from the place risk registers. This reports bi-monthly to the West Yorkshire ICB Board and quarterly to the West Yorkshire ICB Audit Committee with a request to report at each of the five places. The detail of these risks is set out at appendix 4 – common risks are highlighted in 'orange'.

6.2 Common risks are defined as place risks with a score of 15+ that have been identified as being common to more than one place, having the potential to impact multiple places, or requiring active management by a number of organisations.

7. Next steps

7.1 Following review by the BDCH&CH Partnership Board, the BDCH&CP Partnership Risk Register will conclude its first risk cycle. Any closed risks will be archived and open risks carried forward to the next risk review cycle.

7.2 BDC H&CP will provide the ICB with information on place risks throughout cycle four to inform the risk report for the ICB Board.

APPENDIX 1: Risk Scoring Matrices (Qualitative Measures of Consequence)

Consequence ▸	1. Insignificant	2. Minor	3. Moderate	4. Major	5. Catastrophic
Financial	£1k - £10k	Up to £50k	Up to £250k	Up to £1M	Over £1M
Harm	Minor bruises/ discomfort/ affects wellbeing.	Some minor injuries/ ill-health - minor. <3 days absence	Many minor injuries/ ill-health – temporarily incapacitating. RIDDOR reportable.	Some major injuries/ ill-health - permanently incapacitating	Multiple injuries/infections Unexpected Death
Disruption	One day Service disruption/1 or 2 staff absent.	One week Service disruption/<5 staff absent.	One month Service disruption/5-10 staff absent.	Up to 6 months Service disruption/11-20 staff absent.	6 months to 1 year Service disruption/21-50 staff absent.
Litigation	Replacement of property.	Replacement of property and finances.	Minor out-of-court settlement.	Civil action – no defence.	Criminal prosecution.
Damage	Minor property damage/ no environmental impacts.	Slight property damage/ impacts on internal environment.	Moderate property damage/impacts on local environment.	Severe property damage/impacts on local environment.	Loss of whole department/impacts on regional environment.
Reputation/ Confidentiality/Data Loss	Damage to individual's reputation. Minor breach of confidentiality. Minor complaint resolved within team.	Damage to team reputation. Temporary loss of information. Minor complaint resolved by local management.	Damage to Service reputation/local media coverage on day. Loss of information/ records. Some complaints resolved by Senior management.	Damage to Trust reputation/local media coverage <3 days. Irrecoverable loss of vital records/information. Complaints resolved by Chief Officer.	Damage to Health Authority reputation/ national media coverage <3 days. Prosecution under Data Protection legislation. Complaints resolved by Ombudsman or Healthcare Commission
Clinical care	No significant effect on quality of care provided	Noticeable effect on quality of care provided	Significant effect on quality of care provided	Patient care significantly impaired	Patient care impossible

Quality	Negligible negative impact on access, experience and /or outcomes for people with this protected characteristic. Negligible increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minimal injury requiring no/minimal intervention or treatment, peripheral element of treatment suboptimal and/or informal complaint/inquiry	Minor negative impact on access, experience and /or outcomes for people with this protected characteristic. Minor increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minor injury or illness, requiring minor intervention and overall treatment suboptimal"	Moderate negative impact on access, experience and /or outcomes for people with this protected characteristic. Moderate increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in moderate injury requiring professional intervention.	Major negative impact on access, experience and /or outcomes for people with this protected characteristic. Major increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to lead to major injury leading to long-term incapacity/disability	Catastrophic negative impact on access, experience and /or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, an event which impacts on a large number of patients, totally unacceptable level or effectiveness of treatment, gross failure of experience and does not meet required standards

Performance		Internal Standards not achievable	Repeated failure to meet internal standards	National Performance not achievable (Intermittent)	National Performance not achievable (Continuous)
Enforcing action	Audit non-conformance/advice from enforcers.	Breach of procedure/ Directive from enforcers.	Improvement Notice.	Prohibition Notice.	Government Investigation.

Qualitative Measures of Likelihood

LEVEL	DESCRIPTOR	DESCRIPTION
1	Rare	The event may occur only in exceptional circumstances
2	Unlikely	The event could occur at some time
3	Possible	The event should occur at some time.
4	Likely	The event will probably occur in most circumstances.
5	Almost Certain	The event is expected to occur.

Qualitative Risk Grading Matrix; Level of Risk = Consequences x Likelihood

Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
Insignificant 1	1	2	3	4	5

Score	Risk Level
1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-16	Serious risk
20-25	Critical risk

Mapping of risks –1st risk cycle of 2024/254 (as at 1 May 2024)

COMMON RISKS

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Common Risk
Kirklees (2195)	There is a risk that the Kirklees Health & Social Care(H&SC) system organisations are unable to deliver comprehensive care. Due to multiple partners across the H&SC system declaring organisational OPEL 4 for sustained periods of time and pressure across the system partners continuing to escalate. Resulting in increased potential for patient care, safety and experience to be compromised.	3	3	6↓	Common risk re: impact across the system / OPEL 4
Wakefield (2429)	There is a risk that patient experience, staff experience and patient safety is compromised due to the number of patients who are medically optimised for discharge with no reason to reside remaining in the MYTT bed base due to the inability to put in place timely discharge arrangements to places across our system.	3	3	9 NEW	
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	4	4	16	
Wakefield (2401)	Waiting times for Tier 4 beds for children and young people have increased, resulting in young people waiting on sections 3s in inappropriate settings.	4	3	12	Common risk re: CAMHS
Leeds (2243)	There is a risk of delay in accessing MH treatment due to the significant increase in referrals over the past years and a lack of capacity within MindMate SPA to deal with referral numbers, resulting in young peoples mental health deteriorating whilst they are waiting to be triaged by MindMate SPA.	3	4	12	
Calderdale (1977)	There is a risk that Children and Young People's (CYP) will be unable to access timely therapy due to:- a) increase in demand, b) existing high waiting times and c) inability for provider to recruit to vacant posts In particular the risk relates to the waiting times for speech and language (SLT) and occupational health therapies, where we have received a significant increase in the number of referrals in 21/22 compared to previous year. For example SLT new appointments in September 2019 compared to September 21 was an increase of 245%. The same comparison period for follow up shows an increase of 98%. In September 21	3	3	9	

	there were 1314 CYP waiting for a new appointment, 296 waiting for a follow-up with an average wait of 157 days (however, this picture has increased). During Covid-19 lockdown, therapy staff at CHFT were redeployed (as this was a f2f service). Once services reopened, staff returned and virtual/telehealth appointments were offered Workforce remains a risk with vacancies across therapies which Provider are unable to recruit to (national picture)				
Kirklees (2196)	There is a risk of delays for Kirklees' Children & Young people (CYP) requiring mental health services, including access to tier 4 CAMHS when in crisis, Community therapeutic placements. Due to a significant increase in demand from pre pandemic levels & increased acuity. Resulting in patient care and safety to be compromised & CYP being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	3	3	9	
Calderdale (1864)	There is a risk that people with complex mental health needs will not receive the right level of support that they require to meet their needs This is due to current capacity within community mental health services both health and social care resulting in escalating crisis situations for people in the community and requests for out of area locked rehabilitation hospital placements; and delays in discharge for people who are ready to leave out of area locked rehabilitation hospital placements. This leads to an increased pressure upon CCP Specialist Care/CHC team and to potentially increased costs for CCP.	3	2	6	Common risk re: mental health services capacity and demand
Leeds (2018)	There is a risk of increased rates of avoidable deteriorations in mental health due to demand outstripping capacity to provide access to proactive community mental health intervention and support wider social determinant needs, exacerbated by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent increased lengths of stay and reduced system flow within LYPFT MH inpatient provision, resulting in increased utilisation of out of area placements for acute mental health beds that impacts quality, experience and service user recovery outcomes.	4	4	16	

Covid Backlog / Risk of Harm / Performance/ Statutory Duties Risks

Place	Risk	I	L	Score	Proposed Action

Calderdale (62)	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
Wakefield (2409)	There is a risk that the system will continue to see an unprecedented volume of patients attending A&E and therefore will not deliver the NHS Constitution 4-hour A&E target which has been raised from 76% to 78% for 2024/25 due to pressures associated with unavoidable demand, patient choice, capacity and flow out - resulting in long waits, overcrowded ED, harm to patients and patient experience being compromised.	2	3	6	
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk. In combination with the risk of harm to those people who remain in hospital when they no longer have a reason to reside from hospital-related harms and deconditioning while they wait for ongoing services, where their wait is longer than 72h.	4	4	16	
Kirklees (2425)	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT & MYHT will result in; long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution	3	4	12 NEW	Common risk re: failure to meet Constitutional standards
Calderdale (2162)	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT will result in; long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution	3	4	12	
Calderdale (62)	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
Leeds (2016)	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	4	3	12	
Wakefield (2129)	There is a risk of delays in people accessing planned acute care due to more complex cases and in some cases higher demand and significant capacity issues due to inability to recruit into key clinical roles, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times.	4	3	12	
Kirklees	There is a risk that Kirklees and Wakefield place will fail to meet the required cancer standards for 62 day cancer waiting time targets due to operational performance and increased referrals for 2ww	3	4	12	

(2049)	at Mid Yorkshire Hospitals NHS Trust (MYHT), resulting in an adverse impact on the quality of care and patient experience, and a failure to meet key national targets potentially resulting in reputational damage to the system and having a negative reputational impact on Kirklees and Wakefield places.				
BDC (2168)	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place-based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	3	5	15	
Wakefield (2146)	There is a risk that demand for adult ADHD assessment exceeds capacity due to increased referrals, resulting in more people exercising Choice and seeking private assessment which presents a financial risk.	3	2	6	Common risk re: adult ADHD assessment (BDC will be reviewed on 3 May - change of risk owner)
Leeds (2354)	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which will cause impact to patient outcomes and significant financial impact	3	5	15	
BDC (2227)	There is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service. The gap between demand and capacity within BDCFT BANDS continues to grow month on month and referrals increase and capacity remains static. There is inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider. Concerns exist between differences in service quality and outcomes between NHS and IS providers of ADHD Assessment/Diagnosis services.	3	5	15	
BDC (2266)	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two-tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	4	4	16	
Kirklees (2180)	There is a risk of non-compliance with the Children & Families Act 2014 and the Health and Care Act 2022 relating to ICB responsibilities with regard to Children with Special Educational Needs and Disabilities (SEND). This is due to Education, Health and Care Plans not being completed within statutory timescales. A key factor is that Health information is not always provided by clinicians in a timely manner.	3	3	9	Common risk re: SEND and Children & Families Act statutory duties

	Resulting in delayed assessment of needs and Health provision not being in place to support access to education. This can lead to complaints, appeals and tribunals.				
Leeds (2253)	There is a risk of not fulfilling the statutory duties to provide timely health advice into EHCPs for CYP with SEND within legislative timescales due to increasing pressures on the system, resulting in delayed support for CYP with SEND and that the EHP Plans do not accurately reflect the needs of CYP and could impact on outcomes and aspirations of CYP. *The consequence is that the contribution of health advice to the ECH Assessment process does not meet with the statutory duties.	3	4	12	
Calderdale (2219)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints.	3	5	15	Common risk re: posture and mobility service
Kirklees (2218)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints. This could result in patient safety being compromised, and people's experience of the service could deteriorate in relation to waiting times.	3	5	15	

ICB Workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2078)	There is an ongoing risk of a continual increase in overdue CHC/joint funding/FNC reviews due initially to business continuity arrangements during Q4 21/22 (when "low risk" reviewing activity was paused), but since, vacancies, recruitment challenges and sickness absence in the CHC clinical team, resulting in a poorer patient experience and a negative impact on the CHC activity and delivery.	3	4	12	Common risk re: continuing healthcare workforce challenges
Kirklees (2074)	There is the risk of delays to Continuing Care administration processes and workflows due to a staff shortage in the business support team, resulting in an impact to clinical workflows, the wellbeing of the team, patient experience and a potential impact to organisational reputation. It also has an impact on the financial position of the CHC team, with delays to invoices being paid and potential impact to NHSE mandated activity.	3	3	9	

Wakefield (2181)	There is a risk of delayed response to changes in healthcare needs or discharge from hospital for children requiring Continuing Healthcare packages, due to MYTT not having capacity to provide Children's Continuing Healthcare packages under the Block Contract. The result of this is the additional costs to the ICB associated with commissioning of external providers and potential poor experience for the patient.	3	3	9	
Wakefield (2297)	There is a risk of potential delays in commissioning patient care, dealing with provider issues and processing payments due to capacity and workforce pressures within the CHC contracting team.	3	3	9	
Calderdale (2092)	The Continuing Healthcare team is currently significantly short staffed with eight (8) live vacancies. This is at a time where the team is experiencing high volumes of complex case management and increased scrutiny and requests for information coming from NHSE. There is a risk with regard to the organisational effectiveness in the delivery and quality of the service provided, patient/carer dissatisfaction and increase in complaints leading to reputation damage to the organisation, non-compliance in meeting national assurance targets set by NHSE, and with regard to financial efficacy. Due to the reallocation of work over fewer staffing numbers, there is a risk of staff burnout, leading to increased sickness levels and difficulty in staff retention resulting in high staff turnover within the team. Staff have alerted Over the past 12 months five staff within the learning and disability and mental health fraction of the team only, have left the team citing excessive caseload as the reasons for leaving. Recruitment to these positions in particular and within Children's Continuing Care has proven to be challenging despite going out to recruitment for these positions on multiple occasions. There are also several projects relating to service improvement occurring across the Calderdale footprint that various staff within the team are contributing to. All these projects aim to provide a more joined up approach and economical delivery model for the people of Calderdale. The current level of staffing shortage within the team risks a delay to the progress of these projects as staff focus on ensuring statutory functions are prioritised.	4	4	16	

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Proposed Action
Calderdale (2156)	There is a risk of a reduction of quality, safety and experience of women accessing maternity services, due to recruitment and retention challenges resulting in poor outcomes and experience	2	3	6 - static	

Leeds (2272)	There is a risk to pregnant people of not achieving the preferred elements of care identified in individual personalised care plans, due to midwifery staffing issues (both recruitment and retention), resulting in a potential for poorer outcomes and experience of care	2	3	6	
Leeds (2269)	There is a risk of poor quality care to pregnant people and their families due to workforce short and long-term challenges (eg: industrial strike action across the maternity sector, recruitment challenges, sickness and absences, etc), resulting in poor patient experience, safety, and clinical effectiveness.	2	3	6	
Wakefield (2128)	Children and young people aged 0-19 years will be waiting between 46 to 52 weeks for their first ASD appointment following referral and 106 weeks for diagnosis outcome due to availability of workforce to manage the volume of referrals. The time taken for a full diagnostic assessment for ASD for children and young people is continuing to increase due to the exceptionally and unpredicted number of referrals. The number of referrals remain much higher and above the capacity planning which was part of the business case for investment. Because of the increased waiting times and pressure/publicity in neighbouring areas the numbers of Patient Choice referrals for assessment has risen in the last 3 months which increases financial pressure on the organisation.	4	4	16↑	Wakefield scores high but not worst for waiting, query differences? Common risk re: waits for CYP neurodiversity Also seek corporate risk
Calderdale (1338)	There is a risk that children and young people (CYP) will be unable to access timely mental health services (in particular complex 'at risk' cases and Autism Spectrum Disorder/Attention Deficit Hypertension Disorder (ASD/DHD)). This is due to a) waiting times for ASD (approx. 14 months) b) lack of workforce locally and nationally to recruit into this service and c) appropriate services not being available for CYP as identified in SEND. Resulting in potential harm to patients and their families.	4	3	16 ↑	
Kirklees (2240)	There is a risk of children being unable to access a timely diagnostic service for neurodevelopmental conditions. This is due to increased demand for the service and the impact of the Covid 19 pandemic on provision of the service. Waiting time at end of December 2023 was 92 weeks, resulting in delays to timely diagnosis, which may also impact upon access to other support services across Health, Education and Social Care and reputational damage.	3	4	12	
Leeds (2301)	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon access to other support services across health, education and social care but also no compliance with NICE standards for assessment within 3 months from referral.	3	5	15	
BDC (2039)	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral	4	4	16 static	Reviewing 3 May

	which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.				
Calderdale (2149)	There is a risk to the ability of care homes to be able to provide a safe, high quality, person centered quality lifestyle due to staffing capacity and gaps in knowledge resulting in poor quality care and experience.	2	3	6	
Wakefield (2138)	Due to the requirement to manage people with increased complexity there is a risk to quality, safety and experience in the independent care sector, rising costs and workforce supply challenges, resulting in insufficient capacity and delayed discharges.	2	3	6	Common risk re: care homes staffing
Bradford 0001 (New risk – no. tbc)	There is a risk that there will be further closures to care and nursing homes, and reduced capacity due to a lack of registered managers (RMs) and registered nurses (RNs) causing delays to patient flow from hospital to community settings which would then be a system (Partnership) problem	3	4	12 tbc new narrative	
Place	**Risk**	**I**	**L**	**Score**	
BDC (0009 tbc)	There is a risk of insufficient social care workforce, specifically care workers and senior care assistants, to deliver safe and quality care services due to a lack of interest/supply from potential domestic workforce. Care sector terms and conditions and pay are a primary reason for a lack of interest from the domestic workforce with workers often choosing higher paid roles in other sectors e.g. hospitality and retail where there has been a shift in some employers paying higher than the National Living Wage, resulting in a reduction of international recruits coming to UK working as care / senior care workers and an insufficiency of social care workforce, causing difficulty in maintaining safe services and delays in hospital discharges, particularly in domiciliary care	4	3	12	Common risk re: social care workforce
Wakefield					

Quality and Safety Risks

Place	Risk	I	L	Score	Proposed Action

Kirklees (2179)	There is a risk of Looked After Children (LAC) not receiving an Initial Health Assessment (IHA) or Review Health Assessment (RHA) within statutory timescales. This is due to an increase in the complexity of individual cases and increasing numbers of LAC from outside the area living in private children's homes Kirklees. This includes an increase in Unaccompanied Asylum Seeking Children (USAC), resulting non achievement of mandatory timescales Resulting in performance targets not being met and assessments being carried out late. Health needs may not be identified early enough to ensure that support is put in place promptly.	3	3	9	Common risk re: Looked After Children health assessments
Leeds (2257)	There is a risk of not meeting target for Initial Health Needs Assessment completion for CLA, lack of capacity within service responsible for delivering IHNAs, resulting in health plans not being available for the first multidisciplinary Child Care Review meeting, delay in identification of health issues and subsequent support. There is also a risk of potential breach of statutory duty.	3	4	12	

Finance and Contracting Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2116)	There is a risk that the transformational changes required to address the approved case for change programme (CHFT) will not be achieved within the required timescales, due to delays in allocating Business Case funding for Huddersfield Royal Infirmary (HRI) due to current political changes. Resulting in failure to deliver improved patient experience, better clinical outcomes and overall system sustainability.	2	2	4	Common risk re: CHFT business case funding
Kirklees (2064)	There is a risk that the allocated Full Business Case funding for Huddersfield Royal Infirmary (HRI) is not released by the secretary of state (Her Majesty's Treasury), due to current political changes, within the required timescales, resulting in an inability to fully implement the estate changes required to address the case for change and failure to deliver overall system financial sustainability.	2	2	4	
Calderdale (821)	There is a risk that the allocated funding is not secured due to the Full Business Case (FBC) not being approved by Her Majesty's Treasury, resulting in an inability to implement the transformational changes required to address the Financial and Quality and Safety case for change and failure to deliver improved patient experience, better clinical outcomes and overall system financial sustainability	4	2	4↓	
Wakefield (2329)	There is a risk that the high level of risk within the collective ICS financial plan 2024/25 and more specifically the impact of that within the Wakefield Place will mean that transformation schemes and investment decisions will be severely limited. The ICB and in particular within Wakefield has significant cost pressures in Prescribing, Independent Sector Activity, Continuing Healthcare Packages, complex packages of care for both Children and adults, ASD and other areas and is therefore at risk from achieving its financial planning control total.	4	4	16 ↓	

Wakefield (2397)	There is a that the WDHCP part of the WYICS will not as a system develop a financial strategy to deliver a break-even position in future years. This is due in part to the fact that the WYICB - Wakefield Place delegated budget has an underlying deficit going into 2024/25. In addition MYTT has a significant underlying deficit. The scale of these pressures will require a financial recovery plan to deliver a break-even position in future years. The result of failure to deliver longer term financial balance will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHSE and a requirement to make good deficits in future years.	4	5	20	Common risk re financial plan and financial control target
Leeds (2413)	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2024 – 25. This could result in the system as a whole not meeting the statutory duties.	4	5	20 NEW	
Kirklees (2393)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	4	4	16	
Calderdale (2300)	The risk is that WYICB-Calderdale Place will fail to deliver the 2023/24 financial plan. This is due to 23/24 financial plan submitted to the WYICB including a number of pressures/risks which have been articulated in the plan development process.. These risks include activity pressures on independent sector acute contracts, prescribing and under-delivery of QIPP. The QIPP challenge for 23/24 is significant at around £5m as a minimum. This includes a £2.3m share of WYICB additional savings requirement. The result of failure to deliver the plan in Calderdale will be a risk to the overall WYICB achievement of its financial plan and financial statutory duties.	4	4	16	
Calderdale (2299)	There is a risk that the Calderdale Cares Partnership part of the WYICS will not as a system deliver its planned financial position. This is due to in part to several key elements including : - the level of inflation, the scale of efficiency challenge, uncertainty around ERF income, pay award uplift, under delivery of efficiency programs, higher than planned agency costs and use of non recurrent resources. Strike related cost pressures continuing to add risk. The result of failure to deliver will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHS England and a requirement to make good deficits in future years.	4	4	16	
BDC (2337)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding	5	4	20	

	and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.				
BDC (0008)	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes	5	5	25 NEW	
BDC (2173)	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures. There is also a risk that BMDC will not be able to set its budget if Exceptional Financial Support is not received from the government. If additional support is not received a section 114 notice will be issued.	5	4	20↓	
Kirklees (2394)	There is a risk that measures being taken to control expenditure in Kirklees District council will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the Kirklees and WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures.	4	4	16	Common risk re LA financial position
Place	**Risk**	**I**	**L**	**Score**	**Proposed Action**
BDC (2386)	There is a strong and increasing risk to the sustainability of the VCSE sector. This includes the risk of VCSE organisations and services across Bradford District and Craven closing or reducing their delivery or activities. The risks centre around financial sustainability, ability to recruit and retain staff (especially due to employment uncertainty and cost of living) and the decision to withdraw the VCSE infrastructure contract due to local authority budget pressures. All these issues ultimately decrease the sector's resilience and sustainability and would decrease its capacity to	4	4	16	

	engage with the system. This in turn has a knock-on effect on the wider health and care system, both in terms of increase usage of statutory services and a reduction in proactive preventative work to tackle inequalities.				VCSE sustainability risk
Leeds (2415)	There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of VCSE services and closure of VCSE organisations in the current economic and financial context. Loss of VCSE services will result in increased demand on already overstretched mainstream and community NHS services.	4	4	16	

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	10
Meeting date:	17 May 2024
Report title:	Spotlight on Staff Survey & Employee Feedback
Report presented by:	Melanie Hudson, People Committee Chair, Andrew Milner, Assistant Director- Workforce, Jo Harrison, Director of People and Organisational Development, ANHSFT and Sector Leads
Report approved by:	Melanie Hudson, People Committee Chair
Report prepared by:	Andrew Milner, Assistant Director- Workforce, Jo Harrison, Director of People and Organisational Development, ANHSFT

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate	Information ☐

Previous considerations and any resulting action:

BDC People Committee 17 April 2024

Executive summary and points for discussion:

Staff morale has been prominent within national discourse following publication of the 2023 NHS Staff Survey results and issues related to the ongoing Industrial Action from Doctors in Training (DiT).

Workplace culture, morale and retention is also highlighted within the NHS Operational Planning Guidance for 2024/25, with DiT being emphasised

Using data from the NHS Staff Survey data, the GMC National Training Survey (GMCNTS) and qualitative intelligence, we will look to prompt a discussion around wellbeing and culture across the partnership.

Given ongoing Industrial Action, we will focus initially upon Doctors in Training before broadening the discussion to the wider workforce.

By addressing the full partnership means that data included is high level, taking into consideration that the data will not allow us to get a true representation of culture within organisations/ sectors or the ‘cultures within cultures.

Outline how this supports our partnership vision and strategy

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

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

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

Recommendation(s)

The BDC Partnership Board is asked to:

1. **DISCUSS** and **IDENTIFY** challenges from the workforce data presented across the Partnership
2. **IDENTIFY** any strategic direction and action resulting from the discussion

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

N/A

Appendices

1. Workforce Spotlight Slides

Acronyms and Abbreviations explained

1. BDC: Bradford District and Craven
2. DiT: Doctors in Training
3. GMC: General Medical Council

Bradford District and Craven
Health and Care Partnership

ACTasONE

Spotlight on Staff Survey & Employee Feedback

Partnership Board

May 2024

Introduction

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- Addressing the full partnership means that data included is high level.

Doctors in Training

Context: Doctors in Training

- Since March 2023, there have been 39 days of industrial action from Doctors in Training.

- As widely publicised, the dispute is primarily related to terms and conditions, although additional issues have been raised regarding:
  - Fair Working Hours (including flexible working and rostering practices)
  - Patient Safety (including staffing levels)
  - Wider Contractual Terms (including leave entitlements)
  - Recognition and Respect

- Nationally, NHS England (previously Health Education England) have looked to address many of the 'non-contractual' issues through the Enhancing Junior Doctors Working Lives programme which was instigated following the last DiT dispute in 2016.

- The programme has focussed on issues doctors identified as significantly impacting their working lives, including rostering, access to flexible working/ training, the cost of training, and approaches to recruitment.

- Primary source of intelligence for DiT is the GMC NTS survey, the focus being primarily educational.

GMC NTS 2023- National Headlines

- **Wellbeing** – Nearly a quarter (23%) of trainees are now measured to be at high risk of burnout, an increase of four percentage points since 2022.

- **Discriminatory behaviours** – There was a higher proportion of negative responses from doctors in their early stages of training to our new questions. There's also a wide variation between specialties, with surgery, obstetrics and gynaecology and emergency medicine responding more negatively.

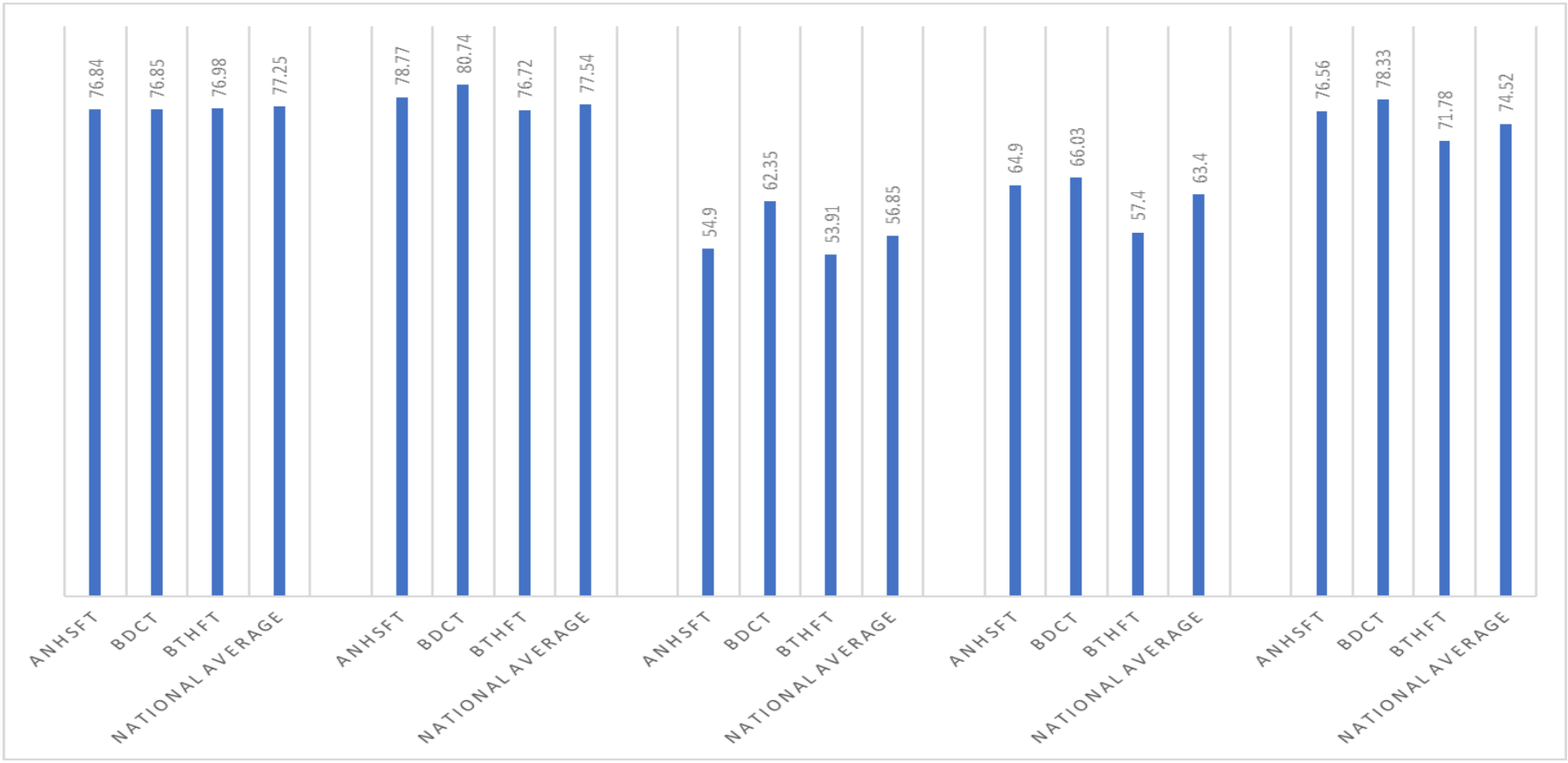
- **Developing leadership skills** – There's a decrease since 2022 in the proportion of positive responses across all training levels and most specialties when asked about opportunities to develop leadership skills.

- **Rota design** – A quarter (26%) of all trainees think that their training is adversely affected because rota gaps aren't dealt with appropriately. The same proportion (25%) do not think that rota design optimises their education and development.

- **Impact of changes due to the Covid-19 pandemic** – Innovations introduced during the pandemic are viewed increasingly positively, especially simulation facilities.

- **Quality of training** – Despite the continued pressures on the health services, the quality of training remains high: 86% of trainees were positive about their clinical supervision and 83% said the quality of their experience was good or very good

BDC Health and Care Partnership Headlines



Adequate Experience

Overall Satisfaction

Rota Design

Study Leave

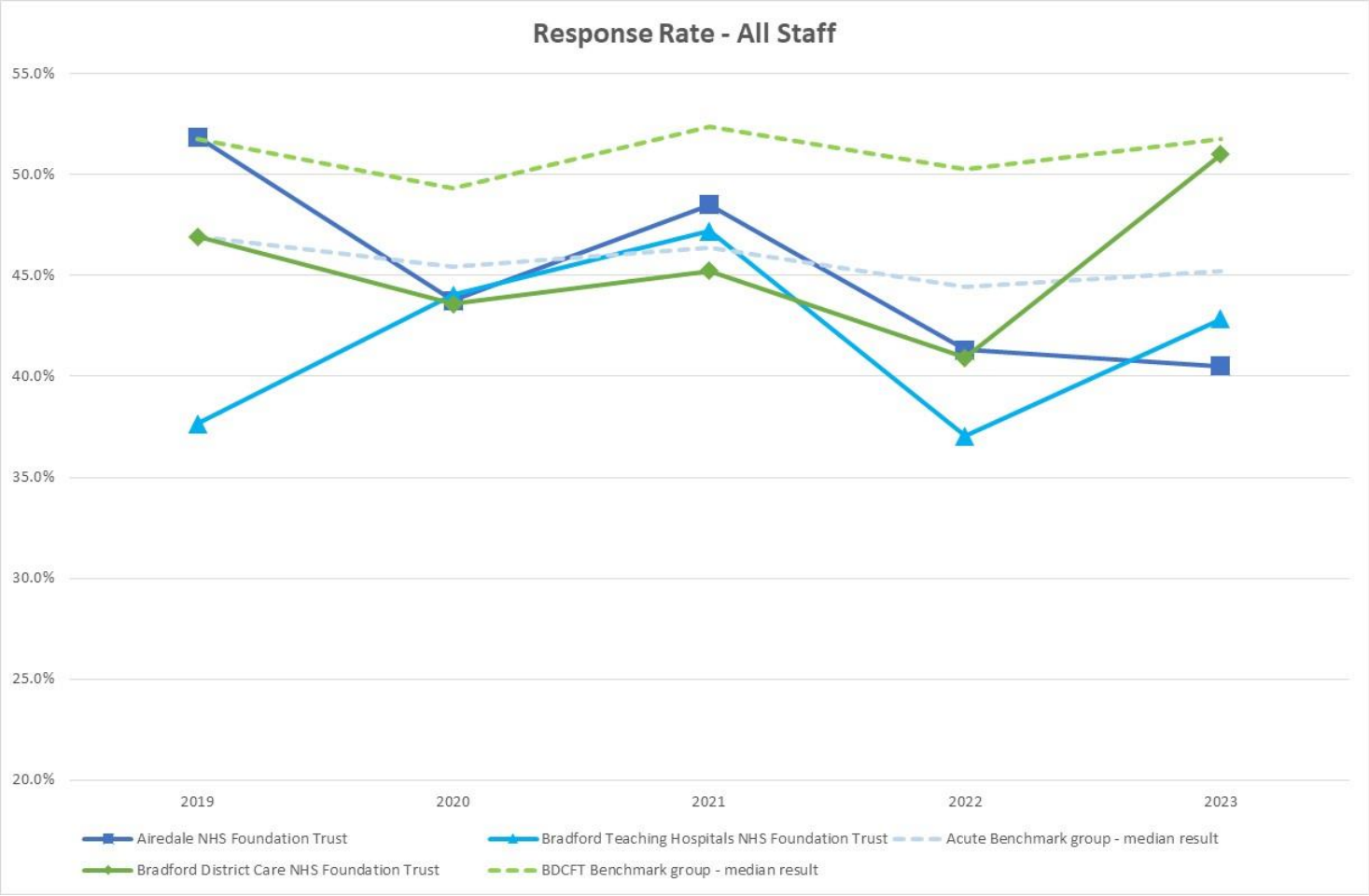
Supportive Environment

The wider workforce across the Partnership

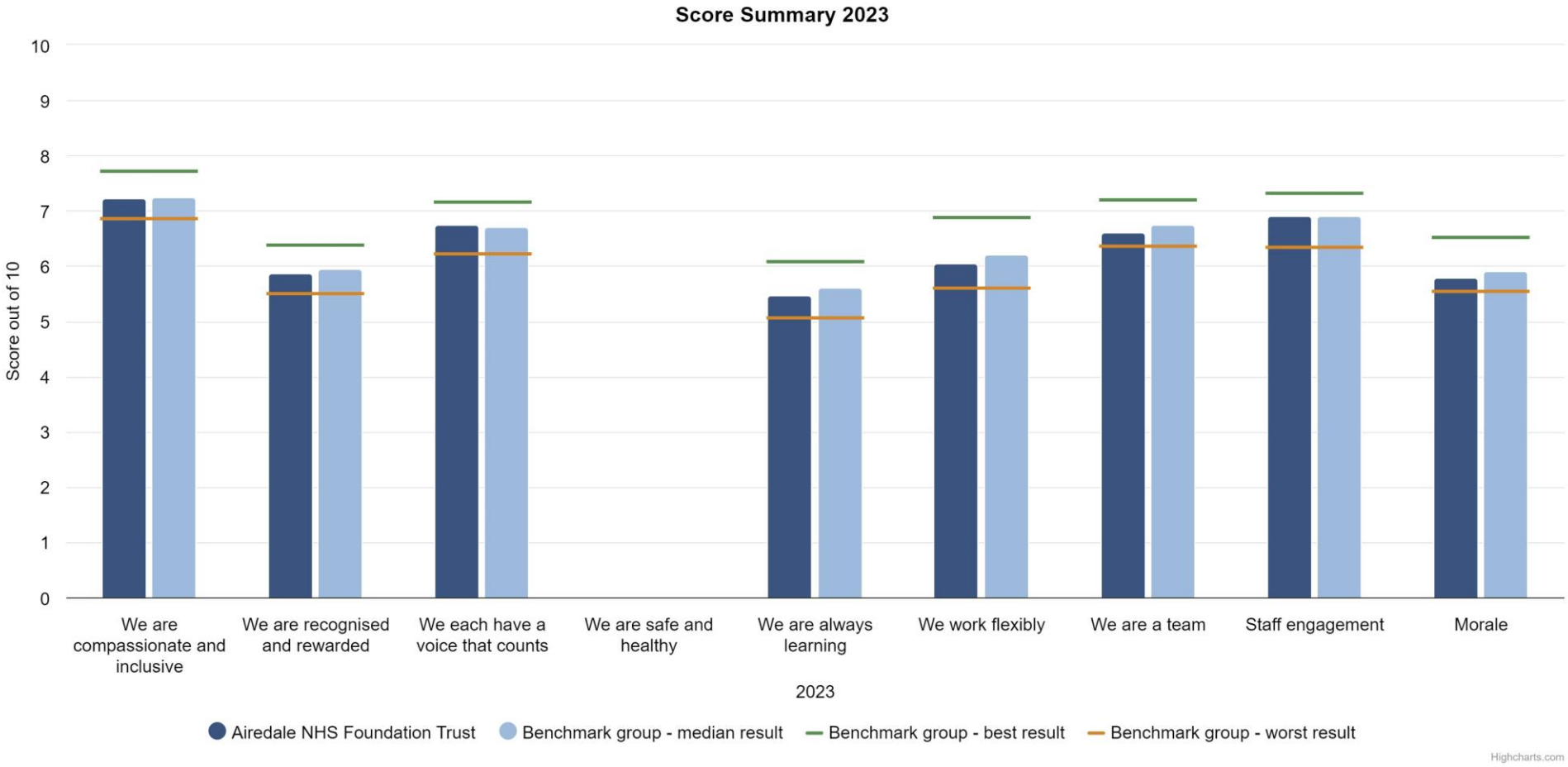
Background

- Staff experience and retention has been highlighted as a priority in the NHS Planning Guidance for 2024/25, with the experience of DiT given particular emphasis.
- The contribution of retention has been highlighted by all partner organisations as a part of workforce operational plans for 2024/25.
- NHS Staff Survey is completed each Autumn and all NHS Staff are asked to participate (including bank and GP staff). Results are split across 7 domains of the NHS People Promise.
- Formatting of results mean that identifying scores for Primary Care organisations is challenging (*n*) and therefore qualitative feedback is included.
- Feedback is split across the domains of the NHS People Promise
- Narrative feedback on staff morale and experience is also included from the Social Care and VCSE sectors.
- This item was discussed at the People Committee in April, and as a result several themes and domains have been identified for discussion with the Partnership Board.

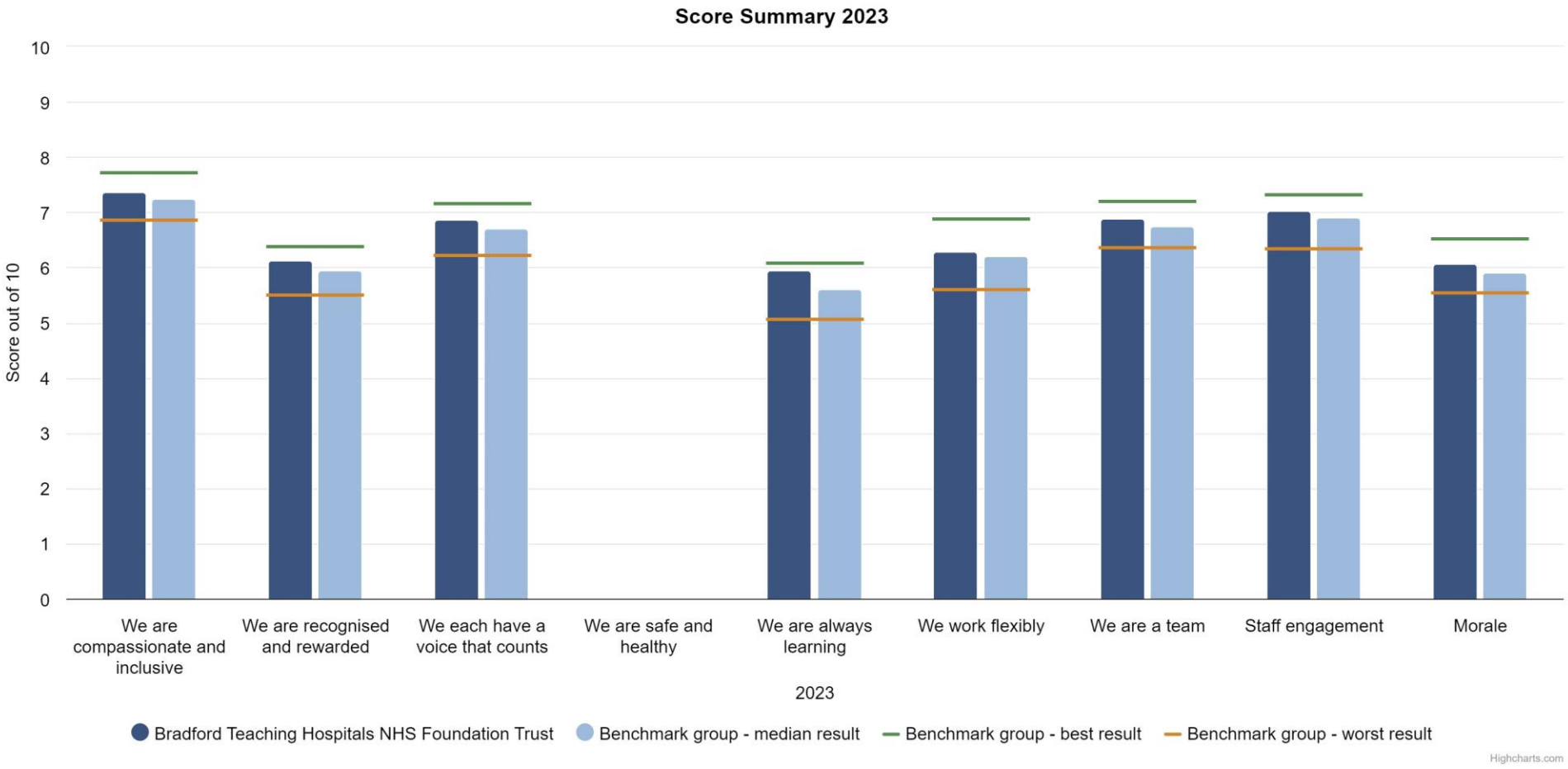
NHS Staff Survey Response Rate



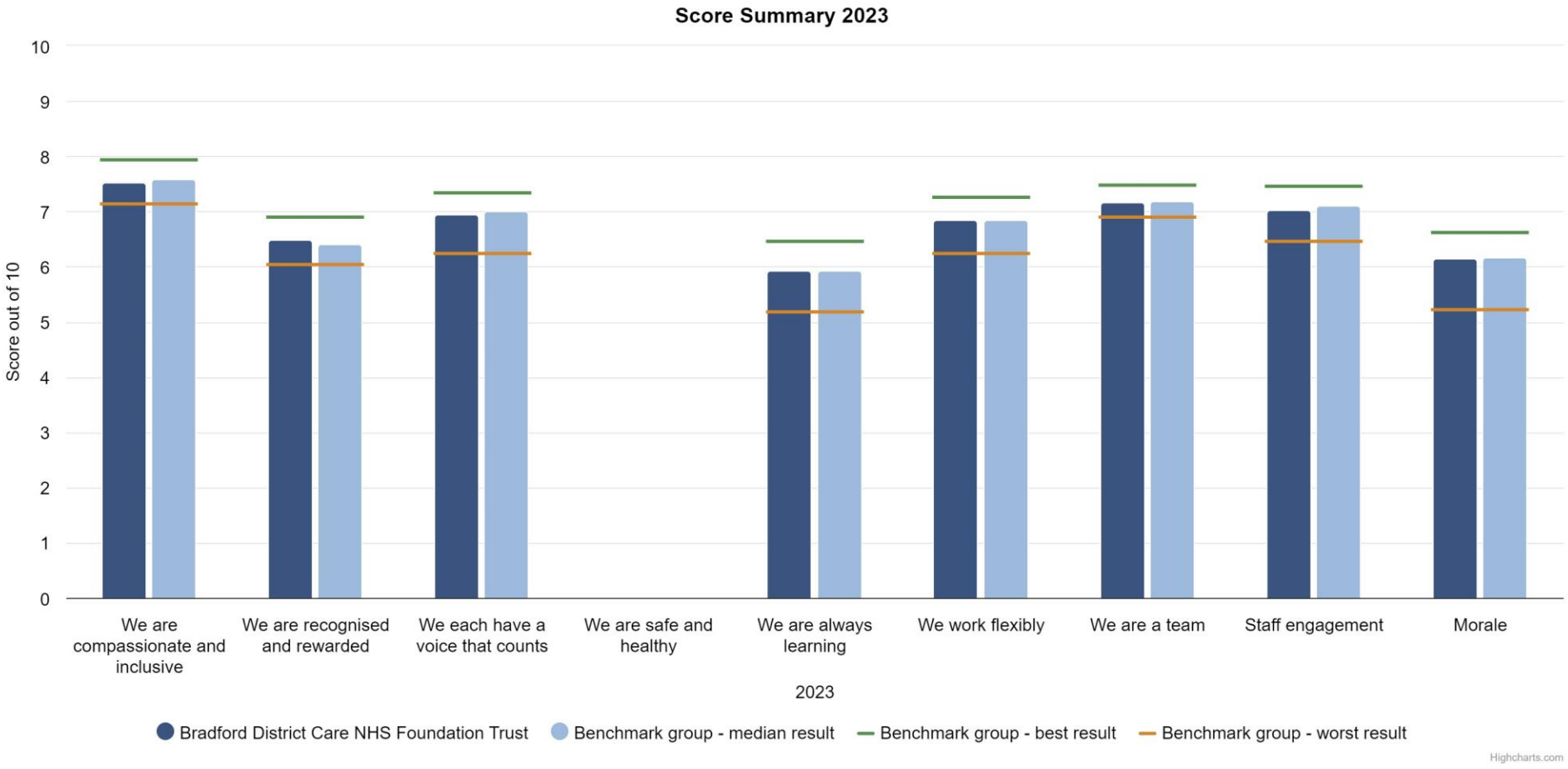
NHS Staff Survey- Score Summary, Airedale NHSFT



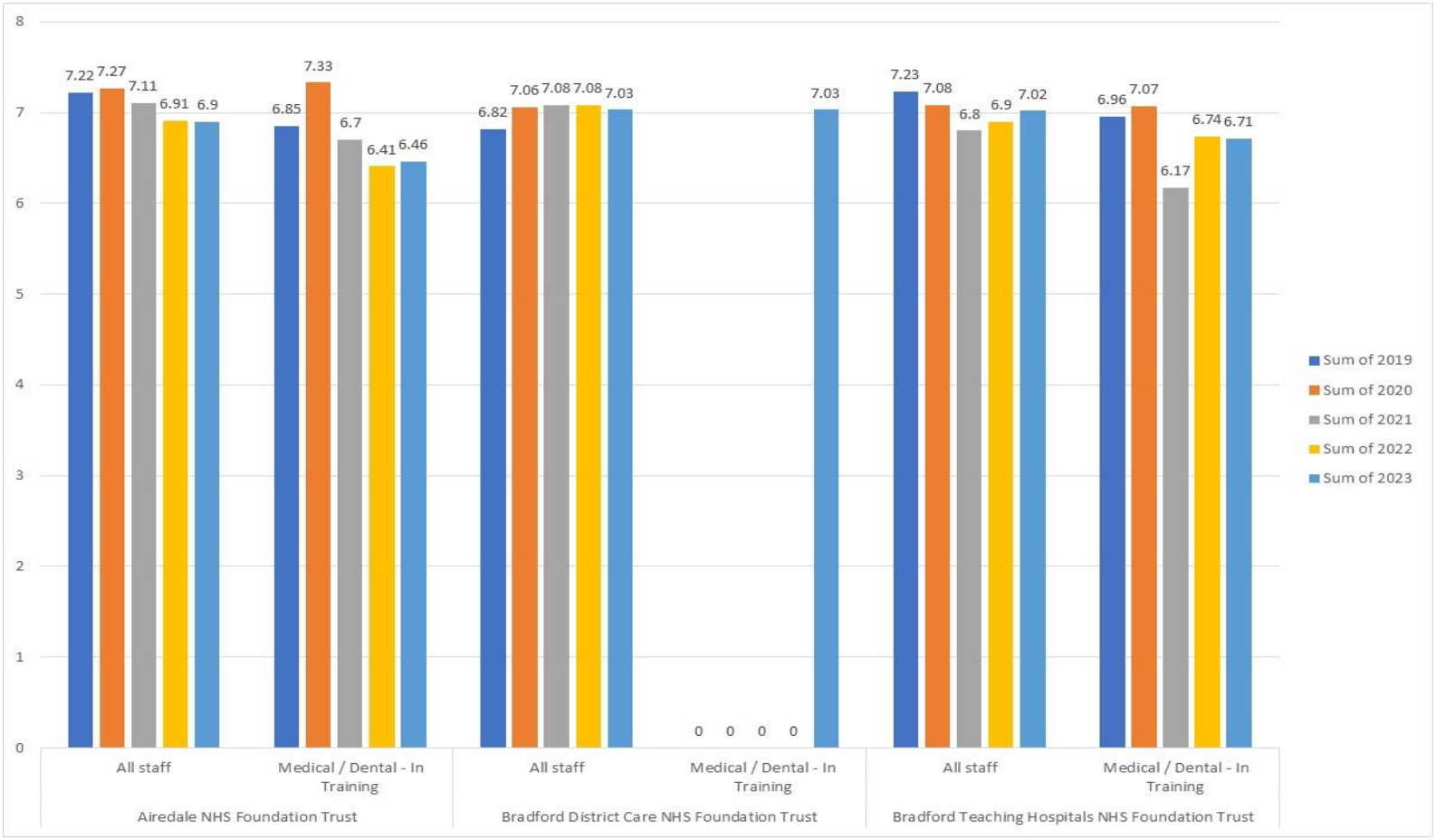
NHS Staff Survey- Score Summary, Bradford Teaching Hospitals FT



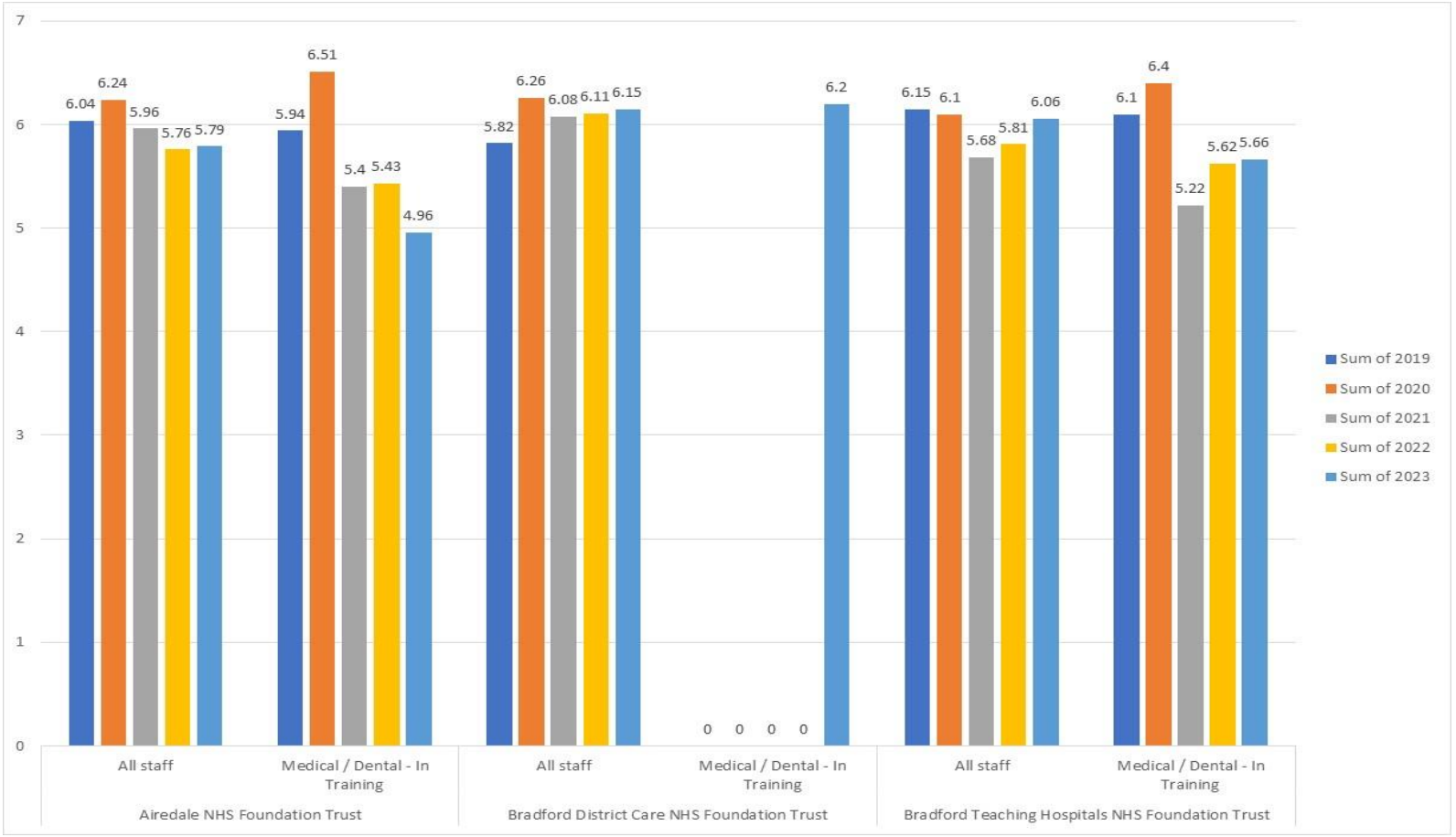
NHS Staff Survey- Score Summary, Bradford District Care Trust FT



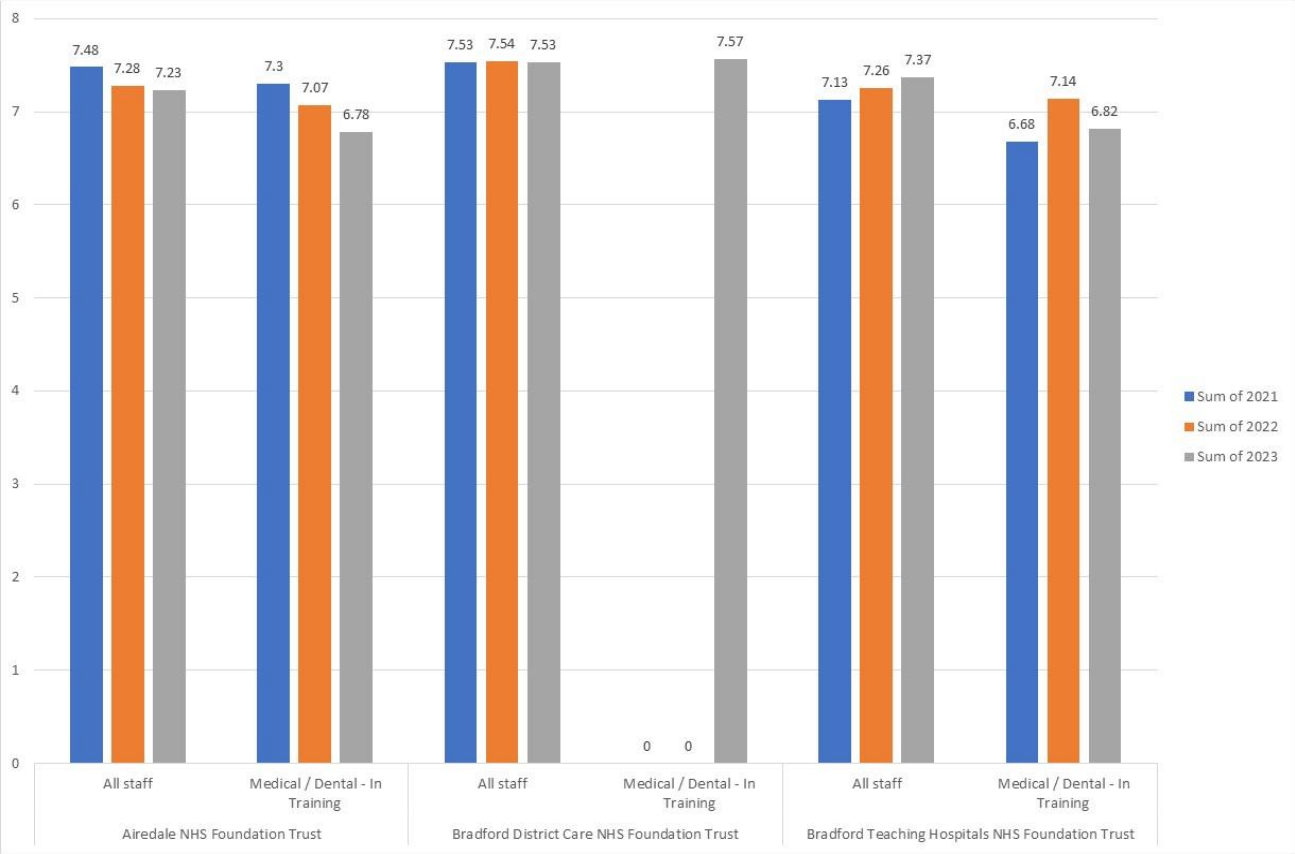
NHS Staff Survey- Staff Engagement



NHS Staff Survey-Morale



NHS Staff Survey Compassionate and Inclusive



We do not tolerate any form of discrimination, bullying or violence.

We are open and inclusive.

We make the NHS a place where we all feel we belong.

Together, WE make the NHS the best place to work.

We are the NHS.

BDC- VCSE

Huge instability in the sector makes us less attractive than other parts of our system

Short term contracts, short term extensions, late confirmation, and gaps between contracts add to this instability

Relatively lower salaries, terms and conditions add to above

Lack of uplift to contracts results in inability to increase salaries to meet cost of living increases

Instability threatens recruitment and retention of staff

BDC- VCSE (continued)

Cuts to public services funding has resulted in loss of around 60 jobs in the VCSE sector recently

Public sector advertising jobs that would be better placed in VCSE drain talent and expertise from the sector

Lots of volunteering opportunities in many VCSE organisations, could, and already do, offer placements, mainly larger VCSE organisations that have the capacity to provide the support required for this

VCSE sector is excellent at attracting people from diverse communities

We don’t have a VCSE sector workforce plan

Independent care sector staff well-being surveys

- BCA undertook 2 staff surveys between August 2022 and April 2023 to find out how care staff were feeling and what the key challenges are for them
- 250 + care workers responded between 2 surveys (low percentage of workforce but BCA reliant on Managers sharing survey with their staff)
- Consistent messages were heard between the two surveys

Challenges heard

- Poor pay levels and real difficulties in meeting rising costs of living
- Having to choose between heating and eating
- Concerns about being able to afford petrol, car insurance / repairs and childcare costs, and impact of then not being able to get to work
- Zero-hour contracts – not in control of their income / no set monthly income
- Only Statutory sick pay paid when ill, and the related fear of impact of going off sick

Impact of challenges on health and well-being

45% of staff reported that these challenges were impacting on their health and well-being, including:

- Constant feelings of anxiety and fear about situation they were in
- Stress levels increased
- Lack of sleep due to worries / constant tiredness
- Headaches / poor concentration
- Depression / feelings of hopelessness
- Increased sickness (making situation worse)

21% of staff reported that the challenges were impacting on their ability to work properly

Strategies to support

BCA
Bradford Care Association

1. Provision of information and poster by BCA to put in staff spaces / newsletters / WhatsApp groups on Care accessing:

- Care Workers Charity Crisis Loan
- FREE health and well-being resources / support and emergency mental health help-line numbers

2. Established relationship with Bradford Credit Union (CU) to enable workforce of smaller care providers (via a BCA landing page on CU website) to start saving and give access to CU offers (e.g. school uniform club, Christmas consolidation loan, food saver offer)

3. Secured £51,750 of remaining 'well-being' funds for the Credit Union to offer £30 incentives to start workforce saving and a £200 loan plus financial support advice / guidance package - focus on lowest paid workers in BD&C health and care partnership (social care, primary care, VSCE)

Bullying and feelings of not being valued

- BCA is aware (anecdotal conversations) with managers of presence of a 'bullying' culture from some health professionals towards the managers and care workforce, including: threats made to 'safeguard them'; spoken to in a belittling manner when do not have equivalent level of 'medical' knowledge; opinions not listened to / discounted though they know the person they are advocating for far better than the professional
- Staff report feelings of being treated as second class citizens and feeling less valued than NHS or Local Authority colleagues, e.g. attitudes displayed towards them, lower pay, less favourable terms, conditions and reward schemes
- This has been discussed at People Committee previously ('deep dive' into social care) with only limited progress to date made
- Access to Occupational Health agreed in principle from anchor organisations but not yet available
- WY Living Wage T& F group – scoping done and report to be taken to WY Partnership Board for support, to start to reduce pay inequalities
- WF Programme Board - workstream beginning to look at access to 'reward schemes' for all system partners (Angela Thompson, SRO)

West Yorkshire
Primary Care Workforce & Training Hub

Bradford District & Craven GPs and Practice Managers

(Feedback as Part of a Workforce Planning Exercise in Q4 22/23)

GPs included in this report are Salaried GPs, Partner GPs and Locum GPs.

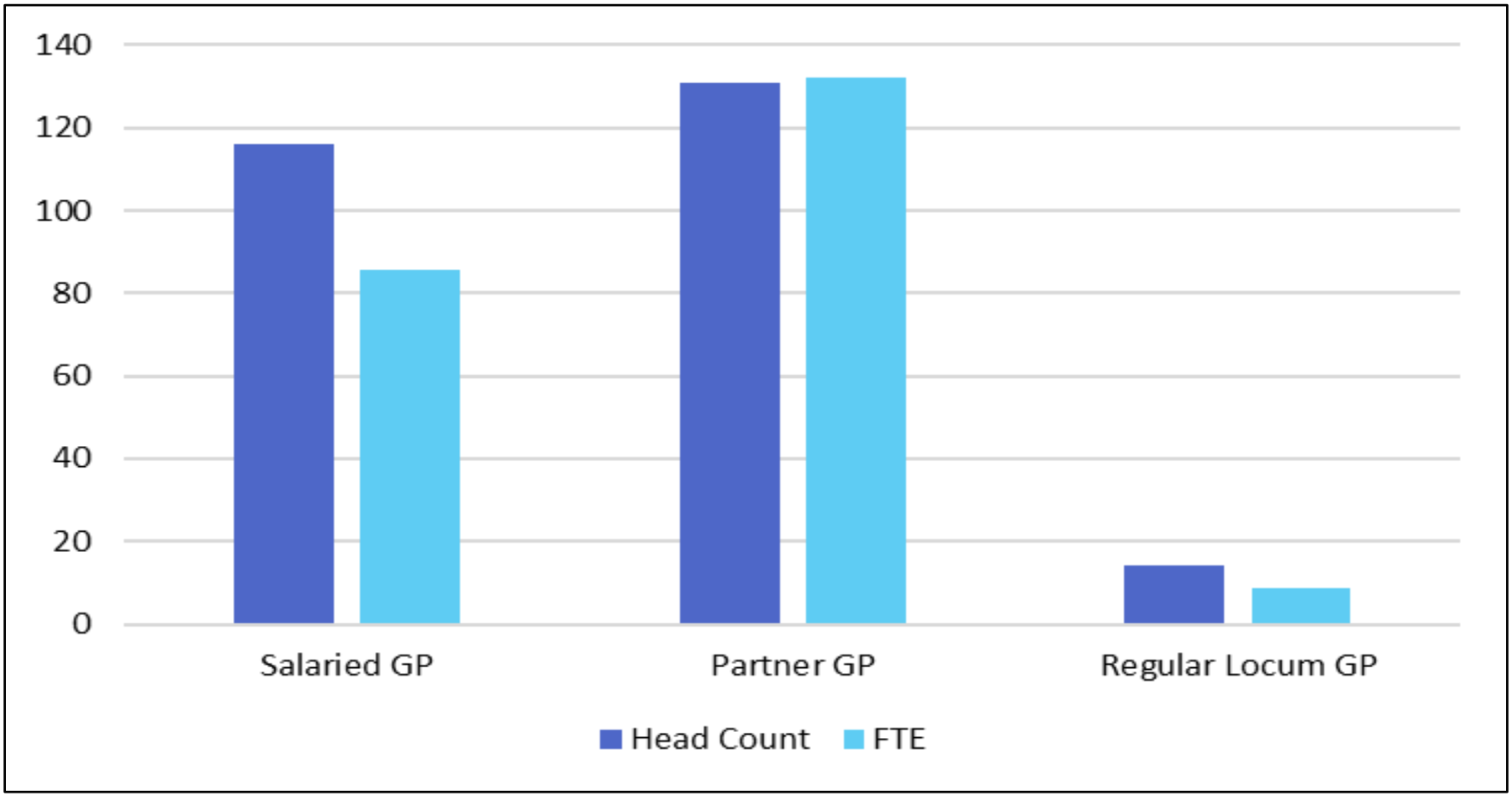
Managers included in this report are Practice Managers, Business Managers, Assistant Practice Managers and Other Managers.

Other Managers Include - Multi-Site Practice, Practice Business, Operations, Rota, HR, Patient Services, Extended Care, Admin & Nursing, Finance, Assistant Business, Admin Team, Office, Mentor/Buddy Practice, IT, PCN, Deputy Practice, Reception & Head of People and Wellbeing.

Head Count & FTE Profile of the GPs

The graph shows the current head count and FTE hours of the GPs who have completed the survey working in Bradford District & Craven.

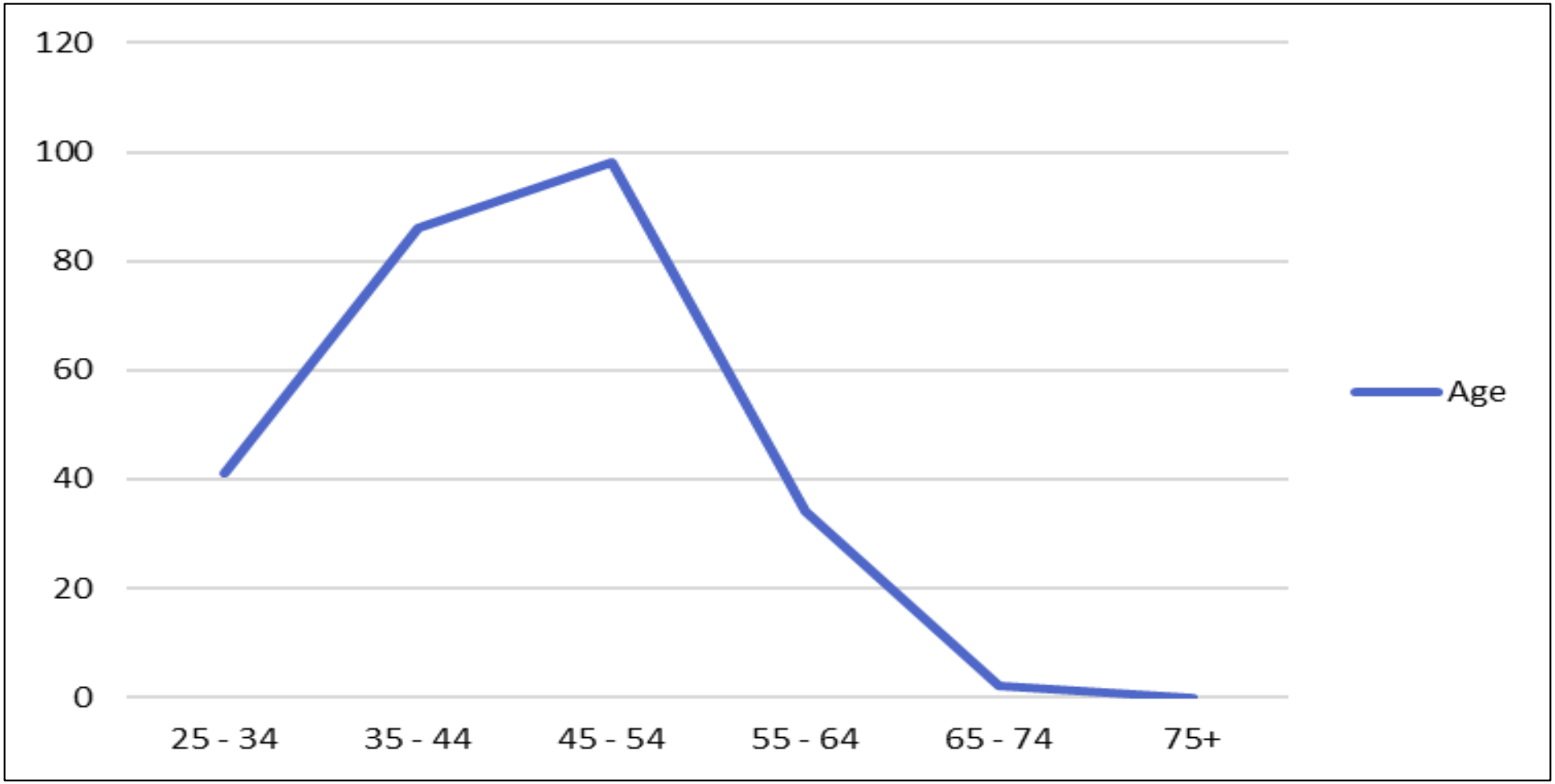
Bradford District & Craven total head count is 261
Bradford District & Craven total FTE hours is 226.7



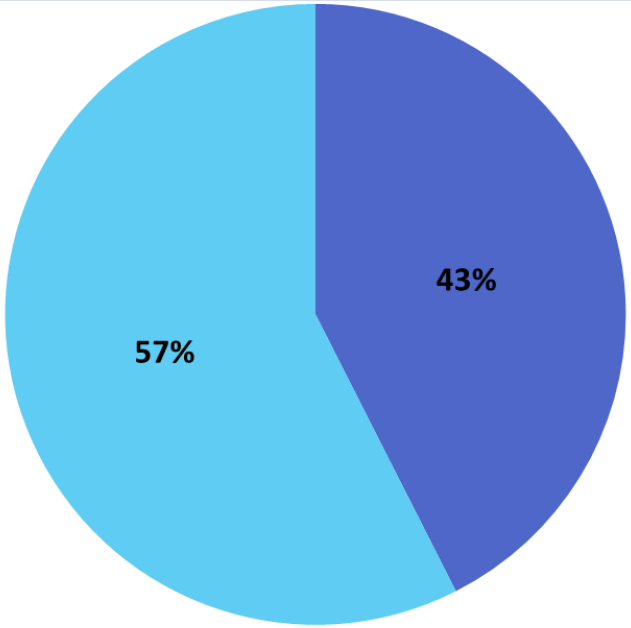
Bradford District & Craven GPs on average work 6 Sessions & 32 Hours a week

Age Profile

The line graphs show the current ages of the GPs working in Bradford District & Craven



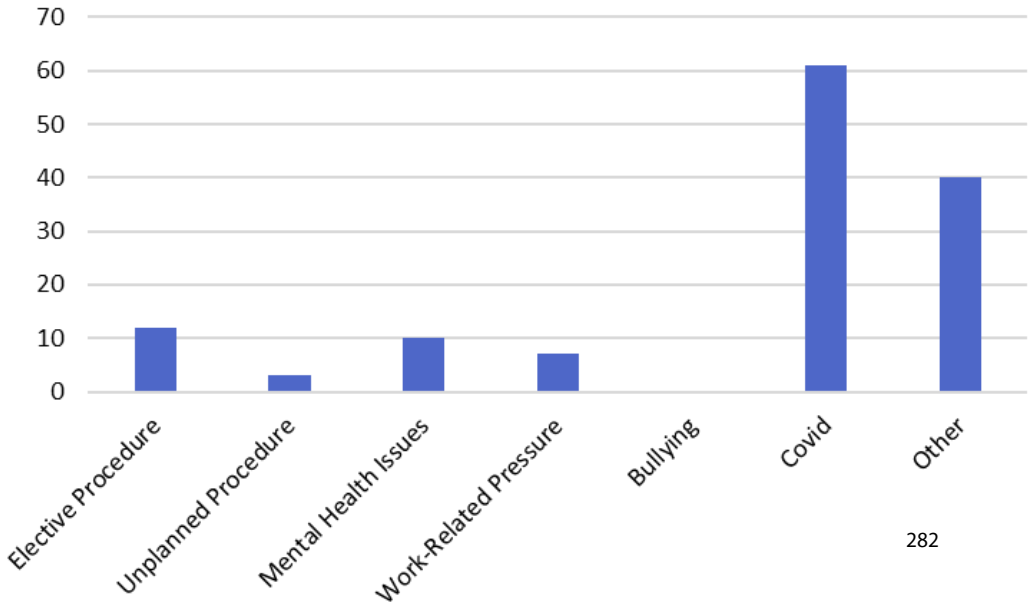
Sickness Profile



The pie chart shows if the Bradford District and Craven GPs have taken time off sick in the last 12 months.

Yes	111
No	150

The graph shows the reason the Bradford District and Craven GPs have taken time off sick.

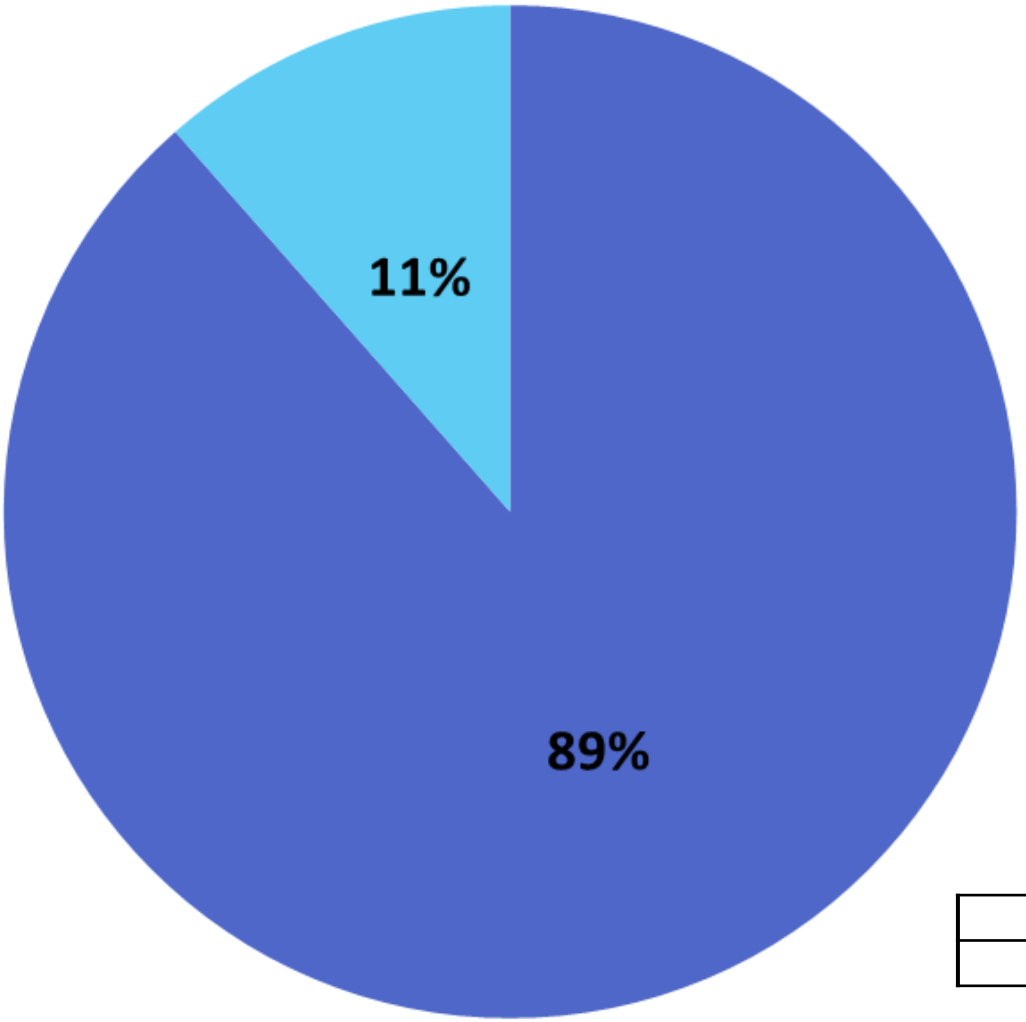


Other Answers

Cancer treatment
Viral illness
Headache / Migraine
Stress related
Bereavement
URTI
D&V
Pregnancy related illness
Injury
Gastroenteritis
Carer responsibilities
Family illness/issues

Annual Leave Profile

The pie chart shows if the Bradford District and Craven GPs feel if they are able to take time off for annual leave.



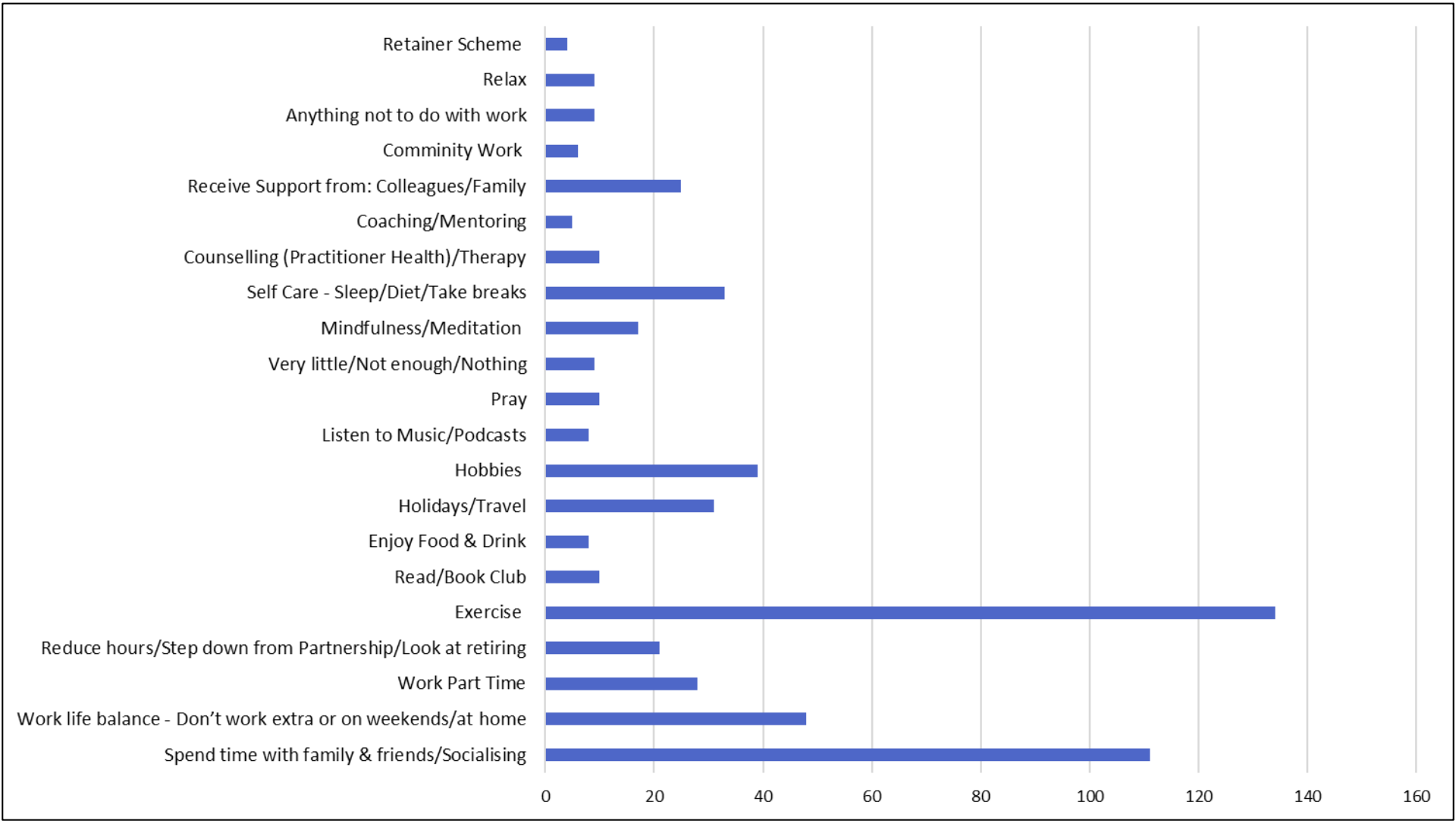
Yes	231
No	30

Reasons For Answering No

Working as single handed GP
Puts more pressure on colleagues
Feel obliged to ensure practice properly staffed
Just come back to even more work
Very difficult due to practice responsibilities
Difficulty finding cover
Inflexible annual leave allocation
Work accumulates whilst away
Workload and workforce pressures
I take time off but am logging on to complete work that builds up if I don't
Not when I want to take it as I have to share school holiday dates with colleagues
Worried about short staffing, makes it hard on everyone else, not enough locums and they don't cover the paper work/bloods

Bradford District & Craven Well-Being Profile

Bradford District & Craven GPs were asked what they did to protect their own well-being. The graph shows their responses.



Bradford District & Craven Career Advice

Bradford District & Craven GPs were asked If a friend of yours was considering becoming a GP, what would your advice to them be and why?

Do it, I still think it's a great career due to the variety of options available within general practice.

It is a great job, we're under some pressure at present but with good colleagues around you it is still a wonderful job. Don't listen to all the negatives.

Do it as long as you always keep the patient at the centre of everything you do. Remember why you chose this career and remember almost everyone on a 6 figure salary works insanely hard whatever the job. Enjoy it but don't let it take you down. It's only a job and life is short.

I wouldn't do anything else. Lots of branches available to suit anyone. Well supported throughout.

Consider it carefully. I feel it is a fantastic job and one that I feel privileged to have done for most of my career. However I feel the workload has increased especially over recent years. There is a fundamental lack of GPs. Insufficient training numbers, those that do work usually work part time or have a portfolio career meaning significantly lees WTE actual GPS. GPSI work and "committees" etc valued more than day to day general Practice which is fundamentally the most challenging part of the role. Choose careful the ethos of the practice you join.

Personally I love the job but it has changed into something else now and the training is arduous hoops that don't prepare you for real life. Perhaps be a GP, but not a partner.

Think carefully, the public opinion has turned and lots of anger directed at the profession. It's stressful but ultimately rewarding.

It's a rewarding interesting career but the hours are long, it's hard to control your work load, and you have to deal with constant change, which isn't always in the best interest of patients or staff, but is often at the whim of politicians. Develop a speciality or other role to keep your options open.

Do something, anything, else. Unbelievable pressures on the service in terms of both volume and type of work. Complete lack of insight into General Practice from central government, who do not value the service.

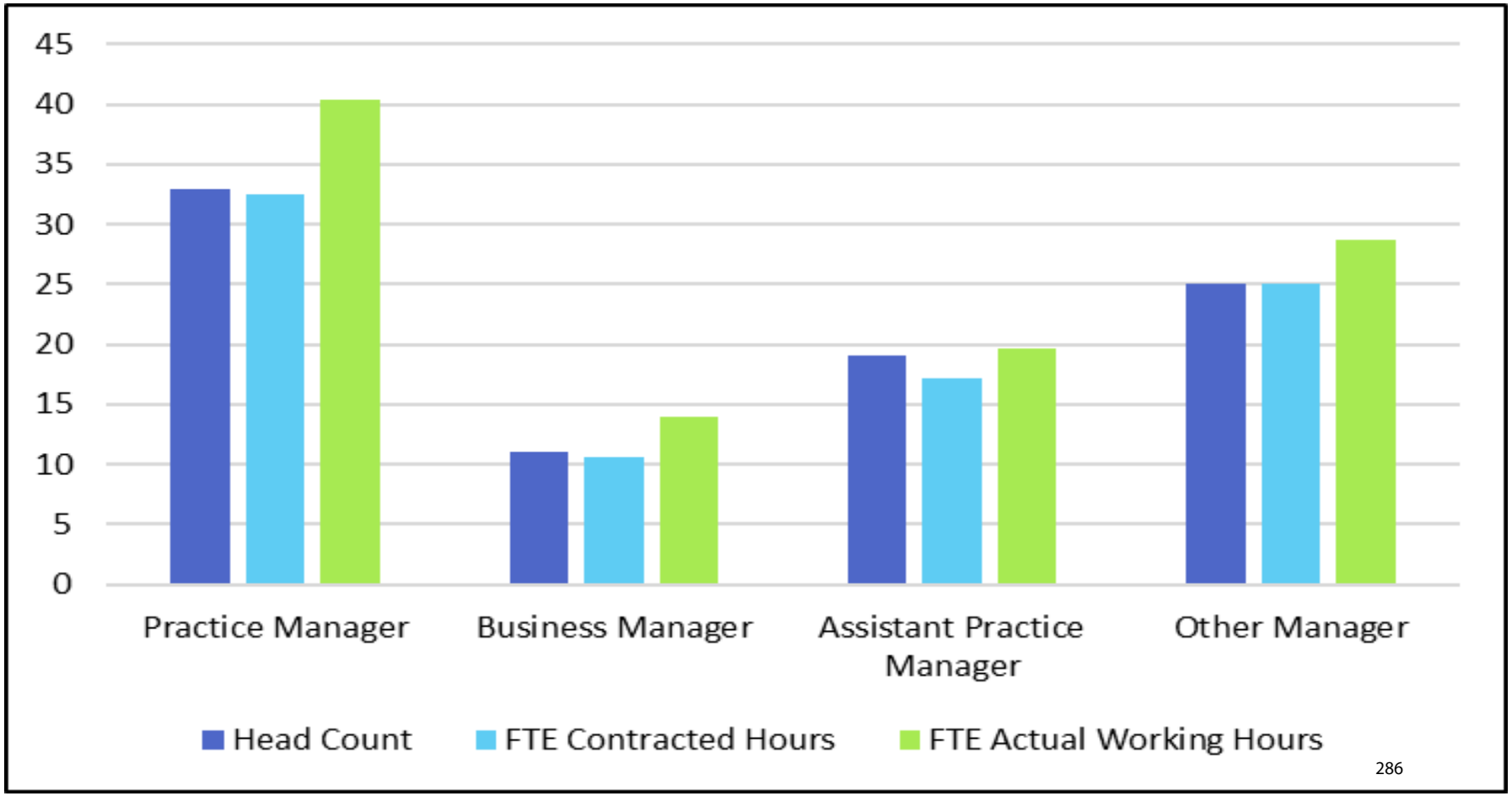
Don't. It's not a career that gives job satisfaction, everyday is fire fighting. general practice is a sinking ship. T
here's feels to be no real future in the career. It does however pays the bills and there's no weekend working (currently)!.

I would most definitely advise them against it at the current time because the workload and the hours are unsustainable. You never feel on top of your work despite working for hours longer than you are paid for.

Head Count & FTE Profile of the Managers

The graph shows the current head count, FTE contracted hours and FTE actual working hours of the managers who have completed the survey working in Bradford District & Craven.

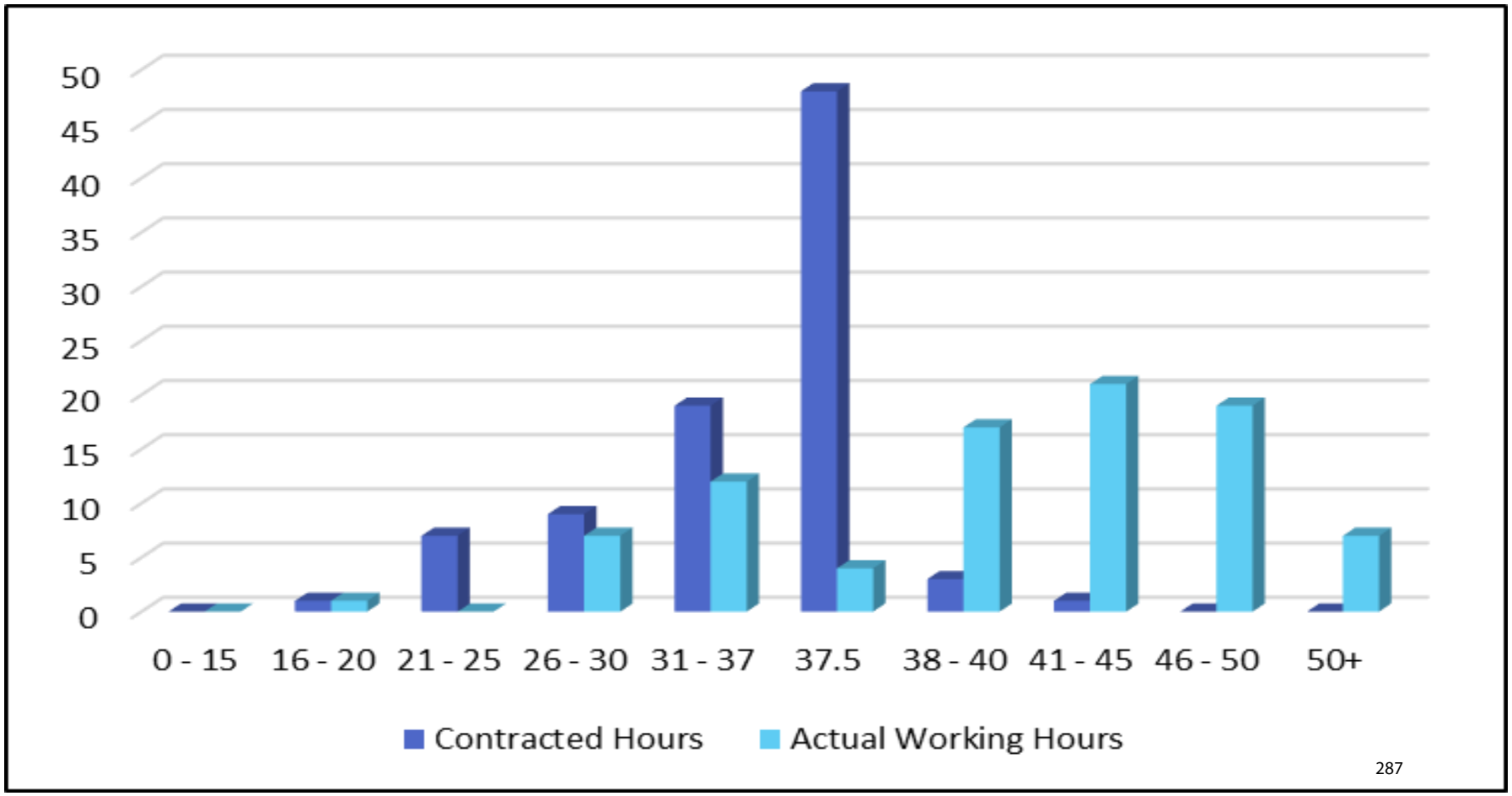
Bradford District & Craven total head count is 88
Bradford District & Craven total contracted WTE is 85.4
Bradford District & Craven total WTE by actual hours worked is 102.7



Contracted & Actual Working Hours Profile

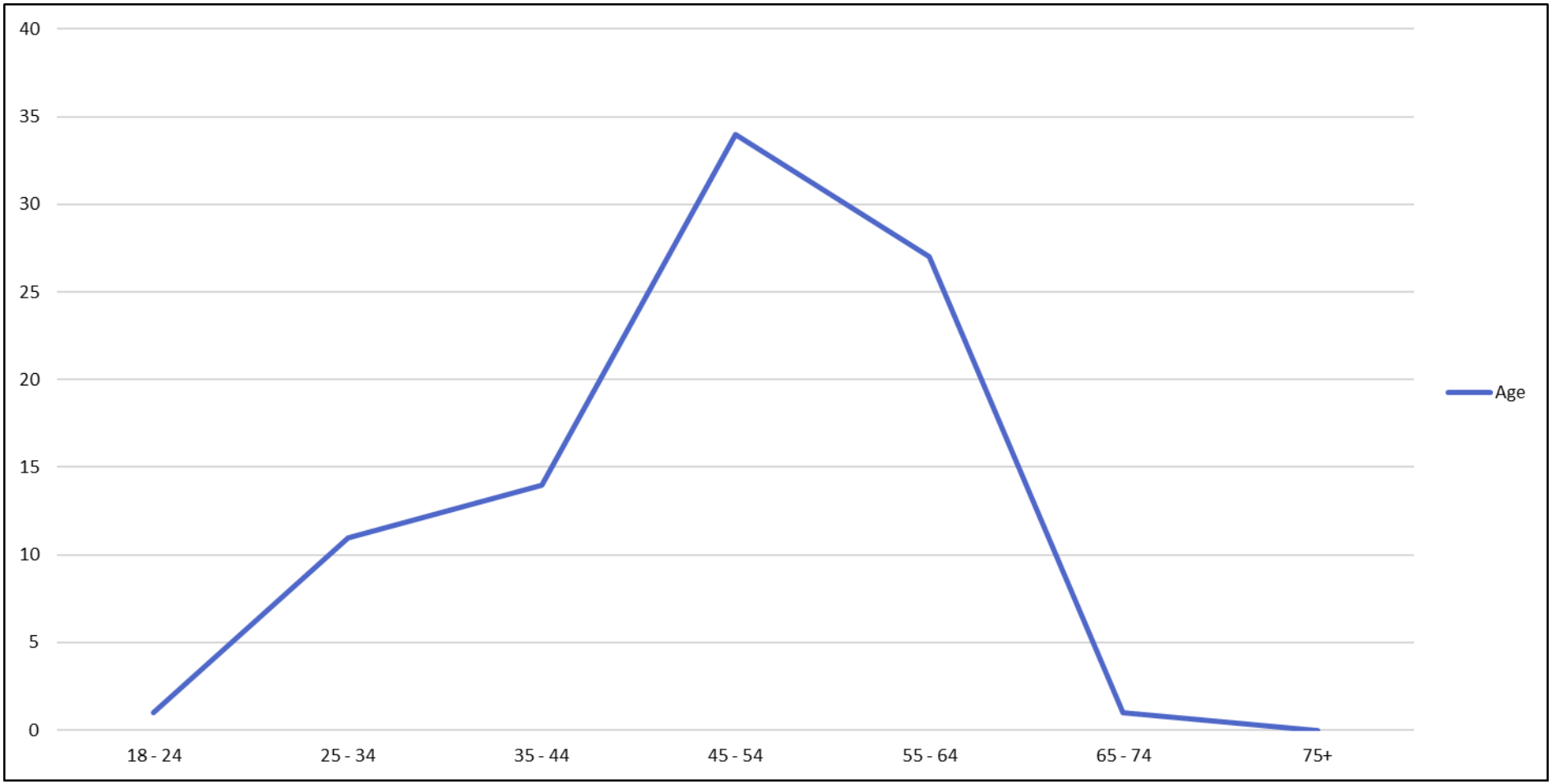
The graph shows the hours the managers are contracted to work a week and the hours the managers actually work a week in Bradford District & Craven.

On average Bradford District & Craven Managers work 8hrs over their contacted weekly hours



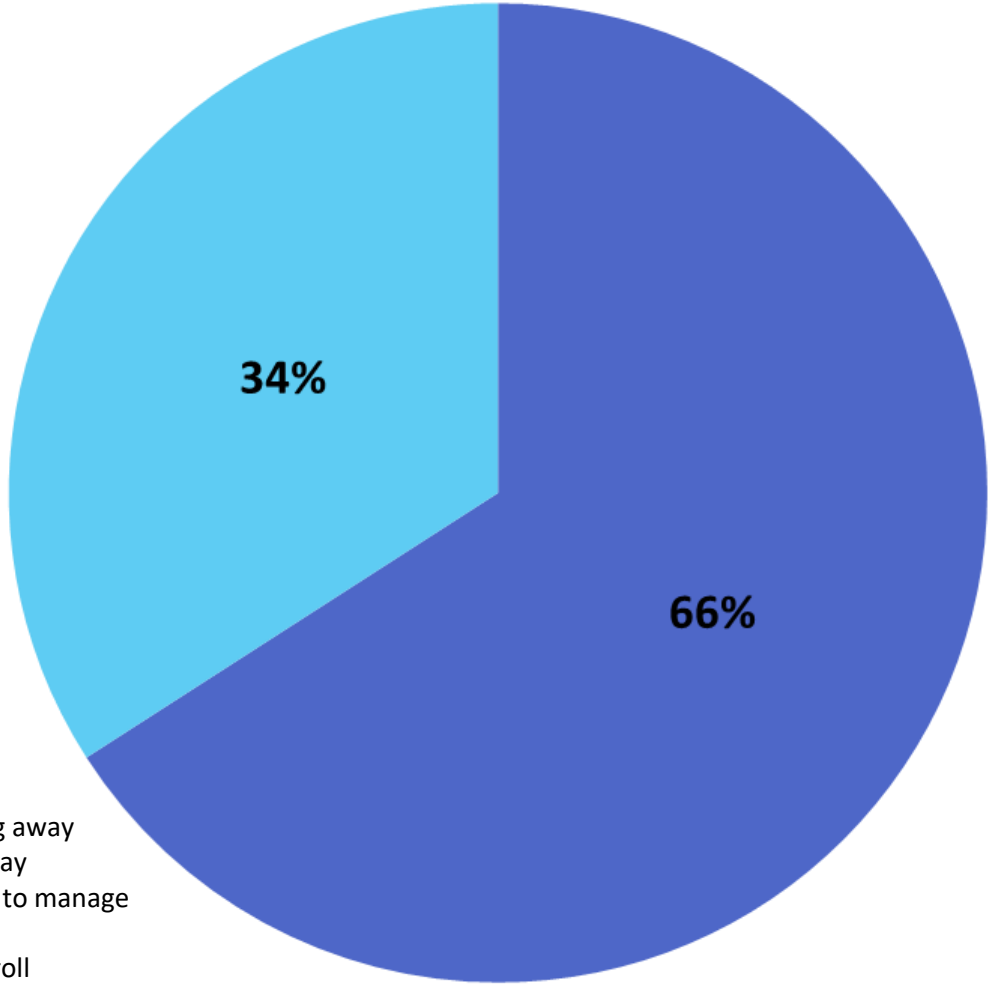
Age Profile

The line graphs show the current ages of the Managers working in Bradford District & Craven



Annual Leave Profile

The pie chart shows if the Bradford District and Craven managers feel if they are able to take time off for annual leave.



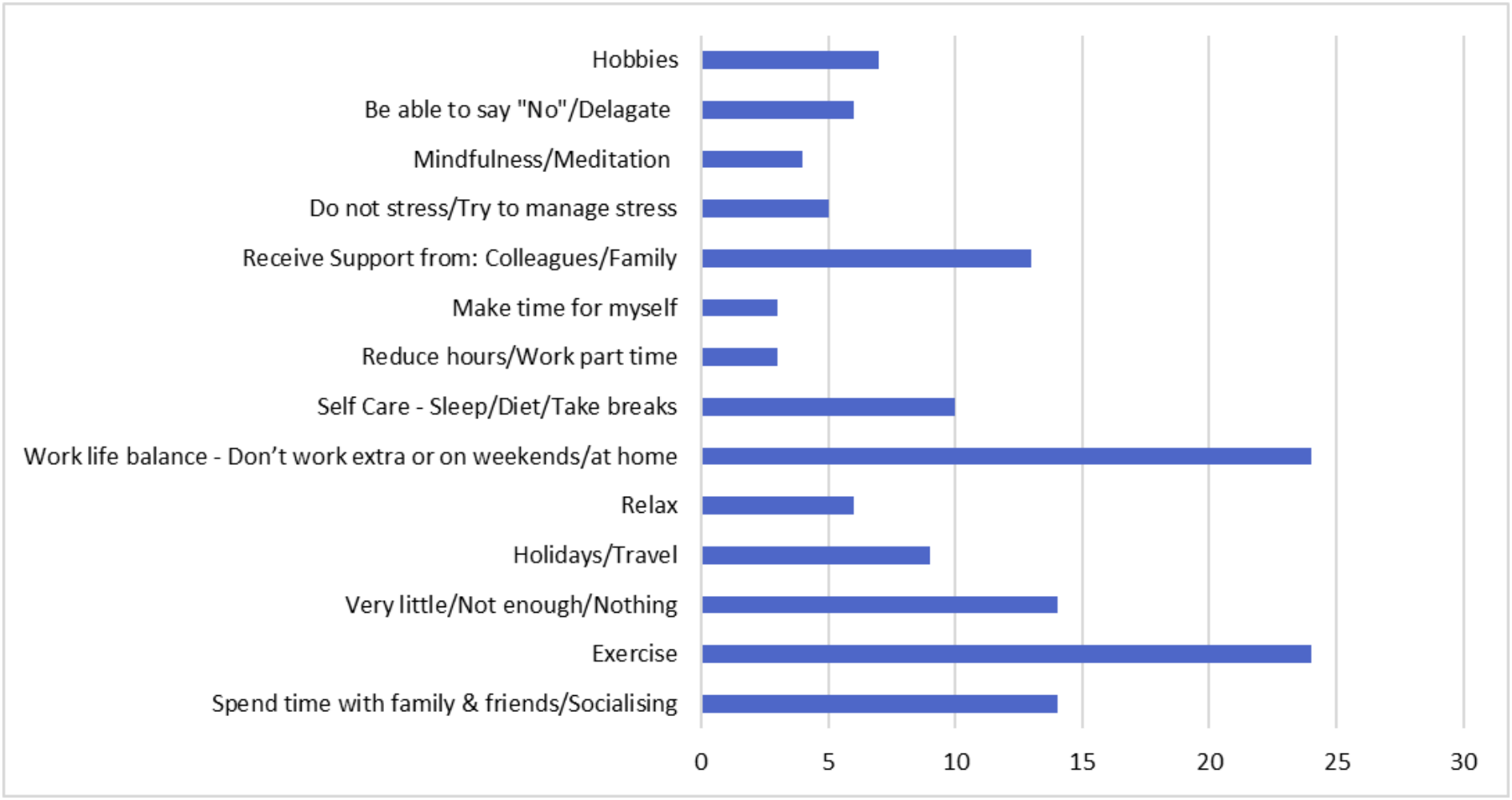
Yes	58
No	30

Reasons For Answering No

Feel guilty / letting practice & staff down for being away
Workload is so high and work isn't done whilst away
Come back to huge backlogs which is doubly hard to manage
Delays work that needs to be done
Difficult to take due to having to plan around payroll
No cover for my role
Still have to come into work or answer emails/calls on annual leave
Come back to 100's & 100's of emails
Annual leave just adds more stress
Extreme anxiety on return
Impacts on myself and organisation

Bradford District & Craven Well-Being Profile

Bradford Districts & Craven Managers were asked what they did to protect their own well-being. The graph shows their responses.



Bradford District & Craven Career Advice

Bradford Districts & Craven Managers were asked If a friend of yours was considering a career in Practice Management, what would your advice to them be and why?

You have to be a multi tasker, enjoy a varied role, be resilient to many changes and thrive on challenges.

Go for it and enjoy every minute. Its a tough job, but you can make a real difference to the patients you serve. Be realistic in what you can achieve and be prepared for constant change its the NHS! Its a fantastic job, enjoy the ride it can be bumpy but massively rewarding.

There is a LOT to take in so ask lots of questions, build a network of support and it is ok to say you are not sure about an answer.

Interesting and varied job needing flexibility stamina and patience.

Great opportunity to work as a PM. You will need to be very strong character to deal with current primary care climate. Manage expectations of your employers and staff.

It’s hard and often stressful. You need a thick skin. You need to be organised and be prepared for anything to happen.

You will need a passion for the job, it is incredibly difficult and not for the faint hearted.

Choose your Practice & the Partners carefully. Every Practice Manager's role is different so read the job description very carefully. The role is constantly evolving & you will need a shared ethos to progress, succeed and thrive.

That it is very challenging, stressful and frustrating but can sometimes have a great sense of achievement. There are no half measures in this role or you fail.

I would tell them it's not a job for someone with a young family due to the hours and pressure of the role. Despite the fact that the job is never boring it will be the hardest role they will ever encounter with the longest job description and the least amount of support.

I would be honest that being a Practice Manager is Jack of all trades and master of none.

Don't do it, it is a very stressful role.

To look for another career path. Too many changes and fast changes. It used to be a great career - now it is impossible. The entire model of General Practice needs to change.

Walk away and protect your family and your mental health.

Meeting name:	Health and Care Partnership Board
Agenda item no:	11
Meeting date:	17 May 2024
Report title:	2024-25 Financial Planning Update
Report presented by:	Mike Woodhead, Lead Finance Director
Report approved by:	
Report prepared by:	Mike Woodhead, Lead Finance Director

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☒

Previous considerations and any resulting action:

n/a

Executive summary and points for discussion:

BDC Place is submitting a £47.6m deficit plan for 2024-25 on 2 May 2024. Whilst this has reduced considerably since the first planning submission on 22 February (£83.7m deficit), it should be noted that:

- The plans contain significant risks and high savings targets
- BDC has a disproportionately large deficit compared to other WY Places
- We are under continued scrutiny and pressure to further close the gap

The paper describes the outcome of a recent WY peer review and challenge session and outlines the next steps in terms of system workstreams, governance, and other options currently under consideration.

Outline how this supports our partnership vision and strategy

Our Purpose and Population – The paper outlines the importance of us all working to close the financial gap in order to optimise the outcomes for our population under sub-optimal financial conditions.

Our Partnership – The paper outlines the importance of collaborating to achieve greater value through the best use of our collective resources, minimising duplication and waste.

Recommendation(s)

The Heath and Care Partnership Board is asked to:

1. Note the reduced deficit plans.
2. Discuss the challenges in further closing the gap.

3. Take/ seek further assurance regarding the work being undertaken to further close the gap.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
The report quantifies the headline financial risks to NHS organisations in the partnership and describes steps being taken to mitigate those risks.
Appendices
Acronyms and Abbreviations explained

What are the implications for?

Residents and Communities	Potential impact of services impacting on health outcomes/ patient experience
Quality and Safety	Potential impact of quality of services available
Equality, Diversity and Inclusion	Risk of impact on health inequalities
Finances and Use of Resources	Failure to meet statutory financial duties
Regulation and Legal Requirements	See all of the above
Conflicts of Interest	
Data Protection	
Transformation and Innovation	Need for greater transformation and innovation
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	Need for citizen and stakeholder engagement

2024/25 Financial Planning Update

Bradford District and Craven Health and Care Partnership Board

17th May 2024

1. **Purpose**

This paper gives a brief update to the HCPB regarding the 2024/25 financial plans and next steps.

2. Financial Headlines

Table 1 shows the headline planning numbers for the 2 May submissions, compared to earlier versions.

Table 1: Planning Headlines 2024-25

	22 Feb £m	21 Mar £m	26 Apr £m	2 May £m	*Incl CIP £m*	*CIP %*
ANHSFT	(26.3)	(25.3)	(22.7)	(20.8)	*13.0*	*5.0*
BDCT	(7.6)	(5.5)	0.0	0.0	*14.2*	*6.9*
BTHFT	(29.4)	(26.3)	(22.6)	(19.0)	*33.9*	*6.0*
BDC ICB	(20.4)	(14.2)	(7.8)	(7.8)	*12.9*	*2.8*
Total Place (NHS)	**(83.7)**	**(71.3)**	**(53.1)**	**(47.6)**	***65.3***	

The NHS system deficit plan has reduced by 43% since 22nd February and now stands at £47.6m, attributable mostly to the two acute trusts. The £47.6m deficit is predicated on achieving £65.3m savings, at the same time as containing challenging demand and cost pressures. That level of savings (ranging from 5% to nearly 7% across the three providers) is, of course, well above any levels of savings achieved in recent years, suggesting a high degree of risk.

The plans also need to be seen in the context of the wider system environment and other risk factors, including:

- Bradford Council financial distress (savings target of £35m-£40m p.a.).
- Escalating and costly estates issues (Lynfield Mount, Airedale RAAC, Skipton Hospital etc).
- Demand pressures (urgent care, waiting lists, “no criteria to reside” and “length of stay” issues, continuing healthcare demand).
- Care home market pressures.
- Out of area patients/ service users.
- Workforce pressures (agency/locum spend, workforce constraints, industrial action).

- Impact of new Electronic Patient Record system at ANHSFT.

The £47.6m deficit plan accounts for a disproportionate share - approximately 38% - of the WY ***Place***[1] deficit plans. The ICS and BDC Place are coming under increasing pressure and scrutiny to close the gap further.

3. Scrutiny to date

System wide scrutiny to date has largely been in the form of:

- BDC place meetings (e.g. System Finance and Performance Committee, BDC Health and Care Partnership Board, Local Directors of Finance meetings, Place Leadership Executive, Closing the Gap Steering Group, etc).
- West Yorkshire meetings
    - Peer to peer reviews (finance led).
    - WY Finance Forum.
    - WY ICS Health and Care Partnership Board.

There have also been several standalone escalatory interventions leading up to a whole-day peer review session (on Friday 26th April) with colleagues from across West Yorkshire, including Accountable Officers, Medical Directors, Chief Nurses, Chief Operating Officers, Human Resources Directors, Chief Information Officers, Chief Finance Officers, and others. This was followed up with phone calls to each of the acute trusts Chief Executives and Chairs.

The feedback from the all-day peer review session is summarised in Table 2.

Table 2: Peer Review Session Feedback

Panel Feedback	BDC reflection
There is lots of good work going on to progress opportunities for which savings aren't yet reflected in the plans (question: are BDC organisations being too cautious?)	This might be true for some specific opportunities but, overall, plans include an unprecedented level of challenge and risk as they are, and individual organisations must feel able to sign up to them. Since the review session, the two acute trusts have reduced their deficit plans by £5.1m in total.
There is more scope for the organisations to come together at system level.	Agreed. Objectives 2 and 4 of the Closing the Gap Mandate address this (see section 4.1). We will continue to consider further opportunities of joint working.
We might need to progress some of the opportunities ahead of any West Yorkshire timetables/lead.	Yes, although we need to consider which specific opportunities that might apply to.
There are good opportunities that will deliver in future years, and we should make sure that is reflected in the narrative of our plans.	Agreed. This will be reflected in a system-wide 3-year plan.

[1] The overall deficit plan for WY ICS is around £100m, but that includes around £24m "surplus" held at WY level, not attributable to individual Places. If we just compare BDC to the other Places, BDC accounts for approximately 38% of a £124m deficit – down from 47% at the last plan submission stage.

There is no doubt that external scrutiny and pressure will persist beyond the May 2nd plan submission, and there is an increasing likelihood of more intrusive regulatory intervention (e.g. sending a "big firm" in to work with the Place and/or acute trusts). The form, nature and timing of that intervention will depend heavily on the national planning landscape, and NHSE's capacity to intervene at scale.

4. Next steps

4.1. System workstreams and governance

The Closing the Gap programme has 4 agreed objects as follows:

OBJECTIVE 1	Agree the top opportunities for improving productivity and tackling waste.
KEY RESULT 1	Using benchmarking and key data-sources such as the Model Health System, GIRFT, NHS IMPACT, AOMRC RightCare, NHS Benchmarking, DSCRO , SLAM, FutureNHS etc, identify the main opportunities for each organisation to: - Reduce waste - Stop Procedures of Limited Clinical Value - Reduce unwarranted variation in quality - Reduce unwarranted variation in cost - Reduce unwarranted variation in referrals and demand - Maximise productivity
KEY RESULT 2	Gain assurance that a realistically challenging programme plan is in place to achieve the above opportunities in each organisation, including measurable outputs, timescales, owners, and actions.
KEY RESULT 3	Instigate quarterly local 'check and challenge' sessions.

OBJECTIVE 2	Identify and prioritise services that could be stopped / slowed, paused, and scaled down.
KEY RESULT 1	Each organisation to complete review of services (modified EY template) during H1, including a focus on fragile services.
KEY RESULT 2	Agree system-wide prioritisation of 'opportunities' identified in Key Result 1, with QEIAs where needed.
KEY RESULT 3	Facilitate workshop(s) to identify opportunities for further collaboration and/or rationalisation across organisations.

OBJECTIVE 3	Progress our system population health approach
KEY RESULT 1	Complete population segmentation work and health needs assessment and analysis to inform in-year allocative efficiency opportunities and future planning rounds.
KEY RESULT 2	Align health needs assessment with programme budgets.
KEY RESULT 3	Implement a programme of work to address agreed PLE priorities, as and when required, that emerge as opportunities.

OBJECTIVE 4	Progress immediate system priorities with City of Bradford Metropolitan District Council
KEY RESULT 1	Implement a programme of work to tackle: - Complex children's packages of care and out of area placements - Intermediate care reform and the review of the Better Care Fund spend - Housing for health - Strategic estates work

These programmes are being managed and overseen through the revised system governance arrangements, which include:

- Closing the Gap Programme Board, responsible for the 4 objectives/programmes above, reporting to Place Leadership Executive. This is a multi-disciplinary group representing place.
- Business Care Appraisal Panel, responsible for apprising business cases (for investment or disinvestment) and making recommendations to Place Leadership Executive. This is a multi-disciplinary panel representing place.

It is worth re-emphasising that Quality and Equality Impact Assessments will be undertaken wherever appropriate, before final decisions are made/implemented.

4.2. Other options under consideration

In addition to the programme of work described in section 4.1, all organisations and places are required to consider what other options are available to further close the gap, and what the impact of such actions would be.

WY ICS have asked each organisation to explain whether it has implemented or is considering the following options (and if not, why not):

1. Recruitment freeze: non-clinical staff .
2. Re-setting non-clinical staffing establishments to 2019/20 levels.

3. Reductions to staff health and well-being services.
4. Holding vacancies: clinical staff.
5. Staff to West Yorkshire Association of Acute Trusts (WYAAT) safe staffing ratios.
6. Restrictions on medical locum usage.
7. Reductions to overtime spend.
8. Reduction in secondary care take home drugs days.
9. Reduce services where offer exceeds specialised commissioning specification.
10. Ward closures (linked to people not requiring a hospital bed).
11. Service reconfiguration reviews across multi-site working (may be 2025/26 implementation).
12. Implementation of evidence-based interventions/limited clinical value procedures.
13. Reduction in Mental Health out of area placements.
14. Better Care Fund review of arrangements.
15. Reductions to Voluntary, Community and Social Enterprise (VCSE) contributions.
16. Discharge funding opportunities.
17. Capacity fund opportunities.
18. Controls on discretionary non-pay.

This is not an exhaustive list. Individual organisation's responses will vary and be nuanced. Again, QEIAs would need to be undertaken where appropriate.

5. Recommendations

Members are asked to:

- Note the reduced deficit plans.
- Discuss the challenges in further closing the gap.
- Take/ seek further assurance regarding the work being undertaken to further close the gap.

Meeting name:	Partnership Board
Agenda item no:	
Meeting date:	17th May 2024
Report title:	2024/25 Operational Planning
Report presented by:	Mike Woodhead, Lead Director of Finance, Bradford District & Craven Health & Care Partnership
Report approved by:	Mike Woodhead, Lead Director of Finance, Bradford District & Craven Health & Care Partnership
Report prepared by:	Kerry Weir, Associate Director Planning, Performance & Business Intelligence

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations:			
Draft plans presented at the 8th February meeting.			
Executive summary and points for discussion:			

The following provides and update on this year's operational planning and our final submission.

Key points to note are:

- Detailed guidance has now been published, although planning had already commenced. Final plans were submitted to West Yorkshire Integrated Care Board (WYICB) on 26th April.
- The national guidance sets out 3 key focus areas: Recovering core services; Supporting the workforce; and Improving productivity, underpinned by six planning themes and 4 areas for future planning.
- There are also a set of national objectives that plans must deliver and some national assumptions setting the context in which plans should be developed.
- The main changes in requirements from our draft plans are some increased national targets and a number of new planning trajectories. There are also a number of new requirements (which don't require detailed trajectories) that we might need to build into our Act as One work as they could come under increased scrutiny.
- In general, activity and performance trajectories deliver all national requirements with the following exceptions:
  - Bed occupancy plans are above the national 92% target;
  - Yorkshire Ambulance Service (YAS) Category 2 Response times plan is above the 30-minute target;

- Airedale NHS Foundation Trusts (ANHSFT) activity plans are impacted by reduced capacity during implementation of the new Electronic Patient Record (EPR); and
- 95% or above of patients will be seen within 6 weeks for all diagnostic specialties, with the exception of audiology (90% by March 25) due to the current significant backlog.

- Plans still show a financial deficit position to be addressed, but this has significantly improved since the beginning of the planning process. However, plans assume significant cost improvement programmes (CIPs) can be delivered.
- Following further triangulation with finance and activity, workforce plans now show no growth in staff in post. Plans still assume reductions in temporary staffing across the year, no further industrial action in 2024/25, a continued reduction in bank/agency use and that recruitment plans will deliver temporary staffing reductions.
- We currently have challenges in recruitment and retention of GPs and wider GP workforce, especially in deprived areas. Our planning assumption therefore remains regarding no growth planned for 2024/25 but that current staffing levels can be maintained.
- There remains a number of risks which could impact the delivery of our plans.

Outline how this supports our partnership vision and strategy

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

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

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

Recommendation(s)

The Partnership Board is asked to:

1. Note the update on the 2024/25 Operational Plan

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

Appendices

1. Presentation: 2024/25 Operational Plan

Acronyms and Abbreviations explained

1. A&E – Accident and Emergency
2. ANHSFT - Airedale NHS Foundation Trust
3. ARRS - Additional Roles Reimbursement Scheme
4. BDC – Bradford District and Craven
5. BDCFT - Bradford District Care Foundation Trust
6. BTHFT - Bradford Teaching Hospitals Foundation Trust
7. CIP - Cost improvement programme
8. CDC - Community Diagnostic Centre
9. CYP - Children and Young People's
10. EPR - Electronic Patient Record

11. ERF – Elective Recover Fund
12. FDS – Faster Diagnosis Standard
13. IA – Industrial action
14. IS - Independent Sector
15. LD - Learning Disabilities
16. LoS - Long length of stay
17. MH – Mental Health
18. NCTR - No Criteria to Reside
19. PIFU - Patient Initiated Follow Up
20. PCN – Primary Care Network
21. RAAC - Reinforced Autoclaved Aerated Concrete
22. RTT - Referral to Treatment
23. SMI – Severe mental illness
24. VW – Virtual Ward
25. WYICB - West Yorkshire Integrated Care Board
26. YAS - Yorkshire Ambulance Service

What are the implications for?

Residents and Communities	Delivery of services that fulfil NHS constitutional requirements, meet the needs of the population, and improve population health
Quality and Safety	Delivering high quality and safe services
Equality, Diversity, and Inclusion	Services accessible to all
Finances and Use of Resources	-
Regulation and Legal Requirements	-
Conflicts of Interest	-
Data Protection	-
Transformation and Innovation	Service transformation to deliver improved performance
Environmental and Climate Change	-
Future Decisions and Policy Making	Performance against strategic priorities to inform decision making
Citizen and Stakeholder Engagement	-

Bradford District and Craven
Health and Care Partnership

ACTasONE

2024/25 Operational Planning

Health & Care Partnership Board

17th May 2024

2024/25 Planning Guidance

Bradford District and Craven Health and Care Partnership

The national guidance has now been released and sets out 3 key focus areas: Recovering core services; Supporting the workforce; and Improving productivity. These are underpinned by :

- Maintaining a focus on quality and safety of services, particularly maternity and neonatal services, and reducing inequalities in line with Core20PLUS5.
- Improving ambulance response and A&E waiting times by supporting admission avoidance and hospital discharge.
- Reducing elective long waits and improving performance against the core cancer and diagnostic standards.
- Making it easier for people to access community and primary care services, particularly general practice and dentistry.
- Improving access to mental health services so that more people of all ages receive the treatment they need.
- Improving staff experience, retention and attendance.

The guidance also sets out the need to plan for the future in terms of:

- **Improving health and joined up care:** Systems to work together to build on their initial Joint Forward Plan (JFP), set out steps to address the most significant causes of morbidity and premature mortality, and improve service co-ordination including steps to expand evidence-based approaches to population health, join up care closer to home, integrate and streamline UEC pathways, and drive improvements in productivity and operational effectiveness.
- **The NHS Long Term Workforce Plan:** Systems to set out their workforce plan in the JFP, describe how to deliver the skill mix required to meet population needs over the next 5 years.
- **Modernising the infrastructure:** Systems to work together to develop infrastructure strategies by July 2024 for modern, sustainable infrastructure that deliver high quality care and the net zero commitment.
- **Harnessing data, digital and technology:** Systems to continue supporting the levelling up of provider digital maturity across all sectors, focusing on deploying and upgrading electronic patient records, championing the NHS App and engage with the rollout of the Federated Data Platform.

2024/25 National Objectives

Bradford District and Craven Health and Care Partnership

Quality and patient safety	• Implement the Patient Safety Incident Response Framework (PSIRF)
Urgent and emergency care	• Improve A&E waiting times with a minimum of 78% of patients seen within 4 hours in March 2025 • Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25
Primary and community services	• Reduce long waits in community services • Improve access to primary care, support practices to ensure appointments within 2-weeks and urgent assessment same day or next day • Increase dental activity towards pre-pandemic levels
Elective care	• Eliminate waits of over 65 weeks by September 2024 • Deliver system specific activity targets, consistent with the national value weighted activity target of 107% • Increase proportion of first appointments or procedures in outpatients to 46% across2024/25 • Improve patients' experience of choice
Cancer	• Improve performance against the 62-day standard to 70% by March 2025 • Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 (80% by March 2026) • Increase stage 1 and 2 cancer diagnosis to achieve 75% early diagnosis ambition by 2028
Diagnostics	• Increase proportion of diagnostic tests within 6 weeks to 95% by March 2025
Maternity, neonatal and women's health	• Continue implementation of the Three-year delivery plan • Make progress towards national safety ambition and increase fill rates against funded establishment for maternity and neonatal services • Establish and develop at least 1 women's health hub in every ICB by December 2024
Mental health	• Improve flow and work towards eliminating inappropriate out of area placements • Increase those accessing transformed models of adult community, perinatal, and children and young people's mental health • Increase completed treatments for anxiety and depression in adults via NHS Talking Therapies with at least 67% achieving improvements and 48% recovery • Deliver a full annual physical health check in at least 60% people with severe mental illness by March 2025 • Increase dementia diagnosis rate to 66.7% by March 2025
People with a learning disability and autistic people	• Deliver annual health checks in 75% of those aged 14+ and on the GP learning disability (LD) register • No more than 30 adults with LD or autism per 1 million population (or 12-15 for under 18s) receiving inpatient mental health care
Prevention and health inequalities	• Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025 • Provide lipid lowering therapy treatment for 65% of people with CVD risk score of greater than 20% by March 2025 • Increase children and young people's vaccination uptake • Address health inequalities and deliver on the Core20PLUS5 approach
Workforce	Systematic implementation of the People Promise retention interventions • Increase choice and flexibility in Junior Doctor rotas, reduce duplicative inductions and payroll errors • Provide sufficient placements and apprenticeships to meet the NHS Long Term Workforce Plan
Use of resources	• Deliver a balanced net system financial position for 2024/25 • Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

Planning Assumptions

Bradford District and Craven Health and Care Partnership

- Updated revenue allocations for 2024/25 have been issued with 1% increase in base growth to reflect additional pressures since the allocations were published in January 2023.
- Integrated Care Boards (ICBs) will continue to receive Service Development Funding (SDF) allocations to support the delivery of national objectives set out in the guidance.
- The published baseline ICB capital allocations to 2024/25 remain the foundation of capital planning for future years.
- The finance incentive element will operate in broadly the same way as the 2023/24 scheme with up to £150 million capital available.
- Capital allocations will be topped up with £150 million nationally, in line with the incentive scheme for providers with a Type 1 A&E department.
- The contract default between ICBs and providers for most planned elective care will continue to be to pay unit prices for activity delivered.
- System plans must be triangulated across activity, workforce and finance, and signed off by ICB and partner NHS Trust and Foundation Trust boards.
- ICBs and their partner Trusts are asked to work with their local authorities and other system partners to further develop their JFP to address the priorities set out in the 2024/25 guidance by 30th June 2024.

Key changes

Bradford District and Craven Health and Care Partnership

The majority of the requirements set out in the guidance are areas we were already being asked to address but there are some changes that we have had to incorporate in our latest plan:

- **Changes to targets:** Increase from 77% to 78% A&E performance; 95% diagnostic performance across all modalities; Confirmation of 60% SMI health check target for 24/25 with an aspiration for 75% beyond this.
- **New trajectories:** Plans for increased dental access; Plans for Urgent Community Response (UCR) activity has been re-instated but now captures all referrals; Community waiting times is now focussing on long waits (52+ weeks) and not the overall waiting list size; Increase proportion of first appointments or procedures in outpatients to 46% across 2024/25.

Work continues across our system to deliver the elements set out in the guidance, but there are a number of new requirements that we might need to build into our Act as One work as they could come under increased scrutiny.

- Implement the Patient Safety Incident Response Framework (PSIRF).
- Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities.
- Develop a comprehensive plan by June 2024 to reduce the overall waiting times for community services, including reducing waits over 52 weeks for children's community services.
- Increase vaccination uptake for children and young people year on year towards WHO recommended levels.
- Improve the working lives of doctors in training and reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25.

Bradford District and Craven
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Activity & Performance

Non-Elective & Flow

Bradford District and Craven Health and Care Partnership

- **4-hour A&E standard:** This has been a challenge at Airedale NHS Foundation Trust (ANHSFT), but the Trust has now completed a significant amount of its two-year recovery plan and performance is beginning to improve (68.9% in March). Bradford Teaching Hospital Foundation Trust (BTHFT) performance was 82.7%. **Both Trusts are planning to deliver the 78% requirement by March 2025.**
- **Adult General & Acute (G&A) bed occupancy, Length of Stay (LoS) & No Criteria to Reside (NCTR):** G&A bed occupancy at BTHFT remained high in March (94.68%) but occupancy improved for a second month at ANHSFT to 88.8%. There were 62 patients with a LoS) > 21 days at ANHSFT against a planned number of 38, largely driven by the number of with NCTR in hospital, although these reduced to 51 patients. At BTHFT the daily average number of patients with a LoS >21 days reduced to 121 in March and the percentage with NCTR also improved. Issues impacting flow continue to be high acuity and social care capacity to enable discharges. System work to reduce NCTR and improve flow continues as part of our Intermediate Care (IMC) Review. **Plans show average bed occupancy of 93.4% and 93%, average LoS > 21 days of 65 and 130 and the % of beds occupied by NCTR patients of 24.1% and 13.9% for ANHSFT and BTHFT respectively.**
- **Virtual Ward (VW):** At the end of April we had 149 VW beds. The budget for the additional virtual ward bed capacity has been reduced in 24/25 but over the next 12 months we will be working at pace to better understand what our VW service offer will need to look like to maintain capacity. **The plan therefore is to maintain the 149 beds.**
- **Ambulance Category 2 Response:** Yorkshire Ambulance Service (YAS) average monthly performance has continued to improve since a peak of 46 minutes in December, with an average response time of 29:28 minutes in March (2023/24 average of 32:13 minutes). Alongside working with hospital Trusts to reduce ambulance handover times, YAS are also working on a variety of internal improvements. **Whilst remaining above the national target of 30 minutes, plans have therefore improved slightly to an average of 30:15 minutes for 2024/25.**

Elective Recovery

Bradford District and Craven Health and Care Partnership

- **Activity:** Delivering planned activity levels has been a challenge in 2023/24 due to ongoing industrial action (IA). 2024/25 plans assume IA does not continue, although ANHSFT plans assume adjustment for reduced capacity during implementation of the new Electronic Patient Record (EPR). **Trust plans deliver the 107% ERF target.**
- Both Trusts have outpatient (OP) transformation work underway. **Plans show an increase to 5% Patient Initiated Follow Up (PIFU) by March 2025. BTHFT plans show an increase of 4% in 1st OP or procedures, but the ANHSFT plan is again impacted by EPR implementation.**

  EPR implementation means a significant loss of activity during the upgrade which accounts for a reduction of 15.7% of activity over the six months September to February in ANHSFT plans. However, improvements in theatre utilisation and booking over 2023/24 will offset this reduction to some extent.
- **18 weeks Referral to Treatment (RTT):** RTT waiting list sizes continue to increase and 18- week performance remains below target at between 60-65%. However, the number of patients waiting over 52-weeks continues to reduce. Overall, Bradford District & Craven (BDC) RTT waits improved in February to 1,228 >52-weeks, 284 >65-weeks and 30 >78-weeks. Trauma & Orthopaedics (T&O) continues to account for the majority of long waits. There remain no >104-week breaches. **Plans deliver zero 65+ waits by the end of July. BTHFT plan shows a 10% reduction in the RTT waiting list to match a target agreed by the West Yorkshire Association of Acute Trusts (WYAAT). ANHSFT's RTT waiting list is forecast to increase to reflect the EPR impact.**

Diagnostics & Cancer

Bradford District and Craven Health and Care Partnership

- **Diagnostics:** Performance at BTHFT continues to improve (81.4% in March), however ANHSFT performance fell slightly in March to 83.63%, driven by the DEXA service. Performance at both trusts is expected to improve further as the Community Diagnostic Centre (CDC) capacity increases. Endoscopy, Cystoscopy, Hysteroscopy, Colposcopy, Echo, MRI and Primary Imaging are all now live and an activity plan for 24/25 has been agreed. **Plans therefore show increased activity in 2024/25 with 95% or above of patients seen within 6 weeks for all diagnostic specialties, with the exception of audiology (90% by March 25) due to the current significant backlog.**
- **Stage 1 and 2 cancer diagnosis:** ICB plans have been developed by the Cancer Alliance. Early cancer diagnosis has improved in West Yorkshire, by around 3%, and is moving towards the ICB's initial goal of a rate of 62%, as described in the Joint Forward Plan as a result of improved performance against national standards. The ICB has also seen some improvements in early stage of diagnosis amongst local areas impacted by health inequalities, for example in areas which have taken up the targeted lung health check programme. **ICB plans deliver all the national panning requirements including increasing the % of Lower GI Suspected Cancer referrals with an accompanying fecal immunochemical test (FIT) result to 80% by March.**
- **Cancer 62-day standard:** ANHSFT again achieved this standard in March. The 62-day backlog has continued to reduce at BTHFT to meet the 2023/24 planning target, resulting in ongoing improvement against the 62-day standard, although this still remains below target. **Plans deliver the 70% target by March.**
- **28-day faster diagnostic standard (FDS) standard:** Performance was above target in March at both Trusts. **Plans deliver the 77% target by March.**

Mental Health (MH) & Learning Disabilities (LD)

Bradford District and Craven Health and Care Partnership

- **Out of Area (OOA) Placements:** There was a further increase in March in the use of OOA beds. The increase in the last 2 months is due to an increase in demand, although since November when Bradford District Care Foundation Trust (BDCFT) introduced the bed/flow managers, the average has been around 310 days per month compared to around 590 for April to October. Plans therefore show improvement from 13 placements in December 2023 to 7 by March 2025.
- **SMI Health Checks:** 66.8% of patients recorded with a severe mental illness (SMI) on GP registers receives and full annual health check in 2023/24. **Plans deliver the 60% national requirement.**
- **Talking Therapies:** Access and performance continues to improve as a result of a fall in referrals since January and a reduction in the number of vacancies, which is positively impacting the service. In December, 50% of patients were reported as achieving recovery and 67% improvement. **Plans therefore deliver the 48% recovery and 67% improvement targets.**
- **Dementia diagnosis:** 73% of dementia patients had a diagnosis in February. Referral rates in Memory Assessment Services continue to rise and the service has a huge capacity issue with currently no agreed investment to expand. Shifting the medical model of delivery to look at re-aligning of medical capacity. **Plans for 2024/25 are above the national target of 66.7% at 69%.**
- **Transformed Community Mental Health Services:** December data shows 9,225 adults/older adults received at least two contacts with core community mental health services in the last 12 months against a trajectory of 4,607 for Q4. This new metric is only capturing activity for PCNs with transformed services i.e. where community mental health services have been aligned with PCNs to create integrated models of primary and community mental health care. There are plans to further extend the model across more PCNs but challenges remain regarding recruitment of ARRS roles (Additional Roles Reimbursement Scheme where PCNs can claim reimbursement for the salaries of 17 new roles including MH practitioners) and PCN reporting is currently incomplete. **Plans for 2024/25 are therefore only based on current BDCFT activity but show an increase across the year.**

Mental Health (MH) & Learning Disabilities (LD)

Bradford District and Craven Health and Care Partnership

- **Specialist peri-natal mental health:** 290 women (year to date December) have received specialist peri-natal mental health services, and it is now very unlikely that we will deliver the 2023/24 plan of 364. There remain workforce challenges (specifically consultant post which is pivotal to the access target and safety of the service) and BDCFT has yet to confirm any additional investment to support increased access. **The plan for 2024/25 is 350.**
- **Children & Young People's (CYP) MH:** As of February, 11,145 CYP had received at least 1 contact with CYP mental health services in the last 12 months against a plan of 10,150. However, recruitment/workforce is a huge factor against huge demand across all pathways not just specialist CAMHS and no additional investment has been confirmed. **The plan therefore shows minimal growth of 1.6% across 2024/25.**
- **LD Health checks:** End of year performance against the 75% target for people aged 14+ on the LD register to receive an annual health check (AHC), was 82.2%. Only one PCN out of the 12 did not make the target of 75%. Work will now start again to promote the delivery and uptake in 2024/25, with a monthly dashboard sent out to practices and training planned for May 2024 for practice nurse forum regarding completion of AHCs. **The plan delivers 75% by March 2025.**
- **LD Inpatients**: ICB plans have been developed at a West Yorkshire level. **By March 2025 there will be no more than 54 adults and 4 CYP in an inpatient setting.**

Community

- **Hospital discharge pathway:** In 2023/24 and average of 94% of discharges were to a patient's normal place of residence and required no ongoing support, 4% of patients required some form of short-term home-based intermediate care (IMC), 1.3% required short term care in an IMC bed and 0.8% were discharged into a long-term bedded setting. Our IMC review is looking at demand and capacity for Pathways 1 (reablement at home) and Pathways 2 & 3 (short term/long term residential care). **Plans for 2024/25 maintain this discharge profile, with a 3% increase in demand reflecting historical trends.**
- **Urgent community response** (UCR): We have managed 1,275 referrals against a plan of 1,070 for quarter 3 with an average 89% of people were seen within 2-hours against a target of 75%. We are linking in with a West Yorkshire ICB piece of work looking at how UCR services operate and interface with YAS, in particular around falls. **Plans maintain current referral capacity of an average of 384 per month.**
- **Community bed occupancy:** Plans are based on only NHS IMC capacity (Westwood Park, St Lukes, Eccleshill and Castleberg beds). This equates to 71 beds in total. Work is underway to better understand our NHS community hospital demand and capacity as part of our IMC review. **The plan, based on current data, shows an average of 88% occupancy across the year.**
- **Community services waiting list:** There was only 1 reported 52+ week wait for CYP services in February and 52+ week waits for adult services have improved significantly since March 2023 (73) to 9 reported in February for physiotherapy and speech and language (S&L) services. BTHFT is now reporting waiting list data for community paediatrics, with plans to expand reporting across their other community services. As a result, waiting lists may further increase. **Plans therefore currently maintain the latest average 6-month position of 3 and 7 for CYP and adult services respectively.**
- **GP Appointments:** Our forecast outturn for 2023/24 shows 7% more GP appointments than 2022/23 and an average of 86.7% of appointments were seen within 2 weeks. Whilst the national driver is still increasing volume of appointments, we locally want to work on quality of interaction, better integration of community services and other measures that may eventually lead to a reduction in appointments. **Plans are for 3% growth with an aim to deliver the 85% seen within 2-week expectation.**
- **Dental:** Plans have been developed by the West Yorkshire team, but we have requested some insight on how these will improve access for the BDC population. **Plans show an increase in dental activity for both adults and CYP.**

Finance

Financial Plans

Bradford District and Craven Health and Care Partnership

	22 Feb £m	21 Mar £m	26 Apr £m	2 May £m	*Incl CIP £m*	*CIP %*
ANHSFT	(26.3)	(25.3)	(22.7)	(20.8)	*13.0*	*5.0*
BDCT	(7.6)	(5.5)	0.0	0.0	*14.2*	*6.9*
BTHFT	(29.4)	(26.3)	(22.6)	(19.0)	*33.9*	*6.0*
BDC ICB	(20.4)	(14.2)	(7.8)	(7.8)	*12.9*	*2.8*
Total Place (NHS)	**(83.7)**	**(71.3)**	**(53.1)**	**(47.6)**	*65.3*	

- Significant improvement on draft plans, but financial position remains challenging.
- Plans assume significant cost improvement programmes (CIPs) can be delivered.
- Underlying deficit position driven by a range of factors including: Slippage on 2023/24 challenging waste reduction programmes; Workforce cost pressures and agency spend; Higher than expected service demand across a number of areas; Inflationary pressures/funding; ANHSFT RAAC and EPR impact; Continuing Health Care & primary care prescribing costs.

Bradford District and Craven
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Workforce

Trust plans

Bradford District and Craven Health and Care Partnership

Staff in Post	March submission			April submission			Sickness absence rate %	Turnover rate %
	Baseline Mar 24	Plan Mar 25	Growth	Baseline Mar 24	Plan Mar 25	Growth	Plan Mar 25	Plan Mar 25
ANHSFT	3605.6	3668.5	1.7%	3605.6	3606.9	0.0%	4.50%	10.50%
BTHFT	6313.9	7503.9	18.8%	7112.8	7112.7	0.0%	5.20%	9.75%
BDCFT	3413.4	3408.5	-0.1%	3469.3	3315.1	-4.4%	6.51%	16.77%

- Following triangulation of finance, activity and workforce, Trust plans show a reduction in staff in post growth.
- ANHSFT New Hospital Programme growth has been amended to reflect assumptions about contractors vs direct employment.
- BTHFT plans reflect further work on waste reduction.
- All plans assume a reduction in agency staffing via filling of current vacancies, no further Industrial Action in 2024/25 and recruitment plans will deliver temporary staffing reductions

Primary Care

Bradford District and Craven Health and Care Partnership

Staff in Post	March submission			April submission		
	Baseline Mar 24	Plan Mar 25	Growth	Baseline Mar 24	Plan Mar 25	Growth
Total Workforce	**2269.8**	**2269.8**	**0.0%**	**2378.6**	**2378.6**	**0.0%**
Total GPs	492.4	492.4	0.0%	495.8	495.8	0.0%
Total Nurses	251.1	251.1	0.0%	260.2	260.2	0.0%
Direct Patient Care roles	532.6	532.6	0.0%	553.7	553.7	0.0%
of which ARRS funded	*355.2*	*355.2*	*0.0%*	*355.2*	*355.2*	*0.0%*
Other Admin/ Non-Clinical Staff	993.8	993.8	0.0%	1068.8	1068.8	0.0%

- Plan refreshed with February data, showing an increase in the baseline position from November across all staff groups
- We currently have challenges in recruitment and retention of GPs and wider GP workforce, especially in deprived areas.
- Assumption remains regarding no growth planned for 2024/25 but that current staffing levels can be maintained, although still a risk there could be a reduction in ARRS roles due to PCN funding
- Still some data quality issues r.e. what is reported nationally by practices/PCNs - potential duplication and some under-reporting

Bradford District and Craven
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Risks

Risks

- Challenging financial context - the most challenging financial position seen in recent times which means that we will need to prioritise what we do and be clear on the performance levels that we can achieve
- Deliverability of challenging waste reduction / cost savings targets
- Plans do not account for the loss of activity or additional temporary staffing usage required if IA were to occur in 2024/25
- Workforce challenges: Recruitment; Staff engagement/morale
- Strategic ambition is being delivered through our priority areas - further resource to support these priority areas in 24/25 will have to come from re-allocation of existing resource within services
- Increasing demand
- RAAC and EPR risk to ANHSFT plans
- Financial pressures faced by Bradford Council may lead to service reductions and increased pressures for Health

Meeting name:	BDC Partnership Board
Agenda item no:	
Meeting date:	17th May 2024
Report title:	Better Care Fund 24-25 Plan update
Report presented by:	Iain MacBeath
Report approved by:	
Report prepared by:	Javeid Karim

Purpose and Action			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐

Previous considerations:

The Better Care Fund plans for 2023-25 were approved by Mel Pickup on behalf of the Partnership Board in May 2023. The 23-25 plans were approved and signed off by the appropriate colleagues.

Executive summary and points for discussion:

A two-year Better Care Fund (BCF) plan was submitted to the BCF national team on 27th June 2023. This included a jointly agreed plan with an accompanying narrative which was signed off by the chair of the Health and Wellbeing Board on 24th June 2023.

As we enter the second year of our two-year Better Care Fund (BCF) plan, the BCF national team has released the reporting guidelines for 2024-25. This includes a requirement for local areas to agree spend for 2024-25 and establish the use of the Adult Social Care Discharge Fund.

The BCF 24-25 funding contributions include:

- Minimum NHS Contributions (£49.5m) – increase of 5.66% from previous year towards uplifts to services.
- Improved BCF (£23.4m) – same as previous year, ringfenced to social care.
- Adult Social Care Discharge Fund (£10.7m) – Increased by £4m to support pressures on hospital discharge.
- Disabled Facilities Grant (£5.6m) – increase of £400k, reference to housing adaptations.

The BCF national team has set a deadline of 10th June 2024, for the submission of the planning template. This allows an eight-week period to finalise and agree any alterations to the BCF 24-25 plans. PLE will be sighted on the plans on 24th May 2024. A paper will then be presented to the Health and Wellbeing Board for approval of the plans on 11th June 2024.

Substantial effort was invested in ensuring transparency in the 2023-24 expenditure plan. The Council expresses assurance in its effective utilisation of the BCF, supporting core services and aligning with the fund's national criteria and metrics. Further analysis of the ICB expenditure is underway to agree spend for 2024-25.

All funding contributions for our BCF will need to be agreed by HWB areas and updated on our section 75 agreement (as detailed in the NHS Act 2006). The NHS contribution to social care from the ICB will be agreed and will need to meet the minimum expectation of fund.

The BCF 24-25 plans will continue to commit to maintaining or improving current delivery.

An updated capacity and demand plan is required for 2024-25. Where appropriate, the C&D plan will align to the NHS operational plan. Further work is underway to understand the full extent of demand & capacity across all services.

Finance and data leads from both organisations are working collaboratively to finalise the BCF report. The aim of the 24-25 plan will be to achieve transparency by aligning our spend to the BCF conditions. An updated planning template will be submitted to the BCF national team which meets or exceeds the minimum expectations.

Due to discrepancies in the timing of the BCF report deadline and the governance/assurance meetings, we are still underway with reaching an agreement on the use of the BCF to fulfil the fund conditions.

Outline how this supports our partnership vision and strategy

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

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

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

Recommendation(s)

The Partnership Board is asked to:

1. To delegate authority to Therese Patten to approve the BCF 24-25 plan on behalf of the Partnership Board;
2. To note the reporting requirement and deadlines of the BCF 2024-25 plan;

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

Appendices

1. BCF 24-25 planning template

BCF 2024-25 Planning Template Bla

2. BCF Narrative for 23-25 – Final Version

Bradford Narrative.docx

Bradford Appendix.docx

3. BCF Planning template for 23-25 – Final Version BCF Planning Template 2023-25 - B
Acronyms and Abbreviations explained
1. BCF – Better Care Fund 2. WY - West Yorkshire 3. HWB - Health & Wellbeing Board 4. iBCF - Improved BCF 5. ASC DF - Adult Social Care Discharge Fund 6. DFG - Disabled Facilities Grant 7. LA - Local Authority 8. ICB - Integrated Care Board

What are the implications for?

Residents and Communities	Delivery of services that will meet the needs of the population, and improve population health
Quality and Safety	Delivering high quality and safe services
Equality, Diversity, and Inclusion	Services accessible to all
Finances and Use of Resources	-
Regulation and Legal Requirements	-
Conflicts of Interest	-
Data Protection	-
Transformation and Innovation	Service transformation to deliver improved performance
Environmental and Climate Change	-
Future Decisions and Policy Making	Performance against strategic priorities to inform decision making
Citizen and Stakeholder Engagement	-

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	14
Meeting date:	17 May 2024
Report title:	BDC Partnership Board Triple A Report
Report presented by:	Elaine Applebee, Independent Chair, BDC Partnership Board
Report approved by:	Elaine Applebee, Independent Chair, BDC Partnership Board
Report prepared by:	Catherine Smith, Governance Officer, NHS West Yorkshire ICB

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations:			
N/A			
Executive summary and points for discussion:			
This report contains the Triple A report submitted to the NHS West Yorkshire Integrated Care Board to provide assurance and to alert the ICB Board on any key risks and asks.			
Outline how this supports our partnership vision and strategy			
Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives.			

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes. **Our Place -** Making our district a great place to live, work and thrive. **Our Partnership –** Greater value through the best use of our collective resources, minimising duplication and waste.
Recommendation(s)
The BDC Partnership Board is asked to: 1. **NOTE** the March 2024 BDC Partnership Board Triple A Report
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Risk Register or Partnership Assurance Framework? If yes, please detail which:
N/A
Appendices
1. March 2024 BDC Partnership Board Triple A Report

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven Partnership Board

Date of meeting: 8 March 2024

Report to: WY ICB Board

Report completed by: Catherine Smith for Elaine Appelbee (chair) & Mel Pickup (place lead)

Date: 12 January 2024

Key escalation and discussion points from the meeting
Alert:
• **Financial position** – members received an update on the significant financial challenges faced by the Health and Care Partnership. It was highlighted that there is an underlying deficit of £80-90m across the NHS partners going into 2024/25 - this represents approximately half the deficit position for NHS West Yorkshire ICB. Related risks on the partnership risk register include in-year financial performance - risk 2386 - and underlying financial deficit - risk 2337. An update was provided on the closing the gap programme, which had been established to help the partnership to take collective approach to the challenging financial situation affecting all of the individual organisations and to close the gap between the budget available and the current expected spend across all sectors. • The challenging **financial position of Bradford Metropolitan District Council** (BMDC) was reported. It was noted that the council are reporting a budget gap of approximately £121m in 2023/24. Exceptional financial support from the government had been approved (£220m over the next two years - £80m in 2023/24 and £140m in 2024/25) though difficult savings still need to be made. The council had agreed a budget which would see £40m cuts to local services with the need to make further cuts of £35m a year for the next five years. The exceptional financial support from the government means increased debt to the council, which must be repaid with interest. This is reflected on the partnership risk register through the risk relating to BMDC's financial position (risk 2173) which has a critical score of 25 and the Board agreed to reduce the risk to a score of 20 due to exceptional financial support being agreed.
Advise:
• An update was provided on the risk related to the **sustainability of the VCSE sector** (risk 2386 on the partnership risk register) which had increased during cycle six of the risk register to become a critical risk with a score of 25. It had been agreed as part of the council's budget that the infrastructure support to the VCSE sector would reduce from £1.2m to £300-350k due to the increase in the financial challenge of BMDC (risk 2173). The significant impacts on the sector were highlighted and it was noted that there was work with colleagues in the council on the reduced offer to the sector with a commitment to work collaboratively and involve partners. • An update was provided on the **operational planning for 2024/25** and highlights from the key areas in the draft submission were provided. It was noted that the submission included

continued emphasis on improving access, reducing waiting lists and waiting times, maintaining effective hospital discharge pathways and reducing health inequalities.

Assure:

- **Listen in -** members received a report following the first cycle of the second year of the 'Listen in' programme which focused on children, young people and their families. The key themes from the cycle included mental health and wellbeing, the school environment and experience, waiting times and waiting well. It was noted that the information from the cycle was presented to the Healthy Children and Families Priority Board and the information would be used to inform the focus for the priority in the coming year.
- An update was provided from an exceptional meeting of the **Clinical Forum** which took place in February 2024 to consider the place financial challenge and the response required to deliver an improved financial position (the closing the gap programme). The Board received assurance that an open and honest conversation was had which tested out a collective understanding and response to the significant financial pressures, in terms of finance, quality and performance, and direct engagement with the system finance lead was welcomed in order to strike the right balance between quality and finances.