Bradford District and Craven Partnership Board

21 July 2023
9:30-12:30pm
John Day Hall, Thornbury Centre, Bradford, BD3 8JX

AGENDA

ATTENDEES TO NOTE: the meeting may be recorded to assist with minute-taking. Whether a meeting is being recorded will be confirmed at the start of the meeting by the Chair. All recordings will be destroyed after approval of the minutes to which they relate.

Item	Lead	Purpose	Time	Mins
1. Welcome, introductions and apologies	Chair	Information	09:30	5
2. Conflicts of interest	Chair	Assurance	09:35	0
3. Minutes of the meeting held on 12 May 2023/action log/matters arising	Chair	Approve and to note	09:35	5
4. Public questions	Chair	Information	09:40	5
5. Public voice/feedback from Listen In Bradford East	Victoria Simmons	Discussion	09.45	15
6. General Practice access	Louise Clarke/ Danielle Hann	Discussion	10:00	55
Break – 10:55-11:10				
7. Place lead's update • ICS operating model review	Mel Pickup	Information	11:10	10
8. Reports from committees, Citizen's Forum and the Clinical Forum	Committee and Forum Chairs	Information	11:20	20
9. Partnership risk update • Update on RAAC at Airedale Hospital	Sue Baxter/ Foluke Ajayi	Assurance	11:40	15
10. Committee effectiveness key messages and Partnership Board Terms of Reference review	Sue Baxter	Assurance	11:55	10
11. Joint Forward Plan	Clare Smart	Approve	12:05	15
12. To note – Better Care Fund 2023-25 plans	Jane Wood	Information	12:20	5
13. Any other business	All	Information	12:25	5
14. Reports/escalations to WY ICB, and review of meeting	Chair	Information	12:30	1

Date and time of next meeting –
Friday 1st September, 9:30-12:30 – Shipley – venue TBC
For any queries regarding this agenda, please contact: catherine.smith4@bradford.nhs.uk

Chairing arrangements and decision-making processes

Meeting chairs have responsibility for ensuring the appropriate management of conflicts of interest during the course of BDC Health and Care Partnership meetings (see below for a definition and examples of 'interests'). In particular they must ensure:

- They are familiar with the contents of the Registers of Interests as pertinent to their Group or Committee. WY ICB and BDC HCP registers of interest will be available from August 2022.
- Declarations of interest will be a standing item on all meeting agendas.
- The chair of a meeting has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.
- In the event that the chair of a meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action in order to manage the conflict of interest. If the vice chair is also conflicted, then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict.
- In making such decisions, the chair (or vice chair or remaining conflicted members as above) may wish to consult with the Conflicts of Interest Guardian, Chief Executive, Place Accountable Officer, Director of Corporate Affairs, or ICB Governance Leads.
- It is good practice for the chair, with support of the committee's Governance Lead and, if required, the Conflicts of Interest Guardian to proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for particular agenda items of private sessions/meetings are not sent to conflicted individuals in advance of the meeting.
- The chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the meeting should declare any interests which are relevant to the business of the meeting whether or not those interests have previously been declared. Interests declared at meetings are cross referenced with the register of interests to ensure that it is up-to-date.
- It is the responsibility of each individual member of the meeting to declare any relevant interests. However, should the chair or any other member of the meeting be aware of facts or circumstances which may give rise to a conflict of interest but which have not been declared then they should bring this to the attention of the chair. The chair will decide whether there is a conflict of interest and the appropriate course of action to take in order to manage the conflict of interest.
- If, after a meeting, the chair or any other member becomes aware that a conflict of interest has not been declared, they should raise this with the committee's ICB Governance Lead in the first instance. The ICB Governance Lead will consider the appropriate course of action, including

escalation to the Conflicts of Interest Guardian, Chief Executive, Place Accountable Officer or Director of Corporate Affairs.

- When a member of the meeting (including the chair or vice chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or vice chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:
- Where the chair has a conflict of interest, deciding that the vice chair (or another non-conflicted member of the meeting if the vice chair is also conflicted) should chair all or part of the meeting
- Requiring the individual who has a conflict of interest not to attend the meeting
- Ensuring that the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict
- Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s). In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the audience in the public gallery
- Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared
    - Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest, but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be the appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion.

- Where the conflict of interest relates to outside employment and an individual continues to participate in meetings pursuant to paragraph 9.1.10, he/she should ensure that the capacity in which they continue to participate in the discussions is made clear and correctly recorded in the meeting minutes. Where it is appropriate for them to participate in decisions they must only do so if they are acting in their ICB role.
- If an individual leaving the meeting impacts upon quoracy, the chair reserves the right to adjourn and reconvene the meeting when appropriate membership can be ensured.
- Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interest or

potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed.

- In making the decision the Chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the ICB's Standing Orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interest, the Chair of the meeting shall consult with the Chief Executive on the action to be taken. This may include:
- Requiring another of the ICB's committees or sub-committees, which can be quorate, to progress the item of business.
- Inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the Board/committee/sub-committee in question) so that the ICB can progress the item of business:
    - An individual appointed by a partner member to act on its behalf in the dealings between it and the ICB;
        - A member of a relevant Health & Wellbeing Board
        - A member of a Board of another ICB

These arrangements must be recorded in the minutes.

Types of interest

1. Financial Interests

This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model
- A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations
- A management consultant for a provider
- A provider of clinical private practice
- In employment outside of the WYICB
- In receipt of secondary income
- In receipt of a grant from a provider

- In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider

2. Non-Financial Professional Interests

This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients
- A GP with special interests e.g., in dermatology, acupuncture etc.
- An active member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared)
- An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE)
- Engaged in a research role
- The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas or
- GPs and practice managers, who are members of the governing body or committees of the WYICB, should declare details of their roles and responsibilities held within their GP practices

3. Non-Financial Personal Interests

This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider
- A volunteer for a provider
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation
- Suffering from a particular condition requiring individually funded treatment
- A member of a lobby or pressure group with an interest in health and care

4. Indirect Interests

This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include:

- Spouse / partner
- Close relative e.g., parent, grandparent, child, grandchild or sibling
- Close friend or associate or
- Business partner

Bradford District and Craven Partnership Board

DECLARATION OF INTERESTS

	Chair/non-executive member
Independent chair of BdC Partnership Board	Elaine Appelbee • Member of St. Thomas' Parochial Church Council, Sutton-in-Craven • Member of West Yorkshire Health & Care Partnership (WY HCP) Board • Attendee of Bradford District Health and Well-Being Board • Fenetic Well-Being, an online limited company selling mobility and other care aids/furniture to the general public, is jointly owned by son Thomas William Appelbee. The company has no past or current contracts with the NHS or Social Care sector.
Finance and Performance Committee of the BD&C partnership	Julie Lawreniuk • Board member at Incommunities • Non-Executive Director at Bradford Teaching Hospital Foundation Trust (BTHFT) • Deputy Chair BTHFT • Daughter works as a Business Manager at BTHFT
People Committee of the BD&C Partnership	Melanie Hudson • Non-Executive Director of Airedale NHS Foundation Trust • Chair, AGH Solutions (subsidiary company) • Trustee Kirklees Active Leisure • Kirklees befriender in the local community

Quality Committee of the BD&C Partnership	Andy Withers • Non-Executive Independent Chair, System Quality Committee • Non-Executive Director of Airedale NHS FT • Daughter is AHP working for Airedale NHS FT	
Clinical Forum	David Crampsey • Executive Medical Director, Airedale NHS FT • Yorkshire Imaging Collaborative Executive Lead • Member of WYAAT Medical Directors Provider Collaborative • BMA Committee of Medical Managers Elected Member • Director of Immedicare LLP which is a joint venture with Airedale and Involve. • Director of Integrated Pathology Solutions and Integrated Laboratory Solutions. JV between Airedale, BTHFT and HDFT	
Citizen's Forum	Helen Rushworth CEO, Healthwatch Bradford	
Organisation	**Chair**	**Chief Exec**

Airedale NHS FT	Andrew Gold • Chair – Airedale NHS FT • Non-Executive Director Ecology Building Society • Member of Skipton Rotary club - fundraising activities can involve interaction with the Hospital Charity • Member of Yorkshire & Humber NHS Chairs' Network • Member of Chairs & Leaders Network for WY HCP • Chair of Net Zero Board Leads Network for WY H&CP • Member of Committee in Common for West Yorkshire Association of Acute Trusts (WYAAT CiC) • Member of West Yorkshire Health & Care Partnership (WY HCP) Board • CIC for WY Association of Community Health Provider Collaborative • Non-Executive Director for Ramblers Holidays Group Limited; RWH Travel and Ramblers Travel Agency	Foluke Ajayi • CEO – Airedale NHS FT • WY ICB Lead – Planned Care • WYAAT Lead – Elective Recovery • Member of Committee in Common for WYAAT • Member of WY&H HCP Board • Member of WY&Y System Leadership Executive • Chair of Airedale, Wharfedale & Craven Provider Alliance • Member of Bradford & Craven Health & Care Executive Board • Deputy Representative on North Yorkshire Health & Wellbeing Board • Director/Trustee – Hope for Justice • Chair and Trustee – North Church UK • Member of Bradford MDC Health & Wellbeing Board • CIC for WY Association of Community Health Provider Collaborative • Director Encontrar Properties Limited

Bradford District Care NHS FT	Linda Patterson • Chair, Bradford District Care NHS Foundation Trust • Trustee Royal Society of Medicine • Fellow of Royal College of Physicians, London and Edinburgh • Registered with General Medical Council • Governor, London Metropolitan University • Chair, Blackshawhead Parish Council, Calderdale • West Yorkshire Mental Health Provider Collaborative • West Yorkshire Community Services Collaborative • Bradford Place Partnership • Member of Yorkshire & Humber Chairs' Network • Member of West Yorkshire Health & Care Partnership (WY HCP) Board	Therese Patten • Chief Executive, Bradford District Care NHS Foundation Trust • NHS Providers: Trustee • Blackburne House Group: Vice-Chair and Non-Executive Director • Northern Housing Consortium: Non-Executive Director • Chair of the MHLD provider collaborative

Bradford Teaching Hospitals NHS FT	Max Mclean • Chairman, Bradford Teaching Hospitals NHS Foundation Trust • Member of West Yorkshire Health and Care Partnership Board • NIHR Yorkshire and Humber PSRC Advisory Board Member • Wife's sister employed as a nurse at Bradford Teaching Hospitals NHS Foundation Trust • Tutor at the University of Essex online (MSc Criminology and Psychology) • PhD supervisor University of Huddersfield • Chair, NHS England Independent Investigations Governance Committee (oversight of NHSE mental health homicide investigations) • Chair of Yorkshire and Humber Applied Research Collaboration • Chair, Bradford Hospitals Charity • Chair, WYAAT Committee in Common • Member of Yorkshire and Humber NHS chairs' Network	Mel Pickup • Employee (CEO), Bradford Teaching Hospitals NHS Foundation Trust • Place Based Lead / Accountable officer for Bradford District and Craven • Bradford District and Craven Health and Care Executive • WYAAT representative on the WY&H HCP System Oversight & Assurance Group • Bradford Health & Care Partnership member • WYAAT lead Critical Care and Trauma • WYAAT lead for PPE • WYAAT lead for LMS • Honorary Professor at the University of Bradford • Member of WYAAT Committee in Common • Member of Bradford Culture Company Ltd Board (City of Culture 2025)
Organisation		

Local Medical Council	Danielle Hann • Deputy Chair/Director of YORLMC Ltd • Director in Hare Medical Service Ltd • Associate Wellbeing director funded by LMC Services Yorkshire CIC t/as GPMplus
Healthwatch North Yorkshire	Ashley Green • CEO, Healthwatch North Yorkshire

City of Bradford Metropolitan District Council	Kersten England • Employee (Chief Executive) of City of Bradford Metropolitan District Council • Member of the Bradford District and Craven Integrated Care Board • Member of the Council of the University of Bradford • Chair of The Young Foundation • Chair of the UKPRP funded 'Act Early' partnership • Chair of the Board of Digital Makers • Member of the Bradford District Wellbeing Board • Chair of the Bradford District Wellbeing Executive group	Iain MacBeath • Strategic Director of Health and Wellbeing, City of Bradford Metropolitan District Council • Director of Integration with Bradford District Care Foundation Trust (honorary contract) • Trustee and Hon Treasurer of the Association of Directors of Adult Social Services (unpaid) • Chair and Company Director of New Choices (Bradford & District) Ltd local authority trading company (not paid) • Trustee and Hon Treasurer of the	Marium Haque • Employee of City of Bradford Metropolitan District Council • Interim Strategic Director of Children's Services, City of Bradford Metropolitan District Council • Secondary Director of the Bradford Integrated LEP	Sarah Muckle • Director of Public Health, City of Bradford Metropolitan District Council • Trustee of Yorkshire Sport Foundation • Non-executive Director of the Bradford Children's Trust

	• Member of the Advisory Board of the Bradford Literature Festival • Member of the Board of Active Bradford • Member of the Bradford Cultural Place Partnership • Member of the Bradford Economic Partnership • Co-chair of the West Yorkshire Local Resilience Forum • Chair of the Yorkshire and Humber CX group • President of the Society of Metropolitan Chief Executives • Member of the WYCA culture and creative industries committee • Canon of Bradford Cathedral	Association of Director of Adult Social Services charity (not paid)		

North Yorkshire County Council	Richard Webb • Corporate Director, North Yorkshire County Council (full-time paid employment) • Co-chair, County Councils Network DASS and DPH forum • Member of the Association of Directors of Adult Social Services (with some specific lead roles across Yorkshire and Humber and the North of England) • North Yorkshire County Council representative in various Humber and North Yorkshire ICB fora • Spouse runs a management consultancy business that has, in the past, undertaken commissioned work nationally and regionally, including within the ICB area. I have no involvement in the business. No current commissions within the ICB area.	Louise Wallace • Director of Public Health, North Yorkshire County Council • Fellow of the Faulty of Public Health • Member of the Association of Directors of Public Health for Yorkshire and Humber and lead DPH sponsor role for Sector Led Improvement and Healthy Weight, Nutrition & Food and Physical Activity Community of Interest. • Lead public health partner representative for HNY ICB and co-chair of the Population Health and Prevention Executive Committee of the HNY ICB.
Bradford Care Alliance & Clinical Advisory Board	Richard Haddad • Chair of Bradford Care Alliance CIC Ltd • GP Partner at the Saltaire & Windhill Medical Partnership (S&WMP are also shareholders in Trust Primary Care Ltd, GP federation). • Clinical Director for the WISHH Primary Care Network • Deputy Chair of WISHH Community Partnership	

Bradford Care Association	Louise Bestwick • Chief Executive, Bradford Care Association • Director & Employee of an independent social care provider (Newline Care Home & Newline Care Services Ltd)
North Yorkshire Independent Care Group	John Pattinson • Director of Operations, Independent Care Group
VCSE sector in Bradford District	Sam Keighley • CEO VCS Alliance/VCSE System Lead • Chair, Key Fund (NED position – payment goes to VCS Alliance)
VCSE sector in Craven District	Jonathan Kerr • Chief Officer, Age UK North Craven • The Place in Settle CIO, Voluntary Chair • Coniston Cold Parish Council, Councillor • Bell Busk Community Action, Chair • Settle and District Chamber of Trade, Leadership team • Townhead Surgery, Settle, Patient Participation Group Chair

DRAFT Minutes of the Bradford District and Craven Partnership Board
Tuesday 12th May 2023
9:30-12:30
Carlisle Hall, Carlisle Business Centre, BD8 8BD

Present:

Elaine Appelbee	Independent Chair of Bradford District and Craven Health and Care Partnership (BD&C H&CP)
'Foluke Ajayi	Chief Executive of Airedale NHS Foundation Trust
Mel Pickup	Chief Executive of Bradford Teaching Hospitals NHS FT/BD&C Partnership Place Lead
Max Mclean	Chair of Bradford Teaching Hospitals NHS FT
Melanie Hudson	Non-executive chair of the People Committee of the BD&C H&CP
Julie Lawreniuk	Non-executive chair of the Finance and Performance Committee of the BD&C H&CP
Andy Withers	Non-executive chair of the Quality Committee of the BD&C H&CP
David Crampsey	Chair of Clinical Forum/Executive Medical Director, Airedale NHS Foundation Trust
Linda Patterson	Chair of Bradford District Care NHS Foundation Trust
Therese Patten	Chief Executive, Bradford District Care NHS Foundation Trust
Ashley Green	Chief Executive, Healthwatch North Yorkshire
Iain MacBeath	Strategic Director – Health and Wellbeing, City of Bradford MDC
Helen Rushworth	Chair of Citizen's Forum/Chief Executive, Healthwatch Bradford District
Danielle Hann	Deputy Chair, Bradford and Airedale Branch of YORLMC
Richard Haddad	Chair, Bradford Care Alliance
Dena Dalton	Head of Health Collaboration, Community First Yorkshire
Louise Bestwick	Chief Executive, Bradford Care Association (items 7-12)
Victoria Turner	Public Health Consultant, North Yorkshire County Council (attending on behalf of Louise Wallace)
Soo Nevison	CEO, Community Action Bradford and District (attending on behalf of Sam Keighley)

In Attendance:

James Drury	Director of Partnership Development, BD&C H&CP
Robert Maden	Director of Finance, Planning and Performance, BD&C H&CP
Mike Woodhead	Director of Finance, Contracting and Estates, Bradford District Care NHS Foundation Trust
Shak Rafiq	Strategic Communications and Stakeholder Engagement Lead, BD&C H&CP
Victoria Simmons	Senior Head of Communications and Involvement, BD&C H&CP
Sue Baxter	Assistant Director of Governance and Assurance, BD&C H&CP
Karen Dawber	Chief Nurse, Bradford Teaching Hospitals NHS Trust
Kerry Weir	Associate Director, Planning, Performance and Business Intelligence, BD&C H&CP (item 8)
Helen Farmer	Programme Director – Access to Care, BD&C H&CP (item 9)
Louise Clarke	Programme Director – Healthy Communities/Director of Strategy Transformation, Primary & Community, BD&C H&CP (item 9)

Sasha Bhat	Programme Director – Healthy Minds/Deputy Director of Integration and Transformation, BD&C H&CP (item 9)
Nagina Javaid	Programme Director for Children, Young People and Families, BD&C H&CP (item 9)
Fazeela Hafejee	Programme Lead for Neurodiversity, BD&C H&CP/Assistant Director of Adults with Disabilities, BMDC (item 9)
Catherine Smith	Corporate Governance Manager, BD&C H&CP (minutes)
Apologies:	
Andrew Gold	Chair of Airedale NHS Foundation Trust
Nancy O'Neill	Chief Operating Officer, BD&C H&CP
Sam Keighley	CEO, VCS Alliance
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
Sarah Muckle	Director of Public Health, City of Bradford MDC
Kersten England	Chief Executive, City of Bradford MDC

Members of the public: 5

1 Welcome and introductions

Elaine Appelbee welcomed everyone to the Bradford District and Craven Partnership Board.

It was noted that Andrew Gold had sent apologies but had provided comments on the agenda items to the Chair before the meeting.

2 Conflicts of Interest

The members register of interest was noted and the following was highlighted –

Item 6 – in relation to the request for the Board to delegate the sign-off of BCF plans to the place lead – those members/partners providing a service under the Better Care Fund have a direct financial interest however the Board is asked to delegate the sign-off of the plans to the place lead.

Item 8 – members/partners providing services under a NHS contract/agreement have an interest in the operational and financial plans for 2023/24 however the items are for the noting of the submissions.

3 Minutes of the meeting held on 3 February 2023/action log/matters arising

The minutes of the meeting held on 14 March 2023 were agreed as a true and accurate record.

James summarised the open actions on the action log –

2023/04 – Nancy O'Neill to present an approach to estates to a future Board meeting (following presentation to the Partnership Leadership Executive). Action to remain open – date for presentation to the Board to be confirmed.

2023/06 – paper on the succession plan for the role of director of quality and nursing in the Bradford District and Craven Health and Care Partnership to be presented in a future Board meeting – a paper was included as an appendices in the place lead's update so it was agreed that this action is complete.
2023/07 – Mel Pickup and 'Foluke Ajayi to provide information on the impact of the strikes on elective activity and resultant cancellations – an update was included as an appendices in the place lead's update so it was agreed that this action is complete.
2023/08 – questions for the Board to consider in relation to the priorities to be circulated in advance of the meeting in May – action complete.

4 Public questions

James referred to a previous question received by the Board in relation to how the Board involves people and meeting arrangements - it was agreed that an offer would be made to meet with representatives from the Craven Communities Together Community Partnership – the meeting is being progressed.

The following two questions had been received ahead of the meeting and it was agreed that full written responses would be provided to the people who had submitted the question and published on the website.

- I would like to know why there is no specialist menopause service available for women in the Bradford area; why are we not able to have access to a service similar to the one in Leeds; and if we do get a cross boundary referral why the waiting times can be up to 2 years (compared to a few weeks for Leeds residents)?

- I notice from the papers that the question about a hybrid/virtual attendance was actually asked by a member of the public at the last board meeting but didn't receive a response noted in the minutes as they were going to contact them to discuss concerns. Perhaps you could raise the point that this has again been asked and then if there is a response to the question from last time it could be shared so we can understand why this isn't the case?

It was suggested that future meetings are audio recorded and it was agreed that this would be explored.

5 Public voice/feedback from Listen in Bradford West

Victoria Simmons presented a report following the 'listen in Bradford West' week which took place from 29 March to 5 April 2023 in the Bradford West locality. It was the fourth cycle in an ongoing programme of involvement with engagement events and visits taking place in localities in Bradford District and Craven ahead of each Partnership Board meeting. Board members and other colleagues across the partnership visited 20 different community groups, took up a stall at Oastler Market in the city centre and joined the Knife Angel event in City Square using the five priority areas to frame conversations on what matters most to local people.

Victoria highlighted some of the key themes that were highlighted throughout the week including a lack of trust in NHS services and a feeling of disconnection, access to primary care, issues with follow through and communication after appointments which affect people's experience of health and care, and understanding the NHS system and expectations. Victoria highlighted that well-connected VCS organisations have been seen in previous cycles however in Bradford West the community support was not as cohesive as in other areas and issues with resources and resilience for community groups was noted in terms of concerns on funding and sustainability and reliance on volunteers.

Victoria highlighted that by the end of July 2023 the 'listen in' cycles will have been around the six localities and a meeting has taken place to discuss a proposal for deliberative events to take place over the summer to take the insights from the cycles and explore the 'so what' questions, understand the actions that the system including communities can take forward, and consider challenges and opportunities. The first deliberative event is planned in September 2023. The second year of the 'listen in' cycles will focus more on communities with interest, trying to reach different people, getting deeper insights and going back to communities to report back on the actions.

Soo Nevison suggested a separate discussion outside of the meeting in relation to community support not being as cohesive as in other areas to explore whether some additional investment from the West Yorkshire Health and Care Partnership (WY H&CP) could be used to develop community hubs in Bradford West. Therese Patten referred to issues raised with schools, exclusion and misunderstanding following discussions with people from the Roma community. Shak Rafiq suggested using funding to encourage people from communities that do not regularly engage to attend the deliberative events in order to get better representation across different communities and to develop relationships so they can be community advocates for key messages. Shak also suggested including the work that is currently taking place with young people, such as the healthy minds apprentices, into the events.

David Crampsey suggested that the Clinical Forum and Citizens Forum work together to understand more about staff attitudes which had been raised in the feedback as this could relate to staff burnout and compassion fatigue. Shak referred to a session taking place in June to understand the support from the involvement side in the priorities and work with the Citizens Forum on any gaps and how these can be addressed.

'Foluke raised the need to understand the demographics of Bradford West in relation to doing something different in the area. Andy Withers referred to the need to empower the population and maximise community assets. Soo added that the intention of the additional investment from the WY H&CP would be to work with hubs, community anchors and the community partnerships to focus on this. James referred to an opportunity to link between themes coming out of future cycles with future agenda items for the Board and the deliberative events through forward planning.

Victoria raised the need for leaders to bring a representative spread from organisations who can take power on staff attitudes in the events and to consider how networks can be assets to share messages. Elaine suggested the development of a new NHS contract between patients and partners highlighting communities as part of the system.

Shak welcomed a representative from the Dominica Community Association who has an experience of accessing emergency dental services and was invited to attend the meeting.

The Bradford District and Craven Partnership Board:

1. **Considered how the insights from the involvement report will inform the delivery of our priorities in the Bradford West locality and across our place.**
2. **Identified specific learnings from the Listen in activity that can be acted upon by our partnership.**

6 Place lead's update

Mel Pickup 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.

Mel referred to a request in the previous Board meeting to quantify the impact of the industrial action in health and care, noting that this information was an appendix to the report, and highlighted that the information does not account for the work to plan for the strikes. Mel thanked colleagues for their support in the recent industrial action by members of the Royal College of Nursing which affected BTHFT.

Mel highlighted that an Ofsted monitoring visit on our SEND services took place in May 2023 – the visit provided an opportunity to find out more about the progress made in the improvement areas following the formal inspection which took place in May 2022. The feedback from the inspection was used as an opportunity to reset the relationship between children's services across Bradford District and Craven. Positive verbal feedback on the progress made and changes in the relationships between all partners which noted following the visit, which is testimony to the work under the children, young people and families priority and the work of nursing colleagues.

Mel explained that as part of the NHS's 75th birthday on 5th July there will be engagement and listening events across the ICBs focusing on the future of the NHS. Specific questions will be taken into these conversations and feedback will be provided.

James explained that the Board is asked to delegate authority to Mel as the place lead to sign-off plans in the Better Care Fund. It was noted that those members/partners who provide a service under the Better Care Fund (BCF) have a direct financial interest however the recommendation is for the Board to delegate the place lead to sign-off the BCF plans. The plans which are currently being developed in the Planning and Commissioning Forum will be reported to the Partnership Leadership Executive with final sign-off taking place in the Health and Wellbeing Boards in Bradford and North Yorkshire in July. The Board agreed to delegate authority to Mel as the place lead to sign-off the plans in the Better Care Fund.

Mel referred to the inclusion of a joint report from the three local NHS Trust Chief Nurses who are collectively leading on the ICB quality and nursing portfolio as part of a new distributed leadership arrangement following a request in the previous Board meeting for an update on the arrangements. Andy welcomed the arrangement however noted that primary care, dentists, ophthalmology and pharmacists are not included in the arrangements and asked that these areas

are considered in terms of quality assurance. Karen Dawber suggested that this is discussed outside of the meeting so assurance can be provided.

Victoria referred to workforce engagement as part of the NHS's 75th birthday and suggested including insight from our workforce which will be fed into the 'listen in' deliberative events and could be captured locally and nationally.

The Bradford District and Craven Partnership Board:

1. **Received and noted the Place Lead's update.**
2. **Delegated authority to the Place Lead to make recommendations for the use of the Better Care Fund to our Health and Wellbeing Boards on behalf of the ICB.**

7 Reports from committees, Citizen's Forum and the Clinical Forum

The reports were taken as read with the following highlighted by the chairs –

Finance and Performance Committee
Julie Lawreniuk noted that the operational and financial plans are agenda items and thanked the directors of finance, organisations and the system for working together to achieve the financial position for 2022/23 with a small surplus.

People Committee
Melanie Hudson explained that the committee have recently undertaken a deep dive to understand some of the issues with adult social care delivery from a people perspective with other meetings taking place to discuss how a strategy and plans can be developed together.

Quality Committee
Andy Withers highlighted that development session took place at the end of May 2023 to describe the ambition of the committee and how the agenda of the committee can be taken forward.

Clinical Forum
David Crampsey referred to a development session which looked at the recently published delivery plan for recovering access to primary care with the session considering other roles to support delivery of the actions, such as community pharmacists.

Citizens Forum Steering Group
Helen Rushworth explained that there are considerations for a development session on the work and focus of the forum with work to ensure the right representation at future meetings. Helen thanked Ashley Green for being deputy chair of the forum as he is standing down noting that Healthwatch North Yorkshire will continue to be represented at the meetings.

8 Operational Plan, Joint Forward Plan and budget for 2023/24

It was noted that Board members providing services under a NHS contract/agreement have an interest in the operational and financial plans for 2023/24 however as the items are to note the plan submissions no further action was needed.

2023/24 Operational Planning

Kerry Weir provided an update on the final operational planning submission which was submitted in line with the deadline in March 2023 and with minimal changes from the draft version. The plans work towards the required national targets with some risks to delivery, including workforce, RAAC at Airedale Hospital, the ability to increase theatre productivity and reduced reliance on the independent sector, no confirmation on additional capacity funding to support patient flow and with a significant financial gap in the plans. Kerry added that there was an additional ask from NHSE for a further submission by 4th May 2023 with a focus on delivering financial balance.

Kerry summarised the current plans for activity and workforce in the submission from Bradford District and Craven, as detailed in the paper, including elective recovery, non-elective activity and flow, mental health and learning disabilities, community and workforce, and highlighted a number of challenges. There is a commitment to deliver the additional capacity above 2019/20 activity and the required elective recovery target of 108% and therefore no further stretch on activity is possible. Referral to treatment (RTT) and non-referral to treatment waiting lists dictate that a 25% reduction in outpatient follow up activity will not be met although there are plans to double the use of patient initiated follow ups. There is a commitment to reduce the 18 week RTT waiting list and 52+ week waits although the reduction in 52+ week waits is now going to be slower than the draft plans indicated due to a more challenging end of year position and the impact of industrial action in health and care. There are commitments to improving the diagnostic 6 week waiting times performance across all modalities towards March 2025 expectation of 95% with the ambition to improve on the Cancer Alliance based targets.

In terms of non elective there is commitment to the asks in terms of bed occupancy levels with ANHSFT above the 92% national expectation, which is unable to reduce further due a number of factors however mitigations are already in place. The Improving Access to Psychological Therapies access plan has been revised to reflect ongoing recruitment and retention issues with access likely to remain at quarter four 2022/23 levels until quarter three in 2023/24. Other mental health and learning disability plans remain unchanged from the draft submission and commit to delivering national requirements.

There has been no change to the draft community services plans and the plan for community services waiting times assumes some reduction based on BDCFT forecasts but it has been suggested that ANHSFT waiting lists may initially increase due to staffing gaps and therefore there is no significant reduction in the final plans.

Pharmacy, ophthalmology and dentistry services were fully delegated from NHSE to the ICB from April 2023 and there was an ask for places to develop plans for the number of completed referrals to the community pharmacist consultation service so the plans assumes that current referral levels continue. The plan shows increased activity for dental activity in WY but the final version at place has not been shared.

There are no significant changes in the workforce plans from the draft plans with no change to the primary care workforce plan with only growth in the additional roles reimbursement scheme. There is growth planned in the workforce of the NHS trusts with a reduction in sickness, staff turnover and converting agency into bank staff.

Kerry referred to the Joint Forward Plan (JFP), which links the operational plan with the strategy, and will be delivered over the next two to three years. The 4Ps of the strategy (purpose, population, place and partnership) are embedded into the JFP alongside the Act as One programmes and enablers. The JFP is currently being drafted.

Helen queried whether patients have been consulted on the plans to double patient initiated follow-ups. 'Foluke explained that this is a national programme that involves patients arranging their follow-up appointments when they are needed. The programme, which uses resources more effectively, has been very successful in other areas with positive feedback from patients.

The Bradford District and Craven Partnership Board –
1. Noted the update on the 2023/24 operational plan

2023/24 Financial Plan

Robert Maden presented a report which provided information on the 2023/24 financial plan for the Bradford District and Craven Health and Care Partnership (BD&C H&CP) and the 2023/24 Bradford District and Craven Place financial plan, which will form part of the overall WY system financial plan submission to NHS England in May 2023. It was noted that there have been further developments since the paper was written.

Robert highlighted that at the previous Board meeting it was reported that the draft 2023/24 plan position included a surplus of £6.2m for BD&C H&CP and a deficit of £71.1m for the BD&C Place and since then the 2023/24 plan position has improved to a surplus of £0.1m in BD&C H&CP and a £4.3m deficit in BD&C Place.

Robert added that since the March plan submission NHS England asked ICSs with deficit plans if they could improve their plan positions in return for access to additional revenue funding for 2023/24. For the WY ICS the improvement target was £50m in return for access to additional non-recurrent funding of £32m – the share of the improvement target for the BDC place is £11.4m. The WY ICS and BD&C Place have confirmed that this target can be met which has improved the ICB (BD&C) plan position from a deficit of £12.9m to a break-even position.

Robert referred to a process to list areas for potential improvement, which are listed in the slides as confirmed or indicative and a number of areas, such as virtual ward expansion, elective recovery and Mental Health Investment Standard, which were considered but not supported. There is a planned savings total of £8.7m, of which £7.3m has been identified with the remaining £1.4m expected to be realised from further in-year slippage. The savings targets for continuing healthcare and prescribing are thought to be achievable.

Robert referred to the significant financial risks associated with the plan including cost inflation and the need to manage demographic growth cost pressures within existing resources. There are no contingency reserves available to manage the risks with tight financial control being applied to mitigate the position and manage 2023/24. All budget lines are being reviewed to identify any further opportunities with in-year savings being generated where possible. It is proposed that a detailed review of financial performance takes place in August (Month 5) to determine any further action required to manage the BD&C HCP and BD&C Place financial position.

Mike Woodhead explained that the WY ICS have since agreed with NHS England that a break-even position would be planned for 2023/24.

Karen Dawber referred to a difficult position for the NHS and the partnership going forward as all providers have challenging cost improvement programmes. An equality impact assessment is being developed for West Yorkshire for schemes that would remove costs or where a current investment might be stopped, and this would include considerations for potential impacts on equality, quality, workforce, safeguarding, health inequalities, sustainability and the environment. This will feed into the place Quality Committee which will have oversight of the impacts across the partnership.

Melanie asked if the significant risks for 2024/25 if systematic change is not achieved have been articulated. Mike explained that there needs to be a focus on 2024/25 during this financial year in order to address the underlying recurrent situation recognising the risks.

Iain MacBeath provided some context to the budget of Bradford Council noting that reserves were used to balance the budget in 2022/23 with reserves also being used this financial year, however from 2024 there will not be sufficient reserves remaining to balance the budgets. There is no appetite to take any financial risks due to the uncertainty in 2024/25. Victoria Turner referred to significant cost pressures in North Yorkshire Council and a similar use of reserves alongside cost pressures in Humber and North Yorkshire ICB.

‘Foluke explained that ANHSFT are forecasting an underlying financial deficit in 2023/24 due to the implementation of patient records and RAAC.

Mel referred to areas that are important in BD&C, such as inequalities, prevention and community investment, and which are viewed as discretionary and are not included in national targets. Linda Patterson referred to this as an opportunity to do something different and reminded the Board of the commitment to health inequalities, parity of esteem, prevention and involving patients and communities. Elaine referred to different streams of money in the partnership noting that the VCS brings in additional money and advised being as smart as possible with sums of money.

The Bradford District and Craven Partnership Board –
1. Noted the improvement in the 2023/24 Bradford District and Craven Health and Care Partnership Plan which now shows a surplus of £0.1m and which will form part of the West Yorkshire ICS plan submission in May 2023
2. Noted the improvement to the Bradford District and Craven (of the ICB) Place plan position which now shows a deficit of £4.3m and which will form part of the West Yorkshire ICS plan submission in May 2023
3. Approved the Bradford District and Craven Health and Care Partnership Plan for 2023/24.
4. Noted that Place financial risk management arrangements will operate to help manage 2023/24 plan delivery.
5. Supported the proposal for a detailed review of financial performance at Month 5 to determine any further action required to manage the financial position.

9 Priorities

An update was provided on the five strategic priorities of the BD&C H&CP – Healthy Communities, Healthy Minds, Children and Young People, Access to Care and People (workforce). In the Board meeting in 2023 the scope and approach of each priority was described and it was agreed that the Board would have further opportunity to understand the priorities and how they enable delivery of our integrated care strategy. Members were invited to consider a number of questions to frame the discussions. Louise Clarke referred to the partnership strategy which focuses on the 4 Ps – purpose, population, place and partnership – with ongoing work to refine workstreams within the priorities in order to deliver the strategy supported by the enablers. The programme directors provided a brief summary of work within their priority and members were invited to reflect on the priorities.

Therese referred to considerations in the children, young people and families priority to harness the voice and having voices for different pillars and how this can be done. Mike highlighted a gap in the priority programmes in terms of understanding clear measurable benefits and expectations with a suggestion for a priorities list which recognises the need to make system savings. Louise referred to work currently underway to develop metrics and what the priorities are trying to achieve alongside a challenge that some will need some short term investment to make long term savings. Louise highlighted that there is a prioritisation toolkit and suggested a link is developed between the priorities and committees. Andy added that the Quality Committee is keen to engage with the priorities and to consider how it can support them. Julie added that the Finance and Performance Committee are also keen to support and challenge the programme areas and suggested that the priorities attend a future committee meeting discuss the priorities with a finance and performance view. Melanie Hudson raised a question about the resource available to support the People (workforce development) priority as this priority area is relatively under-resourced in comparison to the other priority areas and noted that the senior responsible officer for the priority has recently left the post.

Action – 'Foluke Ajayi to raise the resourcing of the People (workforce development) priority at PLE to ensure appropriate arrangements are put in place to rectify this.

Linda suggested building on the data and evidence that is already available, such as Born in Bradford research and the Innovation Hub. James referred to a fifth enabler on research and innovation which can connect research into the priorities. Helen Farmer added that enablers are a key part of the work, with digital as a wicked issue, and the referred to the need to broaden conversations alongside the enablers.

The Bradford District and Craven Partnership Board:
1. Discussed the questions in relation to the five strategic priorities.

10 Partnership risk update

Sue Baxter presented a report detailing the high-level risks (scoring 15 or above) on the BD&C Health and Care Partnership risk register during cycle one of 2023/24, the NHS West Yorkshire ICB risk register and an update on the development of the ICB Board Assurance Framework (BAF), which was approved by the ICB Board in March 2023.

Sue summarised that there are 26 open risks on the risk register with 12 high level risks. Two new risks in relation to reinforced aerated autoclaved concrete (RAAC) at Airedale Hospital are being developed to replace the current risk related to RAAC – the first new will relate to the risk of long-term disruption to service provision and the second to a risk to delays in decision or unsuccessful bid to the new hospitals programme. 'Foluke Ajayi agreed to bring an update on RAAC at Airedale General Hospital to the next Partnership Board meeting.

Action – 'Foluke Ajayi to present an update on RAAC at Airedale Hospital to the next Board meeting

Sue added that the risk related to the underlying financial deficit will be updated to reflect the 2023/24 position and highlighted that a new risk has been added in relation to increasing financial pressure in the costs for children's ADHD and autism assessments. Sue highlighted a number of emerging risks in relation to workforce in terms of recruitment and retention, primary care in terms of connectivity with network outages and the impact on practices.

The Bradford District and Craven Partnership Board:

1. Received the BDC H&CP cycle one risk report and confirmed assurance on the critical and serious risks scoring above 15.

2. Discussed any identified risks that are currently not recorded on the risk report and signposted the partnership governance team to the relevant risk owners for liaison in preparation for cycle two of 2023/24.

3. Received the ICB risk register for consideration and confirmed assurance on the BC&C H&CP risks captured in the ICB risk register.

4. Noted the ICB BAF which was approved by the ICB Board on 21 March 2023.

11 Any other business

Shak updated that a meeting has taken place with NHS England to discuss Shipley Hospital where they broadly supported the approach outlined in terms of the involvement with communities on a move of the services from the hospital and then further discussion on what communities want to happen with the money from the sale of the building. Support has also been provided by the local MP and the Health and Overview Scrutiny Committee.

Therese Patten referred to an item in a future ICB Board meeting on CAMHS and invited members to attend.

Sue Baxter highlighted that the Partnership Board Terms of Reference were appended to the place lead's update in order for them to be reviewed by members and invited any comments or amendments before the end of May.

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

None identified.

Date and time of next meeting:

Friday 21 July 2023
9:30-12:30
John Day Hall, Thornbury Centre, Bradford, BD3 8JX

Ref No	Meeting date	Agenda item	Action Required	Lead	Due Date	Status	Notes
2023/04	3-Feb-23	11 - partnership risk update	Nancy O'Neill to present an approach to estates to a future Board meeting (following presentation to the Partnership Leadership Executive)	Nancy O'Neill	Date TBC	Open	It is anticipated that feedback from the asset review to inform the development of the estates approach will be presented to the Partnership Board in the Autumn.
2023/05	14-Mar-23	5 - public voice/feedback from Listen In Keighley	James Drury to add primary care deepdive to the Partnership Board agenda planner	James Drury	12-May-23	Complete	Primary care deepdive has been scheduled for the July Board meeting.
2023/06	14-Mar-23	6 - place lead's update	Paper on the succession plan for Michelle Turner's role of director of quality and nursing in the Bradford District and Craven Partnership to be presented in a future Board meeting	Mel Pickup	12-May-23	Complete	Paper included as part of the place lead's update in the May meeting.
2023/07	14-Mar-23	6 - place lead's update	Mel Pickup and 'Foluke Ajayi to provide information on the impact of the strikes on elective activity and resultant cancellations	Mel Pickup/'Foluke Ajayi	12-May-23	Complete	Paper included as part of the place lead's update in the May meeting.
2023/08	14-Mar-23	10 - priorities - preparing for our discussion	Questions for the Board to consider in relation to the priorities to be circulated in advance of the meeting in May	Helen Farmer/James Drury	12-May-23	Complete	Questions were circulated and included in the presentation for the priorities item in the May meeting.
2023/09	12-May-23	9 - Priorities	'Foluke Ajayi to raise the resourcing of the People (workforce development) priority at PLE to ensure appropriate arrangements are put in place to rectify this.	'Foluke Ajayi	21-Jul-23	Open	
2023/10	12-May-23	10 - partnership risk update	'Foluke Ajayi to present an update on RAAC at Airedale Hospital to the next Board meeting	'Foluke Ajayi	21-Jul-23	Open	

Public question to the BD&C Partnership Board, May 2023

Question 1

I would like to know why there is no specialist menopause service available for women in the Bradford area; why are we not able to have access to a service similar to the one in Leeds; and if we do get a cross boundary referral why the waiting times can be up to 2 years (compared to a few weeks for Leeds residents)?

Currently women presenting with menopausal systems in Bradford District and Craven are supported in primary care. Referrals to Airedale Foundation Trust and Bradford Teaching Hospitals Foundation Trust can be made whenever additional advice and support is needed.

We are aware that there is a specialist menopause service in Leeds, and we are learning from their experience. Our clinicians have confirmed that the Leeds service is no longer open to patients from Bradford District and Craven as they are not accepting external referrals.

We are exploring options for how we can provide specialist menopause services for women in Bradford District and Craven. This includes how we can offer access outside of normal working hours for working patients seeking additional expertise and advice.

We are keen to establish community-based services and we are exploring potential funding routes to do this.

We have recently created:

- A menopause network which focuses on education and shared learning for GPs and those working in primary care to support patients who present to them.
- A series of learning events to provide training in menopause care for primary care staff, with the intention of increasing knowledge, understanding and capacity.

Question 2

I notice from the papers that the question about a hybrid/virtual attendance was actually asked by a member of the public at the last board meeting but didn't receive a response noted in the minutes as they were going to contact them to discuss concerns. Perhaps you could raise the point that this has again been asked and then if there is a response to the question from last time it could be shared so we can understand why this isn't the case?

We are committed to ensuring our Partnership Board is open and transparent to the communities of Bradford District and Craven, and that the work of the Partnership is informed by a good understanding of the needs of local people.

In order to connect with communities the Partnership Board moves around six localities in Bradford District and Craven and meet in community settings in these localities in order to be in venues that are close and accessible to people. We hold a week of 'listen in' involvement and engagement events with community groups and

settings in the locality before each meeting where we listen to what really matters to the local people and the findings of which are presented to the Partnership Board for discussion in the meeting. We invite questions from the public before each meeting which are referenced by the Board in the meeting and answered in full following the meeting. The meetings are held in public with members of the public from any locality in Bradford District and Craven welcome to attend. This approach is working well with good engagement with the public to date.

We have previously explored options to livestream our Partnership Board meetings and due to the high cost of this (approx. £3k per meeting) and the likely number of people who would watch the meeting, the Board agreed not to pursue live streaming or holding hybrid meetings. Instead, the Board agreed to focus our attention on other ways to connect with communities. We were also mindful that livestreaming/hybrid meetings would depend on the strength and reliability of the internet connection of the community venues that we visit.

We have recently enquired with our colleagues in the other places across the West Yorkshire Integrated Care System (ICS) on their approach to livestreaming or holding hybrid meetings and our approach aligns with the other ICB place committees. Their reasons are similar to ours (cost, resource required and technology capabilities).

We are exploring options to audio record future meetings and to place any such recordings on our Partnership website Bradford District and Craven Health and Care Partnership - Bradford District and Craven Health and Care Partnership (bdcpartnership.co.uk) where members of the public could listen back at a time that suits them. Our consideration of this option will take into account the technology available in the community venues where we hold the meetings and an analysis of the costs and benefits of the approach.

Partnership Leadership Executive

28 April 2023

9am – 12pm

MS teams

Present:	
Mel Pickup *(MP)*	Place Based Lead, CEO, Bradford Teaching Hospitals Foundation
Therese Patten, *(TP)*	CEO, Bradford District Care Foundation Trust (BDCFT)
Iain MacBeath, *(IMB)*	Strategic Director of Health and Wellbeing, (CBMDC)
Sam Keighley, *(SK*)	VCSE Sector Lead and CEO of VCS Alliance
David Crampsey, *(DC)*	Chair of BdC Clinical Forum
Richard Haddad, *(RH)*	GP/Chair of Clinical Advisory Board
Charlotte Ramsden *(CR)*	CEO Bradford Children and Families Trust
Louise Bestwick *(LB)*	CEO Bradford Care Association Ltd
Foluke Ajayi *(FA)*	CEO, Airedale NHS Foundation Trust. (ANHSFT)
Dannielle Hann *(DH)*	Medical Director and Deputy Chair, LMC
Mike Woodhead *(MW)*	Director of Finance, Contracting and Estates (BDCFT)
Sarah Muckle *(SM)*	Director Public Health
In Attendance:	
Louise Clarke, *(LC)*	Director of Strategy Transformation, Primary & Community (BdC HCP)
Nancy O'Neill, *(NoN)*	Chief Operating Officer/Director of Partnership Delivery (BdC HCP)
James Drury, *(JD)*	Director of Partnership Development, BdC Partnership (BdC HCP)
Sue Baxter, *(SB)*	Assistant Director of Assurance (BdC HCP)
Helen Farmer *(HF)*	Programme Director – Access to Care (***item 3)***
Kerrie Lee Barr *(KB)*	Voluntary sector alliance (***item 3)***
Claire Smart *(CS)*	Associate Director of Strategy (***item 4)***
Robert Maden *(RM)*	Director of System Finance (BdC HCP) ***(item 5)***
Kerry Weir *(KW)*	Associate Director Planning, Performance & Business Intelligence ***(item 5)***
Imran Rathmore *(IR)*	Transformation and Executive Support Manager Adult and Community Services, Department of Health and Wellbeing (***item 7)***
Alison Bullock, *(AB)*	PA/Partnership Manager, (BdC HCP)

1. Welcome and apologies for absence	Apologies were received from, Marium Haque, Kersten England
Declarations of Interest	None
2. Notes from 24 March 2023 2 (b) Action log	Members of PLE were invited to join a presentation on the Torbay front door initiative prior to this meeting. Notes of the meeting from the 24 March 2023, were agreed to be an accurate record of the meeting. Action log was updated. SK requested the action around developing the VCSE commissioning strategy and linked to the compact as discussed at the last meeting to be added to the action log.

	The matters arising report was noted. BDC Place Financial Leadership Arrangements (as discussed at the last meeting). The proposal is progressing, from 1 May MW will become Place base finance lead, RM will provide operational support until a recruitment process commences, this role will need to go through the vacancy process. Direct reports are aware but some final elements to be agreed with West Yorkshire ICB before a formal announcement is made. Distributed Leadership Model – Director of Nursing and Quality (as discussed at the last meeting): This role has support from respective boards. Additional resilience has also been put in place with Grainne Eloi the Single point of contact for ICB, Grainne will also attend the Partnership Leadership Team meetings. The Fellowship – Cohort Three: Cherill Watterston (system development lead for WY ICB and is leading the programme for Cohort Three. Cherill will attend PLE touch base on 3 May
Actions:	***Action around developing the VCSE commissioning strategy and linked to the compact to be added to the action log. (AB/JD.)*** ***JD to ensure Shak Rafiq is involved in communications around finance place base lead formal announcement.***
3. Wellbeing Network - funding - linked to operational plan	Due to the late start and extended mobilisation of the hubs, the funding allocated in 21/22 has enabled the hubs to run until September 2023. Using 22/23 unallocated resource and 23/24 winter resilience budget, will ensure continuity of the hubs until May 2024, at that point the funding will cease. No other funding is available to commit to the hubs on a recurrent basis from May 2024. PLE were asked to support the decision to fund the Wellbeing Networks for £1,650,524 as a recurrent annual cost. Following discussions across BdC, it has been suggested that it would be appropriate to consider the recurrent funding of the hubs within the Better Care Fund as it meets National Conditions 2 and 3, however this would require further discussion with system partners as we would need to review other services currently within the BCF to determine if anything can be stopped. It was noted the hubs currently offer critical support to our populations, help improve health inequalities and help reduce pressure on health and care services. KLB described the ongoing work to map services, identify gaps, and work with PCN, Community Partnerships, Reducing Inequalities Alliance, Healthy Communities to create efficiencies and reduce duplication. Whilst recognising the success of the hubs so far, it was felt that there was not enough evaluation or future modelling to be able to commit to recurrent funding at this point. It was acknowledged that the hubs were in the early phases and were still evolving and growing intelligence. Demonstrating how the hubs can ensure all types of support can be offered and how they can respond to changing needs and demand will be important. Noting that the Voluntary sector will need commitment to provide stability for their services and allow them to plan, it was agreed an

	updated proposal which can demonstrate impact and outcomes is brought to the September meeting of PLE. It was noted that if agreement were made to commit to the funding, other services would be impacted. In the meantime, it was suggested alternative sources of funding or opportunities for match funding were considered.
Actions:	***HF/KLB to Review metrics and evaluation to demonstrate impact of hubs and bring an updated proposal in September 2023.***
4. Primary Care update to Partnership Board	This paper builds on the update to PLE in October 2022, noting the new 2023 GP contract, GP access data, and the importance of prioritising safe care. Under delegation ICBs have responsibility for commissioning and contract monitoring GP services in their locality/systems, with NHS England maintaining overall accountability. West Yorkshire ICB has delegated responsibility for the commissioning of primary medical services to 'Place.' Bradford District and Craven Health and Care Partnership is the responsible commissioner for primary medical care in Place. The paper set out some of the challenges faced by primary care, e.g., recruitment and retention and addressed some of the common misconceptions that there are fewer appointments available. The Data shared demonstrated an increase in access to primary care. It highlighted that there has been a fall in satisfaction across a range of health and care services, and access to primary care is now driven by quantity and not quality. DH referred a particular issue around GP finances, this is a national issue but has a significant impact of the finance flow for practices is being escalated through regional routes to raise awareness. Primary care is working in various forums to support transformation, address variation and provide enhanced access. An ask of Primary care is that as a partnership we: • Own messages together (do not need more access) • Discuss how to support each other (if shift work, shift resource) • PLE's continued commitment to support primary care It was felt there was opportunity to maximise resources between community nurses and primary care and explore how the Additional Roles Reimbursement Scheme (ARRS) are being used. It was commented that the Listen in events have highlighted that primary care access has been a system blind spot not just in terms of appointments but also the interface with primary care e.g., telephone systems, need to look at the infrastructure of this. There are also some relationship/trust issues between different parts of the system in terms of referrals to secondary care (only taking referrals from GP's), it was suggested the BdC Clinical forum would be a good place to have a discussion around this. The work around universal healthcare, closer collaboration between the VCS and primary care led by SK and wellbeing hubs would help

	alleviate some of the pressures described. It was noted all these elements related to the Torbay model. In terms of primary care representation across place, there is good representation in different forums. A gap around practice engagement has been identified (engagement moved from practices to PCNs and Clinical Directors) and a plan is in place to reinstate this. LC extended an invite for PLE members to attend an engagement meeting to help build relationships with primary care. It was felt the paper clearly demonstrated the pressures being experienced by primary care and it was important that the message to '*respect for people who work in primary care'* was shared in wider communications.
Actions:	***DC to take forward a discussion to the BdC Clinical Forum around referrals between professionals.*** ***JD to feedback to Shak Rafiq around system message of support /respect for primary care to public.***
5. NHS Operational plan and budget 2023/24 final submission	All plans were submitted within the required deadlines. There was slight change from the draft position in terms of activity. The plan carried some risks e.g., workforce, notably the biggest risk was closing the financial gap and there would be a resubmission today with more detail around finance. The first draft of the first draft of our joint forward plan has been completed. <u>Finance plan:</u> West Yorkshire had a deficit of £109m, this resulted in an improvement target, which was £50m for West Yorkshire, of which Bradford was asked to improve its position by £11.4m. West Yorkshire confirmed that they were able to meet that improvement target, so that released an additional £32m of NHS England funding into the West Yorkshire ICB. Discussions have taken place to understand how this can support current plan positions in each of the five places and the organisations within those places. The conclusion of this is at a West Yorkshire level, will be a £27m deficit. Bradford District and Craven have moved to a position where all parts of our system have a balanced financial plan apart from Airedale, which has a small deficit of £4.3m, Calderdale has the biggest deficit for West Yorkshire. There is an expectation that West Yorkshire may be asked to close the £27m gap. The message to the BdC Partnership Board on 12 May 23 will be that we have a credible plan that has some degree of risk attached to it. In terms of services at risk, it is important that equality, impact assessments are undertaken. IMB requested a conversation around the Better Care fund elements of the plan (to include the Chief operating officers). RM fed back on a discussion at the West Yorkshire Finance Forum around an alternative proposal for the Elective Recovery Fund scheme, which will impact 52 weeks wait target, if agreed an adjustment to the operational plan trajectory will be needed.

	Phlebotomy service: (recommendation from the System finance and performance committee) RM advised there was an inequity in the way phlebotomy services were currently provided across the patch. Bradford practices are funded approx. £2.50 per head to provide the service, Airedale practices are not funded, the phlebotomy service is provided by Airedale NHS Trust over three sites. The proposal is based on establishing equitable service provision to phlebotomy services provided in General Practice across Bradford District and Craven, ensuring that Practices are remunerated on the same basis for providing the same service. There will be a cost pressure for Airedale associated with this. PLE supported the recommendation noting that there would be a need to look at how the service was managed in the longer term.
Actions:	***IMB to convene meeting to discuss Better Care fund elements of the financial plan***
6. Social Care Call to Action - and Trusted Assessors	'Call to action' was launched in October 2022, it brings together the Care Association, NHS, ADASS and local government representatives. The 'Call to Action' network is now becoming well-established, with a steering group and a wider network of stakeholders. The aim is to raise awareness across the system of some of the challenges faced within social care and agree actions to mitigate these. Ten priorities have been identified which have been themed into four workstreams; LB provided a summary of the activities being undertaken by each of the workstreams: • Workforce • NHS Integration • Market sustainability • Data Intelligence PLE welcomed the update and gave their full support to the network. <u>Care Home Trusted Assessor (TA)</u> The trusted assessor role will: • Provide assessment facilitate safe and timely discharge from hospital • Undertake assessments on behalf of the care homes • Ensure that assessment information is detailed and allows an informed decision to be made by the Care Home to meet the individual's needs This will provide a number of benefits for our system and population Leeds Care Association have successfully operated their TA scheme for three years expanding from one to three TA's. A proposal is being drafted and will be presented to PLE in May with a request for PLE to support two TAs at place (in the Bradford and Airedale districts). The aim is for the two roles to be operational in September to support the system with winter pressures
Actions:	***LB to present business case for Trusted assessor at the May PLE.***

7. Draft mutual accountability and assurance framework (MAAF)	The framework was developed as part of the establishment of the BdC Partnership. The framework describes our approach to accountability and sets out how our partnership will enact this and how we will respond to inspections/national regulatory bodies as a system. The document will have measures set out to ensure it is working. The MAAF framework sits alongside the the Strategic partnering Agreement and governance handbook and provides a robust governance approach across our partnership. PLE approved the mutual accountability and assurance framework acknowledging it would be an evolving document particularly in relation to how we respond to regulators and supported the proposal to set up a Mutual Accountability and Assurance Reference Group (MAARG), IM will invite the relevant people from partner organisations.
Actions:	***None***
8. Risk register/Governance update	Board Assurance update: This has been reviewed by internal auditors and has achieved significant assurance in terms of the detail around the risk register. One new risk identified – 2226 Costs for childrens autism assessments. A number of emerging risks have been identified throughout the previous and current cycles from the sub committees and there is a plan to do some dedicated work with the priorities and enablers. Work is ongoing to recalibrate the risk register. RAAC (reinforced, autoclaved, aerated concrete) at ANHSFT. Work is underway to reword the risk and its associated sections to reflect the mitigating actions at a partnership level but to maintain consistency across the three risk registers (Partnership, WY ICB, ANHSFT) recognising the different focus of each level.
Actions:	***None***
9. Items to note	The following forward plans were shared for information: a) PLE and development session b) Wellbeing Board / Wellbeing Exec
Actions:	***None***
10. Any other business	No other business was raised.
Actions:	***None***
11. Key messages	None
Date and time of next meeting	9am – 12pm, 26 May 2023 Via MS Teams

Partnership Leadership Executive

26 May 2023

9am – 12pm

MS teams

Present:	
Mel Pickup *(MP)*	Place Based Lead, CEO, Bradford Teaching Hospitals Foundation ***(Chair)***
Therese Patten, *(TP)*	CEO, Bradford District Care Foundation Trust (BDCFT)
Iain MacBeath, *(IMB)*	Strategic Director of Health and Wellbeing, (CBMDC)
Sam Keighley, *(SK)*	VCSE Sector Lead and CEO of VCS Alliance
David Crampsey, *(DC)*	Chair of BdC Clinical Forum
Richard Haddad, *(RH)*	GP/Chair of Clinical Advisory Board
Charlotte Ramsden *(CR)*	CEO Bradford Children and Families Trust
Louise Bestwick *(LB)*	CEO Bradford Care Association Ltd
Foluke Ajayi *(FA)*	CEO, Airedale NHS Foundation Trust. (ANHSFT)
Dannielle Hann *(DH)*	Medical Director and Deputy Chair, LMC
In Attendance:	
Louise Clarke, *(LC)*	Director of Strategy Transformation, Primary & Community (BdC HCP)
Nancy O'Neill, *(NoN)*	Chief Operating Officer/Director of Partnership Delivery (BdC HCP)
James Drury, *(JD)*	Director of Partnership Development, BdC Partnership (BdC HCP)
Alison Smith (AS)	Head of Partnerships, Strategy, and Integration BTHFT (***item 4)***
James Greenwood (JG)	Strategy and Transformation Manager – Diabetes Community Workstream Lead ***item 4***
John Holden (JH)	Deputy Chief Executive and Director of Strategy and Integration ***(item 4)***
Kerry Weir *(KW)*	Associate Director Planning, Performance & Business Intelligence ***(item 5)***
Sue Baxter (SB)	Assistant Director of Governance and Assurance ***(item 11)***
Alison Bullock, *(AB)*	PA/Partnership Manager, (BdC HCP)

1. Welcome and apologies for absence	Apologies were received from, Kersten England, Marium Haque, Mike Woodhead, Sarah Muckle, and Robert Maden.
Declarations of Interest	Item 4 Diabetes Transformation Programme – PCN Model of Care – RH declared a declaration of interest as a level 2 provider at Saltaire and Windhill Medical Practice. RH remained in the meeting for the discussion but did not contribute.
2. Notes from 28 April 2023	Notes of the meeting from the 28 April 2023, were agreed to be an accurate record of the meeting.
2 (b) Action log	Action log was updated. Matters arising report: <u>Update on Shipley Hospital public engagement:</u> Support has been received to carry out an involvement rather than a public consultation. Views will be sought on the proposed move of the physiotherapy services. This will be followed by a public conversation to find out more

	about how they would want any funds reinvested in the local community should we be able to access 50% of the funding from the sale of the building by NHS Property Services. Specialist menopause service (response to Partnership Board question): This has highlighted that whilst this does not sit within our priorities, it may require some resourcing and we will need to consider how would we prioritise (things not in priority areas) in the future. Flu prescribing arrangements: Expectations on services for the provision of antiviral drugs for the treatment and post-exposure prophylaxis of influenza-like illness (ILI) in at-risk patients including care home residents Sarah Muckle advised that there may be gaps in local provision related to the expectations of this letter. Agreed this needed resolving before winter. Rob Webster meeting with local MP Naz Shah: Actions are being progressed.
Actions:	***LC to escalate Flu prescribing arrangements to James Thomas***
3. People Priority leadership arrangements and resourcing	JD talked through the current resource arrangements for the people priority of which FA is the Partnership Leadership Executive sponsor. Jo Harrison, Director of People and OD at Airedale has offered to provide support and expertise as co-SRO on a short-term basis (3 months initially), whilst longer term plans are agreed. Delivery of the four pillars is led by HRDs from the Local Authority and NHS trusts, and in some instances co-led by partners e.g., from VCS, care sector, ICB etc though this has not been possible in all pillars. A number of options were shared for information at this point, a worked-up proposal would be brought to the July PLE meeting. MP noted that whilst individual organisations have their own way of working through HR/OD which will need working through, there is an opportunity to progress the more transactional stuff e.g., shared services. LB advised that due to capacity issues BCA colleagues were struggling to attend all meetings. PLE supported proposed approach.
Actions:	***FA/JD to bring back proposal to June/July PLE***
4. Diabetes Transformation Programme – PCN Model of Care	*DOI - Richard Haddad – level 2 provider of the service at Saltaire and Windhill Medical Practice. RH remained for discussion but did not contribute.* The Diabetes Transformation Programme has been working towards a PCN model of diabetes care for over 3 years. It has been developed across the system with leadership from the Diabetes Programme Board and Diabetes Clinical Forum, as part of the wider diabetes transformation programme. This is a huge issue for the population and a significant driver of inequalities. It was noted this was just for primary care and community element of the service. An option appraisal which explored the pros and cons of all options was shared: • PCN model of care • Procurement exercise for single provider • Provider collaborative • All patients requiring enhanced care go to one of the hospitals

	• Do Nothing AS shared the background, rationale, and benefits for wanting to change service. The new model of care proposal for a PCN model of care will align the service across our partnership and put it on a sustainable footing for the future. The building blocks are already in place; Assist BCD supports all GP practices with clinical decision making and over four hundred people have attended training days for GP practice teams. It was reported that whilst PCNs are supportive of the PCN clinical model of care, additional funding would be required. A proposal was made that the additional funding could be sourced within the existing diabetes budget, by releasing it from a contract with Leeds Teaching Hospitals Trust (LTHT) which currently maintains point-of-care testing machines for diabetes, (DCA machines that are used for point-of-care HbA1c). Modern diabetes care makes less use of point-of-care testing and PCNs support a reduction in the number of DCA machines (82 machines down to 30). It was noted that renegotiation of the LTHT contract to release the additional funding could take a year, therefore it was proposed the part year cost in 23/34 could be covered by using diabetes transformation funding. AS confirmed that finance colleagues were supportive of the approach of moving away from an activity-based contract, also noting that it was recognised that the contract with LTHT was historic and needed review. The proposal has been discussed with PCN's, the LMC and the Partnership Leadership Team, all have supported the recommendation. It was acknowledged there was a sense of urgency around resolving this and it was agreed the proposed PCN model would deliver the best service as it could be tailored to the population. Though it was noted reducing the number of machines should not increase inequalities. **PLE supported the proposal to progress the work as described which would transition this to a conclusion.** On reflection it was felt that this item demonstrated that there was still work to do around the journey of papers to PLE so there is assurance that they have been to the appropriate groups.
Actions:	***JD to work on a process around the preparation of papers coming to PLE***
5. Draft BdC Joint forward plan (JFP)	The Health and Care Act 2022 set out new statutory arrangements for health and care systems including the creation of Integrated Care Boards. As part of these changes, requirements were set out for the development of Integrated Care Strategies which would be owned by Integrated Care Partnerships (for West Yorkshire this is the Partnership Board) and JFPs, which would be owned by Integrated Care Board and would describe the delivery of the NHS elements of this strategy. The JFP is therefore a statutory document owned by the West Yorkshire ICB. This first Joint Forward Plan sets out the aims of our priority areas for the next 5 years and our commitments for 2023/24, both set within the context of our partnership strategy and our operational plan. Whilst the

	plan will be an appendix to the West Yorkshire ICB plan, it will be used locally to provide a discipline around what we are doing in BdC. In terms of governance, the Partnership Board have already approved the overall strategy and delegated overseeing delivery of the plan to PLE. The final version of the strategy will be presented at the July Partnership Board. Engagement through the various governance structures will take place before this, e.g., BdC Clinical forum and citizen forum. Given the next formal BdC Partnership Board in in July and to address any potential challenges for the Partnership Board it was suggested that the document went to the System Committees separately. The following were identified as gaps in the document: • Dementia (resource and support) • The measure of success/metrics (currently not included or defined) • BCF metrics • Engagement (Listen in) • Financial context in which plan is based • Describe governance and the plan to view and monitor going forward • Risks – set in the context of challenges KW will continue to circulate the document around the various governance routes and gathering feedback, before presenting the final version at the BdC Partnership Board in July prior to inclusion in the West Yorkshire ICB plan.
Actions:	***1) JD to consult with Committee chairs to inform them of process*** ***2) Any further comments to be sent to KW*** ***3) Final document to go to BdC Partnership Board in July***
6. Better Care Fund plan for 2023-24	This year's Better Care Fund (BCF) is a 2-year plan (2023-25), draft plans (planning template and narrative) were submitted at a West Yorkshire (WY) level to the locality BCF team on the 19th of May, with final plans by the 28th of June. The two core policy objectives are: • Enabling people to stay well, safe, and independent at home for longer; and • Providing the right care, at the right place, at the right time. IMB provided an overview of the plan, financial breakdown of the funding and priorities for 2023 to 2025. It was acknowledged there had been a much more inclusive approach this time and a more positive process. The metrics and data that play into community parts of the system was welcomed, it would be good to demonstrate some outcomes. LB noted the approach would allow the independent care home sector to flex and adapt to what is needed. It was noted that there may be some tough decisions to make around the intermediate care element of this and work is ongoing to look at capacity and pathways. In terms of the BCF funding, if services need to stop because funds are being committed elsewhere then we need to understand any impact. In terms of the governance process MP has the authority to sign off the plan on behalf of the Partnership Board.
Actions:	***PLE supported the use of the BCF 2023-25***

7. Care Home Trusted Assessor business case	A Care Home Trusted Assessor (CHTA) conducts assessments of hospital patients on behalf of care homes, who need to consider what the patient's needs are and whether they would be able to meet those needs. • In BdC there remains a significant gap with the current approach for pathways into the independent care sector which results in extended lengths of stay. The CHTA would work alongside the current discharge team (not duplicating work) to collate a fully comprehensive assessment of the patients' needs and undertake assessments on behalf of the independent care homes if required. LC shared some of the benefits the CHTA role could bring to our system, these included: • Reduce waiting times for assessments and placement failures. • Respond to and support system resilience during periods of peak pressure and maintain a clear flow of communication and engagement. • Provide System savings by facilitating the Right care, right place, right time. • Offer impartial signposting and support to self-funding patients. The proposal was to implement and launch CHTA project across BdC by September 2023 to support winter pressures. Whilst the paper did not demonstrate the impact these roles would make, apart from patient experience, LC estimated the financial impact at around £300k per year for pathway three. It was noted that this proposal linked with the intermediate care review being undertaken in the Healthy Communities programme and from a funding point of view would fit with the Better Care Fund but by committing to this there would be an impact on other parts of the system. It was agreed there was an opportunity for connectivity with what already exists in the system (Healthy Communities programme) ensuring also there is no duplication with the Local Authority roles. It was suggested that the Trusted assessors are made accessible to community staff too. PLE supported the CHTA roles in principle but asked for more detail around finance and impact.
Actions:	***LB to consult with Mike Woodhead/IMB/System Finance Committee around funding and how this could work alongside LA***
8. Response to BCA letter previously shared regarding care fee annual uplift 23/24	LB advised a response has now been received but wanted to highlight a concern around the Continuing Health Care (CHC) funding for Nursing Care. The Local Authority have brought the nursing home care fee uplift in line with the residential care fee uplift, but the ICB could not match this, so this would remain still at 1% less of an uplift. The current impact is low as the CHC rate is still above the nursing rate, but in October following the implementation of the new enhanced nursing rates which are being brought in as part of the fair cost of care and the market sustainability funding will mean the CHC rates will be below the Local Authority

	enhanced rate. An agreement in principle was made that the CHC funding would be at equivalent to the enhanced rate of nursing needs. It was noted Bradford is considered an outlier and lower than other areas. There is a risk in October that nursing homes may refuse to take certain placements e.g., CHC. IMB advised that whilst the Local Authority have been provided with grants able to bring the nursing homecare fee in line with the residential care fees, the ICB have received no extra funding to pass on to care providers. This variation poses a significant risk to the stability of the Bradford care sector particularly for CHC patients. Additional funding that could be made available later in the year to Local Authorities could complicate this issue further. It was also suggested a review of CHC packages is needed as there are a number of large care packages that need reviewing. It was agreed this needed a strategic financial discussion. JD advised the draft operating model described CHC as place based which will allow different discussions/arrangements but there will need to be some consistency across West Yorkshire. Alongside this it was requested that how CHC funding for Children and Young people is also considered.
Actions:	***LC to take forward a discussion with Mike Woodhead***
9. Approval of Planning and Commissioning Forum Terms of Reference	The purpose of the Planning & Commissioning Forum (PCF) is to provide system leadership and strategic direction to the joint planning and commissioning arrangements between health and care within the 'Act as One' local framework across Bradford & District. It is also responsible for overseeing and managing the section 75 agreement, including the Better Care Fund. The ToR have been revised as this will now be a formal decision-making group. The PCF will submit an annual report to the Partnership Leadership Executive meeting.
Actions:	***JD to add PCF annual report to forward plan***
10. System Awards Ceremony plans	SR presented this proposal which has been shaped the PLE discussion in December 2022 and a small steering group, made up members from different agencies and sectors that make up BdC place-based partnership. The following options were supported by PLE for the event which will be held on Thursday 19 October, starting at 7pm: The venue will be the Aagrah in Thornbury, the maximum capacity is 450 and the venue is fully licensed. The previous specific award category for kindness and compassion has been withdrawn as it was agreed this should be a golden thread throughout all awards and be part of the award criteria. The event hosting and entertainment proposal was also supported, PLE members will be involved in the judging process but not be asked to judge all awards. A communications campaign will begin on 12 June and nominations can be made up to 11 August.

	It was acknowledged the venue was not centrally placed but it was proposed a bus would be hired to transport colleagues from the Airedale end of the patch to the venue and back. In terms of funding (£35k) this was coming from an underspend of the transformation funding, it was noted this would not be available next year. Sponsorship is being sought but not confirmed at this time. <u>NHS75 story telling project</u> To celebrate NHS75, there is a plan to recognise and include people from across all parts of our BdC partnership. Staff will be asked to make a short selfie video which describes their role and what working in the BdC Health Care partnership means to them.
Actions:	***1) PLE members to encourage staff to nominate teams/colleagues and attendance at the event.*** ***2) PLE to pass details of any potential sponsors to SR*** ***3) PLE to consider if any staff within our system can support the event management*** ***4) SR will share the information with PLE members to share onwards within individual organisations and teams***
11. PLE Committee effectiveness	The West Yorkshire ICB and its Place committees are required to undertake regular reviews of their own effectiveness. In line with good governance practice an annual review of committee effectiveness was undertaken with all relevant internal committees as best practice also. Seven people responded, this equated to a 54% response rate, ideally the figure would be 70% or above, overall, the responses were positive. Feedback suggested: • there is good collaborative/partnership working, the meeting allows for challenge, however refining clearer roles would be beneficial. • The group has benefited from more informal discussion such as the PLE touch base. • Agendas are felt to be full and need to be refocused on the delivery of partnership ambitions and what matters most to our population. It was felt that the membership was NHS heavy, and action was needed to rebalance this. CR welcomed the opportunity to involve Children and Young People discussions at PLE. Other comments included: • The process of where a paper goes before being presented at PLE needs reviewing. • How do we link North Yorkshire colleagues in (revisit membership)
Actions:	***1) JD to liaise with CR and Local authority colleagues around agenda setting.*** ***2) JD to revisit membership within the terms of reference.***
12. Items to note	The following forward plans were shared for information: a) PLE and development session b) Wellbeing Board / Wellbeing Exec The next PLE development session is on 6 July, it was suggested this meeting included a conversation around the ICB operating model. The deep dive into Primary care at the Partnership Board in July will focus on General practice.
Actions:	***None***

13 Any other business	LC has met with the CQC manager for Bradford place and will invite her to a future PLE meeting. IMB reported that new CQC inspections for adult social care will begin in October 2023, PLE members may asked to interview for these. IMB has drafted a ASC vision and plan and will share this with PLE
Actions:	***1) LC to invite Laura Knowles (CQC manager) to a future PLE meeting.*** ***2) IMB to give a presentation at PLE around what the Adult Social Care CQC inspection may look like.*** ***3) IMB to share ASC vision and plan***
11. Key messages	Consider how key messages from discussions at PLE can be communicated through the communication network.
Actions:	***SR to consider how we communicate wider what is discussed at PLE***
Date and time of next meeting	9am – 12pm, 23 June 2023 Via MS Teams

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Partnership Board
Agenda item no:	5
Meeting date:	21 July 2023
Report title:	Feedback from Listen in
Report presented by:	Victoria Simmons, Senior head of communications and involvement
Report approved by:	Shak Rafiq, Associate Director 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:

- Proposal presented at Partnership Board meeting July 2022
- Citizen Forum Steering Group 23 August, 4 October 2022, 22 November 2022
- Healthy Communities Board 18 November 2022
- Listen in Craven feedback presented at Partnership Board meeting December 2022
- Listen in Bradford South presented at Partnership Board meeting February 2023
- Listen in Keighley presented at Partnership Board meeting March 2023
- Listen in Bradford West presented at Partnership Board meeting May 2023
- Healthy Minds Board June 2023

Executive summary and points for discussion:

‘Listen in’ is an ongoing programme of involvement, with focused weeks of activity in our six localities. Our fifth cycle of ‘Listen in’ activity took place in the Bradford East locality from 5 to 10 June 2023. Partnership Board members, senior leaders from our partnership and a range colleagues took part alongside our involvement teams, using the five reset priority areas to frame open conversations about what matters most to local people.

Findings have been collated and analysed into a summary report which includes a summary of general themes and detailed insights linked to each priority area. The Board is asked to consider the report and to identify specific learnings that will be acted upon.

The final cycle of the first year of Listen in takes place in July. Plans are in development to embed the learning and drive action in response to findings through our priority boards and in the locality collaboratives which are being established.

To bring together the insights from across all six localities, place-wide deliberative involvement will take place in September through an event bringing together our partners, our workforce and our citizens.

Further deliberative approaches at locality level will be supported by working in partnership with Healthy Communities teams, to ensure that dialogue and relationships established in year one of Listen in are maintained and that communities are actively engaged in next steps.

From Autumn 2023, cycles of Listen in activity will focus on reaching into specific communities of interest to gather more detailed insight and coproduce actions to address the issues identified.

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 how the insights from the involvement report will inform the delivery of our priorities in the Bradford East locality and across our place.
2. Identify specific learnings from the Listen in activity that can be acted upon by our partnership.

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. Detailed report of findings from Listen in Bradford East

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 may 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.

1. Listen in - background

1.1
Listen in is an ongoing programme of involvement, with focused weeks of activity in our six localities: Craven, Bradford South, Keighley, Bradford West, Bradford East, Shipley. Listen in weeks involve direct conversations with the public, visits to community groups and other engagement activity that builds relationships at local level to help us understand what matters most to local people when it comes to health and care.

Working in localities involves collaboration with community partnerships, ward officers, local organisations, and neighbourhood teams – ensuring that what they know from their work 'on the ground' is captured and connected into our decision-making structures.

Leaders from our Partnership Board and across our health and care system play an active part, enabling them to hear directly from local people and deepen their connections within our place. Our schedule is linked to the bi-monthly Partnership Board meetings which also rotate across the six different localities. Our listening activity takes place a few weeks before the board meeting, to allow time for insight to be analysed and a report produced.

We are taking a 'test and learn' approach to continually develop, evaluate and improve methodology for the 'Listen in' programme. Qa Research were commissioned to advise on method and practicalities, as well as analyse and report on the data collected from communities.

2. Listen in Bradford East – where did we go, what did we hear?

2.1

Our fifth cycle of 'Listen in' took place in the Bradford East locality.

26 colleagues from across our partnership visited 20 community groups and talked to people in public spaces across the area.

Partnership Board members, senior leaders and colleagues took part alongside our involvement teams. We used our five reset priority areas to frame open conversations about what matters most to local people.

2.2

Key themes

Accessing GP appointments remains the most common issue – As with all other cycles, the main frustration and feedback from people living in Bradford East was how hard it they found it to access primary care. The impact of this is not only frustration, but feeling let down and disillusioned, leaving some people feeling like it is not worth trying to see a GP any more. However, for balance, some residents were happy with their GP access.

Low awareness of options regarding health – It appeared that many Bradford East residents had a limited understanding of their options in urgent but non-emergency situations. This was compounded by lack of digital confidence and English skills, making the system confusing for some people.

Lack of trust in formal healthcare system –There is a sense from some residents of Bradford East that the health and care system is not trusted to deliver what the population needs. Some people did not feel listened to. Mis-trust in formal mechanisms of health and care in some communities, means residents feel more comfortable in informal settings with figures that they know and trust.

Community groups for social and mental health – It was very clear that the community groups available in Bradford East were strong assets and have a positive impact on local people's lives. This shone through very strongly, especially in terms of socialising and combating loneliness, a sense of community and supporting good mental health. These direct benefits were articulated clearly by residents, as well as practical help such as exercise opportunities and advice on finances or services.

Trusted figures in groups supporting health and wellbeing needs – Local group leaders are supporting people in a much more holistic and involved way than might be expected - offering advice, mental health support, signposting or referrals, completing applications or phoning GPs, and much more. There was some concern about the pressure that these individuals are under by taking on this level of responsibility for others and how they could be more supported by services.

Health speakers in community venues are an opportunity – Several community groups and venues had already hosted health speakers or testing services e.g. blood pressure checks, talks about hepatitis or diabetes, and discussion of healthy living. Certainly, there was an appetite to absorb health information in these trusted environments rather than a more formalised healthcare settings that are less accessible or comfortable to many residents.

Transport was a challenge for some residents – While some residents were happy with their local access to walking distance groups and services, others found themselves struggling to attend due to transport issues. The cost of transport is another barrier for some people, for example refugees, homeless people or simply those affected by the cost of living crisis.

Language was also a barrier to positive experiences with health and care – Some communities struggled with language barriers when it came to accessing healthcare or wellbeing services. Many relied on family members, which sometimes worked and sometimes felt uncomfortable, as people did not always want to disclose their private health symptoms to their children, for example.

2.3

Findings linked to our partnership priorities

People described their current experiences in relation to our five strategic priorities and talked about what it would be like if our partnership were 'getting it right'.

Healthy communities

Support groups in Bradford East are invaluable to their members. Very different people attend in contrasting life situations, and group leaders have created a trusting and safe environment. People are accessing direct support e.g. health talks, testing and mental health signposting, as well as indirect support e.g. socialising, wellbeing support, activities.

Access to primary care is a priority issue as GP appointments feel unattainable for many residents. This is complicated by their English language skills, housing situation, disabilities and legal status in the UK. For some, community groups serve as a great access point to improve health instead of struggling to see their GP.

Access to care

There is a sense of lack of trust in the NHS which stems from various factors, including long wait times, inadequate communication by healthcare workers, and a sense of not being listened to. The issues accessing primary care are a big contributing factor, as people do not feel they will be seen in a timely manner. This issue is particularly prominent in certain communities, which lack support or adjustments for different languages, disabilities, and various situations**.**

Mental health, learning disability & neurodiversity

The prolonged waiting period for a neurodevelopmental diagnosis significantly impacts individuals with learning disabilities. The uncertainty and lack of clarity during this time can be emotionally distressing and hinder their ability to access the appropriate support and interventions. Mental health waiting lists are similar, with issues often exacerbating, or individuals forced to rely on others while they wait, for example community workers picking up a lot of the support needs.

Workforce

Current or former healthcare workers have expressed significant concern regarding burnout and its impact on mental health. While community groups have played a vital

role in assisting people with wellbeing, employment, and other issues, they face limitations due to resource constraints and burnout. However, there is interest in health and care professions from various communities, including refugees.

Children, young people and families

Children and young people face similar challenges to adults, such as access to GPs and mental health. In some areas, youth workers feel children are particularly vulnerable to a range of issues including vandalism, violence, mental health and physical health e.g. smoking. While youth groups help keep young people safe and supported, they have limited resources and are already going beyond their remit.

Detailed insight is presented for each priority area in the Qa Research report.

3. Recommendations

Consider how the insights from the involvement report will inform the delivery of our priorities:

- What changes can residents expect to experience by the time our Listen in cycle comes back to Bradford East in 12 months?
- How should programme boards, community partnerships or other parts of our system respond to the findings and report back to communities?

Listen in

hearing from local communities about what matters most

Listen in Bradford East: 5 June to 10 June 2023

Contents

1. Background & aims

Background:

- Bradford District and Craven Health and Care Partnership are conducting the 'Listen In' programme, which is a continuous 'always listening' approach rather than closed assurance groups.
- The fifth of 6 cycles took place in March in Bradford East.
- Qa Research were commissioned to advise on method and practicalities, as well as to analyse and report on the data collected from communities.

'Listen In' aims to introduce the Partnership's five big priority areas and uncover insights about:

- How people experience the challenges the Partnership aims to address.
- Local people's expectations of what they would experience if the partnership were getting it right in each priority area.
- Assets in local communities that could be unlocked to address each priority area—connect people and groups to community partnerships.

2. Methodology

Qa Research developed method and research tools with Bradford District and Craven Health and Care Partnership.

- Qa continued summary workshops, where colleagues who went on Listen In visits could share findings and thoughts
- BDCHCP briefed and trained colleagues, and organised visits
- The same discussion guide was used as in the previous cycles, the simpler form was found to be more effective

5th - 10th June 2023: 'Listen In' activity took place in Bradford East:

- 26 colleagues from BDCHCP had community conversations
- 20 visits to local community groups

Analysis was conducted by Qa Research:

- 2 debrief workshops where colleagues shared observations and findings
- Notes from conversations were shared with Qa for analysis
- Qa conducted qualitative analysis and wrote a summary report, including some quotations from the notes

3. Key findings

Healthy communities

Support groups in Bradford East are invaluable to their members. Very different people attend in contrasting life situations, and group leaders have created a trusting and safe environment. People are accessing direct support e.g. health talks, testing and mental health signposting, as well as indirect support e.g. socialising, wellbeing support, activities.

Access to primary care is a priority issue as GP appointments feel unattainable for many residents. This is complicated by their English language skills, housing situation, disabilities and legal status in the UK. For some, community groups serve as a great access point to improve health instead of struggling to see their GP.

Improve access to care

There is a sense of lack of trust in the NHS which stems from various factors, including long wait times, inadequate communication by healthcare workers, and a sense of not being listened to. The issues accessing primary care are a big contributing factor, as people do not feel they will be seen in a timely manner. This issue is particularly prominent in certain communities, which lack support or adjustments for different languages, disabilities, and various situations.

Mental health, learning disability & neurodiversity

The prolonged waiting period for a neurodevelopmental diagnosis significantly impacts individuals with learning disabilities. The uncertainty and lack of clarity during this time can be emotionally distressing and hinder their ability to access the appropriate support and interventions. Mental health waiting lists are similar, with issues often exacerbating, or individuals forced to rely on others while they wait, for example community workers picking up a lot of the support needs.

Support and develop our workforce

Current or former healthcare workers have expressed significant concern regarding burnout and its impact on mental health. While community groups have played a vital role in assisting people with wellbeing, employment, and other issues, they face limitations due to resource constraints and burnout. However, there is interest in health and care professions from various communities, including refugees.

Children, young people and families

Children and young people face similar challenges to adults, such as access to GPs and mental health. In some areas, youth workers feel children are particularly vulnerable to a range of issues including vandalism, violence, mental health and physical health e.g. smoking. While youth groups help keep young people safe and supported, they have limited resources and are already going beyond their remit.

3.1 General themes

Accessing GP appointments remains the most common issue – As with all other cycles, the main frustration and feedback from people living in Bradford East was how hard it they found it to access GP appointments. Most described waiting in lengthy telephone queues only to be out of appointments, or having difficult interactions with GP reception staff. The impact of this is not only frustration, but feeling let down and disillusioned with the primary care system, leaving some people feeling like it is not worth trying to see a GP any more. However, for balance, some residents were happy with their GP access.

Low awareness of options regarding health – It appeared that many Bradford East residents had a limited understanding of their options regarding booking online, extended hours, or where to go in urgent but non-emergency situations. This was compounded by lack of digital confidence and English skills, making the whole appointment system ever more confusing for some people.

Lack of trust in formal healthcare system – Linked to the perceived lack of access to primary care, there is a sense from some residents of Bradford East that the health and care system is not trusted to deliver what the population needs. Some people did not feel listened to in their appointments, while others questioned what doctors were doing with their time if appointments never seemed available. What this does is contribute to a sense of mis-trust in formal mechanisms of health and care in some communities, meaning residents feel more comfortable in informal settings with figures that they know and trust to have their best interests at heart.

Community groups for social and mental health – It was very clear that the community groups available in Bradford East were strong assets and have a positive impact on local people's lives. This shone through very strongly, especially in terms of socialising and combating loneliness, a sense of community and supporting good mental health. These direct benefits were articulated clearly by residents, as well as practical help such as exercise opportunities and advice on finances or services.

Trusted figures in groups supporting health and wellbeing needs – Something that was very clear was the extent to which local group leaders are supporting people who attend in a much more holistic and involved way than is expected. They are going above and beyond offering advice, mental health support, signposting or referrals, completing applications or phoning GPs, and much more. It's clear these are trusted individuals who have created a safe environment to offer support which is a clear asset to the community, but there was some talk of the pressure that these individuals are under and how they could be more supported by services.

Health speakers in community venues are an opportunity – Quite a few community groups and venues had already hosted health speakers or testing services, to positive reception. For example, blood pressure checks, talks about hepatitis or diabetes, and discussion of healthy living. Certainly, there was an appetite to absorb health information in these trusted environments rather than a more formalised healthcare setting, something that didn't feel accessible or comfortable to many residents.

Transport was a challenge for some residents – While some residents were happy with their local access to walking distance groups and services, others found themselves struggling to attend due to transport issues. Many residents do not drive, so rely on family or friends to drive them to appointments, and local groups are not accessible to them if there is no transport available. The cost of transport is another barrier for some people, for example refugees, homeless people or simply those affected by the cost of living crisis. Given that many people who attend local groups are not in employment, offering free transport (e.g. minibus) is crucial, and was clearly effective when it was offered.

Language was also a barrier to positive experiences with health and care – Some communities struggled with language barriers when it came to booking and attending health appointments. Many relied on family members, which sometimes worked and sometimes felt uncomfortable, as people did not always want to disclose their private health symptoms to their children, for example. It is important to note that people who speak English may not read it, and that ideally information should be sent out in accessible formats according to patient preference.

3.2 Priority area: Healthy communities

How do people in Bradford East engage with their communities?

The Listen In activity took colleagues to an array of **local community groups** in the area, which were, on the whole, well attended and with a positive, friendly atmosphere. The types of centres and groups included:

- Men's and women's groups
- Youth groups
- Older peoples groups
- Groups or centres aimed at a particular cultural or ethnic background
- Groups or centres aimed at particular experiences or needs e.g. mental health, recovering from addiction, learning disabilities
- Religious institutions e.g. churches and mosques
- Groups or centres for low income or financial challenges e.g. homelessness, food banks
- Groups offering activities e.g. gardening, art, exercise

Bradford East residents were **extremely positive about the groups** they attended, often describing them as a 'lifeline'. The most prominent benefits were related to **loneliness, mental health and socialising**, with the Community groups offering a chance to get out of the house, meet people, and have the possibility of making friends. These benefits were felt among all different types of social background and age group, particularly those who were not working and struggled with loneliness. The knock on effect of socialising and doing activities with other like minded individuals should not be understated when it comes to the impact on physical and mental health. Direct mental and physical impacts of exercise groups, gardening, crafting and trips out were also mentioned.

"Before she came to the group, she would never learn anything new, and her brain was inactive. Now, she learns new things about illnesses and recognising what she needs and takes part in fitness classes, gardening and craft activities."

It was very clear from the Listen In feedback that groups were often going above and beyond their remit to meet the needs of the people who attended them. Group leaders, whether this be a cultural group, a learning disability group, or a youth group, were offering signposting support and advice on a whole range of issues facing the people who attended. Sometimes this was benefits support, sometimes phoning GP surgeries for them, sometimes identifying unmet needs and either referring or signposting into particular services. This is a testament to the safe atmosphere created in some of these groups and is a way for residents to get advice from someone not within their family who may know more about the different options, when they feel unclear on what support they need. Residents did not only go to the leaders of the groups, but also asked their fellow attendees for advice on health issues and general life worries.

A number of different groups also had more formal involvement from health professionals who came out into the community to deliver talks or testing on certain conditions or health topics. This appeared to go down really well in the groups where it was used, for example talks on diabetes, hepatitis C, and blood pressure checks.

In this instance, the key factor is trust. As we will go on to explore, the trust in formal primary care (i.e. GP surgeries) can be relatively low within these communities due to poor experiences and perception. In comparison, the trust in the local community groups is extremely high, and many residents feel safe, listened to, and in a better frame of mind to engage with health information. As such, these groups could be a good mechanism for helping communities engage with healthcare that are less likely to come forward to primary care.

"Her father is 82 and has just been diagnosed with diabetes. He absolutely hates visiting the doctors or speaking to any health care professionals and as he feels preached too. He would happily come to a community venue and learn about health and how to prepare healthier meals but he simply will not go to the doctor unless he is forced. She feels much more should be done within the community as people listen so much more to people they trust rather than a stranger."

Clearly, there are opportunities to do more with these groups, and also opportunities to support the leaders who are running them and providing all this extra help, which can be a challenging role. Some did report burnout, and feeling frustrated that the

places they signpost to don't actually end up helping the individual. It then falls back on the group leader to support on issues they may not feel qualified to deal with.

> ***"Feels often has to do a lot of work outside of job remit as no one else to do this […], use YiM (Mind) for support but they are overburdened with numbers, other VSO have waiting lists, lots of referrals, CAMHs and CSC very hard to get hold of if concerns about young person […] Feels services firefighting when it's too late and family may have been struggling for years but that young people need the earlier preventative work and early intervention."***

In terms of maximising uptake of these groups and centres, one interesting finding is that most were encouraged to attend by a family member or friend, and that often it took some convincing. It may be worthwhile to consider how to maximise this, by promoting the groups directly to the family members and prompting them to encourage family along.

How do people in Bradford East experience primary care?

As with all previous cycles, the main complaint of residents when it comes to primary care, and healthcare in general, is the perceived **difficulty of access to GP appointments**. People reported long telephone queues, non-empathetic staff, no availability of appointments, lack of privacy when discussing medical issues with reception staff, having to call at 8am which doesn't work for everyone, language and digital skills acting as barriers. Ultimately this amounted to stress among the person trying to get the appointment, antagonism with the reception staff and a feeling that there are 'no appointments available' and GP is not accessible any more.

> ***"The appointment system is the biggest blunder, front line staff are not empathetic to needs of ill patients, stresses people out, when you finally get through, you're told there's no appointments"***

> ***"I struggle especially when questioned about my symptoms with reception staff, your privacy has ended. If I don't tell her I won't get appointment. I tried to help her understand that some conditions are difficult to explain, and my symptoms discussion should be with the doctor."***

Another experience related to GP appointments is **not being able to talk about multiple issues in one appointment**. Some people suggested that, because it can be so challenging to get an appointment, they should be able to speak about multiple issues in an appointment, especially if they suspect they are related. Some

feel they are being forced to choose between which issue they would rather get treated, when they would rather be treated in a more holistic way.

> ***"Her daughter recently had some health concerns but her GP would only see her for one symptom at a time. She had a problem with her shoulder as well as another symptom and was told to make another appointment for the other symptom. This caused her to be confused and worried that the two symptoms were linked but felt she was being ignored and the Dr did not explain this to her clearly."***

A prominent theme within primary care was the feeling of being rushed, pushed along, and not feeling heard by health and care practitioners. Some reported feeling like GPs are 'trying to get rid of them' or are not taken seriously. This is especially prominent if there are also language barriers in place, which can mean people struggle to fully communicate their health issue and its implications.

> ***"Since COVID there is very little positive experience with Healthcare. You are funnelled through the system so you are weaned away from appointments and seeing the GP. There is no "care" element left in the NHS."***

This is not to say that all experiences with primary care are negative. There were some reports of regular check-ups being very efficiently run, and others who said they could always get an appointment if they needed it.

> ***"With a little help and I guess persistence, the health of all those that visit the church are getting the help they need. Our health services are doing a good job."***

Furthermore, several care workers had very positive experience with a telemedicine service. It allowed them to get advice and help deliver high-quality healthcare to residents much faster than traditional appointments.

> ***"The staff members were very happy with the healthcare that the residents received, everything worked well. They were really happy with the Telemed service, as it gave them quick access to a GP appointment whenever they had any concerns about the residents and they felt this system was excellent."***

However, there was a clear theme that the negative experiences of getting appointments in primary care was contributing to a sense of mistrust in the system. Some people were no longer looking to primary care as a first port of call, and rather were looking elsewhere for informal advice (such as community groups). Other

reactions were to simply be very frustrated, have an antagonistic relationship with GP staff, or just be worried for their own health as issues may get worse before they are seen.

> ***"I don't trust the doctors; no one seems to get appointments at Woodroyd so what are they getting paid for?"***

What are the challenges to healthy communities?

Many of the community groups that offer such strong support were struggling with some aspect of **funding**. For example, one men's club has been very popular, but they've changed their 'acceptance criteria' over time and it's now restricted to men over 55. Attendees feel this is unhelpful because they know people who would really benefit from it but can't go as they are too young.

Similarly, other community centres are struggling to cover their bills and are under threat of closure. Often, groups rely on one or two key members of staff who are passionate and go beyond their remit, but can be **understaffed** for the level of support they end up providing. Also, there is not always funding to offer transport or activities that attendees think would benefit them, such as trips out or swimming.

Transport is a barrier to both community groups and primary care, especially for those who can't access a car; it's pot luck whether the services they need are walking distance or have reliable public transport links. Groups that offer free transport are very much appreciated and enable people to attend that could not otherwise.

> ***"If the minibus was not available none of the ladies would be able to attend the group so this is really important to the centre"***

Digital exclusion / lack of confidence / reading English – making appointments, understanding health information

> ***"Online appointment systems and sending photographs for certain symptoms need to be explained to our family members so that they can help us access this."***

> ***"IT is a barrier for many people when accessing health services. Many can't read or don't understand English when it's written down which means they're unable to access services when they're online. They rely on face-to-face and telephone services if they need to access health services."***

There were mentions of **poverty, unemployment, crime and vandalism** in the Bradford East area, which contributed to a few people feeling unsafe and also the knock-on mental and physical health impacts of these financial and social issues.

> ***"Group often closed early as vandalism to property, vaping when asked to stop, no respect for adults running group, hard to engage on youth's level."***

> ***"Both said that the problem living in BD3 is that there a few drug dealers. 'They operate openly and people are afraid of them. If you grass on them, they can get violent.' Both boys hoping they will get locked up soon. Both put it down to poverty and unemployment and not enough of youth groups like here."***

> ***"The problem with Bradford is there are beggars in the city. You see them in every traffic light and junctions. The group asked why this is being allowed. One mentioned there is no need to beg in this country and think they use the money to buy drugs."***

Residents of Bradford East often brought up **loneliness** as a challenge facing people of all age groups, and described it as a 'silent killer'. Some were keen to point out that loneliness is not just something that affects older age, but can be hard at any age and especially if a person struggles to communicate, either through language, disabilities or mental health challenges.

> ***"It's not just older people that get lonely"***

Alternative options for GP appointments are not consistently explained to patients, or at least there is very low awareness and uptake of these:

- Not aware of Extended Access availability at their surgery and neither was it mentioned to them as a viable option when speaking with the surgery
- Some surgeries had PUSH Doctor service, again this was not something any were aware of
- Also rarely aware of being able to book appointments online and were not registered at the practice for this

GP surgeries appear to not always be as **inclusive as possible regarding things like language and disability**. Examples include a blind man being asked to walk on a line in his examination, and staff either had very little time or didn't read his medical notes so were not aware of his visual disability, which would help in the care options they give. Another example is a woman who does not speak English being

placed with doctors who do not speak her language, bi-lingual doctors being available.

There was clearly some antagonism between residents and **GP surgeries over appointment booking**, which was leading to a mistrust on the residents' behalf and sometimes withdrawing from accessing primary care as a result. The appointment booking system presents many challenges, as residents feel it is very difficult and frequently do not feel like they can access a GP appointment when they need it or that the primary care system is giving them the support they need.

> ***"The staff at practice is quick to jump to abuse….I'm explaining not abusing. There is noncaring attitude at surgeries. If you don't like our service you can go somewhere else."***

What would 'getting it right' look like for healthy communities in Bradford East?

There are a number of things that residents of Bradford East would like to see which would give them a sense of being a healthy community. In terms of 'community engagement' and groups, this includes:

- **Free transport** to get to groups
- More funding and opportunity to **expand the remit of the groups** – trips, walks, swimming, 1-to-1 support

- Groups **promoted more widely** – perhaps among relatives who often persuade and encourage their family members to attend
- **NHS speakers and clinicians** getting involved with trusted venues, where they will access people who do not present at primary care
- Routes into **education and employment** also covered in venues

In terms of primary care, the main asks are:

- Strong **awareness of all appointment options** – e.g. online appointments, extended access, where to go if urgent but not emergency, where to go if GP unavailable
- Positive and **respectful relationships between GP staff and patients**, mainly relating to reception staff and the current antagonistic relationship that can happen at present. It may help for patients to have a greater understanding of the booking system and their options, as well as explanation why things must go through a reception triage, as well as receiving empathetic reassurances that everything they say is in confidence.
- Patients feel they have the time, space and communication aids to **feel heard in appointments**, including the ability to mention multiple issues
- GP surgeries accommodating of patients who are not **comfortable with IT issues, struggle to speak or read English**, or have disabilities e.g. vision impairments. If they collect communication preferences, then it is important to honour them and take time to understand how that patient can best communicate, otherwise the interaction does not solve the health issue or the patient is left feeling frustrated or upset.

3.3 Priority area: Access to care

How do people in Bradford East access health and care?

- Apart from GPs, the main access route is via hospitals (**BRI and Eccleshill Hospital in Bradford and LGI in Leeds**).
- Unlike in previous cycles, no one recounted going to A&E instead of their GP when unable to make an appointment.
- Some participants resorted to private healthcare, even traveling abroad for operations, due to lengthy waiting lists at NHS.

What are current experiences with accessing health and care in Bradford East?

Participants' views are mixed: some had very positive experiences. They thanked doctors and other specialists for being professional, quick, and kind. Others commented on long waiting lists and not being treated properly or fairly. Some patients did not feel that that the staff showed empathy to them and their issue. Instead, they were rushed and treated just as another case to be dealt with, without considering their emotional needs or concerns. This lack of empathy made the patients feel devalued and dismissed, undermining their trust in the healthcare system and leaving them feeling unheard and unsupported in their journey towards recovery.

- **Example 1:** waiting time 4 hours at BRI with children, but patient felt this was fine.
- **Example 2:** husband of carer sent home from BRI with paracetamol despite being in a lot of pain.
- **Example 3:** patient transferred to a consultant in Bradford for a long-standing health condition, and found them to have very poor bedside manner.
- **Example 4:** not feeling taken seriously. A patient with a fibroid problem lives in pain while waiting months for the operation. Feels that BRI and GP push blame onto each other instead of solving the problem.

"No faith in BRI – submitted complaint but found response unsatisfactory, complained again, issue resolution rolled on for a year."

LGI over BRI – Some patients having experience with both LGI and BRI commented on how they preferred LGI and were frustrated with being referred to BRI. Sharing good practice between hospitals/trusts may be useful.

Lack of adjustments for disabilities and conditions – Some disabled patients encountered lack of empathy or adjustment. They feel it is crucial for healthcare providers to familiarise themselves with the medical history and current status of

their patients, enabling them to respond appropriately and provide the necessary support and understanding.

> ***"When you attend hospital it needs to be on your records your degree of disability, so appropriate consideration can be given. The Patient shouldn't have to explain it at every appointment. It made me feel stupid and embarrassed."***

What are the challenges to accessing care?

- **Bureaucracy** can sometimes be an obstacle to getting the right care. For example, not updating the address with GP means one cannot get an appointment, even if the issue is perceived as serious by the patient. In such cases, changing the address may cost precious time for the patient. Another case is the fact that reportedly some GPs demand proof of address to register with them even though having it is not a legal requirement. This puts access to healthcare for people without these documents at risk.
- **Parking at BRI** – A few participants commented on issues with parking at BRI. They mentioned there are not enough spaces so they had to drive around (up to 45 minutes) and then missed their appointments.
- **Transport at BRI** – Furthermore, there are problems with transportation between care homes and BRI. Reportedly, patients have to wait up to 6 hours in the waiting room before the transport can pick them up. Not only it is a source of discomfort and risks patients' health but also causes problems for the care workers: ***"This has a knock an effect to our staff as we have to make sure sufficient staff are on site all the time."***

What would 'getting it right' look like to improve access to care in Bradford East?

- Reasonable waiting times so that patients do not feel they have to access private health care.
- Engage with neighbouring LGI to understand why it is favoured by some patients and implement appropriate changes.
- Solve parking and transport issues at BRI. Explore whether parking space can be expanded or changed to better meet needs.
- Communication with patients is very important. It is crucial to have open discussions about treatment and make sure that the patient has no questions or doubts.
    - For example, one person was prescribed a drug but upon reading the side effects, started worrying and decided against taking it. This could have been avoided if the doctor explained the side effects and that the benefit of taking the drug is higher than the potential side effects.
- Patients feeling they are treated with empathy, patience and respect.

3.4 Priority area: Mental health, learning difficulties and neurodiversity

What are current experiences with mental health and neurodiversity in Bradford East?

Mental health was not a prominent issue in this cycle apart from the fact that **community groups immensely help attendees with their mental wellbeing**.

Mental health support provided by groups is invaluable to many who attend them. For example, at West Bowling centre or Shine they have extremely trusting **relationships with group leaders** who are also of the same cultural background or history (e.g. addiction). Now attendees feel they would rather go to the group with a mental health challenge first rather than see a clinician, because it is more comfortable and not intimidating.

Some participants mentioned that they come to these groups instead of taking their medication (e.g. antidepressants). The groups allow people to socialise, do absorbing activities like gardening or crafting, share things that are worrying them, all of which are contribute to good mental health.

> ***"Someone said that if they were experiencing mental health problems, they would speak to someone at the group first rather than go to see a clinician. This is because they feel that they are listened to at the group and can talk about things to find the underlying issues themselves."***

People who attended the groups identified **community workers as a huge asset** when it comes to supporting good mental health, as they have much more interaction with people and can catch things that formal services miss. However, the challenge may be when this **crosses over into needing professional support** and either this support is not available, or the person in need is unwilling to access it.

Additionally, **language barriers** can make it hard to make new friends and connect with people. Although many participants thought that these groups helped them both learn English and make connections.

People with **learning disabilities generally expressed a positive outlook** on their living conditions and the care workers who support them. These individuals play an invaluable role in their lives, contributing to their overall well-being and enabling them to make the most out of every opportunity.

> ***"He loves coming to the group and would be lost without it – gardening and being with others gives him a sense of purpose and belonging and helps him to feel less lonely."***

What are the challenges that need addressing for mental health and neurodiversity support?

- **Waiting lists for CAMHS** can be very long. Young people are unable to access support at the time they need it. Support needs do not disappear, but are just transferred into other areas that are less equipped to deal with them (e.g. to youth workers).

- **Waiting lists for ADHD and Autism** diagnosis are long as well. This affects families as they are unable to get support in place. The child (usually) is in limbo while waiting, which induces anxiety and can have other knock-on effects which make the picture more complex. Ideally, there needs to be other support present in the meantime to support the unmet needs even if there is no diagnosis yet. Provision of support often falls to people not set up to help (e.g. community workers, parents).

  "He is autistic and was very recently diagnosed as an adult. It has taken a long time for him to be diagnosed. He was not diagnosed as a child and felt ignored and overlooked by health services. Receiving a diagnosis was a long process but has helped him significantly – he is starting to feel better about himself now that he has this information. He has been struggling to find work (has undertaken numerous courses including with the fire service) but hopes that the diagnosis will help him get into the fire service which he is passionate about."

- For some people **cost-of-living crisis** means they are unable to do 'fun things' as often or entertain their kids, which leads to anxiety and stress. Funding and transport provision for this would help.

  "They said having that bus pass will push them to get out and about to help their mental health but it's hard to do it now due to cost of living and prioritising money."

What would 'getting it right' look like?

- Work to make mental health support services more available and reduce waiting lists, particularly CAMHS.
- Ensure more people can come to these community events by spreading the word and providing transport options.
- Diagnosis of neuro-diverse conditions should be streamlined and eased. The patient and family members should be aware of how long it can take and what the next steps are.

3.5 Priority area: Workforce development

What are the current experiences and perceptions of the health and care workforce in Bradford East?

Workers with whom Listen In colleagues had discussions appeared stressed or remembered negative experiences at NHS.

- **Example 1:** One person had bad experience pursing nursing education at BRI. They mentioned being treated unfairly, not receiving appropriate support, so decided to quit to be a youth worker in the community.
- **Example 2:** Another youth worker is very stressed with their job, having to do a lot outside remit and support where the other services were not providing (e.g. CAMHS, CSC, other VSO).

> ***"Reports stress at work as I am told I can't work over hours but can't get all face to face work done and all admin and all extra demands completed or having to come in on AL to support demands. Reports staff often getting burnt out, puts people off coming into working in health and care sector or youth work sector – pressures need alleviating but how when whole system under pressure."***

The participants from Bradford East see that the health workforce does not work as it should. Some are more sympathetic about it and see it is because they are **stretched to their limits** (some of them support strikes). While others show **mistrust into doctors and healthcare** in general. The fact that seemingly after the pandemic doctors have not started seeing patients at the pre-pandemic levels leads to concerns and questioning of why that is. When attending GPs and seeing empty clinics, patients only reinforce that belief.

> ***"I don't trust the doctors; no one seems to get appointments at Woodroyd so what are they getting paid for?"***

There were a lot of conversations about **job searching**, as many participants were actively looking for work and see community groups as important support in that. Community groups play a crucial role in preparing some people for employment, giving them essential skills and knowledge on how to apply for jobs, as well as appropriate clothes and shoes in some cases. There may be opportunities to promote pathways into health and care roles in these groups.

Those working in shifts, particularly **care workers, find it difficult to access health care for themselves**. Making GP appointments is problematic and when appointments at clinics and hospitals get rescheduled (specifically, an example was given about Eccleshill Hospital) this causes great inconvenience and lost income.

What are the challenges faced by the health and care workforce in Bradford East?

- **Precarity** – Helping attendees find a job takes time and skills of the group workers. Given that the voluntary and community sector is often grant-funded, jobs are precarious and the continuity of their work is always under question.
- **Communication** – Similarly, a care home for learning disabilities is being closed down for reasons unknown to both residents and workers. This causes stress and anxiety: people with learning disabilities can take a long time to get used a new place and people as well as social workers job security is in question.
- **Support for carers** – Some unpaid carers struggle to get the support (benefits and mental help) or are not aware it exists.
- **Support services waiting lists** are so long that support needs are falling to workers who don't feel qualified or it is outside their remit and capability to do anything (an example with the youth worker above).
- **Asylum seekers and refugees** often struggle navigating labour systems in the UK. There are a lot of work restrictions and other barriers to starting employment, such as lack of proper information.

What would 'getting it right' look like?

- While finding a job in the care sector may be easy for some, job security and turnover rates can be improved. Skills-based recruitment and raising profile of care sector as a career.

  "Sometimes you can meet a new member of staff and know straight away that they will be good then you can meet someone else and you will know that they are not cut out for this career. We need better quality of people working in care."

- More people should be attracted into health and care roles, particularly from underrepresented backgrounds in the senior roles. This will increase diversity of the workforce and cut backlogs in the system.

  "There should be more encouragement for people from diverse backgrounds to enter nursing and emphasised the importance of receiving support once they are in the profession."

- Integration of asylum seekers and refugees could be improved. They need more accessible information on how to start working and their options. Several participants mentioned being interested working in the care sector.

"We heard different accounts from different people on how, when and what types of work asylum seekers could undertake – could do with being clarified and promoted to these groups."

- Big changes, such as closure of a care home, need to explicitly announced in advance, their reasons given to all stakeholders and everything should be done to ensure the transition is smooth.

3.6 Priority area: Children, young people, and families

What are current experiences with children and young people's support in Bradford East?

Observations and discussions show **group activities encouraged young people to all come together** and engage well together, focus on and discussions around activities that allowed them to engage with feeling more grown up and adult-like.

Youth workers mentioned **some groups are not able to function so well**, including vandalism, vaping, lack of respect for staff and having to provide 1-1 care for kids.

> ***"9-14 year olds – who seem to have a lot of problems with mental health and not having much to do. There're no activities for that age group – they're a bit 'in between'. Where she lives there's been a bit of trouble with vandalism and antisocial behaviour – kids are bored, and need their own space where they can be free but safe."***

There were some arguments and physical altercations at some groups. It is important that it is a safe space and youth workers are equipped to manage emotions and boundaries.

There has been a notable **reduction in health visiting** over the years. While there may be good reasons for this change to the service, new parents still feel they are on their own sometimes, and that they only get to see practitioners when something is wrong, which can be too late. One person mentioned they had issues with their first child around reflux ending up in malnourishment.

What are the challenges for children and young people?

- **General access challenges for primary care and dentistry** – like adults, some struggle to make appointments at their GP or register with a dentist.
- **Lack of prevention** – some reported that prevention is not a key focus when it comes to children and young people. Participants feel that services are 'firefighting' and only providing support when it is too late and the family may have been struggling for years. There needs to be more emphasis and funding to early intervention.

What would 'getting it right' look like?

- Some felt it would be helpful to have a **health visitor attend community centres** once or twice a month as some cannot make it to the hospital and have questions and worries that need addressing.
- Provide support for parents in areas where there are issues with youths. They need a more **holistic family support for the underlying issues**. Many with CSC or CAMHS involvement e.g. ADHD or autism diagnosis, but families report little support from these services as overwhelmed caseloads and long waiting lists.
- There is also a need for increased provision of accessible, appropriate, and **direct support for young people who have increased complex needs** beyond what is available, especially younger age group 7-11.
- After a discussion around **period products** with the Listen In colleague, the group suggested that children need to know more about them. It is important to make them informed of their costs and potentially make available in schools. Further, schools need to raise awareness of STI protection and treatment, hygiene, budgeting, and other practical life skills that they will need in adulthood.

4. Next cycle

Ideas for next cycle

- Continue to adopt a 'right people in the right places' approach, so that Listen In colleagues, where possible, represent the communities they're speaking with. There were examples in Bradford East of colleagues being able to speak native languages which helped discussions flow better.

- Continue to carry information about signposting to services as well as careers in health and care.

- Ensure Listen In colleagues feel confident to take action and resolve a query if a resident raises an issue.

- Continue to be open to new partnerships and take these forward e.g. opportunities for attending community groups.

Project details

Project number HEALT01-9151

Location https://qaresearch.sharepoint.com/sites/QaData_S-ProjectFiles/Shared Documents/ProjectFiles/B/Bradford_Health_and_Care_Partnership/HEALT01-9151_Listen_In/Reports/Cycle_5_June_Braford_East/Bradford_East_V2F.docx

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This research has been carried out in compliance with the International standard ISO 20252, (the International Standard for Market and Social research), The Market Research Society's Code of Conduct and UK Data Protection law.

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Bradford District and Craven Health and Care Partnership

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NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	6
Meeting date:	21 July 2023
Report title:	GP Access
Report presented by:	Louise Clarke, Director of Strategy, Transformation, Primary, Community
Report approved by:	Louise Clarke, Director of Strategy, Transformation, Primary, Community
Report prepared by:	Clare Smart, Associate Director of Strategy

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

Previous considerations

Healthy Communities Programme Board, Bradford District and Craven Partnership Leadership Executive , and West Yorkshire ICB Fuller Delivery Board.

Executive summary and points for discussion

Access is a key area of focus for the NHS, with NHS England publishing the *Delivery Plan for Recovering Access to Primary Care* in May 2023 which aims to deliver on two key areas:

1. To tackle the 8am rush and reduce the number of people struggling to contact their practice.
2. For patients to know on the day they contact their practice how their request will be managed.

In conjunction with the above, work at 'Place' is continuing to collaboratively work with Primary Care Netoworks on developing their local Capacity and Access Improvement Plans.

This paper notes the new 2023 GP contract, GP access data, the importance of prioritising safe care, and issues that can be considered (and addressed) by the health and care partnership. Issues include the impact of the ongoing recovery of access to care in local trusts and the detrimental impact of the ongoing, negative rhetoric about access in primary care.

The Partnership Board has expressed an interest in understanding access to primary medical care. We need to shift from quality of access to considering the *quality of access* based on

1. Urgent on the day care
    a. As part of an integrated primary care same day response service

2. Continuity of care (longer appointments and/or follow up)
    a. GP ongoing medical needs
    b. With MDT (proactive care) – chronic health needs/frailty etc
    c. With non-clinician/VCSE/wellbeing approach – social issue

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.
Recommendations
The Partnership Board is invited: 1. To support the proposal for an 'honest conversation' with the public through Listen In deliberative events. Using this as an opportunity to bring together the public and the GP workforce to codesign pilot models of access within the resources available. 2. To support the proposal for pilots and prototypes of different models of access to address quality of access, including evaluation (both locally and across West Yorkshire) and share learning for other practices. 3. To support the continued the work to understand and, where needed, support practices to address variation in access.
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.
None identified
Appendices
Paper: Bradford District and Craven GP Access

What are the implications for:

Residents and Communities	Patient insights have identified improving access to primary care services as a key concern.
Quality and Safety	Improving quality and access to primary care is central to this paper.
Equality, Diversity and Inclusion	The paper identifies that access is not just about numbers of appointments but also encompasses the boarder aspects of access including addressing barriers to access.
Finances and Use of Resources	Not directly from this paper.
Regulation and Legal Requirements	None identified.
Conflicts of Interest	None identified.
Data Protection	None identified.
Transformation and Innovation	The paper seeks to focus on integration of services and continuity of care.
Environmental and Climate Change	None identified
Future Decisions and Policy Making	The paper focuses on improving access addresses some of the challenges identified.
Citizen and Stakeholder Engagement	Builds on local citizen and stakeholder engagement.

Bradford District and Craven
Health and Care Partnership

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

Bradford district and Craven GP Access

Partnership Board

July 2023

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General Practice Access

1. Purpose

1.1 Our current reactive approach to GP access is unsustainable. This paper discusses how we, as a health and care partnership, can work to improve the quality of access to general practice, rather than simply working to increase the number of appointments. It is informed by the Fuller Stocktake and local learning in Bradford District and Craven from London South Bank University (LSBU) Universal Healthcare pilots. This paper offers an observation and a starting point to discuss the recovery of access in primary care.

2. Background and introduction

2.1 The original paper presented to the Partnership Leadership Executive (PLE) acted as a reminder of the local operating model and set out qualitative and quantitative information to inform a discussion on the local 'narrative' that we use when describing general practice. This discussion was prompted by the ongoing perception by our patients that they cannot access appointments.

2.2 Despite more appointments being made available than ever before, General Practice access is an issue both nationally and locally. We know through Healthwatch reports and our 'Listen In' engagement model that being able to book an appointment with a GP is an is an important concern for our population. The expectations of patients are changing and we have a model of delivery that has changed little over the decades. This is against a backdrop of challenges that leads to GPs in crisis.

2.3 Our GPs, and the wider primary care workforce, face challenges in recruitment and retention, increased workload, safe-working practice, and a national contract continuing to drive the volume of appointments to be made available. The current model is not working for our population or those working within general practice.

2.4 This paper describes the need to shift our focus from quantity of access to quality of access. Using the learning from our Universal Healthcare pilot and successful models such as CLICS (community connectors), we propose an 'honest conversation' with local people about general practice access. This includes the prototyping of co-designed pilots to address the quality of access and working with our practices to understand and support them where there is unwarranted variation in access. This is in line with the direction of travel set out in the Fuller Stocktake, which will inform the basis of the next GP contract, currently under consultation.

3. Our local operating model

3.1 West Yorkshire Integrated Care Board (ICB) is the delegated commissioner for primary medical services, serving a population of 2,651 000. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Guidance can be found here.

3.2 Under delegation ICBs have responsibility for commissioning and contract monitoring GP services in their locality/systems, with NHS England maintaining overall accountability. Community Pharmacy, Dental and Optometry contracts were also delegated to the ICB on the 1 April 2023. The ICB has a statutory duty to improve the quality of services and reduce inequalities, which are critical when referring to accessing in services. Commissioning and contracting are devolved to Places.

3.3 Of the 269 West Yorkshire GP practices, Bradford district and Craven has 60 practices providing primary medical care services under a variety of contract models to a registered population of 658,601. Our practices collaborate in an operating model of 12 Primary Care Networks (PCNs). PCNs are based on GP registered lists and are made up of practices, typically serving 30,000 to 50,000 people.

3.4 PCNs are small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and other providers in the local health and social care system.

3.5 PCNs build on existing primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and care for people. The model is intended as a change from reactively providing appointments to proactively caring for the people and communities we serve. PCNs are led by clinical directors who may be a GP, practice nurse, clinical pharmacist or other clinical profession working in general practice. PCNs are formed via sign up to the Direct Enhanced Services contract specification.

3.6 It is important to also acknowledge the role our other primary care contractors (Pharmacy, Optometry and Dental) play in providing services to our local populations. More recently, the role of Community Pharmacy in supporting improvements in access has become key through the implementation of schemes such as the Community Pharmacy Consultation Service which aims to shift lower acuity presentations from General Practice to Community Pharmacy.

4. The GP contract for 2023/24

4.1 2023/24 is the final year of the 5-year framework agreement which was set out in Investment and Evolution. Over the course of 2023/24 NHS England will engage with the profession, patients, ICSs, government and key stakeholders, building further on the Fuller Stocktake from May 2022 which set out the next steps towards integrating primary care.

4.2 The Chancellor in his Autumn Statement set out a commitment to publish a recovery plan for General Practice access, this was published in May 2023. The Delivery plan for recovering access to primary care is considered in section 10.4.

4.3 Changes to the GP contract for 2023/24 can be reviewed here. In summary, they are in relation to: Access; Changes to Impact and Investment Fund (IIF) and QOF QI modules; Increased flexibility of Additional Roles Reimbursement scheme (ARRS); and Immunisations and vaccinations.

5. GP access data

5.1 This section considers the information available that describes 'GP access' for West Yorkshire ICB and Bradford District and Craven (BDC) HCP. The information from NHS Digital uses March 2023 as a marker as the month had no bank holidays.

5.2 It should be noted that not all appointments are currently flowing through to the national dashboard. For example, the data above does not fully include Extended Access activity or several ARRS roles. From April 2023 this data is starting to flow and, as PCNs work on improving their data, this will increase the number of recorded appointments to reflect true activity.

5.3 NHS West Yorkshire ICB routinely offers over 1.4 million appointments per month for our population of 2.65 million. Of these, 31.5% are routine general consultations, 18.4% are acute consultations, with around 24% used for clinical triage and planned clinics. The mode of consultation has changed in the last 12 months, shifting to more face-to-face work. Most appointments (76%) are face to face, with 20% taking place over the telephone.

5.4 In March 2023, BDC practices offered 423,540 appointments (Figure 1), 28% of the WY total 1,516,638. An increase of 49,651 appointments compared to March 2021. 72.2% were face-to-face, 24% by telephone (Figure 2).

5.5 In BDC 46.4% were offered for the same day, 11.6% next day, and 15.4% within 2-7 days. That is, 73.4% of patients had an appointment within 7 days of booking their appointment in total (WY 70.5%). A further 24% within 28 days, 6.4% over 28 days. Around 48.7% of appointments last 15 minutes or less, and 24% 16 to 60 minutes. On average, 57.9% of appointments are with a GP. The national average is 49.3%.

Figure 1: BDC (36J) Appointments in General Practice November 2020 to April 2023

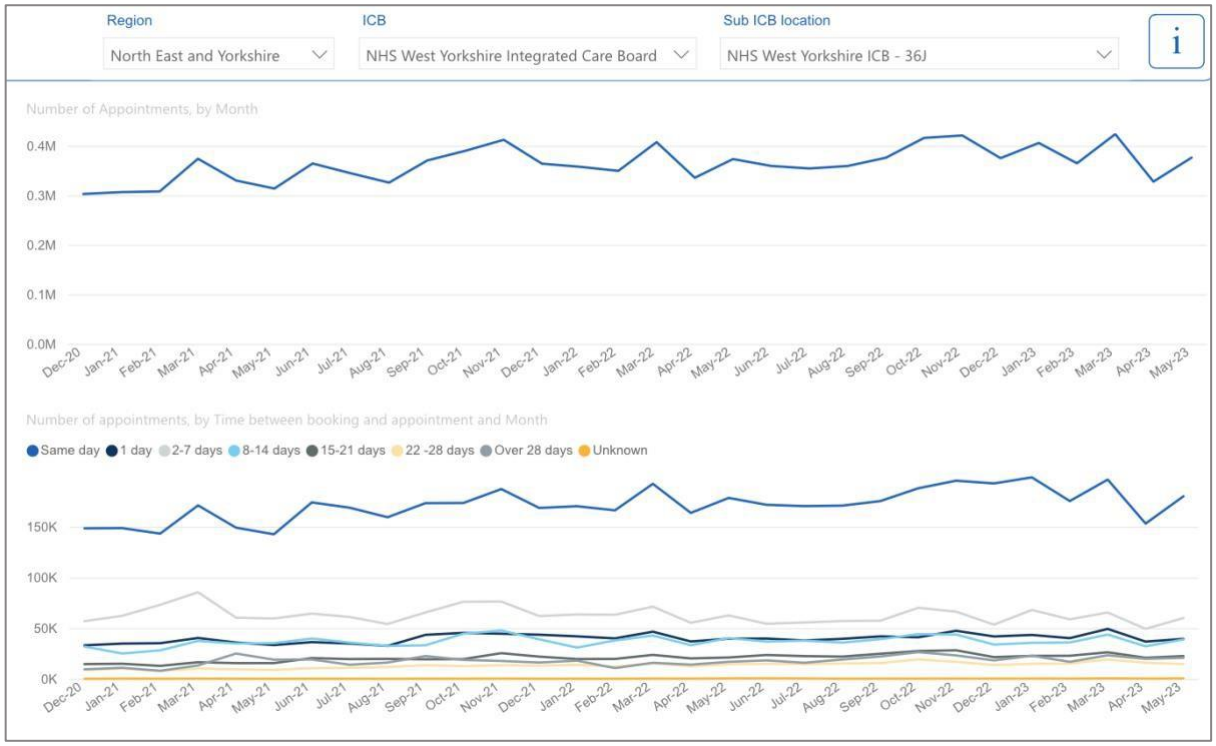


Figure 2: BDC Appointments in General Practice – appointment mode

5.6 Overall, the number of appointments available (Figure 3) and those that are offered on the same day is increasing. More appointments, as a percentage, take place face-to-face locally than nationally (Figure 4).

Figure 3: Benchmarking - Total Appointments per 1,000 Registered Population

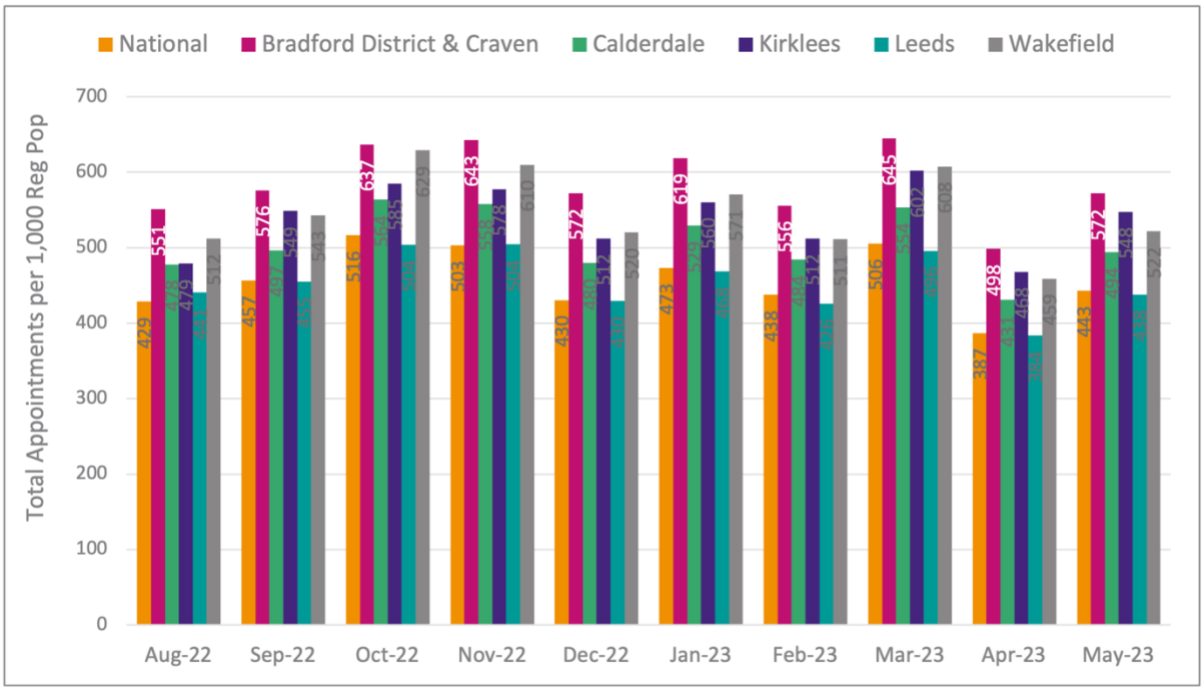
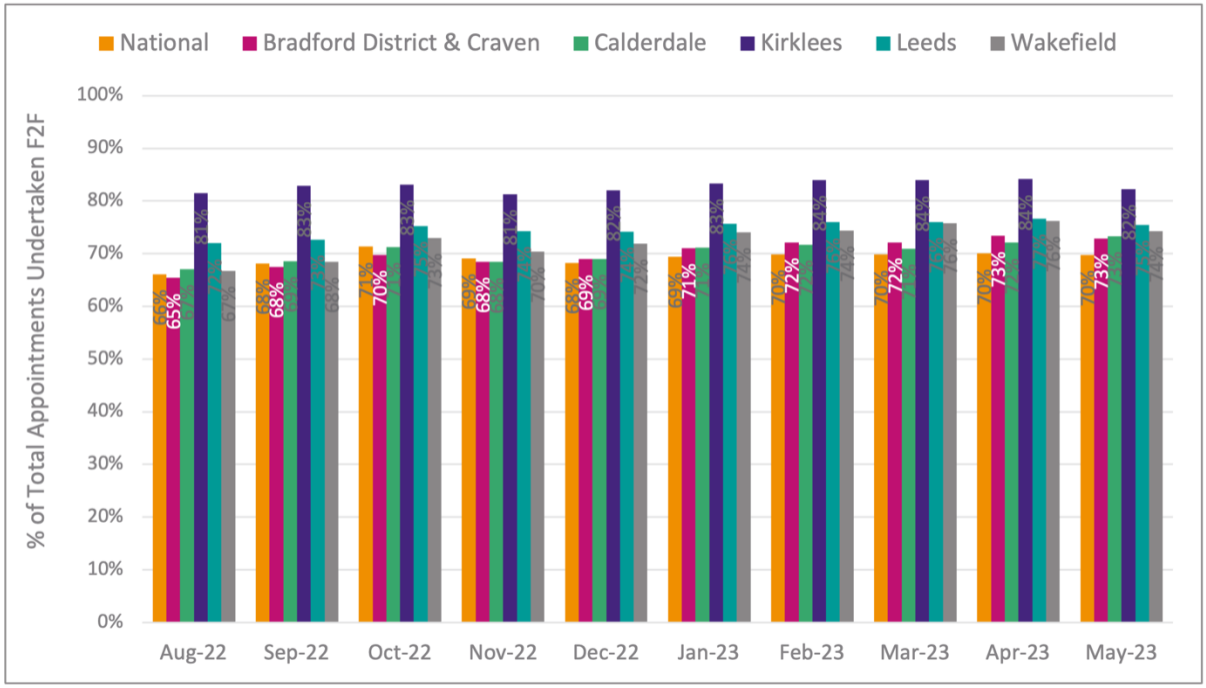


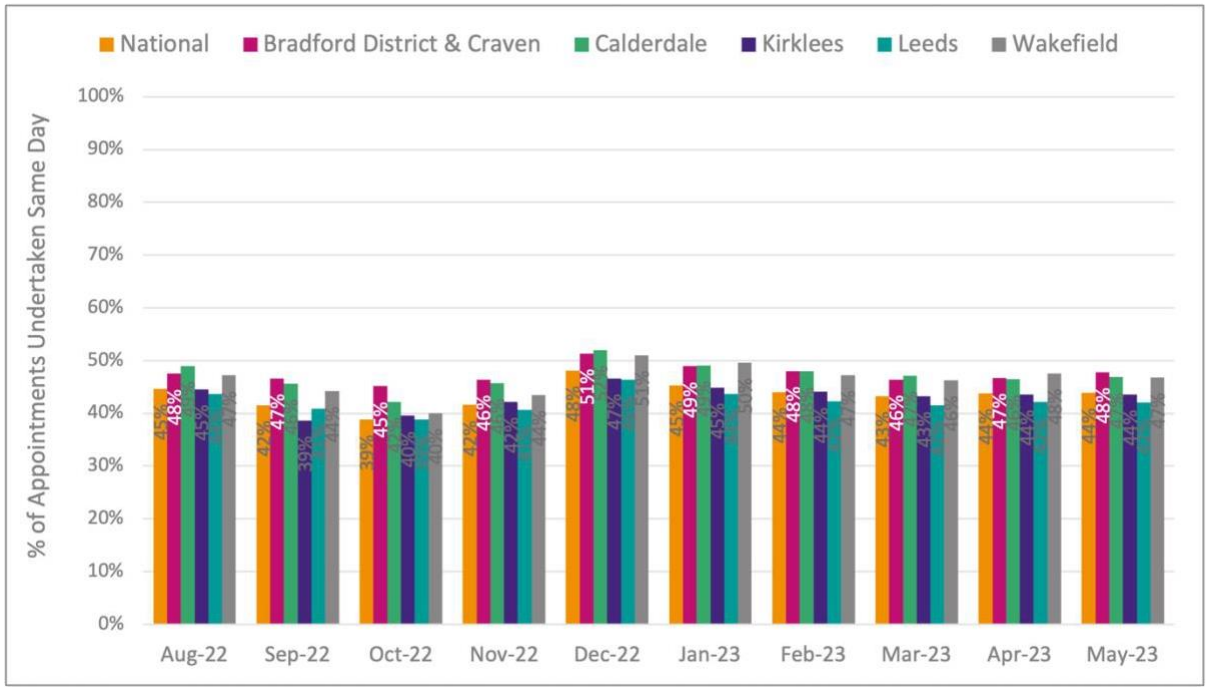
Figure 4: Benchmarking - Proportion of Appointments Undertaken Face to Face (F2F)



5.7 More appointments overall are provided now than pre-pandemic. More appointments are provided on the same day or within one day than the national average.

Compared to January 2020 (pre-pandemic), fewer people wait.

Figure 5: Benchmarking - Proportion of Appointments Undertaken Same Day



6. What does the data tell us?

6.1 Capacity remains a pressure on primary care. A common misconception is that there are fewer appointments available, which is not the case. The number of available appointments has recovered and increased from pre-pandemic levels. In line with the national picture, although we are delivering more appointments there is a higher demand, high expectations of timely access, and significant public dissatisfaction with primary care access.

6.2 Bradford district and Craven averaged 380,000 appointments per month over the last twelve months. Most appointments take place on the same day, most are with a GP, most take place Face-to-Face.

6.3 If we consider pre-pandemic access, the number of appointments has increased.

In **March 2020** there were:

- 327,325 appointments
- 251,782 (83%) of appointments took place face-to-face

In **March 2023** there were:

- 423,540 appointments
- 274,208 (72%) of appointments took place face-to-face

Between March 2020 and March 2023:

- There was **growth** in the number of appointments by 96,215, or **29.39%.**
- There was **growth** in the number of people seen face-to-face of 22,426, or **8.91%**.

6.4 NHS England measures GP workload based on simple appointment data. This gives an incomplete picture of GP activity and fails to reflect the significant number of non-appointment patient contacts. Work undertaken in relation to repeat prescriptions, test results, referrals, targeted clinics, and support groups etc is not currently collected, although work on mapping activity is now underway.

6.5 The pandemic brought its own challenges; from January to December 2022, 104,441 Covid vaccinations appointments took place in Bradford district and Craven, a significant increase in workload that was over and above core general practice appointments.

7. Our General Practice workforce

7.1 The BDC General Practice workforce has increased over recent years rising from 1,565 Full Time Equivalent (FTE) staff in September 2019 to 1707 FTE staff in September 2022, a rise of 142 (9%). Of these, there are 858 FTE clinicians (50% of the total workforce), of which there are 435 FTE GPs (51% of the clinical workforce). Bradford district and Craven has 0.66 FTE GPs per 1,000 patients. We average 1,500 patients per FTE GP. 858 FTE clinicians serving a population of 653,237 people (September 2022 population data).

7.2 Core general practice is funded through a national GP contract, with each practice being an independent contractor responsible for the recruitment, training and development, and individual terms and conditions of its staff. There is no specific standard within the contract that determines what workforce a practice should have in place other than that it is sufficient and safe to deliver core service as outlined in the contract.

7.3 The GP contract is funded to provide 2-3 appointments with a practice patient per year. For our current population that range is 109,600 to 164,400 appointments per month. 435 WTE GPs working at the safe upper limit of 28 patients per day is 210,975 appointments. In March 2023, there were 423,540 appointments.

7.3 Delivering high quality, patient centred care relies on a large, skilled workforce. With our growing population, living longer with more complex, our practice teams cannot continue as they are.

7.4 The GP role is one of the most recognised roles within general practice however the number of GPs has declined nationally. In 2019 as part of the five-year framework for GP contractual reform, additional investment in general practice was identified to support the expansion of multi-disciplinary teams and create capacity within general practice through the Additional Role Reimbursement Scheme (ARRS).

7.5 The scheme sees Primary Care Networks come together to jointly employ and share staff. There are ‘new to primary care roles’ that can be employed under the scheme such as: Social Prescriber, First Contact Physiotherapist, Occupational Therapist, Trainee Nurse Associate, Physician Associate, Pharmacist, Paramedic, Care Co-ordinator, Pharmacy Technician, Dietician, Podiatrist, Mental Health Practitioner, and Health and Wellbeing Coach.

7.6 The additional workforce is a welcomed and valuable part of the general practice workforce. It offers not just a significant increase in capacity (25% increase in the current WTE workforce by 2023/24) but an opportunity for primary care to work differently and collaboratively across practices with a greater skill mix. Still, there are challenges in changing public perceptions of other roles in general practice and continued awareness of these new roles with our patients and wider public is required. It is recognised that these roles also bring challenges in relation to management and supervision capacity, and the infrastructure needed to accommodate more staff and services.

Prioritising safe working

7.7 The great majority of GP appointments are face-to-face and consultation rates per patient have increased. Fewer GPs providing care for more patients increases the risk of harm and suboptimal care through decision fatigue. This also risks GPs becoming burned out.

7.8 The British Medical Association (BMA) provides guidance for GP practices to make decisions that allow them to best prioritise care Safe working in general practice. This can be by deprioritising certain aspects of practice daily activities when they fall outside of core requirements, while staying within the constraints of the GMS contract. Overall, it is intended to allow a practice to devote its resources to those patients it is best placed to help.

7.9 'At Your Service', published by the Policy Exchange states that 28 patient contacts per day is safe. Present contacts per day by GPs in England are significantly more than this. *At Your Service* highlights that GPs are seeing on average 37 patients per day.

7.10 Current BMA standards for a session of GP care is 4 hours 10 minutes. No more than 3 hours of this should be spent in consultation with patients. Practices must provide enough appointments to meet the reasonable need of their patients. This must be done in a way that is safe for both patients and GPs. Remote consulting and triage are safe and effective ways of delivering care that have grown in use and acceptability. Utilising these methods allows practices:

- to provide patient appointments more flexibly;
- direct patients to the most appropriate provider of care; and
- prioritise care for those most in need.

7.11 The RCGP tracking survey describes data on GP's experiences of the effect of workload pressures on the quality of patient care that can be delivered. It notes:

- 68% of GPs say they don't have enough time in appointments to adequately assess and treat patients;
- 64% of GPs say they don't have enough time in appointments to build the patient relationships they need to deliver quality care; and
- 65% of GPs say patient safety is being compromised due to appointments being too short.

7.12 The ongoing, high level of appointments is also impacting on GP retention, with GPs leaving the workforce early at ever increasing rates. The 2022 RCGP members survey found that 39% of the GP workforce across the UK are seriously considering leaving the profession within the next five years. We need to ensure that GPs can work sustainably to ensure our patients receive high-quality care.

8. Our challenges

8.1 Primary care has 15 times more consultations per day than A&E and 5 times more than hospital outpatient appointments for 7 per cent of the NHS budget. To continue to deliver high-quality healthcare, we must start to think in terms of value and sustainability; identifying a balance between cost and outcomes (value) and long-term impacts (sustainability).

Dissatisfaction

8.2 People are less satisfied with the NHS than they were before the pandemic. This is true for different sections of the population, with waiting times rising in prominence as a driver of dissatisfaction. There has been a fall in satisfaction across a range of health and care services, including GPs, NHS dentists, inpatient and outpatient services, Emergency Departments, and social care.

8.3 In the 2022 National GP Patient Survey, the results for West Yorkshire ICB indicated that 71% (of those surveyed) rated their overall experience of their GP practice as good; this was in line with the national results at 72% but was a decline from 83% in 2021. However, the variation across the West Yorkshire PCNs ranged between 43% and 92%.

8.4 The Healthwatch Insight Report notes that access to GPs remains one of the key areas that people are talking to Healthwatch about. People see GPs as the door to wider health and care services, and many feel let down when they cannot access their GP in a way that works for them. The report highlights the variation in terms of communication, access, booking appointments, and access to additional support. There are positive experiences, however for some this remains a challenge.

8.5 These themes were collated from engagement events throughout September and October 2022 with an update presented to a community group in May 2023. Some improvements in satisfaction were noted however it is clear there is still more work to do to reduce the barriers some patients face when accessing services.

8.6 Feedback from recent ‘Listen in’ events across Bradford district and Craven saw people consistently raise the ability to access a GP as a concern.

Elective Recovery

8.7 There is a growing emphasis on redesigning the way we run outpatient care, not least for people with multiple conditions. There is a move towards using specialist expertise in more innovative, less traditional ways, such as online advice and consulting, or patient initiated follow-up. We have seen changes to how secondary care specialists can ensure that they meet employers’ contractual obligations for ongoing follow-up, prescribing, referral, and investigations, in a way that does not further overburden GPs. If innovation and transformation is championed for secondary care, perhaps it is possible to do the same for primary care.

9. What are we doing?

GPAS (General Practice Alert State) / OPEL Reporting

9.1 GPAS or OPEL reporting allows the pressures in General Practice to be presented in the clearest possible fashion. Information from GPAS/OPEL provides tangible evidence the day-to-day pressures in primary medical care and allows data to be presented in a similar format to that from hospitals, helping to demonstrate that pressures in secondary care are more than matched by challenges faced in general practice .

YORLMC track activity per 1,000 patients. As well as showing demand and capacity, it can be used to make meaningful assessments on whether an increase in GP appointments predicts an increase in Emergency Department (ED) attendances. As more data is gathered, it will inform conversations about when and how to support general practice before the ED numbers rise.

It's a GP Practice Thing

9.3 'It's a GP Practice thing' aims to increase awareness of how GP practices are working, the range of services offered and the specialist team members who are available to help people get the care they need.

9.4 The campaign development, led by Bradford district and Craven, took place in October and November 2022 by working with local patient groups and primary care staff to co-create the most effective messages, design style, community language versions and channels. YouTube

Engaging with West Yorkshire primary care

9.5 Although not yet published, media negativity was given by 25% as a reason for staff considering leaving their role in a survey. However, over half of staff said feeling valued would help them stay in their role. We also heard the message about more support against negative media in 5/10 focus groups held in West Yorkshire.

Resolving long-standing process issues

9.6 Small changes can make a difference. We have examples of partners working together to make simple changes that can reduce the burden on primary care. For example, the digitisation of General Ophthalmic Service referral/notification forms.

Enhanced Access and additional capacity

9.7 Enhanced Access means that practices (as part of their PCN) offer appointments up until 8pm in the evening and at weekends.

Understanding variance

9.8 There is variance at PCN level in the number of appointments available per 1,000 patients, those done face-to-face, and those undertaken on the same day of booking. However, this does not necessarily mean that quantity is better than quality. The model of care used by, for example, patients of Bevan medical practice is very different to that of patients living in more affluent areas. Bevan supports many patients with complex physical and mental health needs, chaotic lives, and stark health inequalities. Without a 'soon' appointment they are more likely to be unable to access or to disengage from care. Patients of other practices may prefer a booked appointment balanced around work or social commitments, or long term conditions.

9.9 When looking at the number of appointments available by practice, there is little correlation between appointments and number of FTE GPs, with practices with high appointment rates having some of the highest patient numbers per GP FTE, and vice versa. It is apparent that there are several variables and that there are multiple factors which impact on appointment numbers. We also know that around **50%** of people who make a GP appointment have a social problem rather than a medical need, and that other options may be more beneficial than a GP appointment. Access alone is not a good indicator of quality and in some practices the move is to fewer appointments, done well.

Looking to the future

9.10 Primary care generally waits for people to come to it and then reacts. GP appointments skew to a small portion of the population every year with little left over for proactive work. 40-50% of people registered will not attend primary care in any given year, and a quarter or more have not been heard from for 3-4 years, possibly more. When reviewing the top 100 list of 'super attenders' over half are known to be in a struggling or chaotic lifestyle. Half of GP appointments go to just 5-10% of the population, year-on-year.[1]

9.11 We know that co-morbidities are not always a good indicator of frequent attenders, which are more likely to be for trauma, opioid use, safeguarding issues, anxiety and depression, complex social issues. The needs of this group are rarely met through 10-minute appointments and they tend to 'bounce' around services and become increasingly medicalised. One of the key aspects of the Fuller Stocktake is that patients with complex health needs receive continuity as part of an MDT approach. Our Universal Healthcare pilot offers an opportunity to look at and understand need, consider continuity, and formulate navigation.

We have had some early successes with different MDT approaches for this group of patients. We are also exploring an opportunity to use a VCSE 'front door' to provide continuity (avoiding medicalisation). Our Wellbeing Hubs are having success working with these groups to avoid Emergency Department attendances. This learning could be taken this learning into our future-facing GP model.

[1] Professor Malby LSBU, Lessons from Primary Care

10. What next?

Fuller Stocktake

10.1 The publication *Next steps for integrating primary care: Fuller Stocktake* supports our aspiration for primary care that reorientates the health and care system to a local population health approach. A key aspect of the Fuller Stocktake challenge is in creating the capacity in our workforce, estates, data, and digital. As well as building sustainability through our infrastructure, leadership and representation in key decision-making and delivery forums.

10.2 The Fuller Stocktake proposes that the focus must be on the support to our primary care workforce, and access to care and support for our population. Patients with similar needs could be considered together and offered discrete elements of general practice. But this assumes patients would be happy going to another practice and we recognise that many practices would not support this model. It also risks missing those who need support because of the nature of a transactional, fragmented approach to treatment. Conversely, it risks safeguarding situations where families want to avoid continuity that could lead to scrutiny.

10/3 It is a challenging balance to make and the stocktake is not as widely supported locally as first thought. The next steps for primary care must include allowing for continuity in follow-up and not be seen as the disassembling of partnership-based care.

Access Recovery Plan

10.4 In May 2023, NHS England published the Delivery plan for recovering access to primary care, which has two key ambitions:

- Tackle the 8am rush and reduce the number of people struggling to contact their practice; and
- Patients to know on the day they contact their practice how their request will be managed.

10.5 The plan supports recovery by focusing on four key areas, many of which aim to address some of the challenges identified within this report:

- Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice;
- Implement *Modern General Practice Access* to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment;
- Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed; and

- Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

10.6 Whilst the plan heavily focuses on General Practice access, it is important to note that there continues to be a focus on integration, particularly on integrating primary care through the proposals relating to community pharmacy.

10.7 ICBs are asked to ensure that their actions in relation to the access recovery plan align with the vision described in the Fuller Stocktake. This is with a particular focus on the functionality of digital telephone systems, supporting the future direction of PCNs and places in offering a single system-wide approach to integrated urgent care and integrated neighbourhood teams. As a HCP, we can develop and support plans that incorporate integrated models of care and continuity.

In it together

10.8 Working in primary medical care has never been so hard. The negative, anti-GP rhetoric often heard in the media can fuel patient discontent. Our practices are seeing hundreds of thousands of people each month. A key challenge is putting in place plans that value, recruit and retain GPs and the wider GP workforce and involve the workforce (now and of the future) in designing the model of modern general practice.

10.9 More access is being provided and people are being seen more quickly than ever before, however people feel frustrated when trying to book an appointment. But it's still not enough. Patient – and staff – satisfaction remains low.

10.10 Our aspiration is to have an 'honest' conversation with the public about GP access, the resources we have, and how we can make best use of them together. We can take this courageous step to be open to co-designing and prototyping new models that better meet people's needs. There will be trade-offs, but we can be transparent about these. We have an opportunity to be radical and to think about how we 'contract' with our population in the delivery of our GP services.

11. Summary and Recommendations

11.1 GP access is an issue nationally and we know from our engagement activities that it is a significant concern for local people. An increase in GP appointments should not be our only goal. We can use the opportunity of having a collective strategic focus on GP access to ensure that we co-design new models of care with our staff and patients. We aim to improve our patients' experience and outcomes of care, as well as timely access.

11.2 Despite offering more appointments than ever, on the same day and face-to-face, it is not working for our patients or our primary care workforce. Our practices face significant challenges in retention, recruitment, increased workload, a national contract focused on numbers rather than quality, and the risks posed by all these factors on safe-working practice.

11.3 To meet the needs of our population and retain and recruit the general practice workforce we need to re-think the models of primary medical care across Bradford district and Craven and West Yorkshire. By using our data and intelligence we can develop a model of care that is sustainable and offers enhanced quality of care. This fits with the direction of travel of the Fuller Stocktake, the next round of the GP contract under consultation, and the learning from Universal Healthcare pilots.

11.4 We need to shift from quality of access to considering the *quality of access* based on:

I. Urgent on the day needs

   a. As part of an integrated primary care same day response service.

II. Continuity of care needs (longer appointments and/or follow up)

   a. GP ongoing medical needs;

   b. With MDT (proactive care) – chronic health needs/frailty etc; and

   c. With non-clinician/VCSE/wellbeing approach – social issue.

The Partnership Board is invited:

1. To support the proposal for an 'honest conversation' with the public through Listen In deliberative events. Using this as an opportunity to bring together the public and the GP workforce to codesign pilot models of access within the resources available.

2. To support the proposal for pilots and prototypes of different models of access to address quality of access, including evaluation (both locally and across West Yorkshire) and share learning for other practices.

3. To support the continued the work to understand and, where needed, support practices to address variation in access.

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	7
Meeting date:	21st July 2023
Report title:	Place Lead's Update
Report presented by:	Mel Pickup
Report approved by:	Mel Pickup
Report prepared by:	Mel Pickup, James Drury, Shak Rafiq

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 BD&C Partnership Board

Executive summary and points for discussion:

This report summarises key activities and points to note arising from the activity of the BD&C 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
1. May 2023 Triple A report to the West Yorkshire Integrated Care Board
Acronyms and Abbreviations explained
1. ICS integrated care system 2. ICB integrated care board 3. BD&C Bradford District and Craven 4. VCS voluntary and community sector

1. National context and policy development

New Hospitals Programme and Towns Fund

I was delighted to hear that **Airedale NHS FT has been accepted onto the Government's New Hospital Programme.** This is a much needed development that reflects the issues the hospital is faced with. The new development will benefit the communities local to the hospital and much further afield. We also recognise that this news will bring a welcome boost for colleagues working at Airedale as well as helping us attract people to come and work for us here in Bradford District and Craven.

I am excited to confirm that Keighley has received Government confirmation of the funding it needs to proceed with building a new **Keighley health and wellbeing centre**. The funding of £3.4million forms part of a **Towns Fund grant** from the Department for Levelling Up, Housing and Communities (DLUHC). It means that building the centre can now get underway with the centre expected to open in the summer of 2026.

The new facility will include GP services, self-care and prevention, community care, mental health, dental care, a GP training hub and other healthcare services, at an accessible town centre location. The scheme will also bring around 200 jobs to the town centre, 50 of them being new posts, helping bring extra footfall to local shops and other businesses.

While these successes provide a much needed boost, we are disappointed that our proposals for Lynfield Mount Hospital and Bradford Royal Infirmary did not make it to the list of New Hospitals Programme projects recently announced. We will continue to make the case for these projects, so that our local community can benefit from state-of-the-art facilities across our services.

As the Board is aware, Airedale NHS FT continues to manage the issues faced with Reinforced Autoclaved Aerated Concrete (RAAC) on a daily basis. This is picked up in our risk report at agenda item 9.

Industrial Action

The industrial relations climate remains very difficult across the country. At the time of writing Junior Doctors are commencing an extensive period of strike action between 13-18 July 2023. The BMA Consultants' Committee has announced a two-day strike over 20-21 July 2023; and the Royal Society of Radiographers has confirmed strike action by its members on 25-27 July. The range of derogations is limited and the operational impact on planned care is expected to be significant.

At the time of writing NHS England reports that it is engaged in talks with Government to recognise the impact of strike action on elective recovery and additional expenditure incurred on staffing as a direct result of some of the recent strike action. Talks remain ongoing with Government to clarify how the cost of pay awards made in settlement of earlier strike action by Agenda for Change staff will be met. This may result in further pressure on NHS budgets, and on timely treatment for

the people we serve. In this extremely challenging situation, our actions are guided by our shared partnership values.

Hewitt Review and the Health Select Committee inquiry into Integrated Care Systems (ICS)

Government has published its response to the Hewitt Review and the Health Select Committee inquiry into Integrated Care Systems (ICS). Overall, the response was positive with many recommendations supported. This indicates strong continued support within government for ICSs, and their four core purposes of reducing inequalities, tackling variation in care, using public resources wisely, and contributing to wider social and economic goals. The government has endorsed the need to shift to a preventative model and acknowledges that further devolution is needed to achieve this.

NHS Assembly: NHS at 75

Following a rapid round of involvement activity, in which our BD&C Partnership participated actively, the NHS Assembly has published the NHS75 Report. It celebrates the successes of the first 75 years and suggests how the NHS should evolve to continue meeting peoples needs in the future. It calls for three shifts in how it delivers care in the future which are entirely consistent with our BD&C Partnership Strategy, our Priorities, and the wider West Yorkshire Integrated Care Strategy and Joint Forward Plan:

- Preventing ill health – shifting funding to evidence-based measures to prevent and manage coronary heart disease and other causes of ill health such as smoking and obesity.
- Personalisation and participation – ensuring that people are able to maintain control of their own care, alongside continuity of care with their clinicians.
- Co-ordinated care, closer to home - moving further faster on integrating care in our neighbourhoods and ensuring better out of hospital care in our communities for those with complex needs and frailty.

NHS Mandate

June also saw the publication of the latest NHS Mandate, which reflects the calls made by many systems for fewer national targets. The Mandate informs the accountability framework between Government, NHS England (NHSE) and our Integrated Care Board (ICB). It asks us to focus on three priorities:

- Cut NHS waiting lists and recover performance
- Support the workforce through training, retention and modernising the way staff work
- Deliver recovery through the use of data and technology

Alongside the above objectives, the Mandate requires that the NHS continues their wider work to deliver the key NHS Long Term Plan ambitions to transform the NHS for the future.

Taking the Hewitt Review, NHS75 report and Mandate in the round, it is clear that as a Partnership we must retain a careful balance between effective delivery of care and treatment, and the ongoing shift towards becoming a health creating system. Our agenda today includes updates on how we seek to do that through our Joint Forward Plan and the use of our resources. (agenda items 9 and 12)

NHS Long Term Workforce Plan

The NHS Long Term Workforce Plan has been created in collaboration with staff and has a focus on the three pillars of Train, Retain and Reform. We recognise that the plan will require a concerted effort over the long-term in order for benefits to be fully achieved, but it is a significant stop forward and an opportunity to put staffing on a sustainable footing.

Locally "People" is one of our five priorities. Led by Foluke Ajayi, the People Priority team are working with Kate Sims, Director of People for the ICB, who will be presenting details from the NHS Workforce Plan at the West Yorkshire Partnership People Board on 25 July 2023, where colleagues from across all parts of the care and health system, not just the NHS, will identify the critical actions that we will take together to support our workforce development initiatives

NHS Equality Diversity and Inclusion Plan

Allied to the NHS Long Term Workforce Plan, the NHS EDI Plan identifies six high impact actions that organisations should take to improve equality, diversity and inclusion. Locally, the creation of an inclusive culture where everyone can have a strong sense of belonging is the focus on one Pillar of our People Priority. The People team are now reviewing how we can put ensure the EDI Plan is embedded in our work and makes a difference for our colleagues and future recruits, so they in turn can improve the experience of the communities we serve.

2. West Yorkshire Health and Care Partnership activity and implications for Bradford District & Craven Place Partnership

West Yorkshire Plan

The West Yorkshire Mayoral Combined Authority has published The West Yorkshire Plan. It sets out five missions, which are well aligned with our Integrated Care Strategy, and with the Bradford District Plan:

- A prosperous West Yorkshire – an inclusive economy with well paid jobs
- A happy West Yorkshire – great places and healthy communities
- A well-connected West Yorkshire – a strong transport system
- A sustainable West Yorkshire – making lives greener
- A safe West Yorkshire – a region where everyone can flourish

Across West Yorkshire there are a growing number of areas where the Combined Authority and Integrated Care System work effectively together on shared strategic goals, such as championing inclusivity, and tackling inequality.

Locally, the collaboration between our Health and Care Partnership and the Wellbeing Board similarly reflects our shared ambitions. Current examples include the Physical Activity Strategy and the Good Food strategy.

In October the West Yorkshire Integrated Care Board will be undertaking a development session on the role of integrated care systems in supporting broader social and economic development. Partnership Board members may wish to consider any local examples that they would wish to see highlighted at this session.

Integrated Care System operating model review

At the May meeting of the Partnership Board we noted that all Integrated Care Boards are required to reduce their running costs by 30% with 20% to be delivered by the end of the 2023/24 year, and the remainder in 2024/25. In West Yorkshire Health and Care Partnership we are approaching this as an evolution of the whole Integrated Care System model which we have established together. We are designing our operating model in a way that focusses on the Integrated Care Board's core (and statutory) objectives and values.

Throughout June and July a series of engagement exercises are being undertaken with staff, with many ideas generated. All place based ICB teams, including Bradford District and Craven, are working on outline proposals to share with the Integrated Care Board Executive Team towards the end of July, with further refinement to take place in August. Our local approach to this is:

- to build on our existing strong Act As One arrangements with local partner organisations
- to involve staff fully in shaping proposals, and
- to stay focused on meeting the needs of our population by delivering our strategy through our priorities
- underpinned by our shared values

We will keep the Partnership Board informed as this develops.

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

New Board member

I am pleased to welcome Jonathan Kerr, CEO Age UK, North Craven, to our Partnership Board. Jonathan has been nominated by his peers to bring the perspective of the VCSE sector in Craven. Dena Dalton, Head of Health Collaboration, Community First, will act as a deputy should he not be able to attend any of the meetings. Jonathan has previously attended the Partnership Board as an observer, and has participated in the Listen In programme.

Welcome to Lorraine, new Chief Executive for Bradford Council

I'd like to say welcome to Lorraine O'Donnell who will be joining Bradford Council as the new Chief Executive, taking over from Kersten England who earlier this year announced her decision to retire. I'd like to place on record, once again, my thanks to Kersten for all that she does to drive the work of our partnership and for leading on securing key developments and funding into Bradford. I look forward to working with Lorraine, who is expected to start in October, and will join us from Cheshire East Council where she is currently the chief executive.

Celebrate as One: Bradford District and Craven Health and Care Partnership Awards

I'm pleased to announce that the nomination are now open for our first ever place-based partnership awards. Celebrate as One - will take place on 19 October 2023. Nominations are now open in 12 categories; designed to give projects and teams across the partnership a chance to highlight their work in priority areas for our partnership.

With kind support from Sovereign Healthcare and Stand Out Media, our awards are open to anyone working in the health and care system locally - voluntary, community and social enterprises, independent care providers, our local NHS and local authorities.

Get nominating by visiting www.bdcpartnership.co.uk/awards. Nominations close on Friday 11 August.

Happy 75th birthday to the NHS - you can get involved in marking the milestone

On Wednesday 5 July, the NHS turned 75 and there was lots of activity taking place across our partnership to mark the occasion and much more planned, including an opportunity for you to get involved. We have had TV coverage featuring colleagues from Airedale Hospital on ITV, BBC cameras and radio colleagues at Bradford Royal Infirmary and print coverage of Bradford District Care NHS Foundation Trust marking the service of colleagues. There's still an opportunity for you to get involved in some of our place-based partnership activity to mark the birthday as below:

- Share your story of what the NHS means to you by recording a short video selfie message
- Make a pledge to show how you will help health and care services

Better Care Fund planning

At the May meeting we noted that the process was underway to develop shared plans for the use of the Better Care Fund in North Yorkshire and in Bradford District. Following submission of the plans I'm pleased to say that positive feedback has been received from regional colleagues to whom it was submitted, and the final plan is included on today's agenda for the Board to note (agenda item 12).

Partnership Board Terms of Reference

Following the May meeting when the draft Terms of Reference were considered, Board members have submitted a number of helpful comments. A final proposed version of the Terms of Reference is included for approval on today's agenda at item 10.

Partnership Board Triple A Report

Our recent Committee Effectiveness report highlighted the opportunity for us to improve awareness of the flow of information between our place partnership board and the West Yorkshire Integrated Care Board. As a standing item from now on, we will include the 'Triple A' report that we share with the Integrated Care Board after each of our meetings. The most recent AAA report is appended to this place lead's update.

Tackling inequalities workshop

On Tuesday 27 June, I joined partners from Bradford District and Craven for a workshop organised through the Reducing Inequalities Alliance. The workshop was designed to get people thinking about how we can turn talk of tackling inequalities into action through a coalition of the willing and in partnership through our 'Act as One' ethos. Find out more about the Reducing Inequalities Alliance, download our resources, sign up to the newsletter and see the latest human stories by visiting https://bdcpartnership.co.uk/strategic-initiatives/ria/

Diversity Exchange

On Tuesday 20 June 2023, I joined leaders from across Bradford District at the launch of the Diversity Exchange, a new initiative that aims to make equality and inclusion everyone's business. The Diversity Exchange is designed to be a one stop shop platform for all things related to: equity, diversity, belonging, social connections and trust. It is open to all organisations from social enterprises, grass root groups to large statutory organisations. You can see more about the Diversity Exchange by visiting www.bradfordwellbeing.co.uk

Bradford Literature Festival

From 23 June to 2 July, Bradford Literature Festival once again delivered an exciting and mixed programme celebrating the best of literature, music, theatre, discussions, lectures and interactive workshops for the whole of family. Our Bradford District and Craven Health and Care Partnership was one of the proud sponsors of one of the leading events of its kind that draws crowds from across the world, yet ensures that local audiences and communities can benefit from its extensive programme.

South Asian Heritage Month

South Asian Heritage Month (SAHM) aims to celebrate, commemorate, and educate people about the South Asian cultures, histories and communities. This year's theme

for SAHM is ‘Stories to Tell’, which is all about celebrating stories that make up our rich south Asian community. We will be asking people from across our partnership to share their stories and these will be shared throughout SAHM which officially runs from 18 July to 17 August. I hope that many of us are able to mark the month and take part in some of the events planned locally

Bradford Means Business Awards

Through our healthy minds priority, our Bradford District and Craven Health and Care Partnership, has sponsored the health and wellbeing category at this year’s Bradford Means Business Awards, that are taking place on Thursday 20 July. We have got behind this year’s awards to raise the profile and recognition of our healthy minds website and resources, ensuring that people across Bradford District and Craven have an accessible resource they can access when they need support for their mental health. Our healthy minds website (https://www.healthyminds.services/) is being redesigned to increase accessibility, reflect feedback from people and to ensure it is using the latest user experience for web design.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven Partnership Board

Date of meeting: 15 May 2023

Report to: WY ICB Board

Report completed by: Sue Baxter for Elaine Appelbee (chair) & Mel Pickup (place lead)

Date: 17 May 2023

Key escalation and discussion points from the meeting
Alert:
• None
Advise:
• The NHS Staff Council has accepted the pay offer made by the government for Agenda for Change staff in England. As a result, ministers have been asked to implement this offer, which covers the 2022 / 23 and 2023 / 24 pay years. At the time of writing the Royal College of Nursing (RCN), Unite and the Royal College of Radiographers are expected to re-ballot members on strike action. Junior doctors also remain in dispute regarding their pay and conditions and further action remains a possibility. Impact of the latest junior doctors strike action was noted with: o For Airedale NHS Foundation Trust no major impact on activity levels, however Airedale General Hospital did see exceptionally high levels of attendances in its emergency department on days prior to the latest strike action o For Bradford District Care NHS Foundation Trust experienced minimal impact on direct service provision and all planned activity had been rescheduled o 148 in patient operations, 150 day case procedures, 905 new outpatient appointments and 4,237 follow-up appointments were impacted at Bradford Teaching Hospitals NHS Foundation Trust • Update on the **operational plan** submission for 2023/24 was noted with plans in place to delivery the 108% elective recovery target. Significant workforce challenges were noted with conversion from agency staffing to bank staff showing a reduction in workforce (March 2023/24) • For 2022/23 financial outturn provided for a small surplus. NHS WY ICB and the five places are submitting **a balanced financial plan**, recognising a £4.3m pressure at Airedale NHS Foundation Trust in relation to RAAC maintenance and mobilisation of EPR. In relation to finances it is important to note Bradford Metropolitan District Council position who are reporting a significant financial pressure, without the ability to call on reserves, having utilised them in preceding years

Assure:

- Our latest cycle of **'Listen in'** activity took place in the Bradford West from 29 March to 5 April 2023. Key message a lack of trust in NHS services, especially from marginalised communities. Themes across the four cycles have been collated and a development session is planned with to explore our partnership response to emerging themes.
- Bradford District and Craven Health and Care Partnership have five strategic priorities and enablers, assurance was provided to the Partnership Board on the **five strategic priorities:**
  - **People priority:** set out over four pillars: looking after our people; leadership, inclusion and belonging; new ways of working; and growing our partnership. Focus reducing agency and new workforce leadership training (leaders: Foluke Ajayi, and shared programme director between a post currently vacant and Karen Stansfield)
  - **Children and families:** first 1001 days; universal prevention & early identification; pathways and services; and complex care. Focus on referrals and pathways; early intervention; complex care transitions and perinatal mental health (leaders: Therese Patten and programme director Nagina Javaid)
  - **Healthy communities:** community partnerships; locality collaboratives; and place-based community health and care integration. Focus on core model, additional roles reimbursement scheme (ARRS), new roles, virtual ward, better care fund, integrated care and ASSIST (leaders: Foluke Ajayi and programme director Louise Clarke)
  - **Healthy minds:** mental health; neurodiversity; substance misuse; and learning disabilities. Integration, pooled budgets, parity of esteem and wider social factors (leaders: Iain MacBeath and programme director Sasha Bhat)
  - **Access:** major health conditions; elective (planned) care; urgent care; and collaboration. Wellbeing hubs; diagnostics; ASSIST; crisis and urgent care; acute liaison and discharge (leaders: Mel Pickup and programme director: Helen Farmer)
- A change of lead finance director for the Bradford District and Craven place from Robert Maden to Mike Woodhead. Mike will retain his role as the director of finance of finance, contracting and estates for Bradford District Care NHS Foundation Trust (BDCFT) and Robert will take up lead for Estates.
- The **first risk management cycle of 2023/4** included the ICB Board Assurance Framework, which had been approved by the NHS West Yorkshire ICB Board meeting on the 21 March 2023. By this cycle the partnership risk register has a total of 26 risks logged, with three risks closed to-date. Key messages:
  - risk related to the underlying financial deficit to be updated to reflect the 2023/24 outlook
  - Two further risks will replace the current duplicate of the ICB risk in relation to **reinforced aerated autoclaved concrete (RAAC) at Airedale General Hospital**. (i) Risk of long-term disruption to service provision and (ii) risk of delays in decision or unsuccessful new hospitals programme bid. Foluke Ajayi agreed to bring an item of focus on Airedale General Hospital to the next Partnership Board.

Assure:

- There was agreement to **recalibrate the partnership risk register** through cycle two ensuring that all risks from the assurance committees, partnership strategic priorities and enablers are captured.

- Partnership Board members were asked to review the **Terms of Reference** and feedback by 31 May, a revised copy will be sent to for ICB Board approval in July 2023.
- Decision making: delegation of the **Better Care Fund sign-off** to our Place lead was approved by the Partnership board

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Partnership Board
Agenda item no:	8a
Meeting date:	21 July 2023
Report title:	Citizen Forum Steering Group update
Report presented by:	Helen Rushworth/Vic Simmons
Report approved by:	James Drury, Partnership Development Director
Report prepared by:	Helen Rushworth – Chair Citizen Forum Steering Group

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

Previous considerations:

Citizen Forum AAA reports

Executive summary and points for discussion:

'Citizen Forum' describes a range of ways of bringing people together to influence decision-making – it is not a single fixed group, but an umbrella term which is supported by underpinning workstreams and involvement projects that support the ambitions of our partnership.

The Citizen Forum Steering Group oversees this work and provides assurance and advice to the Partnership Board. Our stated objectives are to work together to co-ordinate and plan how we speak to local people to make sure we listen as widely and as effectively as possible; to make sure we don't duplicate work and to share skills and resources; and to ensure that insight from people and communities can influence our partnership and improve health and care for our population.

Attendance and engagement from partner organisations have been variable over recent months, leading to scheduled agenda items being deferred and the most recent meeting cancelled due to high numbers of apologies. We need to ensure that we have the right representation and active participation from across our partnership. As our partnership governance matures, we need to clarify the relationship between Citizen Forum and other partnership forum/committees.

To explore these issues, clarify our purpose, and evaluate efficacy of the Citizen Forum Steering Group we will be holding a development session later this month, with support from the partnership development team.

The Chair and Operational Lead would welcome the views of Board colleagues re how the Citizen Forum could best support strategic and operational decision making to assist in shaping the next stage of its' development.

An agenda item is planned for September's Partnership Board meeting to update on the outcomes from the development session and proposals for the future.

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 how the Citzen's Forum Steering Group could best connect with other committees and our partnership's priority boards. 2. Consider the Citizen Forum purpose, and suggest opportunities for the steering group to add value to our partnership decision-making. 3. Ensure all partner organisations are committed to ensuring attendance and engagement at Citizen Forum Steering Group.
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. ToR Citizen Forum Steering Group
Acronyms and Abbreviations explained

What are the implications for?

Residents and Communities	**Improved services based on their experience**
Quality and Safety	
Equality, Diversity and Inclusion	**Public voices will directly influence service planning and delivery**
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	

Future Decisions and Policy Making	**Public voice an integral part of future decision and policy making**
Citizen and Stakeholder Engagement	**CFSG will be the 'go-to' citizen and stakeholder engagement tool for the partnership.**

Terms of reference
Citizen Forum Steering Group

Version control

Version:	1.3
Approved by:	Bradford District and Craven Health and Care Partnership Board
Date Approved:	24 January 2023
Responsible Officer:	Victoria Simmons
Date Issued:	24 January 2023
Date to be reviewed:	After 1 year

Change history

Version number	Changes applied	By	Date
1.0	Initial draft	Victoria Simmons	01/11/2022
1.1	Feedback from members	Victoria Simmons	05/01/2023
1.2	Approval from Chair	Helen Rushworth	09/01/2023
1.3	Approval by members	Citizen Forum Steering Group	24/01/2023

1. Introduction and Context.

Bradford District and Craven Health and Care Partnership firmly believes that our communities have the most power to create health and should be equal partners when it comes to decision making.

We want to create opportunities for people to be involved in our decision-making processes and do this in innovative ways. The Citizen Forum Steering Group is established to lead work across our partnership that continually improves the way we involve people and communities (sometimes referred to as engagement, participation or co-production).

2. Purpose

'Citizen Forum' describes a range of ways of bringing people together to influence decision-making – it is not a single fixed group, but an umbrella term which is supported by underpinning workstreams and involvement projects that support the ambitions of our partnership.

The Citizen Forum Steering Group oversees this work and provides assurance and advice to the Partnership Board. We work together to co-ordinate and plan how we speak to local people to make sure we listen as widely and as effectively as possible; to make sure we don't duplicate work and to share skills and resources; and to ensure that insight from people and communities can influence our partnership and improve health and care for our population.

3. Responsibilities

The Forum / steering group will advise and support the Partnership Board as follows:

1. The Steering Group will design and coordinate the arrangements for a 'network of networks', bringing together the wide range of involvement activity that takes place across Bradford and District.
2. The 'Listen in' programme of activity will gather and report insight from each of our six localities and report this insight to the Partnership Board and other place-based committees and programmes.
3. The Steering Group will advise the place-based partnership on methods of involving people and communities in decision-making, ensuring honesty and transparency in our governance arrangements.
4. The Steering Group will take responsibility for the partnership's Experience of Care reporting and will inform relevant system committees of themes and issues in order that appropriate action can be taken.
5. The Steering Group will develop a forward plan that reflects the experience of the public and planned involvement activity across our place, to ensure maximum impact for our population and to enable local people and communities to influence the work of the Bradford District and Craven Health and Care Partnership and the West Yorkshire Integrated Care System.

4. Membership and attendees

Membership

As a steering group our membership will be drawn from networks and organisations that are key to the development of our wider programme of work.

- Healthwatch Bradford District lead offer (Chair)
- Healthwatch North Yorkshire lead officer (Vice-Chair)
- BDCHCP Senior head of communications and involvement (managerial lead)
- BDCFT Patient experience & involvement lead
- BTHFT Assistant Chief Nurse & lead for patient experience
- Airedale NHSFT Patient experience lead
- Here4BDCC consortium citizen engagement workstream lead
- Bradford Council, Head of Policy, Performance, Partnerships and Research
- NYCC Partnerships Officer
- Nominated representatives from each Trust involvement group/panel/governors (x 3)
- Nominated representatives from communities of interest or engagement networks (x3)
- Primary care involvement representative
- Healthy Minds youth apprentice
- Bradford Council, Adult Social Care Transformation lead

For the first 18 months, the steering group will be chaired by Healthwatch leads. Chairs will be supported by a managerial lead from the partnership.

The steering group may invite others to attend meetings, 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.

Regular attendees

- Act Early coproduction lead
- Bradford Council Stronger Communities Head of Service
- NYCC Partnerships & engagement officer
- BDC Innovation Hub Lead
- BDCFT AHP lead & champion for youth involvement
- Act Early coproduction lead
- Living Well engagement lead
- Strategic Equality, Diversity and Inclusion Lead
- Bradford District Child Friendly Programme Lead
- Here4BDCC consortium voice and influence workstream lead

5. Arrangements for the conduct of business.

Chairing meetings

5.1 The meetings will be run by the chair. In the event of the chair of the steering group being unable to attend all or part of the meeting, the vice-chair or managerial lead will chair the meeting.

Quoracy

5.2 For meetings to be quorate, a minimum of 50% of members is required, including the Chair.

5.3 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.

5.4 Members of the steering group 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.

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

Frequency of meetings

5.6 The steering group will normally meet every month. The Chair may call an additional meeting at any time by giving not less than 7 calendar days' notice in writing to members of the steering group.

Declarations of interest

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

5.8 Where any steering group 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 Forum / steering group

5.9 The steering group's lead manager is the Place Based Partnership Senior head of communications and involvement, Victoria Simmons. Administrative support will be provided to the steering group 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 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 steering group is accountable to Partnership Board, which provides the formal leadership and coordination of the local health and care system.

6.2 The Chair shall draw to the attention of the Partnership Board any significant issues or risks relevant to the BD&C Health and Care Partnership.

6.3 The steering group will receive the Experience of Care reports and the Chair will present these reports to the System Quality Committee with commentary and recommendations from the steering group.

6.4 The steering group shall submit an annual report to the Partnership Board.

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

7. Conduct of the Citizen Forum steering group

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

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

7.3 The steering group 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 steering group.

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

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 Clinical Forum

Date of meeting: 13th June 2023

Report to: Bradford district and Craven Partnership Board

Report completed by: Mr David Crampsey / John Hartley

Date: 28th June 2023

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.
• Primary Care Access Plan – beyond General Practice (including Community Pharmacy)
• Learning From Medication Related Deaths
• SystmOne Tasks – proposal for utilising task allocation across organisations
• Annual Review of the Terms of Reference – these are attached for information and ratification having been approved by the membership with the understanding that any further amendments would be completed and signed off via the agreed governance arrangements
• The membership also received the following for information and action as required
  ○ West Yorkshire Clinical Forum Papers
  ○ National Care Recovery Plan Letter
 	
Future items planned for discussion include.
• Further work relating to requirements for Training on Learning Disability and Autism resulting from the previous discussions relating to the Parliamentary Briefing
• Update and requirements from the National Gender Identity Service
• Health Equity Fellows - their story
• Connected Bradford – update on available data and the ask of the Forum
• Listen In feedback
• Clinical and Professional Leadership development – the forum had invited the partnership workforce lead Daniel Hartley to attend and develop our CPL leadership offer. With changed leadership, we look forward to working closely with Daniel's successor as this remains a CPL priority for the forum

Assure:

The Clinical Forum would update the BD&C Partnership Board on the following.

- As previous updates advised of ongoing discussions regarding membership, Public Health representation has now been secured and discussions are ongoing regarding ophthalmology and dentistry.
- 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

Sub Committee Escalation and Assurance Report to the BD&C Partnership Board

Report from: System Finance and Performance Committee
Date of the meeting: 22nd June 2023

Key escalation and discussion points from the meeting
Alert:
• Ongoing industrial action continues to impact on financial and non-financial targets; • There is a significant surge in Q1 for Mental Health Out of Area Placements (driven largely by increased demand for PICU) which will significantly impact on a range of financial and non-financial targets; • BDCT and BTHT were unsuccessful with their New Hospital Programme bids – there needs to be a Place based estates view on this and a single view on clinical service strategy and configuration, alongside work with the ICS and national bodies to explore alternative funding sources and mechanisms. • We are £1.4m worse than year-to-date plan at month 2 and forecast to be £6.2m worse than plan for the full year. • Those adverse variances relate mainly to our £6m share of the additional £25m efficiency target imposed on the ICS in May, for which we have no identified plans/mitigations. • A recent letter from NHSE to the ICS has strongly encouraged us to introduce a range of financial control measures that would normally be mandatory for systems and organisations subject to regulatory intervention. Whilst many of those measures are already in place in individual organisations, there is a danger of applying them too bluntly and/or indiscriminately in an unproductive way or in ways that could negatively impact on financial and non-financial performance. NB, since this meeting, those measures have been made mandatory for WY ICS.
Advise:
• There is a business case in development regarding Autism which will need proper scrutiny through Local Directors of Finance and Deputies, then through System F&P Committee. • NHSE final documentation re WY Elective Recovery Fund scheme should be completed and agreed by the end of the month – the intention is that it should take account of the impact of industrial action (there is a significant risk if it does not) and we need to understand and manage the related Independent Sector activity (the greatest risk is in regard to 52 week waits). • The committee had an update re approved capital bids at AGH (urgent care relocation and New Hospital Programme and RAAC): the urgent care funds of

c£4m, must be spent this year; NHP has confirmed a range of financial quantum, which is less than originally asked for mainly because DHSC expects significant savings across various headings. AGH colleagues are working through the details of that to understand the implications and are also working up initial enabling and programme cost bids (c£105m and £1.1m respectively).

- Keighley Community Health Centre – we have had the green light to prepare an Outline Business Case (needs to be completed by the end of the calendar year) which will come back through the System F&P for scrutiny and recommendations; Robert Maden is working on understanding and managing the Capital Departmental Expenditure Limit impact; he is also working to minimise the risk of abortive costs/ claw-back by using Towns Funds money for most of the development costs We will need organisational and system commitment to engaging in detailed designs and the Outline Business Case.

Assure:

- The committee received the performance report and discussed year-to-date performance issues, which were largely similar issues highlighted in recent/previous reports.
- BDCT reported that the crisis beds were now live and having -ve impact on referrals.
- The CYP with SEND (special education needs and/or disabilities) monitoring visit was undertaken by the Department for Education and NHS England on 5th May. Feedback from the visit was very positive, and the partnership working, and the achievements gained to date against their improvement plan were noted and have now either met or exceeded several target metrics.
- AGH and Bradford Council have worked closely together on the expansion of Valley View, scaling up intermediate care: the unit will be expanding to 50 beds with 30 open, and this has helped to reduce long length-of-stay patients which has lowered occupancy levels and contributed to improved performance.
- The committee reviewed all risks on the cycle two of the partnership risk register and considered if the risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales. The committee also identified any risks that should be escalated to both the Partnership Leadership Executive and the BDC H&CP Partnership Board as part of high-level risk report.

Report from: System Finance and Performance Committee
Date of the meeting: 22nd June 2023

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: 21 June 2023

Report to: BdC Partnership Board

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

Date: 28 June 2023

Key escalation and discussion points from the meeting
Alert:
Nothing to escalate/alert
Advise:
• **EDI update:** Zahra Niazi gave a presentation to provide an overview of the placed based EDI work plan and what has already been developed on a place footprint. The work plan consists of 10 actions around shared system priorities which includes developing a leadership and behaviour framework, which has scope for alignment through the LIB pillar. Mapping work to be done on the offers from partner organisation to determine what we can offer at place. • **Leadership and working arrangements within people plan**: Interim arrangements are in place for the committee SRO to support leadership and working arrangements in this area. There is a likelihood of refreshed arrangements within the People Plan and People Committee to allow for visibility of what's working well, review of what is not working well and how to resource the People Plan ambitions. Further work is being done via workshops and through reporting to PLE to discuss the workforce priority and in turn will review the impact to the People Committee and its responsibilities. • This was supported by the committee effectiveness review completed by all BdC committees and groups, further work to incorporate member feedback will be developed alongside refreshed terms of reference to be reviewed in the August People Committee. • The People Committee agreed that as part of the refresh of arrangements, the committee will be reviewing the work plan to ensure that it aligns with the overarching people plan and focuses more on a clear set of KPI's in addition to the work we are currently sighted on. • **Risk to sufficiency:** The People Committee agreed to the proposal of an overarching risk on workforce sufficiency made up of challenges in recruiting and retaining staff. The recruitment element of this risk has been developed, however further work on the retention element needs to be progressed. This has caused a delay in the risk being managed via the partnership risk register but is still being monitored via the People Committee and pillar risk logs.
Assure:

- **Public Sector Equality Duty:** The Committee was assured that any potential risk of not meeting the Public Sector Equality Duty will be managed by the West Yorkshire ICB team as the statutory organisation.
- **Highlight reports** for each People Plan Pillar/programme of work produced and submitted to the committee. Continued progress on developing success metrics, delivery plans and an outcomes-based approach for all priorities discussed and challenged. There is a stronger focus on the leads of each pillar to provide the committee with assurance within this section.
- **Good news highlights:**
- **Leadership, Inclusion and Belonging- '**Valuing Diversity & Championing Inclusion' award has been included as part of the 'Celebrate As One Awards'.
- **New Ways of Working –** Anticipatory Care work has both clinical and workforce SME's aligned. learning needs assessment have been prioritised and commissioning intentions submitted.
- **Growing our Workforce** - Two Skills for work funded and BCA led events took place in May, creating great connections between employers and with 47 job seekers attending. BDCFT's employment scheme for people with enduring MH issues, will now be referring people to social care roles. CTE supported introduction to medicine (29 students) and radiology (39 students) taken place.

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 System Quality Committee

Date of meeting: 22nd June 2023

Report to: West Yorkshire - Integrated Care Board Quality Committee

Report completed by: John Hartley/Grainne Eloi/Phillipa Hubbard

Date: 26th June 2023

Key escalation and discussion points from the meeting
Alert:
• None
Advise:

Personalised Commissioning / Continuing Healthcare
• New CHC referrals remain consistent, PCD are breaching the 28 day KPI and 198 DST outstanding made up of new referrals and DST's following reviews
• Liaison Care an external company have commenced completing 220 DST/Reviews
• Head of service from Leeds CHC continues to support the team 2 days per week.
 	
Maternity CQC UPdate
• Results of the CQC Maternity inspections at BTHFT and ANHSFT have been received with.
  ○ ANHSFT rated 'Requires Improvement' for both the Safe and Well-Led. Effective, Caring and Responsive domains weren't inspected so the rating remains as 'Good' in those areas.
  ○ BTHFT ratings as follows; Safe - Requires Improvement, Well Led- Good, which makes BRI Good overall. There was recognition of significant improvements.
 	
Tong Park Hotel
• Investigation report and actions shared with all partners, including Home Office and NHSE
• Action plans agreed – Task and Finish group set up to work through the actions from April 2023 onwards
• Freedom of Information (FOI) process currently in place. This is being led by senior leadership at ICB.
 	
Cygnet
• As part of the Quality Improvement subgroup meeting held on the 9th of June it was agreed by/alongside NHSE and WY ICS that both Cygnet Bierley and

Cygnet Wyke would be placed under local ICB monitoring arrangements supported by the quality surveillance team.

Health Protection

- The Sexual Health budget has been reduced in real terms over the years while the demand for sexual health services has increased. Without an increase in funding we may see essential services restricted. A small budget uplift was recently approved but a long term solution is likely to require pooling resources across the system.
- Uptake of all vaccines in particular COVID-19, flu, MMR in some demographic groups continue to be below target despite all system efforts. A local health improvement plan led by the Health & Care Partnership is in development.

Care Homes

- A number of care homes have changed ownership in recent weeks. In some cases, this will impact on the number of nursing beds available across the district. Contract and Quality Team (BMDC) and ICB colleagues are working in partnership to ensure that safety and outcomes are maintained.
- The Contract and Quality Team and ICB colleagues, Patient Safety and Quality Improvement team, are currently looking at the process and policy relating to Care Home visits including the best use of resources and how visits to provider services are undertaken to ensure both social care and clinical monitoring are represented appropriately.

Assure:

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

- The Better Care Fund plan 2023 – 2025
- Items for awareness and escalation
- Recent reports relating to in hospital mortality data and further work required to understand the data
- Enhanced Surveillance procedure for NHS funded care homes
- The annual review of the committee terms of reference

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 System, Finance, Performance Committee papers
- Bradford district and Craven Clinical & Professional Forum

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Target Risk Rating	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	Risk Status
2314	05/06/2023	FPC/QC/PC/PLE/PB	Improve healthcare outcomes for residents	25 (I5xL5)	15 (I3xL5)	Helen Farmer	Mel Pickup	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, 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).	Management groups established: - Securing the future (programme) with responsibility for the planning and co-ordination of the RAAC work. - Capital and Investment Group meetings to discuss capital priorities. - RAAC Executive Assurance Group meeting bi-weekly (delegation from the AFT Board). - Five trusts with RAAC related issues - peer support and shared learning. - Regional RAAC programme board (monthly) - report progress against plan and share risks (all of the North of England). - National structure support group - national shared learning group from all RAAC hospitals. Remedial works funding with NHSE approval for the next three years: £20m in 2022/23, £15m in 2023/24 and £15m in 2024/25 (to address structural works). ANHSFT has built two modular wards so that patients can be decanted out of RAAC areas while repair work takes place. Modular wards can also be used if areas need to be evacuated. North of England and adhoc meetings with NHSE/I colleagues - - Risk summit - EPPR steering group	Application to the new hospitals programme, awaiting outcome of the process (awaited since September 2021). Identification of medium term (potentially years) of continuity of service provision plan. How to provide the service without viable estate at the AGH site. WY ICB is leading the development of a multi-agency RAAC emergency evacuation response protocol - testing of this is currently underway. WY hospital evacuation plan to be completed by Q3 2023/24.	RAAC at AGH (AFT) is registered on the NHS WY ICB risk register and included in the WY BAF and is routinely reported through WY and BDC HCP governance arrangements. RAAC is a known risk for the WY Association of Acute Trusts (WYATT). Emergency planning exercise to be held on the multi-agency RAAC protocol (6 June 2023). Airedale NHS FT is undertaking a continuous programme of actions to monitor and manage the risk of RAAC (regular inspections take place and if issues are identified actions are undertaken to ensure that the area is safe). Structural engineering advice is that the building requires replacement as soon as possible and no later than 2030. Protocol for the identification and management of RAAC which is approved by independent engineers. System planning arrangements regarding capital. Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme.	Emergency planning exercise to be held on the multi-agency RAAC protocol (6 June 2023). Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme.	RAAC at AGH (AFT) has been replicated back onto the BDC HCP risk register and is routinely reported through WY and BDC HCP governance arrangements. This risk is being rewritten to cover - long term disruption to service provision (this risk) and the new hospital programme - delay in decision, partial award substantively below funding required or rejection of the application. Multi-agency RAAC protocol to be taken to the Local Health Resilience Partnership (LHRP) which is attended by all WY acute trusts and mental health and care trusts. National research programme with new guidance from the Institute of Structural Engineers on RAAC - publication due. The national RAAC maintenance allocation is for three years (2022/23 is year 2). For years 2 and 3 there is insufficient funding to meet the maintenance requirements. For 2022/23 (year 2) the shortfall is £3m. Output of the ALARP will be a report on the management of the RAAC risk and to what extent these are being mitigated as low as reasonably practicable.		New - Open
2312	05/06/2023	FPC/QC/PC/PLE/PB	Improve healthcare outcomes for residents	25 (I5xL5)	15 (I3xL5)	Nancy O'Neill	Mel Pickup	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - There is a risk that Airedale NHS Foundation Trust is unsuccessful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030 due to delays, a decision to partially fund or a rejection of the AFT application by the national new hospitals programme bidding process. A decision is awaited from the new hospitals programme board on the AFT application for a new hospital at the Steeton site as part of the 8 new hospitals in England (note - there is no alternative route to funds than the new hospital programme). This could result in service provision at the Airedale General Hospital site not being viable beyond 2030 (or earlier if a significant RAAC incident occurs - see related risk number 2314)	Delegated authority from the Board to the RAAC executive assurance group (which oversees the new hospitals programme). Programme team for securing the future for both RAAC and new hospitals programme. Optioneering cohort for the new hospitals programme (scoping cohort for the five RAAC hospitals) - engage with the process with the new hospitals programme. Strengthens links and arrangements/preparations should the bid be successful.	New hospitals programme board to be established (subject to NHP bid approval). Draft strategic outline case published November 2020 (will only be final if approved by the treasury and join the new hospitals programme). Draft strategic outline case is currently being updated with partner engagement to enable mobilisation at pace. Await announcement.	RAAC at AGH (AFT) is registered on the NHS WY ICB risk register and the WY ICB BAF includes RAAC and is routinely reported through WY and BDC HCP governance arrangements. RAAC is a known risk for the WYATT collaborative. Internal Audit review of governance and assurance 2021/22 focused on the organisation and function of the programmes RAAC maintenance and the new hospitals programme. System planning arrangements regarding capital.	Internal Audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and the new hospitals programme.	RAAC at AGH (AFT) has been replicated back onto the BDC HCP risk register and is routinely reported through the WY and BDC HCP governance arrangements. This risk is being rewritten to cover - long-term disruption of service provision and the new hospital programme - delay in decision, partial award substantively below funding required or rejection of the application (this risk).		New - Open

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Target Risk Rating	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	Risk Status
2214	10/01/2023	QC	Improve healthcare outcomes for residents	25 (I5xL5)	9 (I3xL3)	Laura Siddall	Nancy O'Neill	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 to 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 closure. Severe weather, such as extreme heat or heavy rain or snow, all increase the risk of a RAAC panel becoming unstable and so would result in the ICB having to manage concurrent incidents.	*Airedale NHSFT is undertaking a continuous programme of actions to monitor and manage the risk of RAAC (regular inspections take place and, if issues are identified, actions are undertaken to ensure that the area is safe). * There is a national programme for NHS RAAC sites to ensure that learning and risk is shared nationally and a common approach is taken. * ANHSFT has built a number of modular wards so that patients can be decanted out of RAAC areas while repair work takes place and can be used if areas need to be evacuated. A further delivery of 60 units arrived in Feb 2023.	* It remains uncertain whether the national funding required to build a new hospital for ANHSFT will be approved. * Research into the properties of RAAC, such as flammability, is still ongoing and so there are a number of unknowns as to how resilient RAAC is. * NHS England is leading a programme to develop plans for how the Yorkshire health and care system would manage a partial or full evacuation of the Airedale General Hospital site. WY ICB will be responsible for signing off the regional RAAC plan. WY ICB is leading the development of a multi-agency RAAC response protocol. Both of these plans are in development and not yet finalised. * Further work is needed to test the ability of plans to react to concurrent incident, for example an evacuation at Airedale Hospital due to RAAC failure and heavy snow.	Update (03/04/23) - Risk likelihood has been increased to 5 to mirror AHFT's rating on their register. An exercise is being organised to test the multi-agency response protocol. Update (25/01/2023) - Risk has been updated following advice from the governance team. A multi-agency meeting with WY Local Resilience partners took place on 30th November to develop the multi-agency response protocol to an evacuation of Airedale Hospital. Work is now beginning ti test this protocol with a multi-agency exercise. Airedale NHS FT has confirmed that the Airedale Hospital building will not be viable beyond 2030. There is no further update nationally on whether Airedale NHS FT will qualify for funding for a new build. NHS West Yorkshire ICB is carrying a risk that there will be the loss of services provided by Airedale NHS FT by 2030 (or earlier if a significant RAAC incident occurs) and no mitigating plans to ensure that services remain available to the Bradford district and Craven population. Winter is a period of heightened risk for RAAC panel failures due to the impact of severe weather.	- The trust's monitoring programme has detected areas of weaknesses at an early stage before significant collapses have occurred.	* The risk of RAAC is difficult to quantify due to unknown information (currently, further research is being carried out into the resilience of RAAC). This makes it difficult for the WY ICB to balance the option of commissioning services from ANHSFT (and exposure to RAAC risk) versus the option of not commissioning services from ANHSFT (to avoid RAAC risk) and the subsequent risk to patient care by overburdening the health system across Yorkshire through reduced capacity. * It is unknown how the public and staff would react if a collapse happened at another RAAC site or part of Airedale General Hospital needed to be evacuated. the public and staff may lose confidence and choose not to attend Airedale General Hospital, putting pressure on the Yorkshire health system.		Closed - Closed as replaced by 2 new RAAC risks and RAAC is also on the WY ICB corporate risk register.
2338	28/06/2023	F&P Comm	Enhance productivity and value for money	20 (I5xL4)	9 (I3xL3)	Robert Maden	Robert Maden	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not achieve the financial plan surplus target for 2023/24 due to shortfalls against savings plans, additional cost pressures and financial penalties relating to the Elective Recovery Fund scheme. Following the completion of the planning round for 2023/24, there is an additional savings requirement of £6.1m that needs to be met if financial plan targets are to be achieved.	Ongoing budget management and application of planning principles in relation to new expenditure commitments. Ongoing review of budget commitments to identify uncommitted resources and in-year slippage. Monitoring ERF scheme performance at Place and across the West Yorkshire ICS to ensure keep to plan trajectories. - Monitoring delivery of savings plans and identifying further savings opportunities. - Operation of Place financial risk management arrangements. - Operation of WY ICS financial risk management arrangements.	Savings not fully identified. No contingency reserves to manage in-year pressures. National pressures outside local control, e.g strike action.	Reporting on financial performance and savings plan delivery through the System F&P Committee with escalation to the Partnership Leadership Executive as appropriate. System committees (F&P and Quality) jointly involved in business case review with recommendations to Partnership Leadership Executive. - System F&P Committee oversight of the effectiveness of transformation programmes. - Local DoF group meetings to assess financial performance and financial risks and identify options for managing in-year financial risk. - Review of financial performance by the West Yorkshire Finance Forum to support financial risk management across the ICS.	Significant new expenditure commitments only relate to operational plan requirements, or for statutory or legal compliance. - Unidentified savings value has reduced with further progress against the £11.4m Plan improvement target.	No progress against the additional savings target of £6.1m. High proportion of current savings are non-recurrent and do not support long term sustainability.		New - Open
2337	28/06/2023	F&P Comm	Enhance productivity and value for money	20 (I4xL5)	9 (I3xL3)	Robert Maden	Robert Maden	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not address the underlying financial deficit and establish a financially sustainable position over the medium term. Following the completion of the planning round for 2023/24, the underlying financial deficit has increased further and therefore this remains a critical risk.	Joint planning process established across the Bradford District and Craven Place which is used to agree operational plan performance trajectories. Business case process to support shared decision making on the use of resources. Expenditure controls in place to limit new expenditure commitments. System transformation programmes established to support demand management. Planning principles agreed which set-out the approach to managing within current resources.	Development of a medium term strategic financial plan to demonstrate the path to recurrent balance. Clarity on the outcomes and financial impact of service transformation work being carried out by Place Priority Programmes to inform the development of the medium term financial plan. Stronger links with BMDC in relation to forward plans to both drive better use of resources and to manage the system impact of decisions taken by Partners.	System Finance and Performance Committee oversight of Place operational and financial planning. System committees (F&P and Quality) jointly involved in business case review with recommendations to Partnership Leadership Executive. System F&P Committee oversight of the effectiveness of transformation programmes.	Significant new expenditure commitments relate to operational plan requirements, or for statutory or legal compliance.	Limited recurrent waste reduction / savings plans in place. Follows the control gap in relation to clarity on the outcomes of priority programmes transformation work which once achieved will enable reporting on the impact of priority programme work.		New - Open
2302	18/05/2023	F&P Comm	Enhance productivity and value for money	20 (I4xL5)	2 (I1xL2)	Andrea Dobson	Grainne Eloi	There is a significant risk of the All Age Continuing Care Service having to make financial redress to patients, their family or their estate, due to care homes applying 'top-ups' to the care costs that should have been met by the service. This will result in reimbursements being made in line with the Financial Redress Policy and SFI's. NOTE: Impact is an estimate based on reimbursement costs of 1 case at £50k plus interest paid in line with Redress policy covering a 4-year period. The interest is currently very high because the RPI has increased rapidly in the last 6 months.	Changes have been made to the AACC letter which notifies patients/families that their care costs will be met by the service and additional costs should not be incurred for healthcare interventions. In future when a patient chooses a more expensive home there will be a clear record of the conversation within the running record and the care home must be able to separate the additional costs from the care costs being paid by the service. In line with the private arrangements policy (NHSE)	Contracts with all care homes identifying a continuing healthcare rate and a list of 'extras' that may be considered at the home, e.g. suite, garden views etc. Notes must identify clearly that a patient has been given alternative care homes where all costs are covered by the service,	Working group set up to look at all assurance and monitor progress.	The issue has been identified and a plan put in place to identify all potential charges. The AACC service has a reimbursement process, documents and letters that are aligned to the NHSE Redress Policy, SFI and also HMRC's reimbursement process.	1. There is a lack of clarity around the contracting arrangements for the area. 2. There do not appear to have been a record of alternative placements kept in the patient's running record therefore the service will not be able to use the private arrangements policy retrospectively.		New - Open

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2215	13/01/2023	Both FPC and QC	Tackle inequalities in access, experience, outcome	20 (I4xL5)	2 (I2xL1)	Mike Woodhead	Robert Maden	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.	Outline Business Care updated. Expression of interest for £90m NHP scheme submitted. Joint Expression of Interest for NHP funding submitted with AGH and BTHFT. Contract with Cygnet to address increased OAPs. Additional staffing and CCTV in place to mitigate impacts upon quality, privacy and dignity impacted upon by the environment. Additional cleaning and maintenance staffing resourced	Uncertainty regarding NHS funding available nationally, & locally. Causes additional cost pressures, additional requirements to verify compliance with good quality & safe services, & future uncertainty due to temporary contract arrangement. Uncertainty of temporary staffing arrangements due to nature of temporary staffing contracts, additional cost pressure to increase CCTV arrangements based on need. Additional cost pressures that are unsustainable to maintain levels of quality.	Ward to board quality assurance and oversight structures in place to identify, manage and action any emerging issues relating to quality and safety within inpatient services. Daily Lean Management, oversight of incident trend and themes, feedback from service users and staff, all triangulated with audit and quality visits. GO see framework and reports up into Quality Safety Committee and Board. Maintenance work funded through revenue and capital budgets. Oversight of occupancy and bed numbers in relation to safer staffing levels available, ability to deliver safe care maintained on a daily basis. Agreement in 2019 to reduce beds on Ashbrook from 25 to 21 to mitigate ward size and impacts upon quality, safety and recruitment and retention agreed and enacted. Capital works undertaken to create co-horting space to support IPC on 3 wards. Inpatient Clinical Risk Formulation Training and Ligature Risk Training delivered within real time clinical settings with staff teams. Content includes impacts that environment has upon the way risks within the setting presents and therefore the formulation and interventions. Assessment of the environment in the context of the persons clinical presentation and vice versa is dynamically considered and assessed to manage patient safety, privacy and dignity & experience. Inpatient Services engaged in Quality Improvement Initiatives covering the following areas: *Sexual Safety *Reducing restrictive practice	Ward to board quality assurance and oversight structures in place to identify, manage and action any emerging issues relating to quality and safety within inpatient services. Daily Lean Management, oversight of incident trend and themes, feedback from service users and staff, all triangulated with audit and quality visits. GO see framework and reports up into Quality Safety Committee and Board. Maintenance work funded through revenue and capital budgets. Oversight of occupancy and bed numbers in relation to safer staffing levels available, ability to deliver safe care maintained on a daily basis. Agreement in 2019 to reduce beds on Ashbrook from 25 to 21 to mitigate ward size and impacts upon quality, safety and recruitment and retention agreed and enacted. Capital works undertaken to create co-horting space to support IPC on 3 wards. Inpatient Clinical Risk Formulation Training and Ligature Risk Training delivered within real time clinical settings with staff teams. Content includes impacts that environment has upon the way risks within the setting presents and therefore the formulation and interventions. Assessment of the environment in the context of the persons clinical presentation and vice versa is dynamically considered and assessed to manage patient safety, privacy and dignity & experience. Inpatient Services engaged in Quality Improvement Initiatives covering the following areas: *Sexual Safety *Reducing restrictive practice	Ongoing increase in demand to access services, causing additional pressure that are unsustainable on workforce & assurance measures. Increase in cost & maintenance demands causing additional pressures that are unsustainable. Additional pressures that are unsustainable. Additional pressures on workforce that are unsustainable.		Static - 3 cycle(s)
2173	17/10/2022	F&P Comm	Enhance productivity and value for money	20 (I5xL4)	12 (I4xL3)	Robert Maden	Robert Maden	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC will impact on other Place partners. This could affect hospital discharges and the management of winter pressures.	Working with BMDC to understand the issues, options being considered and system impact. Review of use of intermediate care capacity. Partnership Leadership Executive oversight and consideration of options available to minimise impact.	Clarity on Health flexibilities for system support.	System Finance and Performance Committee review of options and system impact.	Initial session held by system DoFs to understand BMDC position and options already considered to manage the position. Follow-up session on the 25th October. Winter Plan being finalised to help manage system pressures. Additional national discharge / social care funding of £500m announced.	Value of and guidance on additional discharge / social care funding allocated to Place.		Static - 4 cycle(s)
2171	17/10/2022	F&P Comm	Enhance productivity and value for money	20 (I4xL5)	9 (I3xL3)	Robert Maden	Robert Maden	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not address the underlying financial deficit and establish a financially sustainable position over the medium term as we exit the pandemic	Joint planning process established across the Bradford District and Craven Place. Business case process to support shared decision making on the use of resources. Expenditure controls in place to limit new expenditure commitments. System transformation programmes established to support demand management.	Completion of prioritisation framework for use of Place resources. Development of a medium term strategic financial plan to demonstrate the path to recurrent balance.	System Finance and Performance Committee oversight of Place operational and financial planning. System committees (F&P and Quality) jointly involved in business case review with recommendations to Partnership Leadership Executive. System F&P Committee oversight of the effectiveness of transformation programmes.	Significant new expenditure commitments relate to operational plan requirements, or for statutory or legal compliance.	Limited recurrent waste reduction / savings plans in place.		Closed - Risk no longer relevant to the CCG
2170	17/10/2022	F&P Comm	Improve healthcare outcomes for residents	20 (I5xL4)	12 (I4xL3)	Robert Maden	Robert Maden	CAPITAL AVAILABILITY There is a risk that NHS capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments.	Capital priorities included in the West Yorkshire ICS capital infrastructure strategy. Place organisations represented at the West Yorkshire Capital Working Group. Impact of new CDEL cover requirements for leases in relation to local developments raised with ICB DoF and NEY DoF	Lack of certainty over future NHS capital spending limits in light of economic circumstances. Lack of clarity on how the impact of capital cover for leases will be incorporated into the NHS capital spending limit and how this will affect the ICS.	Capital requirements for strategic developments clearly set out in business case proposals for owned and leased assets.	Major strategic developments are recognised and included in the Wy ICS capital infrastructure strategy.	Recent developments will need to be highlighted for inclusion in the WY capital infrastructure strategy once Place commitment is clarified.		Static - 4 cycle(s)

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2082	28/07/2022	Both FPC and QC	Improve healthcare outcomes for residents	20 (I5xL4)	1 (I1xL1)	Vickie Milner	Grainne Eloi	The Personalised Commissioning department are currently holding a backlog of reviews with regard to individuals who are eligible for Fast Track, Continuing Healthcare funding and funded Nursing care. There is also a backlog of cases waiting completion of Decision Support Tools following a referral for an assessment of need against the NHS National Framework for Continuing Healthcare and funded Nursing Care. The impact on quality is with regard to inequity within the CHC process due to long waits for an eligibility assessment and some individuals remaining in the service who are no longer eligible. This backlog also has a direct impact on the allocation of finances and care provision across the local system. This may result in individuals receiving a care package that is over/under resourced and/or one they are not eligible for. The HCP is not currently carrying out it's statutory duties with regard to the application of the National Framework for Continuing Healthcare and funded Nursing care.	The situation is being monitored through: - Weekly updates through the HCP Quality Team and HCP Business Intelligence Team - Monthly updates through the Adult CHC Oversight Group - PCD clinical managers are monitoring the situation on a weekly basis within the PCD. - Individual cases are prioritised based on their clinical risk and location e.g. Individuals who are impacting on hospital discharge/patient flow are assessed as soon as possible and an identified PCD Nurse has been allocated to complete this work - Monthly patient level data sets are being sent into the DHSC & NHSE Quarterly reports are presented to NHSE	- NHSE North and West Yorkshire ICS Chief Nurse has been notified of the current backlog status - PCD have employed 3 additional Band 6 nurses through an agency to complete Decision Support Tools - PCD are in discussions with Liaison Care to re-commence the DST work they undertook earlier this year - An external, joint commissioned service review utilising Kaizen methodologies is nearing completion which is supporting the Bradford PBP team and Local Authority to revise the CHC pathway and process change. The Bradford Place System Quality Committee is aware of the challenges, including newly developed KPI's that will be reviewed monthly at SQC	- streamlining of the CHC process has begun, clear management structure, Processes developed and training for clinicians around DST and checklist, custom and practice and ensure a Lean new process map which should prevent delays - Once revised process is embedded, PCD will request a re-audit the CHC service - The Senior clinical commissioning manager will liaise closely with the NHSE CHC Regional team and ICS CHC Lead Nurse to ensure they are sighted on our activity.	- Individuals are being informed of the referral and subsequent delay in the completion of the Decision Support Tool by letter - Using the newly commissioned reporting system, the CHC weekly activity has been revised in order to determine length of wait against clinical activity - Clinical staff have been given KPIs around activity to enable PCD managers to identify and resolve issues causing delays within the service processes Following the Service review, a plan is in place to revise current process which includes a training programme to educate staff with regard to the Continuing Healthcare process and eligibility 25 May 2023 - Liaison Care commissioned to completed 220 DST - Outstanding DST 198 - 28 Day KPI 68 waiting over 28 day and 2 waiting over 12 weeks this has decreased significantly. Streamlining of policy and introduction (docmail) of new technology will support the transformational change and reduce labour intensive process. Recruitment for 4 band 6 nurses with start dates and a further 5 band 5 adverts, 3 Band 6 nurses and 1 band 6 children's. Fast Track reviews 80 completed 66 triggered for full assessment, new fast track process implemented 24 March 2023 - Work is ongoing with regard to revising internal process to increase efficiencies within team activity. Liaison Care Group have been re commissioned to complete further CHC reviews and recruitment is ongoing to recruit 10 registered staff to bring staff capacity back to original levels. Partnership working continues and current process mapping is	Agency staff are being accessed in order to reduce the backlog in new referrals and review activity. Evidence within the data collection going forward may suggest additional permanent staff resource is necessary to maintain the high demand on the service from the system Newly eligible individuals who are in need of home support will place further demands on independent agency provision which is already noted as risk 2045 The PCD will undergo transformational changes within it's process whilst carrying out it's day to day business, this may impact on the quality of service delivery resulting in a rise in formal complaints 24 March 2023 - Work continues developing the Joint CHC dashboard between ICB Bradford and BMDC. Data cleansing on the new CHC adam system has highlighted some unsafe data that was previously being shared and this is now being resolved through changes within the data capture and team processing of information. 21 November 2022 - Transformational change continues within the team and it's processes. Engagement with stakeholders is occurring when appropriate. A reporting dashboard is being developed alongside Bradford local authority to ensure data is shared and there is agreed interpretation of the data collected. 14 Sept 2022 - PCD managers have began to identify changes to the team structure and ways of working. All staff have been given assurance that their terms		Static - 5 cycle(s)
2266	03/04/2023	BDC PLT	Tackle inequalities in access, experience, outcome	16 (I4xL4)	4 (I2xL2)	Emma Hughes	Christina Holloway	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. £200,000) 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.	Not currently formally communicating across the system around right to choose- as if we did this route for assessment would increase. Work taking place on the current backlog - long waits in services, appear to correlate with an increase in this route. Shared issue across West Yorkshire and work due to take place around a joint approach and tariffs.	A sustainable model of delivery of ND assessments across children and adults.	Escalated to SRO of Autism- Fazeela Hafejee Escalated to Director of Finance Place ICB Will be included in the system ND business case approx August 2023	All invoices are checked to ensure no VAT added and to ensure on NHS framework	An unknown and unbudgeted cost- this is arranged via GP and provider with no ICB oversight until assessment is completed.		Static - 1 cycle(s)
2220	23/01/2023	F&P Comm	Enhance productivity and value for money	16 (I4xL4)	9 (I3xL3)	Claire Kilburn	Louise Clarke	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	Review prescribing budget and review all concession drugs and price changes on a monthly basis. If any actions can be undertaken to reduce the financial risk these are implemented. Messages are being shared with prescribers, pharmacies and patients to support cost-effective alternatives where possible. A prescribing QIPP plan is being implemented to offset prescribing growth We are working with primary care to improve the quality and number of structured medications reviews that can rationalise prescribing and improve cost effectiveness. We are implementing national recommendation on overprescribing to reduce unwarranted polypharmacy.	QIPP plans will take time to implement and may be offset with future price changes. Data on prescribing is released 3 months in arrears creating a lag in time to respond to any fluctuations in spend. Mar 23 - Cost pressures on the prescribing budget are continuing to rise more than anticipated and financial impact for 22/23 has increased. Cost pressures due to price concessions (temporary increases in the price of drugs granted by DHSC) and price increases were £719k in Dec 22 and estimated £530k in Jan 23 compared with £119k in April 22. Overall costs for the first 8 months are 4.8% higher than last year (there is a corresponding increase in items prescribed). The OECD estimate that inflation will fall back to 4.6% next year but due to delays in cost pressures being reflected in the drug tariff it is anticipated that the full impact of 22/23 inflation has not yet fully materialised. Conservative estimates suggest an increase of around 5% next year and in light of the proposed uplift of 2.4% in prescribing for 23/34 it is almost certain that there will be a significant deficit which will have to be met locally.	Review prescribing budget and review all concession drugs and price changes on a monthly basis with oversight from the Commissioning of Medicines Group. Any risks flagged with finance team as a cost pressure.	Monthly prescribing data Ongoing discussions with finance across the ICB	Data on prescribing is released 3 months in arrears		Static - 2 cycle(s)

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2039	11/07/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	6 (I3xL2)	Emma Hughes	Christina Holloway	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 Ofsted/CQC local area SEND inspection held in March 2022.	Local sign off of WSOA metrics September 2022. WSOA presented for sign off by Ofsted and CQC. With on-going monitoring by DfE and NHSE Regular updates at: PLT, System Finance and Performance Committee and Systems Quality Committee CYP neurodiversity business case delivery group CYP autism project team meetings Patient Tracking List	Despite outsourcing of c1000 assessments the waiting list has continued to grow as a result of unprecedented referral numbers.	WSOA developed to review current service provision and support available to families whilst cyp on the waiting list. Minutes of PLT Minutes of Systems Finance and Performance Committee Minutes of System Quality Committee Action log from CYP neurodiversity business case delivery group Full engagement in the ICB led deep dive on autism and ADHD pathways	The patient tracking list (PTL) gives us oversight of the Autism/ADHD waiting list across all service providers. The autism project manager has oversight of the outsourcing of assessments to external providers both as a result of the 2021 business case and additional capacity bought by our NHS providers where funding slippage has been identified. On-going validation of all long waits continues and reasons for delays in accessing assessment have been established which include family choice to delay or clinical decision. Providers are challenged and asked to review all exceptionally long waits. A monthly short-term ND oversight group is being established to provide a dedicated space for tracking progress and identifying any barriers to achieving the WSOA targets.	Referral numbers continue to increase, impacting on our ability to deliver a reduction on the overall waiting list numbers. The PTL continues to be developed manually on an Excel spreadsheet. We continue to seek support from CAER (DATA1 project) to develop an electronic system which will combine the data from our three providers.		Static - 5 cycle(s)
2227	02/02/2023	Both FPC and QC	Tackle inequalities in access, experience, outcome	15 (I3xL5)	6 (I3xL2)	Walter O'Neil	Fazeela Hafejee	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 quallity and outcomes between NHS and IS providers of ADHD Assessment/Diagnosis services.	Occasional updates to the assurance committees including FPC, QC, PLT and Healthy Minds PB. Non-recurrent funding to - enhance service staffing, outsource 250 referrals from BANDS to clinical partners - ended March 2023	Healthy Minds PB to explore and determine key options to deliver a sustainable adult ADHD service. No identified clinical lead for Adult ADHD Pathway No agreed Adult ADHD strategy or plan to address growing demand/capacity gap and revise Adult ADHD Pathway	Briefing on current state of BANDS adult ADHD to PLT - March 2023 Briefing and initial proposals to be presented to Healthy Minds PB - July 2023 Monthly data reporting to commissioners.	Briefing on current state of BANDS adult ADHD to PLT. Briefing and initial proposals to be presented to Healthy Minds PB. Monthly data reporting to commissioners.	KPIs for the service are being revised and reporting will be improved. Project group under the Healthy Minds PB to be established.		Static - 2 cycle(s)
2168	17/10/2022	F&P Committee	Improve healthcare outcomes for residents	15 (I3xL5)	4 (I2xL2)	Robert Maden	Kerry Weir	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."	System F&P Committee meets bi-monthly and planning now undertaken on a system footprint. System performance and recovery dashboards in place Transformation programme's supported to monitor delivery and impact upon performance 13/04/23 Recovery plans submitted as part of 2023/24 operational planning process. Delivery will be monitored via SF&P 05/06/23 Recovery plans being built into SF&P dashboard. Work underway with priority programmes to identify key metrics to demonstrate delivery of programme objectives and contribution towards national targets	Approach for monitoring and evaluation of service improvements/business cases needs agreeing Data quality issues have some impact on robust reporting and assurance. National targets/plans not yet necessarily 'owned' by all system partners/AaO programmes. Not clear if ability to review performance at a place based system level via national data/reporting mechanisms will continue in the medium to long term once ICBs are full established. "	Provider performance monitoring via Trust performance groups Monitoring of system performance at SFPC Monitoring of provider quality performance at SQC Monitoring of transformation programme work/outcomes at Health & Care Partnerships	Recovery plans submitted Dashboard showing good progress against plans	Impact of Covid moving forwards is unclear. Still some impact on activity and workforce. Significant backlogs remain in terms of waiting lists/times for services.		Static - 4 cycle(s)

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2221	26/01/2023	BDC PLT	Tackle inequalities in access, experience, outcome	12 (I4xL3)	8 (I4xL2)	Duncan Cooper	Sohail Abbas	Failure of the Reducing Inequalities Alliance (RIA) to support and coordinate action across organisations and programmes of the BDC partnership to reduce health inequalities. Due to lack of: [1] engagement and buy-in from wider partners, seeing the remit of the Reducing Inequalities alliance to healthcare alone leading to limiting the potential of RIA to become the system learning and coordination space, [2] reduced influence of the RIA to ensure that inequalities become a golden thread through all programmes, [3] governance and RIA membership and core team capacity to turn analysis into identified action & evaluation of the impact, [4] reduction of specific inequalities funding streams (e.g Core20PLUs5, RIC, health inequalities practice premium) due to system financial pressures. Resulting in Health inequalities getting wider. This has also been influenced by the COVID19 pandemic and continues to be influenced by wider socio-economic inequalities	Reducing Inequalities Alliance network. Defining key metrics for reducing inequalities (measuring impact). Clarity of inequalities funding streams (budget forecast, external or bottom line).	Working to engage partnership further outside health and social care We have not yet agreed across the BDC partnership priorities what the key metrics are (to reduce inequalities within)	Reducing Inequalities Alliance regular network meetings (monthly), deep dive workshops, website and newsletter, RIA core team. BDC partnership dashboard /metrics. Core20PLUS5 place based group, and RIC steering group.	Reducing Inequalities Alliance regular network meetings (monthly), deep dive workshops, website and newsletter, RIA core team. BDC partnership dashboard /metrics. Core20PLUS5 place based group, and RIC steering group.	RIC funding ends march 24 (currently agreeing BAU), core20 budget agreed in principle by WY ICS to 25/26 but current amount not guaranteed for each year or post 25/26		Static - 2 cycle(s)
2169	17/10/2022	F&P Comm	Improve healthcare outcomes for residents	10 (I5xL2)	9 (I3xL3)	Robert Maden	Robert Maden	ELECTIVE RECOVERY FUND CLAWBACK There is a risk that some of the elective recovery funding included in all Place organisation's plans is clawed back by NHS England due to actual elective activity being less than plan.	Finance and performance reports to System F&P Committee. Process in place to maximise the use of elective capacity (NHS and independent sector) in relation to available workforce.	Lack of clarity over national calculation methodology to quantify the impact of actual elective activity on ICB funding.	"Provider performance monitoring via Trust performance groups Monitoring of system performance at SFPC Financial risk assessment included in finance report.	No clawback of funding for H1 confirmed. The indications are that there will be no clawback of funding for H2, but this has not formally been confirmed. Once this has been confirmed the risk will be closed.	None		Static - 4 cycle(s)
2050	15/07/2022	BDC PLT	Tackle inequalities in access, experience, outcome	10 (I5xL2)	10 (I5xL2)	Simon Wilson	Simon Wilson	DUAL DATA CENTRE RESILIENCE Linked to risk 1735 (to be updated to include VDI Desktop slowness experienced) Following the upgrade to Windows 10 there is inadequate computing resource (across our 2 Data Centres) to deliver the required level of failover / resilience required (as previously enjoyed under Windows7). This means that should key equipment fail at either one of the Data Centres then all of the affected users will not be able to connect to another Data Centre and in turn will be unable to use their full Clinical and user desktop. It may result in a reduction in the number of people who could be seen in General Practice, introducing Clinical Risk, place additional stress on the GP workforce and in turn create pressures elsewhere in the place and potentially wider system. Patient experience could be equally impacted and current (nationwide) levels of media attention re provision of GP Services could see a focus on Bradford District and Craven, impacting on Public Relations and reputation. By way of explanation (figures are indicative but not exact - within a 10% tolerance): prior to Windows 10 both Data Centres (one in Calderdale Royal Infirmary and one in Huddersfield Royal Infirmary) provided capacity for circa 2000 users per Data Centre (so 4000 users across the 2) with the daily average number of concurrent users (the number of users logged on at any one time) across both Data Centres being circa 1900-2100. The level of resilience provided at that time therefore would allow almost all users from say Data Centre A to move to Data Centre B in the event that Data Centre A experienced a catastrophic failure. Data Centre B would have sufficient capacity to handle approximately 80-90% of the overall (combined) user base.	Please see previous BD&C Risk Narrative for history of controls initiated at the outset of this risk. We have now completed install phase of the Data Centre Upgrade which will deliver additional computing resource and increase overall resilience (although this is based on current intelligence in the main). We now enter the Optimisation Phase(2-3 months) where the infrastructure is tuned and optimised. Performance improvements will be released immediately and enhanced over the period of Optimisation.	There is no documented plan for Optimisation as this is to be developed now that both Data Centres have been upgraded and released into Production (go-live). Performance will be monitored on a weekly basis and adjustments made to 'tune' and 'optimise' the environment based on usage patterns.	Channel3 remain engaged and working closely with THIS specialists. Channel3 liaise with TSSM as appropriate. The THIS monthly usage reports are shared and reviewed by the Digital Reference Group on a monthly basis. Performance statistics have been shared following installation of the Data Centre Upgrades and will continue throughout the period of Optimisation. These will be shared with the Digital Reference Group who will monitor and provide feedback on performance improvements.	Early evidence from the release into Production at both Data Centres is positive. The monthly usage reports are comprehensive, consistent and easy to digest. No significant issues (as assured by our 3rd party specialist Channel3) are envisaged in the Optimisation phase.	Optimisation plans have not been shared.		Closed - Reached tolerance

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Target Risk Rating	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	Risk Status
2053	15/07/2022	BDC PLT	Tackle inequalities in access, experience, outcome	9 (I3xL3)	3 (I3xL1)	Simon Wilson	Simon Wilson	Revised following CCG Closedown: INFORMATION SYSTEM COMPROMISE (Specific Issue - linked to 2052): There is a risk of information system compromise due to a vulnerability (Log4Shell) found in a widely used piece of software (Log4j) across many trust information systems and infrastructure resulting in the possibility of cyber attackers stealing password/logins, stealing data and infecting systems/networks with malicious software/viruses. This is a national risk being coordinated by National Cyber Security Centre (NCSC), NHS Digital (NHSD) and locally across WYICB.	Next Generation firewalls using advanced protection to detect and deter potential attacks and to block known internet locations where attacks originate from. Next Generation/AI based network defence software. Next Generation Antivirus with Log4j mitigations. Web Application Firewall to protect external websites (non currently have vulnerability) NHSD provided central detection and reporting through Advance Threat Protection. NHSD driving patch releases nationally with all suppliers. Patching of systems as manufacturers make these available. All systems have now been identified where Log4Shell is used.	Some manufacturers have not released patches yet.	Continue to investigate with internal and external systems and infrastructure providers/manufacturers. Work closely with NHSD, NCSC and other WYAAT/ICB organisations to combine findings/knowledge Communicate to end users about email safety to avoid phishing exploitation Key infrastructure is being patched as patches are released. System suppliers are providing updates and timelines for systems where patching is not available.	No known effect of attempted attacks experienced locally to date since this particularly vulnerability was identified. NHSD providing regular updates. All local Cyber Specialist are active members of the Cyber Assurance Network Local Cyber Specialists are working together and sharing intelligence / offering support as required	Awaiting plan from suppliers who have not yet shared a patch. NHSD recognise that this threat may exist for 12 months or more.		Closed - Duplicate (please link to original risk)
2045	12/07/2022	Both FPC and QC	Tackle inequalities in access, experience, outcome	9 (I3xL3)	1 (I1xL1)	Vickie Milner	Grainne Eloi	Procurement and commissioning of Independent care providers is becoming increasingly difficult due insufficient capacity in the independent sector provider market to pick up packages of care for adults, children and young people, funded through NHS CHC, particularly those with more complex/ challenging need. In the past, council contracts have been designed to deliver standard council support in the main rather than NHS needs	The situation is being monitored through the CHC Oversight Group and PCD managers are monitoring the situation on a daily basis within the PCD. Children's' HCP commissioners are exploring what the service offer for children and young people needs to be in the future.	The children's commissioners need to complete their service review as soon as possible with BTHfT. We have informed families that we are limited to the providers we can approach due to capacity in the system. We are offering Direct Payments to families as standard within the PCD.	Updates on the service review are being provided through the CCG's ALT/SLT and PCD Oversight Groups. PCD is linked in with the Local Authority to broaden availability of providers.	25 May 2023 - Rapid improvement group has commenced weekly on a Monday to look at service improvements 24 March 2023 - Following invitation by Walter O'Neill, PCD have been working with Bradford Local Authority in reviewing the adult locality framework for homecare to identify and establish establish low level health care provision within the new framework. Children's commissioners continue to explore what the service offer for children and young people needs to be in the future. 21 November 2022 - Two temporary clinical staff have been employed to support the Children's continuing care activity. BTHfT are considering use of some of their staff vacancy budget to financially financial support this. Walter O'Neill has invited PCD into Bradford Local Authorities review of the adult locality framework to formally establish health care provision within the new framework. Children's commissioners are continuing to explore what the service offer for children and young people needs to be in the future. 14/09/2022 Recruitment is underway for the Band 4 healthcare assistant. Delays in the recruitment process have occurred due to organisational changes and agency cover has been agreed as an interim measure until the vacancy is filled. 11/07/2022 PCD continue to case manage children on behalf of BTHfT and are currently recruiting into a Band 4 post to assist with Children's Continuing Care	BTHFT recruitment of staff to support the complex care for children in the home continues, with the trust attempting to recruit 17 times in the last 2 years. • Partnership stakeholder engagement in potential solution required • Care coordination gap currently managed by PCD is unsustainable • Family/carer engagement to support addressing a solution 24 March 2023 - Children's commissioners continue to explore what the service offer for children and young people needs to be in the future. Review waiting lists continue until staff resource is increased through successful recruitment. 21 November 2022 - Review waiting list remains in place until additional temporary staff have been recruited into post within the next couple of weeks. 14/09/2022 a waiting list remains in place with regard to children's continuing care reviews while PCD support the Children's Community Continuing Care Team with case management and the sourcing care providers.		Static - 5 cycle(s)
2037	07/07/2022	QC	Improve healthcare outcomes for residents	8 (I4xL2)	4 (I4xL1)	Claire Kilburn	Parveen Akhtar	HYDROXYCHLOROQUINE MONITORING There is a risk of retinopathy in patients taking hydroxychloroquine long term (which has been found to lead to permanent sight loss in a small number of cases), due to a lack of a commissioned service across the Bradford District and Craven to screen such patients and difficulties in identifying the patient cohort, resulting in failure to meet Royal College of Ophthalmologists recommendations and potentially resulting in patient harm and HCP liability. [NOTE: the Retinopathy service is commissioned by NHSE, however, the ICB commission the prescribing of the drug and any monitoring requirement would fall to us. This risk was added to the RR following a discussion at the WY&H Head of Meds Opt meeting]	Flagged to service managers to consider commissioning an effective service	A suitable service for screening requires commissioning.	Ongoing discussions with providers	Sept 22 - Chris Balson is having ongoing discussions now with a potential community provider. Oct 22 - Update from Chris - agreed a financial value in principle with the provider , and service specification is currently out for review with clinical leads in our place Once that is back and any amendments agreed we will look to let the contract with the provider at the earliest opportunity There is still some process issues that will need to be agreed, e.g. referral routes both in and out of the provider, but hopeful all can be resolved in approx. next 4 weeks Nov 22 - contract is not quite yet in place, so risk remains until this has been completed. Jan 23 - Service specification has been written, reviewed and accepted, going for site visit w/c 30th Jan and final contract discussion with service, hopeful to commence shortly. Mar 23 - small delay to service start. Expected within weeks. May 23 - small delay due to IT. Expected imminently.	Jun 23 - service ready for referrals. Risk likelihood reduce for now. Once assurance has been obtained that patients are identified, referred and have started to be seen we can close this risk.		Decreasing

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Target Risk Rating	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	Risk Status
2222	26/01/2023	BDC PLT	Improve healthcare outcomes for residents	6 (I3xL2)	4 (I2xL2)	Adam Cole	Helen Farmer	There is a risk of the entire urgent care system including urgent primary care appointments seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would also be likely to impact workforce further reducing the system's ability to deal with the excess demand.	ARI hubs funded from national funding and BD&C winter funding are providing over 800 additional appointments per week across BD&C and over 9000 additional appointments over a 6 month period. These will be provided via BCA, WACA and modality. ACE project and Virtual Wards provide further robustness for the system including discharge to improve flow. Children's Acute Treatment Hub also established to provide additional 17-30+ appointments per day in Bradford.	Public behaviour driving demand, presenting at place of least resistance, 111 being overwhelmed so less direction within the system to the right place therefore additional public comms required to direct people to appropriate use of system resources. Limited availability of care beds continues to provide a challenge for discharging patients in a timely manner. Lack of alternatives in urgent care in BD&C system	ARI hub appointments are providing huge additional resource and metrics are being monitored and reported back into NHS E and UEC board to ensure they are working and fully utilised. Ongoing monitoring of demand and capacity with teams to provide rapid improvements where required. Additional funding now available from the discharge fund to support care sector.	Ongoing monitoring being done by: Assurance returns to NHSE Surge and Escalation meetings Urgent Care Board System Finance and Performance and System Quality Committees	These are new initiatives that are already being used to capacity and the system still experiences pressure, further work will need to be done over the coming months to mitigate this risk.		Decreasing
2040	11/07/2022	Both FPC and QC	Tackle inequalities in access, experience, outcome	6 (I3xL2)	3 (I3xL1)	Ruth Shaw	Karen Dawber	0-19 SERVICES: POTENTIAL NEGATIVE IMPACT ON OTHER HEALTH SERVICE DELIVERY There is a risk of negative impact on health services due to reduced capacity within redesigned health visitor, school nursing and oral health services resulting in inappropriate referrals to other services due to lack of early help and/intervention and increased waiting lists.	CBMDC 0 - 19 services were subject to a WSOA in the Ofsted/CQC SEND inspection which took place in March 2022 which highlighted inconsistent delivery of 0 - 19 and school nursing services, along with ICB commissioned specialist nursing services. This resulted in the development of a response to the WSOA which outlines our planned service improvements and has the support of BD&C HCP. CBMDC public health have taken a decision to increase their investment in the 0 - 19 services by c£1m and delayed their re-procurement by a year. Partners worked with public health to develop a revised service specifications to reflect this new investment through increased workforce capacity. As a result of the SEND WSOA partners are working together to review the early help and prevention offer for children and young people to identify and address gaps in provision and to align service delivery pathways with oversight via the pillars of the CYP&F Programme Board and the SEND Strategic Partnership Board.	There was a possibility that despite additional funding BDCFT would not be able to recruit the required staff and caseload numbers would increase and existing staff would seek alternative employment. We recognise that without increased capacity in the 0 - 19 workforce proposed service developments could not be delivered with the potential we could continue to see inappropriate referrals into other health services	Continued dialogue between partners about the need to take a pathway focused approach to the delivery of healthcare across Bradford district and Craven. Health related elements of the response to the response to the SEND WSOA are being dual reported via the CYP&F Pillars and the workstreams of the SEND Strategic Partnership board. This includes updates and oversight of BDCFT progress in recruitment and retention.	BDCFT have successfully recruited to the new posts they were able to create as a result of the increased investment. Through the work to respond to SEND WSOA3 the BDCFT 0 – 19 team have made significant improvements in the achievement of key performance indicators	Conversations are on-going to understand the reporting mechanisms for the BDCFT 0 - 19 service within the Children's Services system governance arrangements.		Decreasing
2051	15/07/2022	BDC PLT	Tackle inequalities in access, experience, outcome	5 (I5xL1)	5 (I5xL1)	Simon Wilson	Simon Wilson	Previously 1735 (@ CCG), reworded: Computing Resource Demand Management This originated in early 2021 when the CCG at the time was alerted via a call with TPP that a new release of functionality in SystmOne was imminent. The release was to include the record of all COVID Tests done (both positive and negative results) and this functionality would consume a significant amount computing power, mainly memory (RAM) resources. This was outside the immediate control of the then CCG and there was a risk that the current computing power / resources available to the then CCG would not be able to handle this new (additional) requirement. If we could not meet the requirement it would mean that not all users would be able to log on to the environment and consume services in a timely manner, adding delay to the user experience and in extreme case some users would not be able to log on. If this occurred the result would likely lead to a reduction in the number of people who could be seen in General Practice, place additional stress on the GP workforce and in turn create pressures elsewhere in the place and potentially wider system. Patient experience could be equally impacted.	THIS closely monitor the computing resource usage and identify peaks and troughs and activity, these are reported to BD&C Place on a monthly basis. We hold regular Account Meetings with the TPP Account Management Team and have direct links to TPP Directors. We have excellent and now longstanding links with the NHSD TSSM Team (Paul Slater) who are naturally somewhat closer to national initiatives / developments. We have now completed install phase of the Data Centre Upgrade which will deliver additional computing resource and increase overall resilience (although this is based on current intelligence in the main). We now enter the Optimisation Phase(2-3 months) where the infrastructure is tuned and optimised. Performance improvements will be released immediately and enhanced over the period of Optimisation. We have engaged UKCloud to help us define a future Technology Strategy for Primary Care utilising the flexibility of Cloud hosting that would allow us to better react to increased compute demand whether that be temporary or permanent	We do not have adequate visibility on the future TPP Roadmap that would allow us to better plan aligned with current NHSE Capital Investment timelines. Similarly this applies to a number of 3rd party applications that are used by General Practice.	The THIS monthly usage reports are shared and reviewed by the Digital Reference Group on a monthly basis. Performance statistics have been shared following installation of the Data Centre Upgrades and will continue throughout the period of Optimisation. These will be shared with the Digital Reference Group who will monitor and provide feedback on performance improvements.	The monthly usage reports are comprehensive, consistent and easy to digest. The Phase 1 Data Centre Upgrades are complete. No significant issues (as assured by our 3rd party specialist Channel3) are envisaged in the Optimisation phase.	We require comprehensive assurance from TPP (SystmOne) and all other key suppliers in relation to their roadmaps for development and release.		Closed - Reached tolerance

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Target Risk Rating	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	Risk Status
2047	12/07/2022	Both FPC and QC	Tackle inequalities in access, experience, outcome	5 (I5xL1)	1 (I1xL1)	Vickie Milner	Grainne Eloi	DOLS in PCD FUNDED CASES Risk of legal challenge against the HCP and potential harm to patients due to unauthorised Deprivation of Liberty (DoL) in PCD funded community cases resulting in reputational and financial damage. Where people are deprived of their liberty in their own homes as a result of PCD funded packages of care, the CCG is responsible for seeking authorisation from the court, however the court has a large backlog and these cases are outside the scope of the existing Deprivation of Liberty Safeguards (DoLS). This is a nationally recognised problem and Local Authorities and HCPs across the country are taking a risk management approach to prioritise only the most contested cases. The planned Liberty Protection Safeguards (LPS) aim to provide a statutory process for CCGs to authorise CHC funded cases, without the need for court proceedings, this activity has now been paused.	The PCD use a risk management approach to identify cases where there are significant objections or unresolved areas of disagreement relating to the persons deprivation of liberty which are then prioritised for legal advice. Where necessary, an approach is made to the court of protection to authorise the deprivation of liberty. The PCD has a clinical lead in post and established systems for identifying potential DoL in CHC cases. Case numbers are monitored by the PCD.	There is insufficient resource within the PCD to progress all identified cases of DoL and to undertake preparatory work for the court of protection. There is also a lack of capacity within the Court of Protection nationally to deal with even the current number of cases raised by HCPs and LAs.	LPS National Guidance has been published and activity regarding the resourcing and identification of process is being led by Matt O'Connor. This is now paused	12/07/2022 Active monitoring of cases continues on a weekly basis and court activity occurs as necessary. 14/09/2022 No change in position with regard to monitoring and managing this caseload. Activity is occurring on an as necessary basis 29/11/2022 Court of Protection activity continues to occur on an as necessary basis when a Deprivation of Liberty or best interest decision is challenged 24/03/2023 No change in position with regard to monitoring and managing this caseload. Activity is occurring on an as necessary basis and we still await the national guidance on the changes to process/procedures 25/5/2023 Clinical lead has been released from CHC work to prioritise the Community DOL's, currently prioritising the cases and will undertake the DOL's assessment feeding back weekly to managers with caseload.	25/05/2023 Looking at training for Nurses to undertake BIA assessor course to increase the resource within the team. 12/07/2022 PCD's ability to report remains unchanged whilst the team continue to transfer data across to it's new reporting system (adam) 14/09/2022 PCD are still progressing the data input into the new information system. reporting capability on this caseload remains unchanged and limited at present. 29/11/2022 All data has been added to the new information system and is currently being validated. A reporting process that captures all Court of Protection activity is being developed and once completed, this will allow reporting on all activity 24/03/2023 Development of activity reporting continues and at present we wait for notice of any national reporting that may be required		Decreasing
2151	11/10/2022	PCAG	Enhance productivity and value for money	4 (I2xL2)	4 (I2xL2)	David D'Arcy	Parveen Akhtar	One PCN has been approved to deliver 1/3rd of the required service within core hours (Enhanced Access primarily delivered in Network Standard Hours i.e. 6pm to 8:30pm weekdays and 9am to 5pm Saturdays). This may lead to further PCN's seeking to deliver a proportion of the service within core hours and therefore risking viability of the main Enhanced Access service delivery for the service for 9 PCN's subcontracting to BCA GP Alliance.	Any requested adjustments to include core hours delivery for Enhanced Access should be evidenced to meet identified patient need. Continuous monitoring, reporting and commissioner oversight over the 6 months service required for the approved PCN.	N/A	KPI's and outcomes of service delivery for the PCN delivering a proportion of service in core hours. Continuous monthly reporting and monitoring of wider PCN's to ensure the standardised Enhanced Access model meets patient needs.	Tailored monitoring and process of evidencing additionality for the core hours service currently in development.	Unique monitoring and evidence approach yet to be confirmed.		Closed - Risk no longer relevant to the CCG
2152	11/10/2022	PCAG	Tackle inequalities in access, experience, outcome	1 (I1xL1)	1 (I1xL1)	David D'Arcy	Parveen Akhtar	There is a risk to service delivery within our PCN which would impact of GP contract Management following the de-registration of 8,200 patients within AWC Modality. Patients have yet to be contacted (scheduled for week commencing 17 October) and there is a risk of increased patient concerns and their decision to actively register to alternative neighbouring practices.	Monitoring any exceptional number of patients electing to deregister with Modality over a 4 week period following completion of communications to patients for the incident.	N/A	Weekly updates with AWC Modality. Patient communications expected to complete week commencing 17th October 2022.	Clinical risk were identified and addressed as part of the re-registration process following the incident. No patient harm has been reported.	N/A		Closed - Risk no longer relevant to the CCG

Risks Report Summary

CCG: Bradford District and Craven Health and Care Partn

Archive Deadline: 19/07/2023

New Risks: 5

Total Risks: 28

Old Risks: 23

Marked for Closure: 7

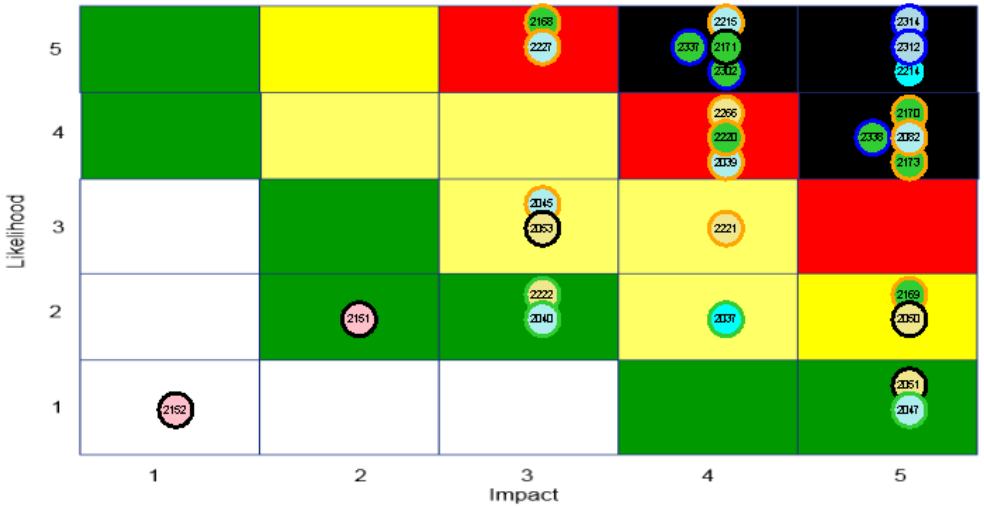
Bradford District and Craven Health and Care Partnership–

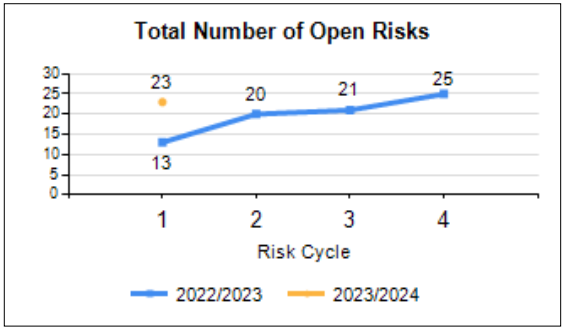
Risk on a Page Report

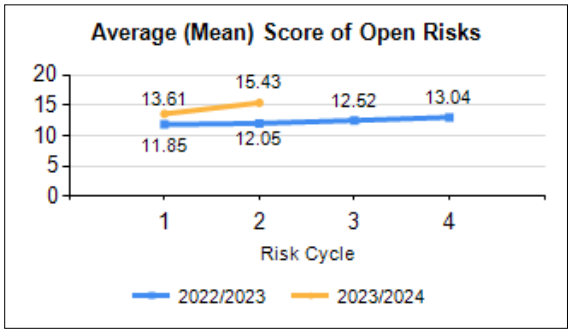
Risk Cycle 2 – May 2023 – July 2023

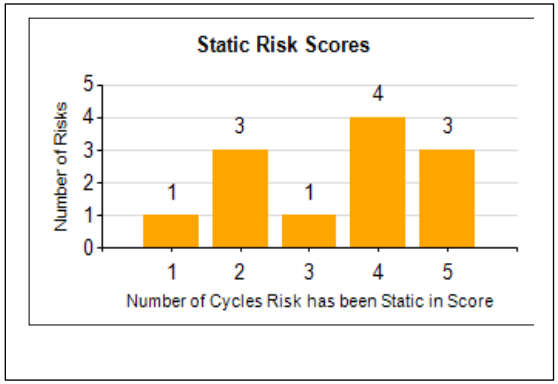
Total Risks	28 (7 closed)
FPC Risks	9 (1 closed)
QC Risks	2 (1 closed)
FPC and QC Risks	7
PC	0
PCAG	2 (2 closed)
PLT	6 (3 closed)
FPC/QC/PC/PLE/PB	2

Movement of Risks		Risk score increasing	0
New	5	Risk score static	12
Marked for closure	7	Risk score decreasing	4









Risk Overview Diagram relates to the current risk cycle

Key

- F&P Comm
- QC
- Both FPC and QC
- PCAG
- BDC PLT
- FPC/QC/PC/PLE/PB

- New Risk
- Closed Risk
- Risk Score Increasing
- Risk Score Decreasing
- Risk Score Static

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
2309	01/06/2023	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	9	(I3xL3)	Keir Shillaker	James Thomas	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 poorer experience and outcomes for CYP and their families	Individual places are utilising increased mental health investment to improve services for CYPMH crisis and eating disorders locally. Across WY there is a joint CYPMH plan seeking to bring partners together to think through joint work on Eating Disorders, Crisis, Transitions and self-harm including identifying gaps in provision and recommendations for future invesment. The WY MHLDA provider collaborative is continuing to develop its working relationships with our places to identify CYP at risk and support early access into RKV when needed	Continued vigilance is needed at place to ensure that investment is going to where it will have the most benefit, including transparency on how funding is utilised and the impact felt between the provider collaborative inpatient provision and place-based community CYPMH services.	Performance across WY on CYP access metrics will need to remain strong, and we would expect to see improvements in Eating Disorder measures and continued low and reducing use of Out of Area placements.	Since the opening of RKV we have seen the number of OAPs drop, although this position does fluctuate, and we have had good local examples of changes in CYPMH provision (ie Wakefield) that have over time moved from more challenging to more stable positions.	The focus on assurance is on those NHSE metrics specific to CYPMH at the more acute end of the spectrum, there may need to be more understanding of the support being held within primary care and within local authority services to triangulate the full pressure on the system.			New - Open
2308	01/06/2023	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	12	(I4xL3)	Keir Shillaker	James Thomas	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.	Individual places are seeking to address ND waiting lists using increased investment where available, and are testing new roles to support people pre and post diagnosis (such as Navigator roles). Across WY we are working jointly to deliver improvements in data collected and reported in ND services and continuing to embed co-production to ensure the voice of the service user informs what we do.	Further discussions are needed with partners beyond the ICB and across wider West Yorkshire society including the education system, local authorities, political representatives and others to understand the scale of the challenge and how we need to radically rethink our current pathways and expectations regarding neurodevelopmental diagnosis.	The current controls are not sufficient to reduce the risk associated with Neurodiversity demand and capacity, though they will help to manage some of the full extent of the demand. Once work has completed on consistent use of data we will be able to use this to compare impact on the waiting list.	There are examples of specific work on waiting lists in our places that have demonstrated an impact, but often these are short-lived. Likewise feedback from service users about some of the navigator and similar roles provides positive feedback on the help provided to people whilst waiting.	We would need to be confident we have got the full support of the whole ICS in identifying and being prepared to respond to the issues presented by the gap in support for our neurodivergent population.			New - Open
2232	09/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	20	(I5xL4)	12	(I4xL3)	Adrian North	Jonathan Webb	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.	1. Oversight at WY ICS Finance Forum, supported by Capital Working Group 2. Utilisation of organisational and place / system risk registers to generate action 3. Risk based approach to prioritisation of operational capital (within our envelope) 4. Risk based approach to lobbying for strategic capital	1. Shared understanding / discussion of the risks arising through the prioritisation process for operational capital.	1. Individual risks flagged through place based risk registers 2. Overview of strategic capital and progress at WY ICB FIPC	1. Presentation of capital information through WY Capital Working Group, and reporting of capital position including forecast and risk highlighted at WY ICB FIPC. 2. Capital position relating to both operational and other capital reported to WY ICB FIPC and WY ICB Oversight and Assurance Group SLT	Assurance provided through WY FIPC.			Static - 2 Archive(s)
2166	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	12	(I4xL3)	Dawn Greaves	James Thomas	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.	Technical and Operational controls, including policies and procedures together with routine monitoring to ensure compliance are in place which meet or exceed NHS Data Security and Protection standards. Dedicated cyber security resource/expertise utilising national alerting and reporting. Regular mandatory data security training (which include this risk area) and updates for staff provided by IG team and Counter Fraud Team (particular focus on the risks from phishing). Monitoring completion of the NHS Digital Data Security Centre Data Security Onsite Assessment Disaster recovery Business continuity plans are in place in the event of a prolonged IT system issue. Cyber war games event being held 26 May with representatives from across the region, to understand the impact of a serious outage and start plan for prolonged periods of downtime.	Investment in replacement of legacy infrastructure. Review of business continuity arrangements due to a successful cyber incident in August 2022 which affected partner organisations critical IT systems.	Annual DSPT self assessment submissions and PEN testing Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	No successful cyber attacks, hacks or data breaches resulting in financial loss, disruption to services or damage to the reputation. Regular phishing exercises and resultant action plans.	None identified			Static - 1 Archive(s)
2120	07/09/2022	Both FPC and QC	Improve healthcare outcomes for residents	20	(I5xL4)	12	(I4xL3)	Jo-Anne Baker	Ian Holmes	There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment, and cuts to existing funding, resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE. For context we have an estimated 11,996 VCSE organisations in WY delivering services and support to local communities reducing pressure on GPs and other health services.	Principle of consideration and investment in the VCSE included in WY Finance Strategy. Paper taken to ICB on VCSE sustainability with recommendations for action at system and place. Recommendations for action accepted and now being considered and implemented. Recent one off investment of £1 million from the ICB has provided some encouragement to the sector and indicates the ICBs commitment to addressing this challenge with more long term, sustainable funding. However, to reduce the risk level there needs to be an ongoing commitment to investment. HPoC has commissioned a review of VCSE infrastructure investment which is almost complete to help inform decision making at place Prioritisation of the VCSE in finance allocation with winter pressures, health inequalities and transformation funding. Finance round table with places and finance colleagues took place in May to consider greater emphasis on social value in contracting and sustainability of funding . Follow up planned.	Control Gaps highlighted as part of the development of the WY Finance Strategy, which includes: - a long term investment model for a sustainable VCSE sector across WY with an identified WY finance lead - delivering on the shift of investment to prevention which includes moving a proportion of budgets from traditional service delivery models to the VCSE sector - re-designing commissioning processes by co-creating them with the VCSE sector - ensuring all place based VCSE infrastructure organisations have sufficient investment at Place - developing shared principles and a plan for how each Programme works with the VCSE sector	Intelligence from HPoC Leadership Group members and VCSE sector commissioned research such as the Third Sector Trends Survey and State of the Sector reports. New data due to be published in June 2023. ICB place based committees oversight HPoC governance structures also provides the space to be sighted on and responsive including VCSE representation on the WY ICB and Place Committees of the WY ICB	VCSE involvement in shaping and influencing ICS strategies and plans. Intelligence from HPoC Board members.	Clarity on total funding provided to the VCSE sector at an ICS and Place level. Currently working with finance colleagues to address this. Lack of insight and data leading to an inability to understand and respond to changes that may impact sustainability of the sector at a local community, Place and ICS level.			Static - 5 Archive(s)
2119	07/09/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I5xL4)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS / ICB will not be able to agree a financial plan for 2023/24 that meets NHS England's requirements not to exceed its revenue resource limit. This is due to the significantly challenging financial environment driven by the local position in relation to the financial underlying position, national efficiency expectations, and ability / capacity to deliver the levels of productivity and efficiency needed to develop a balanced plan. This will result in NHS England intervention, a lower System Oversight Framework (SOF) assessment, reputational impact, and more importantly consideration of actions to live within our means which may impact detrimentally on achieving the ICB's strategic objectives and 10 big ambitions.	The ICB has a number of controls in place 1. Comprehensive reporting and escalating issues to the FIPC and wider ICS/ICB system 2. Investments that are in place or are introduced during the current financial year are affordable, deliver efficiency in the system and are considered as part of wider system investment 3. Functioning WY ICS Finance Forum, and developed and agreed Financial Framework. 4. Escalation of issues for consideration by Board of NHS WY ICB.	1. Working to develop a Efficiency Programme during the current financial year that is in place to reduce costs in 22/23 and beyond 2. Review of the underlying position in a consistent way across the ICB and the ICS, to create a clearer view on gaps, risks and mitigations	1. Efficiency "committees" at place to identify savings in future years; 2. Oversight of finance strategy and medium-term financial planning framework at the WY Oversight & Assurance System Leadership Team and the WY ICB Finance, Investment and Performance Committee	None identified	1/ Full understanding of the ICB underlying position 2/ Creation of draft Medium Term Plans with high level assumptions and sensitivity testing to provide a small number of scenarios of potential future pressures based on variable assumptions of growth, inflation and efficiency.			Closed - End of financial year

2036	07/07/2022	Quality	Improve healthcare outcomes for residents	20 (I4xL5)	9	(I3xL3)	Laura Siddall	Anthony Kealy	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. Severe weather, such as extreme heat or heavy rain or snow, all increase the risk of a RAAC panel becoming unstable and so would result in the ICB having to manage concurrent incidents.	*Airedale NHSFT is undertaking a continuous programme of actions to monitor and manage the risk of RAAC (regular inspections take place and, if issues are identified, actions are undertaken to ensure that the area is safe). * There is a national programme for NHS RAAC sites to ensure that learning and risk is shared nationally and a common approach is taken. * ANHSFT has built a number of modular wards so that patients can be decanted out of RAAC areas while repair work takes place and can be used if areas need to be evacuated. A further delivery of 60 units arrived in Feb 2023. * National funding to build a new hospital for ANSHFT by 2030 was confirmed in May 2023.	- Research into the properties of RAAC, such as flammability, is still ongoing and so there are a number of unknowns as to how resilient RAAC is. - NHS England is leading a programme to develop plans for how the Yorkshire health and care system would manage a partial or full evacuation of the Airedale General Hospital site. WY ICB will be responsible for signing off the regional RAAC system plan. WY ICB is leading the development of a multi-agency RAAC response protocol. Both of these plans are in development and not yet finalised. - Further work is needed to test the ability of plans to react to concurrent incident, for example an evacuation at Airedale Hospital due to a RAAC failure and heavy snow.	Update (23/05/23) An exercise to test the multi-agency RAAC response protocol is taking place on 6 June 2023. This will involve Airedale NHS FT, NHS England, WY ICB, local authorities, police, fire, YAS and other agencies. Update (03/04/23) - Risk likelihood has been increased to 5 to mirror AHFT's rating on their register. An exercise is being organised to test the multi-agency response protocol. Update (25/01/2023) - Risk has been updated following advice from the governance team. A multi-agency meeting with WY Local Resilience partners took place on 30th November to develop the multi-agency response protocol to an evacuation of Airedale Hospital. Work is now beginning ti test this protocol with a multi-agency exercise. Airedale NHS FT has confirmed that the Airedale Hospital building will not be viable beyond 2030. There is no further update nationally on whether Airedale NHS FT will qualify for funding for a new build. NHS West Yorkshire ICB is carrying a risk that there will be the loss of services provided by Airedale NHS FT by 2030 (or earlier if a significant RAAC incident occurs) and no mitigating plans to ensure that services remain available to the Bradford district and Craven population. Winter is a period of heightened risk for RAAC panel failures due to the impact of severe weather.	- The trust's monitoring programme has detected areas of weaknesses at an early stage before significant collapses have occurred.	- The risk of RAAC is difficult to quantify due to unknown information (currently, further research is being carried out into the resilience of RAAC). This makes it difficult for the WY ICB to balance the option of commissioning services from ANHSFT (and exposure to RAAC risk) versus the option of not commissioning services from ANHSFT (to avoid RAAC risk) and the subsequent risk to patient care by overburdening the health system across Yorkshire through reduced capacity. - It is unknown how the public and staff would react if a collapse happened at another RAAC site or part of Airedale General Hospital needed to be evacuated. The public and staff may lose confidence and choose not to attend Airedale General Hospital, putting pressure on the Yorkshire health system.			Static - 5 Archive(s)
2304	26/05/2023	Finance, Investment and Performance	Enhance productivity and value for money	16 (I4xL4)	8	(I4xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS will not deliver the 2023/24 financial requirement of breakeven (with a requirement that the ICB delivers a planned surplus of £25m) which it has agreed with NHS England. The planned surplus represents a 'system risk' for which there is currently no plan to deliver, meaning that the forecast to NHSE from Month 2 onwards will be a forecast adverse variance of £25m. As a system we have until the end of month 6 by NHSE to address the risk and identify mitigations to deliver plan. In addition to the £25m there are c£150m of other unmitigated risks and c£350m of efficiency required to achieve plan (in addition to any new risks that may emerge in year) This is due to the fact that when plans were submitted, no plans existed for the £25m 'system risk', and delivery of the 2022/23 financial position was supported by non recurrent measures, and as such there was an underlying deficit coming into 2023/24. Failure to deliver a break even position will resulting in reputational damage to the ICS/ICB , additional scrutiny from NHS England, a requirement to make good deficits incurred in future year, and potential risks around NHSE financial support which is currently included in 2023/24 financial plans	1. Agreement of West Yorkshire ICS 2023/24 Financial Framework by all NHS organisations setting out arrangements in place to manage financial risk 2. Delegation of resource to five places supported by robust budget setting at place through planning process. 3. Review of financial position via the West Yorkshire ICS Finance Forum	1. Agreed the establishment of an efficiency management group at ICB level - still to finalise; 2. Consider additional controls to manage recruitment to ensure running costs targets are delivered; 3. Absence of a contingency in financial plans to mitigate against unplanned expenditure or efficiency delivery shortfall 4. No formal agreement at this stage on addressing the system risk between the ICB and providers	1. Budget management at places; 2. Overview of financial performance and risk in place committees; 3. ICB Oversight and Assurance System Leadership Team and ICB Finance, Investment and Performance Committee oversight of financial position and risks; 4. ICB Audit Committee oversight of risks and capacity to instruct a deep-dive into areas of concern; 5. ICB Board statutory responsibility; 6. West Yorkshire System-wide management including provider target achievement 7. NHS England review of financial position on a monthly basis	1. Submission of a system financial plan which is an aggregation of NHS provider and ICB plans which were all approved via individual organisational governance following review and challenge; 2. Financial planning assumptions have been moderated across the ICB core and 5 places , they have been subject to peer review and challenge across the WY ICS	1. Further review of risks and mitigations leading to additional unmitigated risk with no formal route to address			New - Open
2176	17/10/2022	Quality	Improve healthcare outcomes for residents	16 (I4xL4)	12	(I4xL3)	Lucy Cole	James Thomas	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.	NSO programme in place to design and implement a sustainable NSO model for West Yorkshire & Harrogate. Implementation of some joint posts for medical staff and implementation of international recruitment options (process underway). Operational group in place to transact mutual aid to ensure gaps in provision are covered whilst the new model is designed and implemented.	Additional workforce / service pressures emerging whilst new model is implemented. New workforce model will take 3-5 years to be fully implemented. Unclear if public consultation process will be required which will extend the timescales for implementation of a new model.	Fortnightly operational level meetings whose governance provides routes of escalations to the Steering group and to WYAAT Chief Operating Officers via the lead COO for cancer. The agreed governance model has representation from all WYAAT providers.	None identified	None identified			Static - 4 Archive(s)
2175	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that the increasing number of patients in WYAAT hospitals without a reason to reside due to capacity in social care and community services, will add extra pressure on the workforce and reduce 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.	Focus by WYAAT trusts on improving hospital-based discharge pathways and reducing delays has been successful. Place focus through Multi-Agency Discharge Events (MADE) to reduce numbers of patients with No Reason To Reside. Participation in the West Yorkshire ICS Discharge programme development and implementation. Bed capacity funding included in 23/24 allocation. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods of significant non-elective activity.	Workforce capacity gaps in social care services remain high. Despite mitigations, no significant or sustained reductions in patients in hospital without a reason to reside.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified			Static - 4 Archive(s)
2174	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that future covid waves, urgent and emergency care pressures and continued industrial action 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, delays to patient care, and implementation of new models of working to address backlogs across WYAAT.	- Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. - Independent Sector group and approach established across WYAAT to maximise independent sector activity. - Planning for protected elective hub sites in progress to enable continuation of elective activity during periods of significant non-elective activity. - System Control Centre (SCC) established by ICB from 1 December 2022 to balance clinical risk over Winter. SCC capability being enhanced with roll-out of UEC RAIDR app from February 2023. - ICB campaigns and programmes of work in place to mitigate risk including discharge programme, vaccination programme and campaigns, staff health and wellbeing hub, and public campaign to 'choose the right service'.	Further industrial action subject to national negotiations.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified			Static - 4 Archive(s)
2313	05/06/2023	Both FPC and QC	Tackle inequalities in access, experience, outcomes	15 (I3xL5)	6	(I2xL3)	Keir Shillaker	James Thomas	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.	Individual places are seeking to address ND waiting lists using increased investment where available, and are testing new roles to support people pre and post diagnosis (such as Navigator roles). Across WY we are seeking to ensure consistent approaches to the Right to Choose agenda and a single commissioning policy to ensure it is more likely that people are referred to trusted providers.	The legal right to choice means that the ICB has an obligation to pay for any assessment undertaken via Right to Choose and there is no ability to fully control this.	The current controls are not sufficient to reduce the risk associated with the Right to Choose and even a consistent commissioning policy for the system will not mitigate the full extent of the risk.	Individual places (ie Calderdale) have been developing AQP frameworks and the learning from these is being used to inform the WY commissioning policy, having demonstrated strong multi-agency working to identify solutions which has improved relationships and 'buy in' to the challenges.	We would need to be confident we have got the full support of the whole ICS in identifying and being prepared to respond to the issues presented by the gap in support for our neurodivergent population, acknowledging that whilst the financial pressure on the NHS is a result of assessment it is a wider system issue to resolve			New - Open

2194	29/11/2022	Finance, Investment and Performance	Enhance productivity and value for money	15	(I3xL5)	6	(I3xL2)	Suzie Tilburn	Kate Sims	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.	- Industrial Action preparedness self-assessment documents from each health provider and the ICB - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Ongoing communications to organisations and workforces - Ongoing communications with unions - Industrial Action Incident Management systems	None identified at this time	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents submission to NHS England via regional team - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Social Partnership Forum agenda and minutes	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents - Social Partnership Forum agenda and minutes - 8 November 2022, 13 December 2022, 1 February 2023, 23 March 2023 and 9 May 2023.	None identified at this time			Decreasing

Risks Report Summary

CCG: WY ICB - Corporate

Archive Deadline: 19/07/2023

New Risks: 6

Total Risks: 46

Old Risks: 40

Marked for Closure: 5

Mapping of risks – 2nd risk cycle of 2023/24 (as at 14 June)

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	9	Common risk re: impact across the system / OPEL 4
BDC (2222)	There is a risk of the entire urgent care system seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would also be likely to impact workforce further reducing the system's ability to deal with the excess demand.	3	2	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.	4	5	20	

Place	Risk	I	L	Score	Common Risk
Wakefield (2135)	There is a risk of delays for children and young people requiring access to CAMHS, including admission for Tier 4 beds due to increased referrals and CYP presenting in crisis, resulting in more children and young people being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	3	3	9	
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 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).	3	3	9	Common risk re: CAMHS

Place	Risk	I	L	Score	Common Risk
	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 that the Kirklees' Children & Young peoples (CYP) mental health service are unable to deliver timely, comprehensive care to those being referred or self referring when in crisis. Due to a significant increase in demand from pre pandemic levels & increased acuity. Resulting in patient care and safety to be compromised.	3	4	12	
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 increased mental health demand, alongside insufficient capacity to provide access to proactive community mental health intervention and support, exacerbated further by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent adverse impact on mental health	4	4	16	

Place	Risk	I	L	Score	Common Risk
	presentations to ED and YAS, increased lengths of stay and reduced system flow in mental health beds, and increased numbers of out of area acute mental health and PICU bed days.				
Calderdale (1493)	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, risk of hospital acquired infection, additional pressure on the acute bed base and pressure on elective recovery plans.	4	4	16	Common risk re: delayed transfers of care
Kirklees (2071)	There is a risk that we will not be able to meet the 2022/23 national Transforming Care trajectories due to 1. to lack of funding in the system to develop new models of care 2. lack of workforce capacity and capabilities 3. inadequate accommodation provision 4. potential risk of hospital closures impacting on additional discharges This will result in the delayed discharge of people currently in an inpatient bed due to there not being the right provision and the right support to put in place within a community setting.	2	2	4	

Covid Backlog / Risk of Harm / Performance/ Statutory Duties Risks

Place	Risk	I	L	Score	Proposed Action
Wakefield (2132)	There is a risk to the overall sustainability of the urgent care services within Wakefield due to the impending end of the lease for the King Street Walk In Centre. This service plays a vital role in the delivery of services at a place level and the building will not be available past the end of May 2024	4	4	16	Common risk re: emergency departments demand

Place	Risk	I	L	Score	Proposed Action
Kirklees (2067)	There is a risk that the system will see an unprecedented volume of patients attending A&E, potentially higher than the pre-C19 levels of demand and therefore will not deliver the NHS Constitution 4-hour A&E target due to pressures associated with unavoidable demand, capacity and flow out - resulting in harm to patients and patient experience being compromised.	2	4	8	
BDC (2222)	There is a risk of the entire urgent care system seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would also be likely to impact workforce further reducing the system's ability to deal with the excess demand.	3	2	6	
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 (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 and acuity of inpatients and the numbers in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	4	5	20	
Wakefield (2182)	There is a risk that the WDHCP will not meet the national ambition of reducing gram negative blood stream infections by 50% by 2024/25 due to a significant	4	3	12	Common risk re: gram negative blood

Place	Risk	I	L	Score	Proposed Action
	number of the cases having no previous health or social care interventions, resulting in failure to meet the requirements of the single oversight framework (should this measure be included).				infections reduction target
Kirklees (2058)	There is a risk that the WY ICB Kirklees Place will not achieve the national ambition of reducing gram negative blood stream infections by 50% by 2024/25 due to the gaps identified in the key controls; resulting in a risk to population health and experience.	3	3	9	
Leeds (2017)	There is a risk of harm to patients with LTC/frailty/mental health conditions due to the inability to proactively manage patients with LTC/frailty/mental health and optimise their treatments due to the impact of covid and other pressures on capacity and access resulting in increased morbidity, mortality and widening of health inequalities and increased need for specialist services	3	5	15	Common risk re: management of patients with long term conditions / frailty / link to health inequalities
BDC (2221)	There is a risk of failure of the Reducing Inequalities Alliance (RIA) and other programmes to support and coordinate action by the BDC partnership to reduce health inequalities due to lack of influence of the RIA so that inequalities become a golden thread through all programmes, lack of identified action & evaluation of the impact of this work, reduction of specific inequalities funding streams (e.g Core20PLUs5, RIC, health inequalities practice premium) which could result in health inequalities getting wider. This has also been influenced by the COVID19 pandemic and continues to be influenced by wider socio-economic inequalities.	4	3	12	
Kirklees (2066)	There is a risk that elective care services will not be able to meet the required level of activity identified in the 22/23 elective recovery plan, (surgery, day case and out-patient), this may result in non-delivery of patient's rights under the NHS Constitution, potentially cause harm to patients, long waits and have detrimental impact on patient experience.	2	3	6	Common risk re: failure to meet Constitutional standards

Place	Risk	I	L	Score	Proposed Action
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	
Calderdale (2311)	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	
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 higher demand and the legacy impact of COVID, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times.	4	3	12	
Kirklees (2069)	There is a risk that Kirklees Health and Care Partnership will fail to achieve both local and the national performance standards (set out in the NHS constitution), due to the impact of the national covid-19 pandemic, the increased demand on urgent and emergency services & the safe restart of elective activity, resulting in a negative provider performance, patient experience & outcomes.	1	4	4	

Place	Risk	I	L	Score	Proposed Action
Kirklees (2049)	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 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.	3	4	12	
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	3	9	Common risk re: adult ADHD assessment
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 resulting in complaints from patients and referrers and scrutiny from council elected members. Inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider.	3	5	15	
BDC (2266)	There is an increase across adult and children of an increase of Right to Choose requests for both ADHD and Autism assessments. This will lead to a significant unbudgeted cost to the ICB (GP's can refer to any provider that is	4	4	16	

Place	Risk	I	L	Score	Proposed Action
	on a NHS framework and the ICB get the invoice in retrospect. In children's the annual cost projected this year is over £200,000				
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. 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.	3	4	12	Common risk re: SEND and Children & Families Act statutory duties
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	

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	3	4	12	Common risk re: continuing healthcare workforce challenges

Place	Risk	I	L	Score	Proposed Action
	team, resulting in a poorer patient experience and a negative impact on the CHC activity and delivery. The number of overdue reviews continues to increase.				
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 MYHT not having capacity to provide Children's Continuing Healthcare packages under the Block Contract resulting in the additional costs to the ICB associated with commissioning of external providers.	1	3	3	
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	3	3	9	

Place	Risk	I	L	Score	Proposed Action
	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.				

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2154)	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	
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	Common risk re: maternity services Also see corporate risk.
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	2	3	6	

Place	Risk	I	L	Score	Proposed Action
	across the maternity sector, recruitment challenges, sickness and absences, etc), resulting in poor patient experience, safety, and clinical effectiveness.				
Wakefield (2128)	Children and young people aged 0-19 years will be waiting for over 52 weeks for autism assessment 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. There have been temporary mitigations which maintained an elements of the pathway at previous timescales However now there is pressure across all elements of the pathway from the 1st appointment to the different assessment elements and final appointment. Resulting in an increase in waiting times for ASD diagnosis for 0-19 year olds which have risen to over 52 weeks for a full assessment to be completed from date of referral. Additionally there is a new framework and operational guidance from NH SE to deliver improved outcomes in all-age ASD assessment pathways which increases the oversight and therefore the reputational risk in relation to this pathway. However 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	3	5	15	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	4	3	12	

Place	Risk	I	L	Score	Proposed Action
	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.				
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. At the end of Jan 23 the average waiting time for assessment was 68 weeks, with 1282 children waiting for assessment. resulting in delays to timely diagnosis, 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 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.	4	4	16	

Place	Risk	I	L	Score	Proposed Action
Kirklees (2147)	There is a risk to the ability of care homes to be able to provide safe, high quality and person centred care due to staffing levels, high cost agency usage, increased costs of living and increased intensity of need of residents. This results on an increased requirement on the systems to provide intense responsive support to care homes, and risks care homes de-registering or closing due to financial unsustainability.	3	3	9	Common risk re: care homes staffing
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)	There is a risk to quality, safety and experience in the independent care sector due to the requirement to manage people with increased complexity, rising costs and workforce supply challenges, resulting in insufficient capacity and delayed discharges.	3	3	9	
Wakefield (2203)	There is a risk that the GP workforce challenges across some GP Practices are not effectively managed which means that leads to demand across system partners and poor patient experience.	3	2	6	Common risk re: general practice workforce
Leeds (2008)	There is a risk of an inability to attract, develop and retain people to work in general practice roles due to local and national workforce shortages resulting in the quality of and access to general practice services in Leeds is compromised.	2	3	6	
Calderdale (1434)	There is a risk that the quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	4	2	8	

Quality and Safety Risks

Place	Risk	I	L	Score	Proposed Action
Wakefield (2186)	There is a risk to patient safety and experience of care Due to specific concerns about quality of and access to care for patients Resulting in the Mid Yorkshire Hospitals Trust continuing to be rated by the CQC as 'requires improvement' overall (inspection March/April 2022)	3	3	9	Common risk re MYHT CQC assessment
Kirklees (2201)	There is a risk to patient safety and experience of care Due to specific concerns about quality of and access to care for patients Resulting in the Mid Yorkshire Hospitals Trust continuing to be rated by the CQC as 'requires improvement' overall (inspection March/April 2022)	3	3	9	
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 achivement 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	4	12	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 (2204)	Capital Availability - There is a risk that capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments	4	2	8	Common risk re: capital spending limits
BDC (2170)	CAPITAL AVAILABILITY There is a risk that NHS capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments.	5	4	20	
Wakefield (2142)	There is a risk that the national capital regime and arrangements for the allocation of funding will mean there is insufficient resource within Wakefield place to support necessary service transformations.	4	4	16	
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.	3	3	9	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.	4	2	8	
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	4	2	8	

Place	Risk	I	L	Score	Proposed Action
	deliver improved patient experience, better clinical outcomes and overall system financial sustainability				

POSSIBLE RISKS FOR TRANSFERRING TO THE CORPORATE RISK REGISTER / RISKS CLOSED DUE TO TRANSFER TO CORPORATE RISK REGISTER THIS CYCLE

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Proposed Action
Wakefield (2145)	There is a risk of insufficient capacity in the Local Care Direct (LCD) - Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increased referral activity and potential changes to referral pathways, resulting in poor outcomes and experience for patients and reduced quality of care.	3	3	9	This is under discussion as to whether should remain as 'common' risk, or be moved to corporate risk register.
Kirklees (2083)	There is a risk to patient safety, experience, the quality of care delivered by Local Care Direct (LCD) - Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increased demand for the service.	3	3	9	
Calderdale (1361)	There is a risk to patient safety, experience, the quality of care delivered by Local Care Direct (LCD) - the provider of Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increasing demand for the service.	3	3	9	

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Proposed Action
	No risks				

Quality and Safety Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2246)	There is a risk to delivery of implementation of the Patient Safety Incident Response framework (PSIRF) due to capacity to train and release staff across the system to investigate patient safety incidents to fulfil the	2	4	8	Possible corporate risk re PSIRF as not Place specific

Place	Risk	I	L	Score	Proposed Action
	requirements of the framework, resulting in not meeting NHSE mandatory timeframes.				
Calderdale (2235)	There is a risk to delivery of implementation of the Patient Safety Incident Response framework (PSIRF) due to capacity to train and release staff across the system to investigate, review and fulfil the requirements of the framework.	2	4	8	

Finance and Contracting

Place	Risk	I	L	Score	Proposed Action
BDC (2220)	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	4	4	16	
Leeds (2158)	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	4	3	12	
Calderdale (2126)	The risk is that WYICB-Calderdale Place will fail to deliver our 2022/23 planned deficit of £0.2m for the year. This is due to 22/23 financial plan submitted to the WYICB including a number of pressures/risks which have been articulated in the plan approval process.. These risks include activity pressures on independent sector acute contracts, **prescribing** and under-delivery of QIPP. The QIPP challenge for 22/23 is significant at £4.5m. 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	2	8	Common risk re: prescribing costs

Appendix 5 - RAAC (Reinforced autoclaved aerated concrete) at Airedale Hospital – risk tolerance

Airedale NHS Foundation Trust is the only Trust to have RAAC floors as well as defects within its structural corbels and concrete structure – the Trust has tolerance for innovation within the design of structural solutions, but only where those solutions have been designed specifically for Airedale by a suitably qualified structural engineer (i.e. registered on the Institute of Structural Engineers' RAAC Group "members with experience" list, in line with independent specialist legal advice). The Trust will adhere to the recommendations of independent structural engineers in the management of RAAC, with very little tolerance to deviate from these plans. Any proposals to deviate from the engineer's advice must be escalated to the RAAC Executive Assurance Group for discussion and decision on next steps.

The Trust has tolerance for deviations or derogations from the delivery of services where it is not safe to operate these services in their current location and if there is no other reasonably practicable way to maintain services within the wider hospital footprint. This could, for example, include postponing clinics or lists to allow for structural work to take place. In respect of the continuation of service delivery from the current hospital buildings, the Trust will continue to provide clinical services at Airedale General Hospital unless:

- the amount of acrow-props or engineering solutions prevent the safe or appropriate use of the space
- deterioration is such that no engineering solutions are available
- there is a significant incident at Airedale
- a significant incident occurs in another RAAC-affected hospital due to an issue that is also evident at Airedale.

Independent structural engineers have advised that the hospital buildings which are constructed of RAAC (83% of site) must be replaced no later than 2030.

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	9
Meeting date:	21 July 2023
Report title:	Partnership risk update (risk report – cycle two 2023/24)
Report presented by:	Sue Baxter, Assistant Director of Governance and Assurance
Report approved by:	Carrie Haywood, senior governance and assurance manager
Report prepared by:	Catherine Smith, corporate governance manager

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

Previous considerations:

People Committee 21 June 2023
Finance and Performance Committee 22 June 2023
Quality Committee 22 June 2023
Partnership Leadership Executive 23 June 2023
Partnership Leadership Team 28 June 2023

Executive summary and points for discussion:

Effective risk management processes are central to providing the Bradford District and Craven Health and Care Partnership (the Partnership) with assurance that all required activities are taking place to ensure the delivery of the Partnership's strategic priorities and compliance with all legislation, regulatory frameworks and risk management standards.

BDC H&CP Risk Register

This report provides details of all high-level risks (scoring 15 or above, or risks escalated from committee review) on the 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 two 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 Bradford District and Craven Partnership Board is asked to:

1. To **RECEIVE** the BDC H&CP cycle two 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 for cycle three.
3. To **RECEIVE** the ICB risk register for consideration and confirm assurance on the BDC H&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. Bradford District and Craven Health and Care Partnership risk register
2. Bradford District and Craven Health and Care Partnership risk on a page report
3. West Yorkshire ICB risk register
4. West Yorkshire ICB mapped common risks
5. RAAC at Airedale Hospital – risk tolerance

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
4. VCSE – Voluntary, Community and Social Enterprise Sector

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 two 2023 – 2024 (17 May – 19 July 2023) Update for 21 July 2023

1. Introduction

1.1 The Bradford District and Craven Health and Care Partnership (the Partnership) with delegation from NHS 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 the 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 (appendix one)

2.1 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, Partnership Leadership Team or a combination.

2.2 There are 14 high level risks for review (appendix one). Of these:

- 7 (50%) are identified as finance and performance risks
- 4 (29%) are identified as being both finance and performance and quality risks
- 1 (7%) is identified as a Partnership Leadership Team risk
- 2 (14%) are aligned to the Finance and Performance, People and Quality Committees, Partnership Leadership Executive, Partnership Leadership Team and the Partnership Board.
- 0 (0%) are identified as quality risks
- 0 (0%) are identified as workforce risks
- 0 (0%) are identified as primary care risks

The below table shows a summary of these risks along with any associated actions. Full risk details can be found in appendix one. Further information on the risk tolerance for the risks associated with RAAC at Airedale Hospital (risks 2314 and 2312) can be found in appendix five.

Ref	Committee	Risk Description	Current Score	Target Score
2314 New	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, 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).	**25 (I5xL5)**	**15 (I3xL5)**
2312 New	FPC/QC/ PC/PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - there is a risk that Airedale NHS Foundation Trust is unsuccessful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030 due to delays, a decision to partially fund or a rejection of the AFT application by the national new hospitals programme bidding process. A decision is awaited from the new hospitals programme board on the AFT application for a new hospital at the Steeton	**25 (I5xL5)**	**15 (I3xL5)**

Ref	Committee	Risk Description	Current Score	Target Score
		site as part of the 8 new hospitals in England (note - there is no alternative route to funds than the new hospital programme). This could result in service provision at the Airedale General Hospital site not being viable beyond 2030 (or earlier if a significant RAAC incident occurs - see related risk number 2314).		
2338 New	FPC	IN-YEAR FINANCIAL PERFORMANCE - there is a risk that we do not achieve the financial plan surplus target for 2023/24 due to shortfalls against savings plans, additional cost pressures and financial penalties relating to the Elective Recovery Fund scheme. Following the completion of the planning round for 2023/24, there is an additional savings requirement of £6.1m that needs to be met if financial plan targets are to be achieved.	**20 (I5xL4)**	**9 (I3xL3)**
2337 New	FPC	UNDERLYING FINANCIAL DEFICIT - there is a risk that we do not address the underlying financial deficit and establish a financially sustainable position over the medium term. Following the completion of the planning round for 2023/24, the underlying financial deficit has increased further and therefore this remains a critical risk.	**20 (I4xL5)**	**9 (I3xL3)**
2302 New	FPC	There is a significant risk of the All Age Continuing Care Service having to make financial redress to patients, their family or their estate, due to care homes applying 'top-ups' to the care costs that should have been met by the service. This will result in reimbursements being made in line with the Financial Redress Policy and SFIs.	**20 (I4xL5)**	**2 (I1xL2)**
2215	FPC	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	**20 (I4xL5)**	**2 (I2xL1)**

Ref	Committee	Risk Description	Current Score	Target Score
		wellbeing, recruitment and retention and on the organisation's reputation due to the deteriorating and failing physical condition of Lynfield Mount Hospital building.		
2173	FPC	BMDC FINANCIAL POSITION - there is a risk that the measures taken to control expenditure by BMDC will impact on other Place partners. This could affect hospital discharges and the management of winter pressures.	**20 (I5xL4)**	**12 (I4xL3)**
2170	FPC	CAPITAL AVAILABILITY - there is a risk that NHS capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments.	**20 (I5xL4)**	**12 (I4xL3)**
2082	Both FPC and QC	PERSONALISED COMMISSIONING DEPARTMENT - the Personalised Commissioning department are currently holding a waiting list for reviews with regard to individuals who are eligible for Fast Track, Continuing Healthcare funding and funded Nursing care. There is also a backlog of cases waiting completion of Decision Support Tools following a referral for an assessment of need against the NHS National Framework for Continuing Healthcare and funded Nursing Care.	**20 (I5xL4)**	**1 (I1xL1)**
2266	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. £200,000) 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.	**16 (I4xL4)**	**4 (I2xL2)**
2220	FPC	INCREASED PRESCRIBING COSTS - there is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	**16 (I4xL4)**	**9 (I3xL3)**
2039	FPC and QC	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS - there is	**16 (I4xL4)**	**6 (I3xL2)**

Ref	Committee	Risk Description	Current Score	Target Score
		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 Ofsted/CQC local area SEND inspection held in March 2022.		
2227	Both FPC and 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)**

2.3 In total there are 28 risks on the partnership risk register, of the 28 risks on the risk register, there are:

- 5 newly identified risks (all 5 new risks are high level risks)

- 7 closed risks (includes 2 high level risks)
- 4 risks decreasing in score
- No risks increasing in score

2.4 Of the seven closed risks on the risk register two were rated as critical risks – RAAC at Airedale Hospital (risk 2214) and underlying financial deficit (risk 2171). The former RAAC risk (risk 2214) focused on the emergency planning response to RAAC incidents at Airedale Hospital and has been replaced by two new risks (risks 2314 and 2312 in the table above) to reflect a risk to service provision in the event of a RAAC incident in Airedale Hospital and a risk that Airedale NHS Foundation Trust would be unsuccessful in securing funding from the new hospitals programme to replace the hospital. The risk related to the underlying financial deficit was closed as it referred to the previous financial year and a new risk (risk 2337) has been opened to reflect the current financial year.

2.5 Of the four decreasing risks one former serious risk has decreased in score to become a moderate risk. This relates to a potential negative impact on health service delivery due to reduced capacity in 0-19 services (risk 2040). This risk will be divided into two risks to cover Bradford and Craven separately – the second risk relating to the North Yorkshire 0-19 service in Craven will be added to the risk register in the next cycle.

2.4 Of the 28 risks:

- 64% were reviewed by the risk owner
- 50% were reviewed by senior risk managers
- 39% have had a static score for more than 2 cycles

3. Emerging risks

3.1 The following risks have been identified as emerging risks through the current cycle from the sub committees.

- The Finance and Performance Committee identified a number of potential emerging risks which are currently being explored in order to be added to the risk register in cycle three –
    - Skipton Hospital.
    - Ongoing industrial action in the NHS and the impact on waiting list access.
    - The financial position and the Elective Recovery Fund scheme.

- The Quality Committee raised a potential emerging risk on the update of vaccines and immunisations as practices are reporting reduced uptake. The potential risk is being monitored.

- An emerging risk has been raised by the reducing inequalities programme in relation to reduced funding which could impact on the delivery of the programme – this risk is being developed in order to be added to the risk register in the next cycle

- There is a risk on the NHS WY risk register in relation to loss of VCSE services across WY due to lack of long-term funding and investment resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside the reputation of the ICS for working with VCSE. Locally we are exploring the related partnership risks associated with this area.

3.2 The following risks were previously reported in cycle one as emerging risks from the sub committees, progress on each risk is below:

- In their meeting in April the Finance and Performance Committee agreed in-year and medium-term financial risks should be added to the risk register and these were added during cycle two.

- There have been previous discussions in the People Committee on having an overarching risk on workforce sufficiency made up of challenges in recruiting and retaining staff, which would be the principle risk for the committee. This risk will be managed across two of the delivery pillars and is currently being developed in order to get a fully rounded narrative from both the recruitment and retention angles. This risk is partially developed and likely to be added in the next cycle having input from the retention workstream leads within pillar 1 of the People Plan.

- The People Committee had previously proposed a potential risk of the BD&C HCP not meeting the Public Sector Equality Duty in relation to obligations under this duty. It was agreed that this duty lies with the ICB as the statutory organisation and would not be a Partnership risk

- Warfarin supply and anti-coagulants had been raised as potential emerging risks in the Quality Committee however it has now been agreed that these are issues and not risks and will be managed through the primary care and medicine management teams and as such do not need to be added to the partnership risk register.

- An increase in cases of TB had been noted as a potential emerging risk by the Quality Committee however it has now been agreed that this is an issue and not a risk and will be managed through the quality team and as such does not need to be added to the risk register.

- The risk of ongoing Virgin Media outages and the impact on general practice has been identified and is being developed in order to add to the risk register in conjunction with IT and Primary Care.

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 BDC H&CP committee and 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 discussions included:

- The Quality Committee requested more information on the impact on quality of some of the risks, such as RAAC at Airedale Hospital. RAAC is a key focus within the Partnership Board in July which will provide the Quality Committee with assurance via the committee chair.

5. BD&C Risks on a Page Report (appendix two)

5.1 The risks on a page document provides an overview of all BD&C HCP risks and is starting to show trends and flag areas that the Partnership Board and its committees may wish to consider.

5.2 information provided on the risks on a page includes:

- An overview of the risk profile, with details of the number of risks. Colour coding helps to highlight the number of risks flagged as being quality or finance risks.
- An overview of whether scores are increasing, decreasing or staying static. As the risk register evolves and stabilises, this overview can help to highlight the management of the partnership's risks.
- A graph showing the changing number of risks on the register – over time, this can help to highlight the management of the partnership's risks.
- A graph showing the average score, this helps to demonstrate the risk profile, and help to alert if the overall risk score is increasing over time.
- The graph will demonstrate over time how long risks have remained static for. A risk that remains static over a number of cycles may be an indication that further work is needed to control the risk.

6. ICB Risk log (appendix three)

6.1 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.

6.2 Reporting for cycle two of the ICB risk register is currently taking place. To summarise:

- In cycle two there are 12 risks scoring 15 and above on the ICB risk register.

7. West Yorkshire ICB Common Risks (appendix four)

7.1 The West Yorkshire Risk Operational Group meets to identify common risks emerging from the place risk registers. This reports bi-monthly to NHS West Yorkshire ICB Board with a request to report at each of the five places. The detail of these risks is set out in appendix four.

7.2 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. In cycle two, themes of note for BDC H&CP consideration are:

- impact across the system / OPEL 4
- delays in access to CAMHS due to increased demands
- mental health services capacity and demand
- delayed transfers of care
- emergency departments demand
- gram negative blood infections reduction target
- management of patients with long term conditions / frailty / link to health inequalities
- failure to meet Constitutional standards
- adult ADHD assessment
- SEND and Children and Families Act statutory duties
- continuing healthcare workforce challenges
- maternity services – due to midwifery staffing shortages
- waits for CYP neurodiversity
- care homes staffing
- general practice workforce
- Looked After Children health assessments
- capital spending limits

7.3 Insufficient capacity in the Local Care Direct (LCD) due to increased demand on this service is a common risk that appears on the Calderdale, Kirklees and Wakefield place registers and is under discussion as to whether the risk should remain as a ‘common’ risk or be moved to corporate risk register.

8. Next steps

8.1 Following review by the Partnership Board, the BDC H&CP Partnership risk register will conclude its second risk cycle. Any closed risks will be archived and open risks carried forward to the next risk review cycle.

8.2 BDC H&CP will provide the ICB with information on place risks throughout cycle three to inform the risk report for the ICB Board

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Partnership Board
Agenda item no:	9
Meeting date:	21 July 2023
Report title:	Airedale General Hospital – Securing the Future Update
Report presented by:	Foluke Ajayi, Chief Executive
Report approved by:	
Report prepared by:	Francesca Hewitt, Senior Programme Manager

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 paper provides an update on progress with the RAAC structural works programme and Airedale NHS Foundation Trust's onboarding to the New Hospital Programme. Key points to note include the high level process for mobilisation of the new hospital scheme, progress against current RAAC works and the process for identifying future capital funding for RAAC.

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 contents of this paper.

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
N/A
Acronyms and Abbreviations explained
1. NHP – New Hospital Programme 2. SOC – strategic outline case 3. PWF – preferred way forward 4. The Trust - Airedale NHS Foundation Trust 5. RAAC – reinforced autoclaved aerated concrete

What are the implications for?

Residents and Communities	
Quality and Safety	
Equality, Diversity and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

1. Main Report Detail

1.1 On Thursday 25 May 2023, Airedale NHS Foundation Trust received the long-awaited news that it had been accepted onto the Government's New Hospital Programme.

1.2 The announcement is fantastic news for people across West Yorkshire, as well as parts of North Yorkshire, East Lancashire and nationally, who access services delivered from Airedale General Hospital.

1.3 A period of "onboarding" has commenced, with a 6-9 month programme of activities intended to identify the status of schemes and progress against the Treasury business case model. Seed funding has been offered to support the Trust in establishing its programme governance and management and to deliver the activities identified.

1.4 The Trust published a SOC in late 2020 and has most recently been working with an external planning specialist to refresh elements of the plan based on the latest available ONS population data and projected demand for services.

1.5 The NHP has indicated that schemes will need to demonstrate extensive system transformation plans to offset anticipated growth in demand for hospital services, particularly in relation to inpatient care.

1.6 Local authority partners have been engaged in informing the SOC refresh described above and further engagement on this and on the clinical services strategy will take place over the coming months.

1.7 The NHP has expressed its intention for all of the "RAAC hospital" schemes to be completed by 2030, which aligns to advice from independent structural engineers on the projected lifespan of their existing buildings.

1.8 In recognition of this, the NHP has allowed trusts to submit early enabling works plans and access funding so they can begin specialist geotechnical surveys and investigations, plus other essential infrastructure works.

1.9 This is an ambitious timescale and will require close working relationships between the NHP, Trust and partners locally and regionally to be able to deliver at pace. The support of partners in prioritising this work will be greatly appreciated and will enable us to realise the wide-ranging benefits for our local populations.

1.10 During the mobilisation phase the Trust will establish a communication and engagement programme to ensure that opportunities to engage stakeholders are fully anticipated and planned in advance.

1.11 Whilst the new hospital is a long-term solution to the challenges at Airedale, the structural risks remain and will continue to require a comprehensive package of monitoring and structural works for the remaining life of the building.

1.12 The latest inspection data suggests that around one third of load-bearing RAAC planks have some damage or deterioration in addition to a risk in relation to the positioning of the planks on their end supports, which is recognised by the Institute of Structural Engineers as a key risk factor for a plank collapse.

1.13 The capital allocation for RAAC is only secured until 24/25 after which the national programme has indicated that a further bid will need to be made as part of the Comprehensive Spending Review.

1.14 Progress is being made on the current year programme with the completion of three wards expected in August, September and November respectively.

2. Next Steps

2.1 Work is continuing on the mobilisation onto the New Hospital Programme as described in this paper.

2.2 The Trust is refreshing its RAAC programme which will be informed by the latest changes to the national guidance. This will form part of a multi-year business case – informed by early indicators from the new hospital planning works – and this will form the basis of its bid for further funding from the national RAAC programme.

2.3 In the meantime, RAAC structural works continue, with the relocation of Endoscopy back to its base ward in September and the decant of wards 13 and 5 to allow work to be undertaken.

2.4 A series of smaller projects are also in progress including the installation of a lift to provide additional resilience on the hospital ward corridor, external coating of the RAAC wall planks, and steel work in a number of other departments.

3. Recommendations

1. The Partnership Board is asked to note the contents of this paper.

4. Appendices

N/A

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	10
Meeting date:	21 July 2023
Report title:	Review of committee effectiveness
Report presented by:	Sue Baxter, Assistant Director of Governance and Assurance
Report approved by:	Carrie Haywood, Senior Assurance and Governance Manager
Report prepared by:	Catherine Smith, Corporate Governance Manager

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:

The 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 own 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 Partnership Board, its three sub-committees (Finance and Performance, Quality and People), Partnership Leadership Executive, Partnership Leadership Team, Citizens Forum Steering Group, Clinical Forum and the Planning and Commissioning Forum have met to discuss the findings from the review of the effectiveness of their committee following the circulation of surveys to both members and attendees in March 2023. The Primary Care Assurance Group are due to meet to discuss their effectiveness results on 26 July 2023.

The report includes a summary of the findings from the review of the effectiveness of the Partnership Board and a summary of the feedback provided from all committees / groups throughout the review which has been collated into main themes.

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 Effectiveness review. 2. To **RECEIVE** the findings from the committee effectiveness reviews. 3. 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 – West Yorkshire Integrated Care Board

Bradford District and Craven Health and Care Partnership
Review of committee effectiveness 2022/23

1. Introduction

The 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 own 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 Partnership Board, its three sub-committees (Finance and Performance, Quality and People), Partnership Leadership Executive, Partnership Leadership Team, Citizens Forum Steering Group, Clinical Forum and the Planning and Commissioning Forum have met to discuss the findings from the review of the effectiveness of their committee following the circulation of surveys to both members and attendees in March 2023. The Primary Care Assurance Group are due to meet to discuss their effectiveness results on 26 July 2023.

2. Partnership Board effectiveness summary

Overall Partnership Board members are happier with the current arrangements than unhappy. Particular highlights included positive comments on the regular 'listen in' agenda item where feedback is provided following a week of engagement and involvement activities in the locality of the Board meeting. In terms of the chairing and meeting arrangements members agreed with the approach of moving the meetings around the district and the inclusion of the public in the meetings was noted positively. Key feedback from members suggested ensuring that the Board agenda focuses on key issues facing the partnership such as population priorities. It was also noted that papers can be too long, with the agenda being weighted to the start of each meeting. In terms of governance some members suggested further clarity on the currently embedding governance arrangements including risk management, conflicts of interest, section 75 agreements and the Better Care Fund.

3. Partnership committees' effectiveness review summary

Below details a summary of the health and care partnership feedback throughout the effectiveness review process within main reoccurring themes across all the committees and groups.

- **Links to ICB / ICS**

Comments related to the ICB / ICS included the need for greater clarity in the roles and responsibilities, autonomy and regulations of the committee, the need to consider the partnership's contribution to the ten West Yorkshire ambitions and to link to the wider ICB agenda. Feedback was provided in relation to understanding the escalations and reporting to and from the ICB and this was also reflected in some members / attendees not being able to answer the questions in the survey related to the provision of a written report to the ICB Board to provide assurance, alert and advise and in relation to assurance that the ICB Board understand the reporting from the committee. There is further work to align the Partnership Board and sub-committees with the ICB Board and to close the loop in terms of reporting.

- **Chairing and meeting arrangements**

There was a general theme noting that the committees and groups are still forming and evolving with positive comments made on the chairing of the committees. It was highlighted that there is wide membership on the committees / groups which reflect the partnership, that memberships feel inclusive and are allowing relationships to form. There were suggestions to consider the frequency of some of the committees / groups and to have more face-to-face meetings. Generally, members / attendees have felt able to contribute to meetings with supportive challenge encouraged. The development of joint working arrangements with other committees and groups was suggested.

- **Meeting agendas, papers and items for discussion**

Particular suggestions were received in relation to the length of papers and the need for time on agendas for items / papers with some agendas covering too many items. It was stated that there is a need to focus on key issues being faced by the partnership within agendas and for the agendas to be more responsive to what the population are telling us in terms of what matters to them. It was suggested that there is a need for more clarity in some papers on what they are asking for.

- **Governance**

It was noted that the governance and risk management arrangements are still being embedded with clarity requested on how discussions in the committees feed into other discussions / decisions / assurance mechanisms within the governance structure and on the lines of accountability to ensure that partnership arrangements are supported appropriately. Other suggestions included clarity on links with other programmes and priorities and for clarity on the purpose and responsibilities of the committee / group.

- **Terms of reference recommendations**

It was suggested that the membership in the terms of reference of some of the committees / groups is reviewed to reflect the full partnership and that the terms of reference focus on the key achievements and differences that the committees / groups want to make. It was suggested that the purpose and the membership is clearly articulated in the terms of reference.

- **Decision Making/Taking**

It was noted that the Partnership Board brings together all partners across the Bradford District and Craven Health and Care Partnership to facilitate collaborative decision-making for decisions delegated by NHS West Yorkshire ICB. There was a suggestion for the development of a partnership scheme of reservation and delegation to support the ethos of the Strategic Partnering Agreement and to complement existing arrangements, and which could strengthen decision making within and for the partnership. There was a suggestion for clarity on the delegation of decisions and decision-making. Sue Baxter, Assistant Director of Governance and Assurance and Carrie Haywood, Senior Assurance and Governance Manage are holding a drop-in session on 20 July 2023 to strengthen understanding in the current governance structure and decision-making processes.

- **Engagement**

Members / attendees of the Partnership Board highlighted the ‘listen in’ item as a method of engagement and involvement which reflects the importance that the partnership places on listening, learning and responding to our communities. It was noted that the ‘listen in’ weeks align to the priorities, and it was suggested that there are further considerations for how the feedback from the ‘listen in’ events can be actioned.

- **Strategic priorities**

The need for the committees / groups to link to the strategic priorities was highlighted alongside the development of a comprehensive approach to leading and supporting the priority areas with the need for clear, standardised routine reporting for the priorities and enablers. There was a suggestion for greater collaboration between committees / groups and the priorities and enablers with opportunities provided for the priorities and enablers to share information.

- **Collaborative/ partnership working**

The building of strong relationships between partners was highlighted alongside a real commitment to work together with increased system co-operation and joint working. It was noted that the committees are showing system working and are

engaging with all partners in the system and listening, reflecting and acting on challenges together. It was also highlighted that the committees are focusing on collective priorities rather than on individual organisations. It was advised that the committees should not be too focused on the NHS and to ensure that they include all parts of the system and be able to recognise other partners challenges.

4. Next steps

Comments captured in the review that relate to the Terms of Reference of the committees / groups will be considered as part of the process to review the Terms of Reference. Committees / groups have been invited to review their Terms of Reference ahead of approval by their parent committee / group in July 2023. The ICB have advised that future reviews of the Terms of Reference should align to the end of the financial year so have recommended that the next review is completed by 1 April 2024. The review of committee effectiveness will remain an annual process and will start again in January 2024.

The Partnership Board had a development session to discuss the findings from the committee effectiveness review in April 2023 and will follow on this discussion in the development session on 21 July 2023. The chairs of the other committees / groups have been encouraged to consider the feedback and include in the arrangements for their group as well as incorporating, where appropriate, into their Terms of Reference. For example, the local directors of finance used the review as an opportunity to discuss the effectiveness of the Finance and Performance Committee and the development of future agendas and agreed improvements to the working of the committee.

5. Actions

- The Board, committees and groups have received their individual effectiveness review feedback with some also using the review feedback as part of development sessions.
- The triple A (Alert, Advise, Assure) reporting guidance slide set is being developed to support chairs of committees and boards to utilise this style of reporting. The process is being improved, whereby the next meeting will receive a copy of the triple A with any feedback from the parent group.
- Terms of reference of each group / committee / board are being reviewed.
- Business planning, agendas and other meeting arrangements are being reviewed to incorporate feedback.

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

Version control

Version:	1.1
Approved by:	NHS West Yorkshire ~~Health and Care~~ Integrated Care Board (ICB)
Date Approved:	DRAFT
Responsible Officer:	James Drury, Partnership Development Director
Date Issued:	~~12 July 2022~~
Date to be reviewed:	After 1 year

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
1.1	Membership changes, alignment with Scheme of Reservation and Delegation (SORD) and further minor changes	Sue Baxter & James Drury	31 May 2023
2.0	Final draft for approval	Approved by the ICB Board	TBC

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 ~~place-based~~ 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) ~~place-based system~~ delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations

ii. agree a plan to meet the health, wellbeing and ~~health~~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), ~~setting principles~~ 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 ~~place~~

vii. agree implementation of the people priorities across the Partnership ~~place~~

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 ~~place~~ 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 and chief executive of Bradford Teaching Hospitals NHS FT –
- 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 Healthwatch Bradford District
- chief executive of Healthwatch North Yorkshire
- chief executive of the City of Bradford Metropolitan District Council
- strategic director health and wellbeing 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
- ~~chief executive of Craven District Council~~
- corporate director of North Yorkshire County Council
- director of public health of North Yorkshire County Council
- director of children's services of North Yorkshire County Council
- chief executive of Bradford Care Association
- the chief executive ~~operating~~ officer of North Yorkshire Independent Care Group
- senior representative of the VCSE sector in Bradford District and Craven Health and Care Partnership
- senior representative of the VCSE sector in Craven ~~District~~
- Children and families trust representative and
- 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 ~~director of finance, planning and performance of the~~ 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 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 ~~paragraph 3.1~~; 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

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 ~~person~~ 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 ~~he/she~~ 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 ~~and~~ 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 ~~is~~ 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 ~~he/she~~ 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.

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	11
Meeting date:	21 July 2023
Report title:	Bradford District and Craven Joint Forward Plan
Report presented by:	Clare Smart, Associate Director of Strategy
Report approved by:	Louise Clarke, Director of Strategy, Transformation, Primary, Community
Report prepared by:	Kerry Weir, Associate Director of Planning, Performance, Business Intelligence Clare Smart, Associate Director of Strategy

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

Previous considerations

Bradford District and Craven Partnership Leadership Executive

Bradford Health Overview and Scrutiny Committee

Executive summary and points for discussion

The Health and Care Act 2022 set out new statutory arrangements for health and care systems including the creation of Integrated Care Boards (ICBs). As part of these changes, there are requirements for the development of Integrated Care Strategies, which should be owned by Integrated Care Partnerships, and Joint Forward Plans (JFPs), which should be owned by ICBs. JFPs describe the delivery of the NHS elements of the ICP strategy. The JFP is therefore a statutory document owned by NHS West Yorkshire Integrated Care Board.

On the 23 December 2022, guidance on developing the JFP was published. The guidance supports ICBs and their partner NHS trusts and foundation trusts to develop their first 5-year JFP with system partners. The JFP should demonstrate how the ICB will operationalise its strategy.

Each of the 5 Places across West Yorkshire ICB were invited to develop a local JFP, which will form part of the overall West Yorkshire plan. Our first Bradford District and Craven Health and Care Partnership JFP sets out, within the context of our HCP strategy, our priorities over the coming 2-3 years. These priorities are to be delivered via our Act as One priority and enabling programmes, linked to our operational commitments for 2023/24.

Current expectations are that the Joint Forward Plan will be refreshed annually.

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.
Recommendations
The Partnership Board is invited: 1. To approve Bradford District and Craven's first Joint Forward Plan
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
Bradford District and Craven Health and Care Partnership Joint Forward Plan

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	Use of collective resources
Regulation and Legal Requirements	Fulfils statutory requirement for an ICB JFP
Conflicts of Interest	N/A
Data Protection	N/A
Transformation and Innovation	Service transformation to deliver improved performance
Environmental and Climate Change	N/A
Future Decisions and Policy Making	Strategic priorities to inform decision making
Citizen and Stakeholder Engagement	Builds on local citizen and stakeholder engagement

Bradford District and Craven
Health and Care Partnership

ACTasONE

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

Bradford District and Craven Health and Care Partnership Joint Forward Plan

DRAFT July 2023

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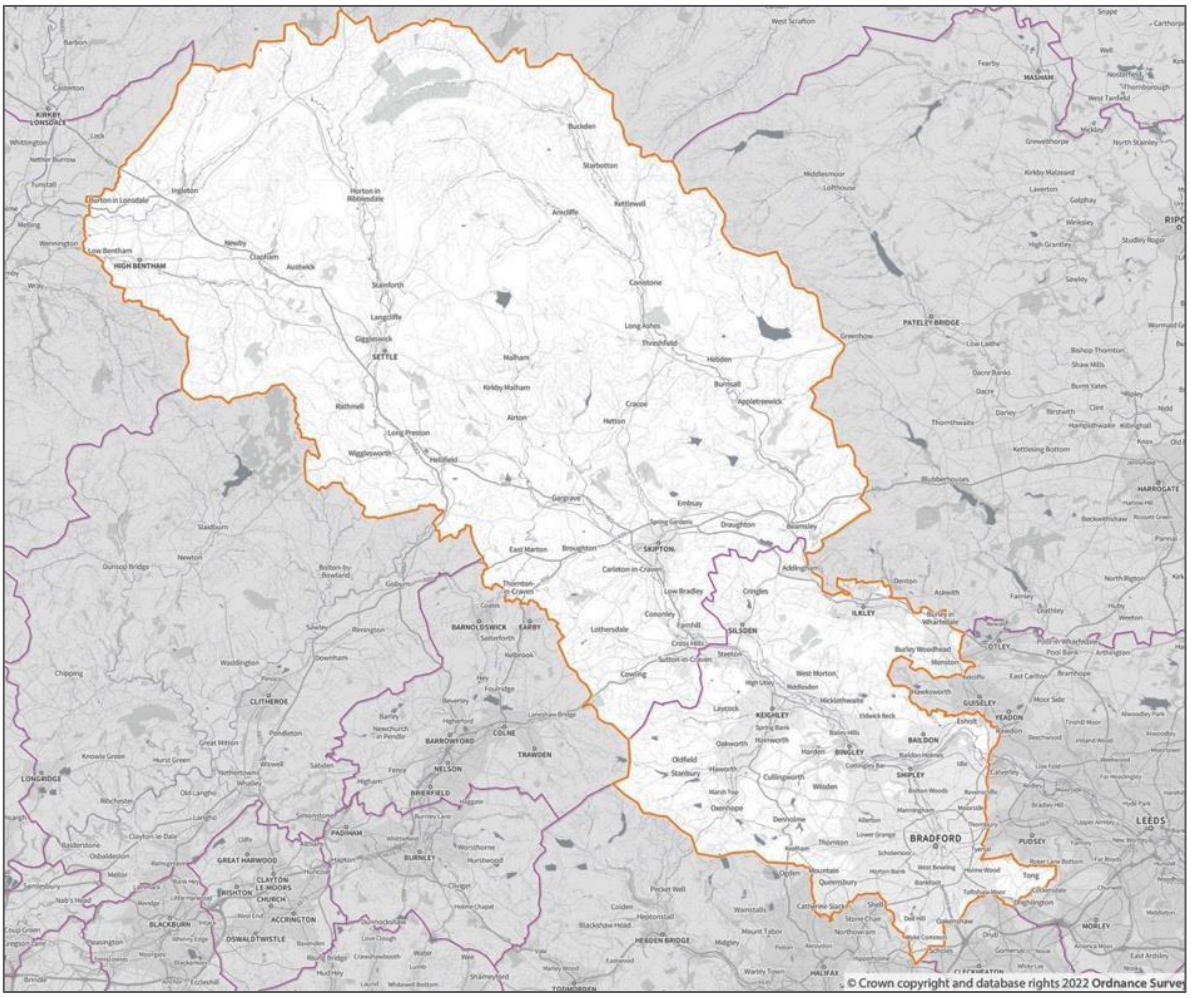
Purpose of this Plan

Bradford District and Craven Health and Care Partnership has developed its Joint Forward Plan:

- To provide a single view on how the partnership will operationalise its strategy;
- To provide clarity for the Partnership Board so it can hold our system to account for the delivery of our key transformational objectives; and
- To enable West Yorkshire Integrated Care Board (ICB) and NHS England to recognise and understand how our plans contribute to the delivery of the West Yorkshire Joint Forward Plan and Integrated Care Board Strategy.

Overview

Bradford district and Craven stretches from Bradford city centre, past Keighley in the Aire Valley, through the large market towns of Ilkley and Skipton, to Ingleton in the Craven basin.



As a partnership we serve a GP-registered population of over 658,601[1] people in this mixed urban and rural area covering 597 square miles (of which Craven is 454 square miles and, as of 2021, is the third least densely populated of Yorkshire and The Humber's 21 local authority areas[2]. Craven GP practices serve around 7.5% of our population (c50,000), with around 9% of the former Craven District Council's resident population covered by Cumbria and Morecombe Bay. Bradford district and Craven represents around 25% of the population of West Yorkshire of 2.6 million people.

Bradford district is an ethnically diverse area, with the largest proportion of people of Pakistani ethnic origin in England. 1 in 4 people describe themselves as Asian/Asian British compared to 1 in 10 for England, and there is a high proportion of our population in Bradford City and Keighley who identify as being from a Black, Asian or Ethnic Minority background. Conversely, most people in our Craven wards are from a White British background.

More than a third of our population live in poverty and the proportion of the working age population is lower in Bradford than the average for England. Whilst wards around central Bradford and Keighley appear in the 10% most deprived wards in the country, wards in the Wharfe Valley are in the 10% least deprived nationally.

We currently have a young population, with the fourth highest proportion of under 16-year-olds in England and a higher proportion of babies, infants, children, and young people than the average for England. However, the largest increase in our population has been in older people (our Craven communities tend to have an older and aging population, which has increased by 23.7% in people aged 65 years and over since 2011[2],), and this is predicted to further grow, bringing with it the challenges associated with managing increasing long term conditions and the potential impact social care.

Bradford District and Craven Health and Care Partnership

Bradford District and Craven Health and Care Partnership is part of the West Yorkshire Integrated Care System. Our partnership brings together the local NHS, other health and care providers, our two Local Authorities, Healthwatch, and voluntary, community and social enterprise (VCSE) organisations, to arrange and deliver services for people who live in Bradford district and Craven (bdcpartnership.co.uk).

By coming together as a formal partnership, building on our years of collaboration, we know that we can improve value and maximise health and wellbeing outcomes, making the biggest difference we can.

[1] NHS Digital patients registered at a GP practice - June 2023

[2] ONS Census 2021 - how the population has changed

By seizing this opportunity, we can shift the conversation from the provision of 'good health and care services' to creating the right environments for 'good health'. Our guiding principle as a partnership is to 'Act as One'; with each organisation working together as one team, pursuing one vision. It acts as a guide in our decision-making and in how we work together.

Engagement

The services we deliver, directly impact the lives of people. We are therefore committed to ensuring that the work of our partnership is influenced by our population through conversations and engagement. Connecting, listening to, and having a consistent feedback loop with communities on an ongoing basis will also help us build trust.

This is something that is being demonstrated through the partnership's 'Listen In' engagement work and through our 'Listening Rooms' project as part of our local equity, diversity, and belonging programme. Our engagebdc.com website provides further information on opportunities for people to get involved and influence decision making locally from involvement exercises through to formal consultations. This gives people an opportunity to join our mailing list and receive updates on issues that matter to people.

Our 'Listen in' programme is a new approach we have developed for the Bradford District and Craven Health and Care Partnership. This is a rolling locality-based programme with focused periods of activity that coincide with our Partnership Board meetings. Each Listen In week takes place in the locality where our upcoming Board meeting will be held. It also offers senior leaders and wider colleagues an opportunity to take part in real-life conversations in community-based settings to find out more about what matters to people, how community groups are helping people, and to receive feedback on people's experience of health and care.

We do not have fixed questions, instead we have open conversations so we can genuinely listen to people about what matters to them, and what it would mean if we were achieving our partnership's ambition to keep people 'happy, healthy at home'. We gather experiences, views and ideas from people, this insight is independently analysed through the lens of our partnership's five priority areas before a report is presented at each Partnership Board meeting.

To date, our listen in events have covered our Keighley, Bradford South, Craven and Bradford West populations. GP access and the cost-of-living crisis impacting wellbeing has been a common theme. Transport and travel are seen as a particular challenge in Craven, but also impacts our residents of Bradford South and Bradford West. The impact of Covid on our children and the lack of mental health support for teenagers has also been raised, as has long waits for mental health support leading to crisis. The positive impact of community support and our VCSE has also been recognised.

The ‘Listen In’ programme has helped us identify areas for more detailed local conversations, which we will be carrying out through planned events. The focus will be on helping people understand what the health and care system, now and in the future, will look like and how they can help us create a service that closely meets local needs while addressing wider challenges. The feedback has helped us have board level conversations and a deeper look at key areas, most notably primary care and access to mental health services and help inform the work of our priority programmes.

In addition, we are triangulating the information we receive from ‘Listen In’ with that which we capture through the system-wide experience of care database. This will result in an updated reporting approach to other key system-wide committees, particularly our system quality committee. The aim behind this is to ensure collective buy-in from committee members on areas that need greater focus, to demonstrate how people’s experiences are helping us make changes to the way we provide care and deliver services across our partnership. This will help to inform community and patient involvement and experience strategies across our partnership. As an example, the work has been reflected in Bradford Teaching Hospitals’ revised patient experience and engagement strategy, and is also supplementing their new ‘reach in, reach out’ community volunteering programme for their workforce.

Challenges

Our diverse population itself creates challenges, and the hugely opposite natures of Bradford and Craven e.g. geographical coverage and accessibility, young vs ageing and different demographic populations, different Local Authority areas, and there are stark health inequalities that exist across Bradford district and Craven, with people living in the most deprived wards having a much shorter life expectancy than those living just a few miles away.

In terms of healthy life expectancy (the average number of years that a person can expect to live in good health that is, not hampered by disabling illnesses or injuries), this gap increases to nearly 20 years i.e. people living in the areas of worst socioeconomic deprivation spend on average 19 years of their lives in poor health.

There are other areas of risk to delivering this plan including:

- Demand: There is an increasing demand for all health and care services and our population is presenting to services with more complex conditions. Managing this alongside our targeted work to address the backlog from the Covid-19 pandemic has resulted in significant system pressures;

- Workforce: There are significant challenges with retention and recruitment of our health and care workforce and the pandemic has had a negative impact on the wellbeing of staff;

- Estates: Lack of available suitable estate and equipment to address increasing demand and the management of people in the community is a challenge. There are also some specific constraints around our existing estate that need to be managed; and

- Finance: Our health and care system is under significant financial pressure, which has been exacerbated by the current financial climate and cost of living crisis. Whilst our system has a surplus plan of £1.8m for 2023/24, to meet this plan we need to deliver a very significant level of efficiency savings totalling £73m (6%). This does not take account of the financial pressures in social care and other non-statutory providers.

Our Strategy

Our Health and Care Partnership Strategy sets out our strategic ambition to reduce health inequalities and improve population health and wellbeing for the people of Bradford district and Craven. We are committed to our partnership vision of keeping people 'Happy, Healthy at Home' through the actions taken to support our population to stay healthy, well, and independent throughout their whole life (Figure *1*).

Figure 1: Our Partnership Strategy

This strategy aligns with the broader scope of the Bradford District Plan, the Wellbeing Board Strategy for North Yorkshire (Craven), and the West Yorkshire ICS Strategy.

Population health management is our common and consistent approach to targeting improvements in the wellness of local people. Through data, we are designing new models of proactive care that make best use of our collective resources, ensuring value. To deliver our strategy we have identified five priority programmes of work (Figure 2) and five enabling programmes of work (Figure 3).

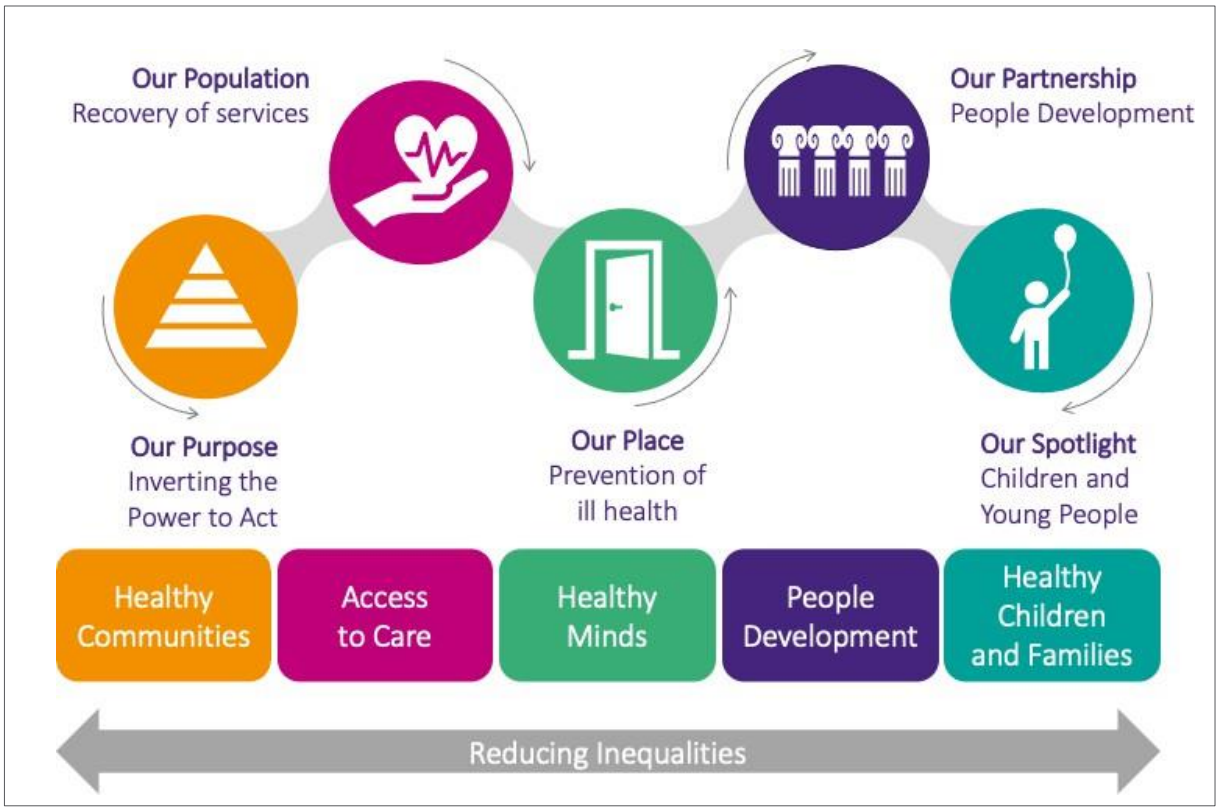


Figure 2: Our 5 Priorities linked to our Purpose, Population, Place and Partnership

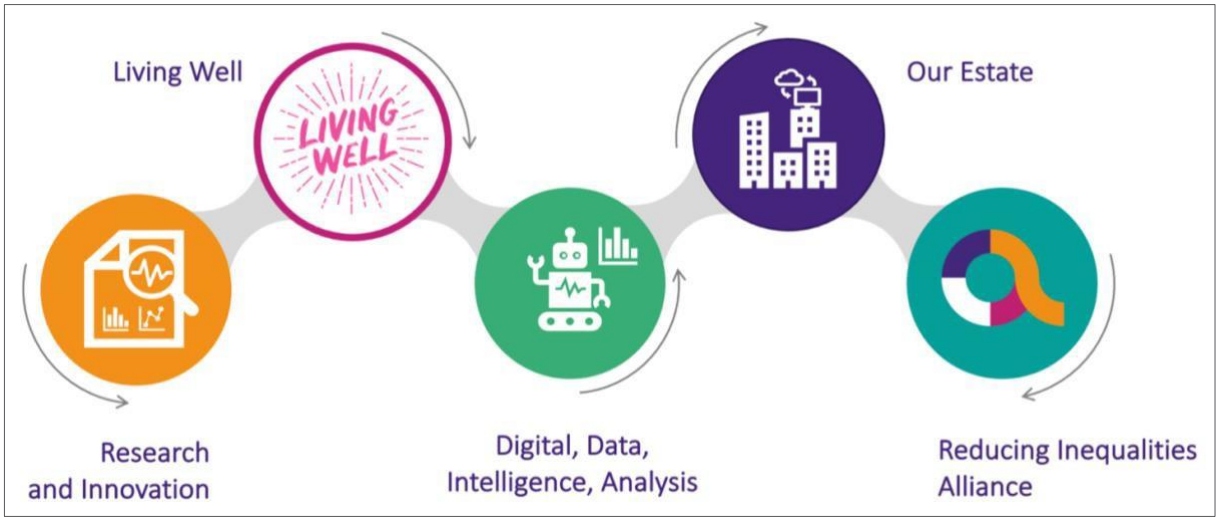


Figure 3: Our 5 Enabler Programmes

The priority workstreams focus on the actions that we need to take specific to our population and communities, and those things that require the close working relationships of the stakeholders who make up our partnership to deliver in collaboration.

There are interdependencies between the work at Place and the work at West Yorkshire. We work with colleagues across West Yorkshire where this affords us the scale required to tackle issues we cannot address alone, and where this provides greater efficiency or where variation is un-warranted.

This, our first Joint Forward Plan, sets out the aims of our priority and enabling programmes of work for the next five years and our commitments for 2023/24. This is set within the context of our partnership strategy and our operational plan (Figure 4).

Figure 4: Our Joint Forward Plan 2023

Together, these are the foundations of our operating framework as a Health and Care Partnership.

Our Purpose

Our four primary purposes as a health and care partnership are:

- 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.

Lives in Bradford district and Craven are being cut short. People living in deprived areas of our district are more likely to die sooner than those in more affluent. To stop people dying early and to help people have a healthy and happy life, we need to work together to create a fairer district for all. To do this we will look to create opportunities for everyone to access quality care, stable jobs, fair pay, good housing, and education.

Reducing Inequalities Alliance

As part of this effort, we have created the Reducing Inequalities Alliance. The Alliance aims to support and coordinate collective action to reduce inequalities in Bradford district and Craven. It is made up of allies across our partner organisations.

Our four aims are:

- Setting the strategic vision for reducing inequalities: The Reducing Inequalities Alliance aims to inspire a shared vision for reducing inequalities in health (and the determinants of health). This will need a culture where addressing inequalities is everybody's business. For this to happen we need to challenge existing processes. We need to apply the inequalities lens to all projects, programmes, objectives, and outcomes. Collectively we need to support and influence local strategies for a systematic approach to reducing inequalities;
- Building confidence and skills in our workforce to reduce inequalities: We want to make reducing inequalities part of everything we do as a workforce. We have created this workstream to encourage everyone across the whole system to work towards this common purpose. We want to support individuals and organisations to know how their work is helping to address inequalities. The purpose of this workstream is to support staff to understand their role in reducing inequalities and to increase leadership capacity within the alliance of partners;

- Supporting best practice in the ways we work, the skills we use, and the evidence we draw on to reduce inequalities: We want to support our workforce to deliver best practice in reducing inequalities. This includes improving the skills and tools we use to assess and reduce inequalities, the evidence base we draw on (both local and international), and the data we use (from personal stories to data led intelligence); and
- Creating opportunities to evaluate our work and share learning: We are committed to reducing inequalities, and to achieve this we need to develop a clearer understanding of 'what works'. A key function of the Alliance is to create the time and space to share learning with our partners, so that we can do this together. The purpose of this workstream is to facilitate the capture and share insight across our place.

In 2023/24 our plans include:

- Continue to support our workforce with our communications programme including our call to action, short animations/films, newsletters, and conference/workshops.
- In the final year of the Reducing Inequalities in Communities programme (a population health management approach to tackling inequalities in the inner-city area) we are developing plans for sharing the learning from this work, and funding successful projects longer term.
- Supporting our Community Partnerships (CPs) to develop plans on how they can reduce inequalities. We have developed a 'reducing inequalities' toolkit and an evidence and data pack for each CP.
- Supporting our system priority programmes to address health inequalities with deliverable actions, funding initiatives, and working with community partnerships and GP practices facing the highest levels of inequalities to close the gap via our Core20PLUS5[3] programme and Health Inequalities Premium (additional funding for the 35 practices with the highest combination of deprivation and health challenges).
- We will continue to work with partners to embed addressing inequalities through:
  - Direct input to a broad range of programmes (e.g. Serious Mental Illness, Children and Young People, Digital Inclusion, and Universal Healthcare);
  - Creating key messages for inclusion in partner organisations' induction programmes (via the People Plan);
  - Supporting participants in the Improving Population Health Fellowship; and
  - Aligning our activity with other key enabler programmes.

[3] NHSE Core20PLUS5

Our Population

For our population, we will all:

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

We have identified three specific areas of focus for the next five years: Access to Services; Mental Health; and Children, Young People and Families.

Access to Care

Our vision is to ensure that our population can access the care they need, in the place that is the most appropriate to deliver it. We will achieve this by:

- Improving access to health and care for the communities we serve;
- Removing the barriers that create inequalities to accessing care; and
- Ensuring our people receive the right care, in the right place, first time.

Our focus will be on tackling the major health conditions experienced by our population, improving access to elective (planned) care services, re-designing how people access urgent care, and ensuring collaboration across providers where there are benefits in doing so (Figure 5).

The latest Global Burden of Disease study shows that the top five causes of early death for the people of England are: heart disease and stroke, cancer, respiratory conditions, dementia, and self-harm.

Our focus on major health conditions (Long Term Conditions) is a key priority in the NHS Long Term Plan as well as for our place, ensuring we can diagnose and treat these conditions earlier, prevent our population from developing a Long Term Condition, and support people to manage their condition following a diagnosis.

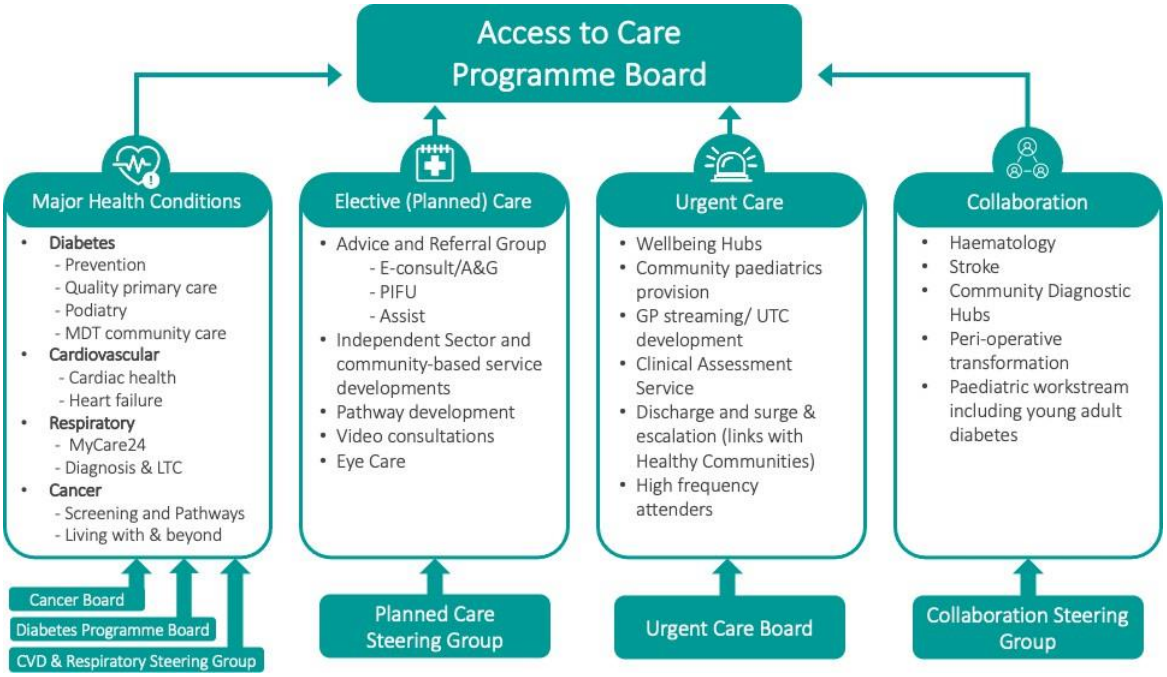


Figure 5: Access to Care workstreams

During the Covid-19 pandemic, we took the opportunity to develop more community-based pathways of care and maximise the support of the independent sector to continue our planned care work. Our focus has turned to how we can maximise the opportunities in the digital arena, focusing on aspects such as e-consults and Assist pathways to support GPs with referrals, patient initiated follow up and the use of digital devices; and patient optimisation as part of their ongoing support and care whilst awaiting treatment.

We also continue to collaborate across secondary, primary, and acute care on new service developments or changes to how and where people are cared for, such as VCSE, primary care, and community models of care, reducing the reliance on traditional hospital-based care pathways.

Urgent care, whilst still transformational, has very specific operational requirements it must deliver, which are nationally driven, but our urgent care agenda is system focused and encompasses all partners across hospices, VCSE, and the social care sector.

We have developed, in partnership, services such as the Wellbeing Hubs and community paediatric hubs to move activity into the community. This recognises that urgent care services might be the most familiar and therefore first point of contact, but we are opening up access to other services to ensure people can receive the right care for their need, closer to their home.

Collaboration is supporting our teams to work collectively on areas of improvement and opportunity to make a difference to how, where, and who delivers care to people in our communities.

We have recruitment and capacity challenges, significant demand increases and will often have to respond to changes in the local, regional, and national landscape. We work collaboratively to develop initiatives once and implement these system wide.

In 2023/24 our plans include:

- An additional 7,700 outpatient appointment appointments, 9,600 inpatient and day-case procedures, and an additional 18,100 diagnostic tests above 2019/20 activity. Doubling Patient Initiated Follow Up (PIFU) activity over 2023/24.
- Reduction in our overall 18-week referral to treatment (RTT) target list size, that is the total number of people waiting for treatment that would be counted against the 18-week target, and a specific reduction in the number of people waiting more than 52 weeks for hospital treatment, with the elimination of waits over 65 weeks by March 2024.
- Improving 6-week waiting times performance for access to diagnostic tests towards the March 2025 expectation of 95%, including opening a Community Diagnostic Centre.
- Improvement in the cancer waiting list backlog (those still waiting for treatment beyond the 62-day national standard) and plans to over deliver against the 75% 28-day faster diagnosis target by March 2024.
- Improve A&E 4-hour performance in line with the 76% national recovery target by March 2024.
- Manage the impact of increasing emergency hospital demand via admission avoidance schemes, improved hospital flow and discharge, and additional beds resulting in a reduction in patients in hospital who no longer meet the criteria to reside and reducing average bed occupancy levels in line with the 92% national expectation.

Healthy Minds

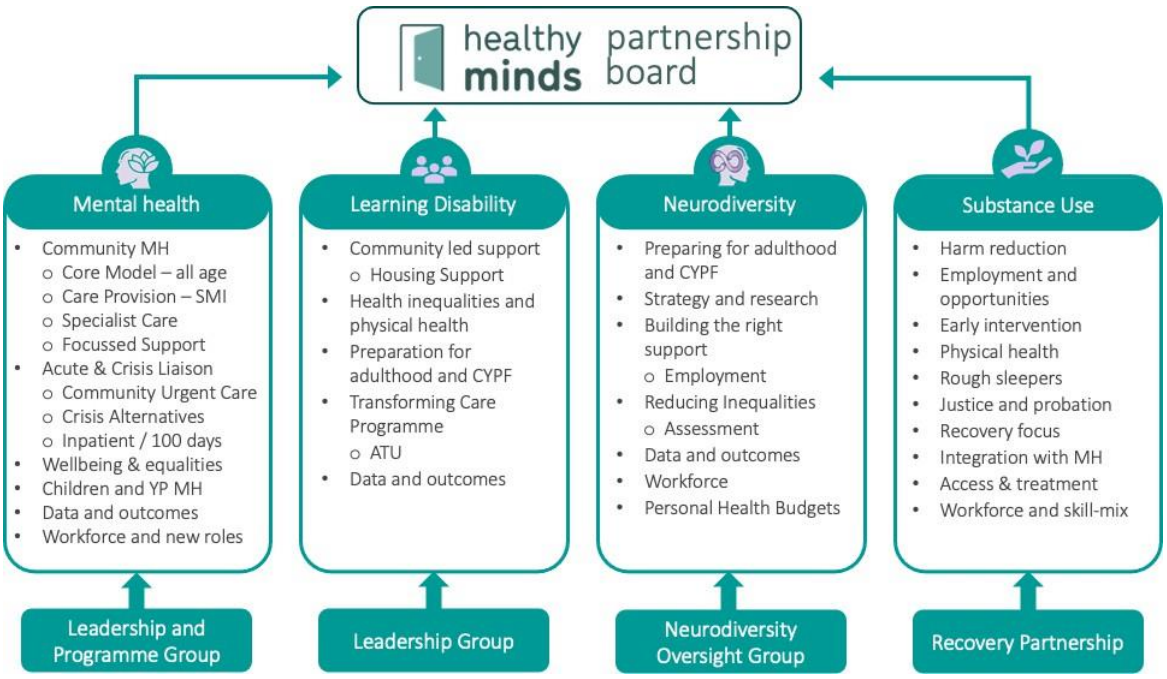


Figure 6: Health Minds Workstreams

Through our Healthy Minds priority programme of work (Figure 6) we will:

- Increase the years of life that people who have mental health needs, substance use issues, live with a learning disability or neurodiverse needs, live in good health;
- Achieve a reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population. In doing this we will focus on early support for people across their life journey;
- Establish new and integrated models of primary and community mental health care to support adults and older adults who have severe mental illnesses, so that they will have greater choice and control over their care and be supported to live well in their communities;
- Establish an improved comprehensive round the clock crisis service across our district that can meet the continuum of needs and preferences for accessing high quality crisis care in the least restrictive and most appropriate place – whether it be in communities, people's homes, emergency departments, multi-agency, or inpatient settings;
- Work as a whole system to promote, protect and improve children and young people's mental wellbeing to enable them to lead full, happy, and healthy lives;

- Promote the health of people and reduce the inequalities gap in access and support to services, and support to achieve independent living;
- Work together with people with learning disabilities to reduce health inequalities, uphold people's rights and help them achieve their aspirations, ensuring that people get the right support at the right time in their local community or least restrictive setting;
- Transform the lives of people who are autistic/neuro-diverse. We do this to enable them to live the lives they choose, achieve their personal goals, feel valued and know their voices are heard. Together, we transform lives;
- Deliver a world class substance use treatment and recovery system, reduce the use of recreational drugs, and deliver fair opportunities for people; and
- Across all workstreams, we will maximise the opportunities to improve addressing the wider determinants of health and deliver hope, choice, and independence as core themes to our approach.

In 2023/24 our plans include:

- Increase the number of people who first receive Talking Therapies recognised advice and signposting (previously known as Improving Access to Psychological Therapies or IAPT) from 12,237 per annum in quarter 4 2022/23, increasing to 13,164 per annum from quarter 4 2023/24.
- Increase the number of women who have had at least one attended contact in the year with Perinatal Mental Health Services, which is face to face or by video, from 78 in quarter 1 to 104 in quarter 4 2023/24.
- Further improve our recorded dementia diagnoses to estimated dementia prevalence rate to 69% (above the national recovery target of 66.7%).
- A 5.5% growth in the number of children and young people aged 0-17, supported through NHS-funded mental health services, receiving at least one contact.
- Reduce the number of inappropriate, adult acute mental health, out of area placement (OAP) Bed Days to no more than 90 bed days in quarter 4 2023/24.
- Increase the number of adults and older adults receiving at least two contacts with core community mental health services by 4% through increased investment into core mental health services and the development of new roles.
- 75% of people with a learning disability will have an annual health check.

Healthy Children and Families

Our children and families partnership work (Figure 7) focusses on:

- Best 1001 days: Improve the outcomes for maternal care across Bradford district and Craven and reduce disparities in experiences by working as a whole system;
- Universal prevention and early identification: Children and young people are at the heart of all we do. Universal and targeted services will work together seamlessly so that: All babies, children, and families are able to live a healthy, happy life, and when they do need additional help, they receive the information and support they need easily and as early as possible; Inequalities are reduced and every child, young person, and family with additional needs is identified and supported by skilled and confident workers (and peers or volunteers) at the right time, in the right place, by the right people; and Families' strengths are built on so they can develop skills to build healthy relationships and social connections;
- Pathways and services: A vision will be developed with service users and programme pillar workstreams, but the areas of focus will initially be to look at physical health, emotional wellbeing and mental health, and learning disability and neurodiversity services; and
- Complex care: To improve the health and well-being, and reduce inequalities, of children and young people (aged 0-25) who have complex health and care needs.

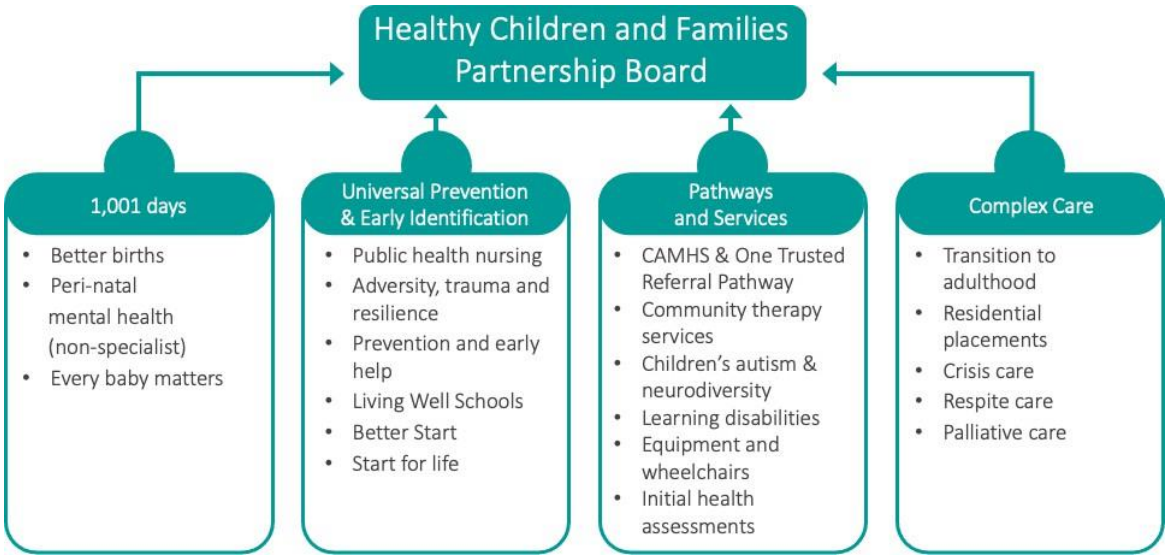


Figure 7: Children and Families workstreams

We will work in partnership with the new Bradford Children's and Families Trust and are working at place on creating a child-friendly place and city. Similarly, we are working with North Yorkshire Council to ensure that the needs of our children within the Craven communities are identified and appropriate services in place, with work underway to help prepare for a Special Educational Needs & Disabilities (SEND) inspection.

In 2023/24 our plans include:

- We will continue to deliver the actions from the final Ockenden report for maternity and neonatal services, ensuring that all women have personalised, safe and equitable care so that outcomes (stillbirths, neonatal mortality, maternal mortality and serious intrapartum brain injury) will improve.
- We are working collaboratively across our health and care partnership to provide support to meet children and young people's identified needs, to reduce reliance on the requirement for a formal diagnosis of autism while waiting for assessment. This includes a commitment to reduce the current waiting times for autism assessments.
- We are committed to improving waiting times for children's community therapy services.
- We will work with partners to demonstrate improved outcomes in the health and wellbeing of children with SEND, ensuring they receive timely support'.
- We will consider the specific needs of children and young people and reflect the Children and Young People's Core20PLUS5 in plans to reduce health inequalities.

Our Place

We will all:

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

Living Well

Living Well is our whole system approach to obesity and improving wellbeing. Our vision is to create a district where we are all making it easier for everyone to live a healthy and active lifestyle. We aim to enable the places and organisations in which we live, work, learn, and play to promote health and wellbeing by making it easier for people of all ages to adopt healthier behaviours and become better able to care for themselves.

Living Well is made up of multiple projects, which together enable the system to achieve our vision through the following four workstreams (Figure 8):

- Individuals and Families: enabling behaviour change through provision of accessible, personalised support services directly to people and families;
- Communities and Organisations: enabling behaviour change through facilitating adjustments to policies and practices in schools, businesses, health, and community settings to create health-promoting places across the district;
- Physical Environment: enabling behaviour change through facilitating physical changes to our environment to default people into being more active and have a healthy balanced diet; and
- System Enabler projects: enabling behaviour change through the Living Well core support offer e.g. communications, and education offers to the public, workforce, and policy makers.

Figure 8: Living Well workstreams

In 2023/24 our plans include:

- Improving wellbeing through embedding prevention offers into care pathways for adults by making it easier for people and clinicians to access the Living Well Service offers to help people adopt healthier lifestyle behaviours as a normal part of their care.
- Increasing awareness and referrals into our new weight management service for children and families and develop a blended pathway model to include other services.
- Establish a viable service model for the new weight loss medications and agree a clear pathway for the thousands of eligible adults.
- Strengthen individual and community capabilities, to create healthier places and reduce health inequalities at locality level. This includes work to improve health literacy, understanding the barriers to behaviour change and developing the social movement into grassroots community settings.
- Finalise and start implementing actions from the Physical Activity Strategy and the Food Strategy across the health and care system.
- Aligning shared priorities to create effective and efficient system enablement to help achieve our vision.
- Stakeholder engagement and increasing partners understanding of how they can contribute to the whole systems approach.

Research and Innovation

Research is an enabler for transformation and innovation in the health and care arena. There is already a strong ethos and track record of healthcare research collaboration within the Bradford district and Craven area, which has been in existence for many years. This has been reinforced by the inception of the Bradford Institute for Health Research where partners across the area have collaborated to increase the research opportunities available to the population.

As a City of Research we intend to:

- Promote a City of Research 'Research as One' culture and partnership that provides excellent quality and research opportunities and equity to our population, which will include both our urban and large rural communities;
- Enable a Research Ready Community (RRC). We already have good engagement in some areas and will increase the awareness and the benefits of research, and stimulate our communities research 'appetite' and enthusiasm to be involved and drive our research agenda;
- Working with research funders, public sector, and industry partners, attract more research income. This will enable greater collaborative working across the region delivering research which meets local and regional health and social care needs and NHS ambitions; and
- Build effective and inclusive communication channels to connect with our communities to encourage greater collaborative opportunities.

By doing this we will support and enable innovative care and services across the health and care partnership.

We intend to collaborate across four key areas (Figure 9):

1. Development of research ideas and development of people to create new research and deliver research studies;
2. Governance of research to be harmonised to ensure that Bradford place has a consistent aligned governance response to research;
3. Delivery strategies to ensure that opportunities can be offered to as many of our population as is possible; and
4. Dissemination of the products of research back to staff but also the participating population.

Figure 9: Overview of City of Research planned activity themes

There is an additional cross cutting theme of communication and engagement where we will promote the importance of research, demystify, and encourage people to take part in research, and to enable all staff to see the value of research and the contribution they can make to it.

Within our communication and engagement, we shall work with all our collaborators to:

- Raise awareness around research in key areas: our population; our staff; and our students;
- Demystifying research: understanding what research is and isn't with staff and population; and consideration of health literacy;
- Highlight the benefits of research: better patient outcomes; better quality of care; access to new and novel treatments; and upskilling of staff and career progression;
- Improve access to research opportunities: joining the local registry; and be part of research the national directive; and
- Adopt a collaborative approach: Research as One; sharing of workforce; primary/community, and secondary care all working together; and developing the next generation health and social care professional/researcher.

Examples of research as an enabler to service improvement and development include: Focus on air pollution; and Join us Move Play

Our Partnership

We will all:

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

Our priority areas for the next five years include the Healthy Communities and Workforce programmes, alongside our Digital and Estates enabling programmes.

Healthy Communities

Our Healthy Communities priority programme of work has four aims:

1. To improve population health on community footprints;
2. To work with communities to identify what matters to them and provide them with the opportunities and resources;
3. To focus on a small number of things that address inequalities in health and care for our population; and
4. To join up the community offers of different services and providers delivering health and care in the community (NHS organisations, Local Authority Teams, and VCSE sector).

To do this we work across three footprints (Figure 10):

- Community partnerships;
- Locality collaboratives; and
- Place-based, community health and care integration.

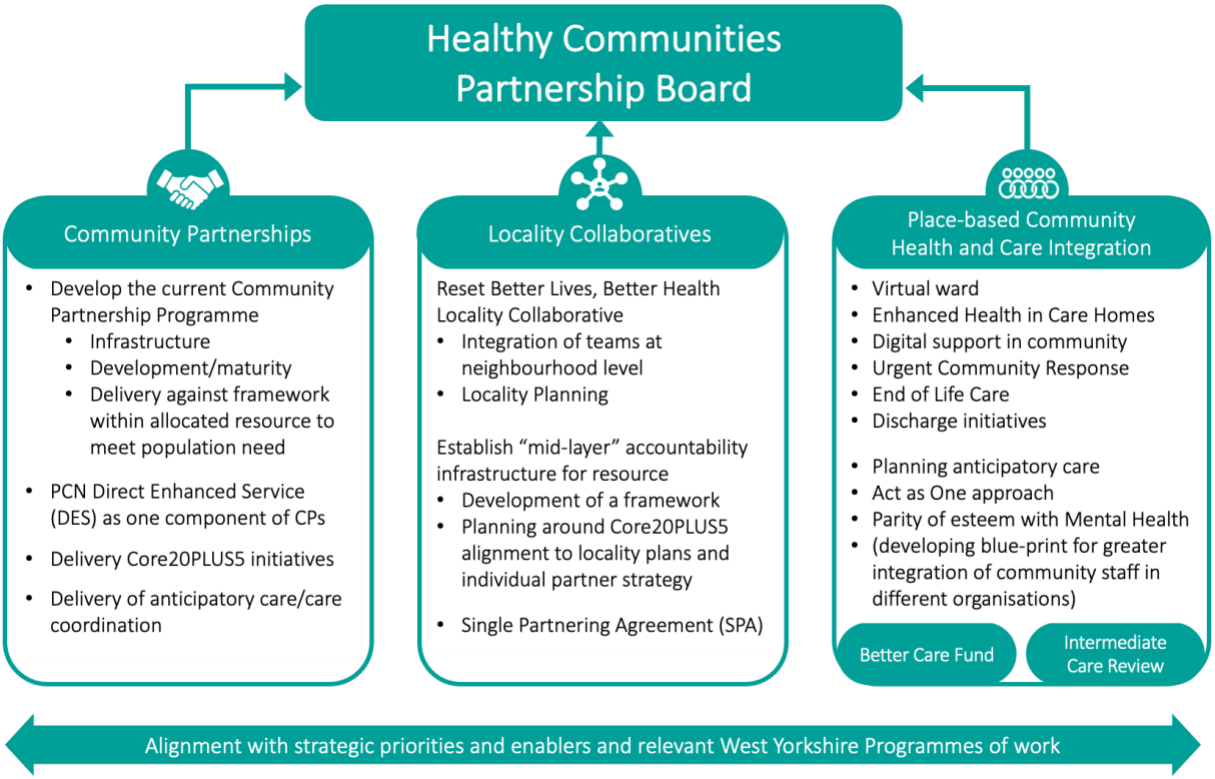


Figure 10: Healthy Communities Workstreams

In 2023/24 our plans include:

- 15% growth in Urgent Community Response activity to avoid hospital admissions.
- An increase in the number of Virtual Ward beds to 155 by April 2024 across a range of specialties using a blended model providing both technology enabled and face-to-face support and interventions.
- Plans to improve community services waiting times for some services, but with the need for a more detailed review and understanding of the issues that need addressing.
- Ongoing work to further improve hospital discharges and ensure community services are in place that enable people to return home and enable them to remain there without a re-admission.
- A 2% reduction in emergency hospital admissions for ambulatory care sensitive conditions (those conditions that can be managed within a primary or community care setting).
- A 2% reduction in the number of our over 65 population who need hospitalisation because of a fall.

- Support more people to remain at home rather than enter long-term residential care.
- 2% growth in GP appointments (just over 90,000 additional appointments in 2023/24).
- Development and implementation of an operating model that integrates health and local authority teams working within neighbourhoods to meet our population's needs.
- Use of Core20PLUS5 funding to deliver changes that matter to local people to address health inequalities.
- Planning and implementation of proactive care models to support people with complex health needs to remain supported at home through multi-disciplinary care teams.
- Development of local Community Partnerships.

Workforce

Workforce is both a priority programme and an enabler programme to the other four priorities (Figure 11). To align with the HCP priorities, we have refreshed the priorities within our people plan to ensure alignment.

Figure 11: Workforce workstreams

Our People Plan is inclusive of all our health and care partners and is focused around 4 Pillars:

- Looking after our people: For our people to be safe and well at work, physically and psychologically, with quality health and wellbeing support for everyone;
- Creating a sense of belonging: To create a compassionate and inclusive culture where everyone feels they belong, have a voice, and feel empowered to make a difference;
- Developing new ways of working: To transform the way we deliver care by maximising digitalisation and enabling our people to Act as One; and
- Growing and retaining our workforce: To grow our collective workforce for the future by recruiting and retaining our people. To be the best place to work; enabling people to progress and fulfil their potential by providing 'careers for life'.

Each pillar is led by a Director of Human Resources within the Health and Care Partnership. This allows us to collaborate on our sector and organisational plans.

In 2023/24 our plans include:

- Growth in our hospital workforce as we focus on reducing our vacancies.
- Growth in staffing to support new initiatives including our pharmacy transformation work, additional day case capacity, additional virtual ward beds, children's assessment unit plans and increase in midwifery to support continuity of carer and Ockenden roles.
- Growth for mental health investment funding in children's and young people's mental health, perinatal mental health, and psychological therapy services.
- A reduction in sickness and turnover and a shift from using agency to local bank staffing over the next three years.
- A mix between domestic recruitment/newly qualified and the use of apprenticeships along-side international recruitment.
- Further development and recruitment to the Additional Roles Reimbursement Scheme (funding for a range of new primary care roles).
- The development of new ways of working to ensure we have the right roles and capacity to support immediate priorities.
- We will continue to 'grow our own' through proactive work with schools via our place-based Careers and Technical Education (CTE) Board. We will also continue to grow the number of schools we work with on a regular basis; building on the interview technique sessions and school assemblies delivered in 2022.

Digital, Data, Intelligence, Insight

The aim of our Digital enabling programme is to best support the needs of our population and the requirements of our colleagues through providing world class leading enabling digital technology. The programme has the following six workstreams:

- Work as One: Any staff member should, with minimal effort, be able to work from any other sites owned by a partner organisation and be able to access all the resources required to perform their role;
- Shared Care Records: To achieve seamless sharing of relevant health and social care information among organisations across the place to ensure seamless transition of care and our people improving their access to and journey through our services;
- Digital Inclusion: No citizens will be excluded from having access to digital devices, adequate affordable connectivity, and the necessary skills to use them to improve their livelihoods;
- Digital workforce: Ensure we have sufficient skills capacity to meet with the current and growing demand for Digital, Data and Technology (DDaT) workforce;
- Cyber Security: Create a cross organisational Cyber Security Working Group where members will contribute to the ongoing cyber readiness and share resources, knowledge, tools, and costs (economies of scale); and
- Information Governance (IG): To develop, implement, and embed an effective IG framework that will support appropriate clinical and organisational record management and record sharing within the Bradford district and Craven footprint enabling our shared care record.

The workstreams will deliver priority objectives through formal priority-themed groups, with clearly identified aims and deliverables that focus on 'getting the basics right' by investing in increased system interoperability and data sharing.

We also have an ambition to make the data that partner organisations hold work harder, to enable population health insights that will improve health outcomes, and by giving health and social care professionals all the information they need wherever they are working.

Our 'Data as One' work will continue to draw all the organisations in the partnership closer together, mitigating administrative barriers for the VCSE sector (e.g. supporting IG accreditation) and establishing closer working with the local authorities.

In 2023/24 our plans include:

- Completing a digital maturity assessment to measure progress towards the core capabilities set out in 'What Good Looks Like', utilising the framework for all the priority work streams as a measure of success.
- Developing the right data architecture for population health management.
- Putting digital tools in place so people can be supported with high quality information that equips them to take greater control over their health, care, and wellbeing.
- Continuing the sharing of resources, knowledge, learning, and tools to maintain a strong cyber response to all threats.
- Mapping the current IT infrastructure, bottlenecks, technical constraints, and limitations across organisational sites, identifying, and sharing good practice that may be applied across partners. Agreeing long-term convergence principles (e.g. technology, support model) and strategic principles.
- Developing a whole system Digital, Data and Technology workforce plan.
- Progressing our Digital Inclusion work including:
    - developing the Digital Inclusion Index to identify key priorities and associated support on a locality basis;
    - securing funding for the appointment of Digital Inclusion Officers in communities;
    - developing further the idea of a digital bus;
    - developing the creation of a digital device donation offer; and
    - Seeking opportunities to extend the Digital Health Champions.
- Further developing our use of Technology Enabled Care (TEC) to support people in their homes.

Our Estate

Our vision for our estate reflects those set out in the Naylor review where we will:

- Provide a modern estate equal to delivering our vision for health and social care;
- Ensure our strategic estates planning reflects changing delivery models;
- Align with future clinical service strategies;
- Proactively maintain our assets and reduce backlog maintenance; and
- Replace what cannot cost-effectively be maintained.

Our NHS infrastructure is essential to the long-term sustainability of our ability to meet healthcare needs for our population; unlocking efficiencies and helping manage demand. It is also fundamental to high-quality patient care, from well-designed facilities that promote quicker recovery, to staff being better able to care for patients using equipment and technology that they need.

We are redesigning the way we deliver and receive care and support, ensuring that our local population receive exceptional care now and into the future. At the heart of the desired future state is a strong primary and community-based, 'out of hospital' model of care that cares for most of the health and wellbeing needs of the local population.

The model is a coalition of primary, community, mental health, social care, VCSE, and urgent care services. Focusing on personalisation, designing support based on delaying and preventing the need for care through proactive care planning, strengths, and asset-based approaches. Our estates strategy will shape how we operate and where we focus our resources, to support this model.

We have clarity in terms of an agreed ambition to plan for the next generation, with an estate that is fit to deliver health and wellbeing for our population in ways that reduce inequalities and improve population health. We recognise the need to work in partnership in the best interests of our population, this is our anchor.

As we shape our system estates strategy, we are considering what services might be best centralised on each hospital site, with hub and spoke approaches to different specialties and pathways of care. We approach our planning by viewing our estate as a whole, with core services on both acute trust sites, including, but not limited to, Emergency Departments and Maternity Services.

Community Diagnostic Centre

Wherever possible, we want services to be provided in local neighbourhoods. Only when the safety, quality and cost-effectiveness of care are improved by providing it at a greater scale will services be provided elsewhere. This already includes diagnostics, outpatients, endoscopy, and minor surgery. We were successful in securing national funding for a local Community Diagnostic Centre, which will enable us to deliver a better diagnostic service and more personalised experience by providing a single point of access to a range of services in the community.

Integration of our services

In developing our estate strategy, we plan to use this as an opportunity to provide greater detail about our plans to ensure that the estate is focused on the optimum location of services to achieve our ambitions of investing in wellness, reducing inequalities and bringing care closer to home.

Our emerging clinical strategies are shaping our future estate needs, along with a programme of required projects, investment, and associated system benefits. Work has begun on considering the new models for providing social care services, which entails reconsidering the location and potential co-location with health services. This provides an opportunity to align with the reconfiguration of community and primary care estate.

We have worked collaboratively to gain a shared understanding of the totality of our community estate and how we can rationalise and increase value from this together. This asset review will be used to shape and inform plans for our locality model of working.

In 2023/24 our plans include:

- Managing the ongoing impact of Reinforced Autoclaved Aerated Concrete (RAAC) at Airedale Hospital, ahead of the building of a new hospital and Urgent Care Centre.
- Modernising the estate of Lynfield Mount Hospital.
- Developing our 'hub and spoke' locality model of health and care service delivery aligned with parliamentary constituency boundaries.
- A new surgical day-case facility at St Luke's Hospital.
- A Community Diagnostic Centre at Eccleshill and a business case for a 'spoke' centre in Airedale.

Oversight and Assurance

The Bradford District and Craven Health and Care Partnership is led by an independently chaired Partnership Board, which operates with delegated authority and accountability from the West Yorkshire Integrated Care Board.

The Partnership Board agrees our place-based strategy and associated high-level budget allocations. It receives assurance from following three committees:

- Quality Committee: Provides assurance on the quality, safety and effectiveness of services and the contribution services make to improving health outcomes for local people;
- People Committee: Ongoing assurance of the delivery of the partnership's people plan and that the outcomes of the four pillars of the people plan are being achieved; and
- Finance and Performance Committee: Provides a collective focus on financial and performance outcomes.

The Partnership Board is also advised and informed through a comprehensive process of public involvement, a citizens forum, a clinical and professional forum, and a planning and commissioning forum (Figure 12).

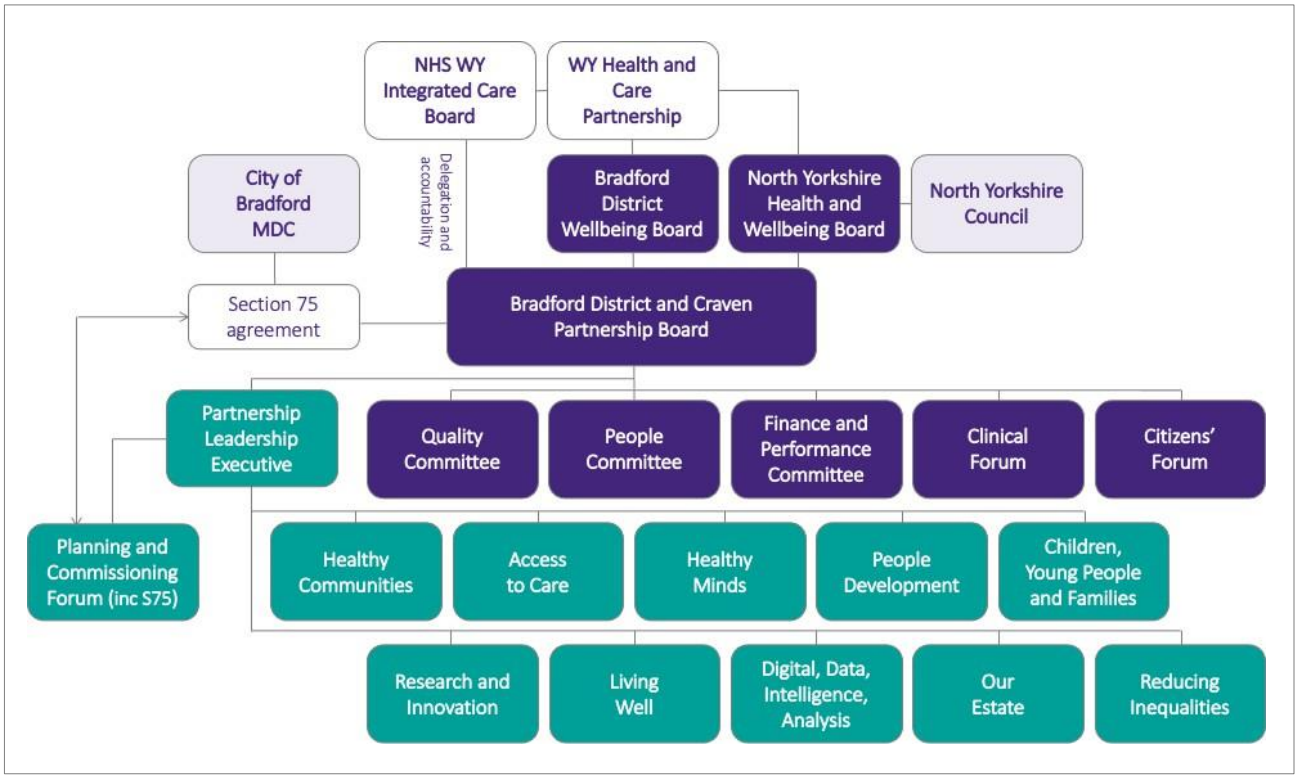


Figure 12: Our Partnership Governance Structure

The implementation of our strategy is led by the Partnership Leadership Executive (PLE), which is accountable to the Partnership Board. The PLE is a muti-sectoral, senior leadership group, chaired by the Place lead, accountable to the West Yorkshire ICB chief executive.

The PLE oversees our Priority and Enabling Programme Boards, the engine rooms through which our plan will be delivered alongside our Place based ICB functions (Figure 13).

Figure 13: Our Partnership Operating Model

The Partnership Board will agree our local Joint Forward Plan, following advice and recommendation from the PLE. Thereafter, the PLE will receive regular updates on progress with implementation of the plan, whilst our priority enabling programme boards will oversee delivery of individual initiatives that contribute to achievement of our goals.

Metrics

Our overall long-term measure of success will be to increase the healthy life expectancy of the population of Bradford District and Craven. Whilst there are some clear outcomes and metrics identified within this plan in relation to our immediate commitments for 2023/24, there is further work needed to define the measures to demonstrate delivery towards our longer-term objectives.

These measures will need to demonstrate that the work of programmes, both individually, and collectively, are delivering their aims and objectives.

Each of our programmes is at different stages of maturity, and work is underway to help them scope out the key performance metrics that the programme boards and workstreams need to provide assurance and aid decision making.

This work also needs to ensure alignment between Bradford District and Craven, and the West Yorkshire measures of performance and impact.

Report contacts: Kerry Weir and Clare Smart

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Partnership Board
Agenda item no:	12
Meeting date:	21st July 2023
Report title:	23-25 Better Care Fund Plan update
Report presented by:	Jane Wood
Report approved by:	Jane Wood
Report prepared by:	Javeid Karim

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

Previous considerations:

The Partnership Board on 12th May agreed to delegate authority to Mel Pickup to approve the Better Care Fund Plans for 23-25. The plans have been approved and signed off by the appropriate colleagues.

Executive summary and points for discussion:

This year's Better Care Fund (BCF) is a 2-year plan (2023-25).

The final plan (planning template and narrative) was submitted to the BCF national team on the 27th June.

The BCF is a jointly agreed plan between local health and social care commissioners which was signed off by the chair of the Health & Wellbeing Board (HWB) on 24th June 2023.

All funding contributions for our BCF have been agreed by HWB areas and minimum contributions are pooled in a section 75 agreement (as detailed in the NHS Act 2006). The NHS contribution to social care from the Integrated Care Board (Bradford District & Craven) ICB is agreed and meets or exceeds the minimum expectation.

The overall BCF plan is built on 4 budget streams

- Better Care Fund (BCF) - £46.8m
- Improved BCF (iBCF) - £23.4m
- Adult Social Care Discharge Fund (ASC DF) - £6.5m
- Disabled Facilities Grant (DFG) - £5.1m

Finance leads in both organisations have agreed on the spend and have worked together to align the BCF to be more transparent and reflect our actual spend across the different scheme types. The 2024/25 spend (including the increased discharge fund) will be reviewed and updated in Q3 where we are expected to submit a new report on any changes to our plan for year 2. All services have estimated their uplifts for 2024/25 and this has been accounted for in the planning template.

All plans commit to either maintaining or improving current delivery.

A capacity and demand plan for 2023/24 has been included in the planning template. Further work is needed to understand the full extent of demand & capacity across all services.

Where appropriate, the BCF plan aligns with the Bradford District & Carven operational plan.

The BCF has been discussed and approved at a range of Health & Care Partnership governance meetings.

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 note the submission of the BCF 2023-25;

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. Updates from the Better Care Fund 2023-25

   BCF Presentation Partnership Board.ppt

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	-

Bradford District and Craven
Health and Care Partnership

ACTasONE

2023/25 Better Care Fund (BCF) Update

Governance and assurance

Bradford District and Craven Health and Care Partnership

Meeting Name	Date	Lead
Partnership Leadership Team	10/05/23	**Ali Jan Haider and Jane Wood**
Planning and commissioning Forum	15/05/23	**(All)**
Healthy Communities Board	18/05/23	**Iain MacBeath**
System Finance and Performance Committee	25/05/23	**Iain MacBeath**
Partnership Leadership Executive	26/05/23	**Iain MacBeath**
Health and Wellbeing Board	13/06/23	**Iain MacBeath**
System Quality Committee	22/06/23	**Iain MacBeath**
Partnership Board	21/07/23	**Jane Wood**

- The BCF has been approved by the above groups.
- Wider colleagues were involved in the governance and assurance process

Feedback from the BCF team

Bradford District and Craven Health and Care Partnership

- **PR2 - A clear narrative for the integration of health, social care and housing**
  - The narrative would benefit from some detail describing some of the health inequalities people are experiencing and how examples of BCF schemes will hopefully address these. – examples added with support from Helen Farmer.

- **PR3 - A strategic, joined up plan for DFG spending**
  - Good narrative provided but please include narrative on how the issues contributing to the 700+ cases waiting for a DFG will be addressed. – No waiting list. 700 in the system at different stages of the application process

- **PR 5 - An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes**
  - Narrative states that purchasing additional step-down beds had unintended consequences – useful to know what these were. – Narrative was updated. This was already submitted last year in the fortnightly reports (which was approved).

- **PR6 - A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**
  - Narrative states there is an expectation of an increase for enablement (P1) during winter - using BCF to meet demand. Would be helpful to include narrative on how enablement is being expanded/enhanced. – Updated Narrative and referenced throughout.

- **PR 8 - Is there confirmation that the components of the BCF pool that are earmarked for a purpose are being planned to be used for that purpose?**
  - Two schemes require % of overall spend in the Expenditure Tab – Finalised and submitted

Updates

Bradford District and Craven Health and Care Partnership

- Signed by Mel Pickup **(Place lead),** Iain MacBeath **(Strategic Director of Health and Wellbeing)** and Susan Hinchcliffe **(Chair of the Health and Wellbeing Board)**
- **BCF plans were submitted on Tuesday 27th June to the BCF National team**
- Waiting for final feedback and approval letter from the BCF team
- Fortnightly and monthly reports continue to be submitted

- **Forward Plan:**
  - Work on the feedback provided
  - Update Section 75 schedule
  - Improve our data collection for the Fortnightly/Monthly reporting
  - Agree the use of the ASC DF 24-25
  - Recommendations in the IMC review
  - Review and enhance our current services
  - Identify any **potential or new areas** of joint working which can be evidenced in the BCF
  - Continue building links with Housing, VCS and Social Care providers

Bradford District and Craven
Health and Care Partnership

ACTasONE

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

Bradford District

Better Care Fund 2023-25

Narrative Plan

May 2023

Overview

Authorisation and sign-off of the Bradford District Better Care Fund

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Overview

Health and Wellbeing Board(s)	Bradford
Local Authority	City of Bradford Metropolitan District Council
Integrated Care Board (ICB)	NHS West Yorkshire Integrated Care Board
Boundary Differences	The West Yorkshire ICB covers the geography of the five upper tier Local Authorities in West Yorkshire, plus the Craven District of North Yorkshire. Bradford District is wholly within the geography of the ICB
Date of narrative submission:	28 June 2023
Minimum required value of pooled budget:	**2023/24:** £81,919,076 **2024/25:** £86,734,115
Total agreed value of pooled budget:	**2023/24:** £81,919,076 **2024/25:** £86,734,115
National Conditions	This plan is compliant with the following national conditions of the BCF planning framework: **NC1:** A Jointly agreed plan **NC2:** Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer **NC3:** Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time **NC4:** Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

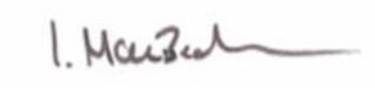
Authorisation and sign-off of the Bradford District Better Care Fund

This Better Care Fund Plan has been produced by local partners who work together as the Bradford District and Craven Health and Care Partnership. This consists of officers across NHS West Yorkshire Integrated Care Board (referred to as the ICB) and City of Bradford Metropolitan District Council (CBMDC), with support from the Voluntary Community and Social Enterprise Sector, Social Care Providers, Housing representatives and Disabled Facility Grant leads.

This plan has been jointly agreed by CBMDC, the ICB and the Chair of Bradford Health and Wellbeing Board. The plan has been presented at a number of forums including the Bradford District and Craven Health and Care Partnership's Partnership Board and Partnership Leadership Executive.

Signatories

Signed on behalf of the ICB	NHS West Yorkshire Integrated Care Board 
By	Mel Pickup
Position	Place Lead – Bradford District and Craven
Date	27 June 2023

Signed on behalf of the Council	City of Bradford MDC 
By	Iain MacBeath
Position	Strategic Director of Health and Wellbeing
Date	23 June 2023

Signed on behalf of the Health and Wellbeing Board	Bradford and District Health and Wellbeing Board 
By	Councillor Susan Hinchcliffe
Position	Chair of the Bradford Health and Wellbeing Board
Date	24 June 2023

1. Background and Context

The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have published a Policy Framework for the implementation of the Better Care Fund (BCF) for 2023-25. The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved.

These are:

1. A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.
2. Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
3. Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
4. Maintaining the NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

The Adult Social Care Discharge Fund (also referred to as Discharge Fund) was announced in 2022 with the intention to tackle the delays in discharging people from hospital who do not meet the criteria to reside. The funding has been re-established and pooled in to the BCF for 2023-25. This encourages health and wellbeing areas to work more collaboratively to reduce hospital admissions as well as uphold safe and timely discharges.

The BCF is held by the Council and the ICB support schemes which sustain admission avoidance, enhanced personalisation, supporting prompt hospital discharge to return people back to their normal place of residence and improve equality and reduce health inequalities.

We have developed this narrative alongside the BCF planning template to respond to the BCF Policy Framework and BCF Planning Requirements for 2023/25.

2. Governance and Approach to Joint Commissioning

We are dedicated to continuously improving our services to better the lives of people we support. We do this by regularly reviewing our joint working arrangements (BCF and Section 75) and provide regular updates to maintain effective service delivery.

We have held several workshops to involve key stakeholders in the planning and oversight of the 2023-25 plans. The workshops have facilitated collaborative working towards our joint commissioning intentions, which will be published later in the year. We have several work streams that were acknowledged through the workshop, which included identifying overlaps in services across our place and ensuring that we pool our resources where possible. This encouraged a more collaborative approach to promote better outcomes for our service users. We are also integrating more virtual teams as part of our approach to joint working. This improves integration and ensures regular communication is maintained through the services we commission as a partnership.

We have a number key groups that form the governance and assurance process for the Better Care Fund. These groups are detailed below.

2.1 Governance and approach to joint commissioning

The Health and Wellbeing Board is the lead partnership in the Bradford District Partnership working closely with the other Strategic Delivery Partnerships.

The Health and Wellbeing Board brings together leaders from across the district including the Council, the NHS, the Police, Fire and Rescue, social housing and the Voluntary and Community sector.

Our shared ambition is:

To create a sustainable health and care economy

that supports people to be healthy, well and independent

The Board provides strategic direction to a wide range of organisations that organise health and wellbeing services, and support people to take good care of their own health and wellbeing; helping more people to take control of their lives and to have more of a say in how their health and wellbeing needs are met. We will lead real improvements in the long-term health and wellbeing of all our population.

2.2 Bradford District and Craven Partnership Board (PB)

The Bradford District and Craven Partnership Board is established as a committee of the NHS West Yorkshire Integrated Care Board (ICB). Its role is to lead the Bradford District and Craven place-based health and care partnership in accordance with the Bradford District and Craven Strategic Partnering Agreement (SPA), and in accordance with the Constitution of the West Yorkshire Integrated Care Board. The Board provide assurance for the BCF prior to sign off from the Health and Wellbeing Board.

The Partnership Board membership has agreed to work towards a common vision that:

- People will be healthier, happier, and have equitable access to high quality care. Our Health and Care Partnership strategy sets out the priority areas of our 'Purpose', 'Population', 'Place', and 'Partnership' as well as a 'spotlight' focus on children and young people. By working to improve on these focus areas we will address the imbalance within our system and allow equal access to health, social and wellbeing services.

- People will be in control of their health and wellbeing, and will be supported to stay healthy, well and independent through their whole life. Communities and the health and care system will co-produce health and wellbeing and will focus on prevention and early intervention.

- Reducing the widening health inequalities in Bradford District and Craven (BD&C) is a priority. We will tackle inequality in access and quality of healthcare, and we will contribute to addressing the wider causes of inequality by playing a full part in social and economic development and environmental sustainability.

- 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. Access to services will include digital options and will be provided as close to where they live as possible.

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

2.3 Partnership Leadership Executive (PLE)

Our Health and Care Partnership Management Forum, the PLE, has two roles.

The first is to support the NHS West Yorkshire Integrated Care Board (ICB) on issues within its remit. The second is to support the wider place partnership. Support is provided through advising and working collaboratively with all members of the partnership.

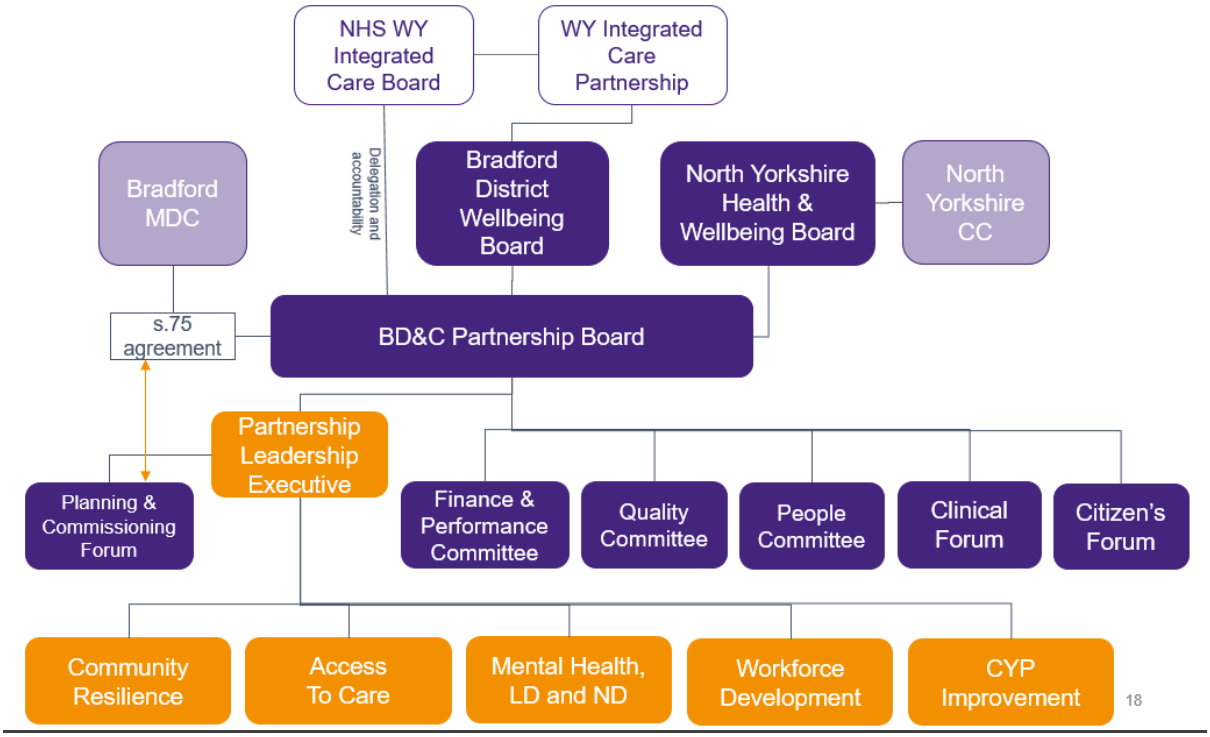
In practice, the PLE carries out both roles by reporting to the Bradford District and Craven Health and Care Partnership Board, which comprises senior leaders from the Place Partnership and is a committee of the ICB.

The members of the Partnership Leadership Executive are:

- The BDC Partnership Place Lead, Chair of the Partnership Leadership Executive.
- The Chief Executive of Airedale NHS FT
- The Chief Executive of Bradford District Care NHS FT
- The Chief Executive of Bradford Teaching Hospitals NHS FT (Place Lead)
- The Chief Executive of City of Bradford Metropolitan District Council (CBMDC)
- The Strategic Director of Health and Wellbeing of CBMDC
- The Director of Public Health of CBMDC
- The Director of Children's Services of CBMDC

- The Chair of the BD&C Clinical Advisory Board
- The Medical Director of the Local Medical Committee
- The Chair of the BD&C Clinical Forum
- The Chief Executive of the Bradford Care Association
- The Voluntary, Community, and Social Enterprise Sector System Lead

Figure 1: Bradford District and Craven arrangements



2.4 Systems Leadership through Act as One

'Act as One' describes our approach for our health and care partnership for Bradford District and Craven that serves a population of around 658,000 people with a health and care workforce of over 30,000 supported by over 5,000 Voluntary and Community Sector organisations. The partnership is made up of NHS, Local Authority, Healthwatch, community and Voluntary Sector organisations and independent care providers.

Our focus is on preventing ill health as much as possible. We will create opportunities that help people stay healthy, well, and independent and tackle inequalities across our communities. We will prioritise prevention and early intervention, fostering healthy lifestyles, self-care and nurturing active communities so that people are happier, healthier and more independent.

Our Partnership has been working together to refresh our priorities, which are:

- Healthy communities
- Access to care
- Healthy minds
- Workforce
- Children, Young People and Families

Our priorities are supported by five enabler programmes which are.

- Research and innovation
- Living well
- Digital data intelligence and insight
- Estates
- Reducing inequalities

We are committed to transforming our systems and modernising health and social care in our area so that our local communities can enjoy the right quality of service and support at the right place at the right time, provided by the right person. Our success in doing so will be determined by local people and depend on our ability to bring together and maximise the potential of our shared resources across health and social care. Our approach requires determined and purposeful leadership that recognises and steps up to the challenge of a creating and realising a new ambition.

Our partnership needs to prepare us for a sustainable future, from sharing good practice, collaborating on workforce developments, to enabling integration to support delivery. Collaboration has become an essential part of a sustainable future; allowing us to design how we will work as we move to acting as one integrated care partnership.

We Act as One in our approach to planning, recovery and priority setting in our pursuit of improved health outcomes. We are held to account, and hold ourselves to account, for the reduction in health inequalities for our population. By doing this we will move closer to our vision of people living ‘happy, healthy at home’.

The system priorities demonstrate how we agree and operationalise our approach to integration with member representation on our boards and committees from our system stakeholders. Joint initiatives such as the joint commissioning road map, development of the system Planning and Commissioning Forum and other key initiatives are leading to sustainable plans for delivery of services.

Our partnership has put reducing health inequalities centre stage in our local strategy and supported this by a dedicated team who have developed a Reducing Inequalties Alliance with NHS and other partners. This is discussed further in 9.2.

Additionally, our Place has begun to utilise resources collectively through creation of joint posts at system level. The Strategic Director Health and Wellbeing within the Council also holds the post of Director of Integration within Bradford District Care NHS Foundation Trust.

2.5 Joint Commissioning

Our senior leadership team consists of assistant directors in the Council who work in conjunction with lead representatives from the West Yorkshire ICB. We have a single joint commissioning approach across the partnership, which is underpinned by Act as One. This is further strengthened with a recently developed People Commissioning Team within the Council.

Our joint commissioning work progresses through our Planning and Commissioning Forum. We also have the Community of Practice, a developmental commissioning group across our system. This involves commissioners working alongside transformation leads in our operational services to strengthen our collaborative developments in existing NHS and Council services.

Our strong relationships with the Independent Sector and Voluntary, Community and Social Enterprise (VCSE) and the Bradford Care Association work collaboratively to deliver the highest levels of care and support to our service users. Through our regular provider forums we identify pressures in our system and work together to tackle service challenges in the community.

Some of the examples of joint commissioning work we have undertaken include:

- Home support innovation site
- Delivery of new integrated contracts for supported living
- Jointly commissioned Carers services
- Early intervention and prevention strategy development
- Commissioning strategy development
- Transformational changes to day care services (for people with learning disabilities)
- Development of Extra Care Facilities for 2023-24

2.6 Better Care Fund Management and Oversight

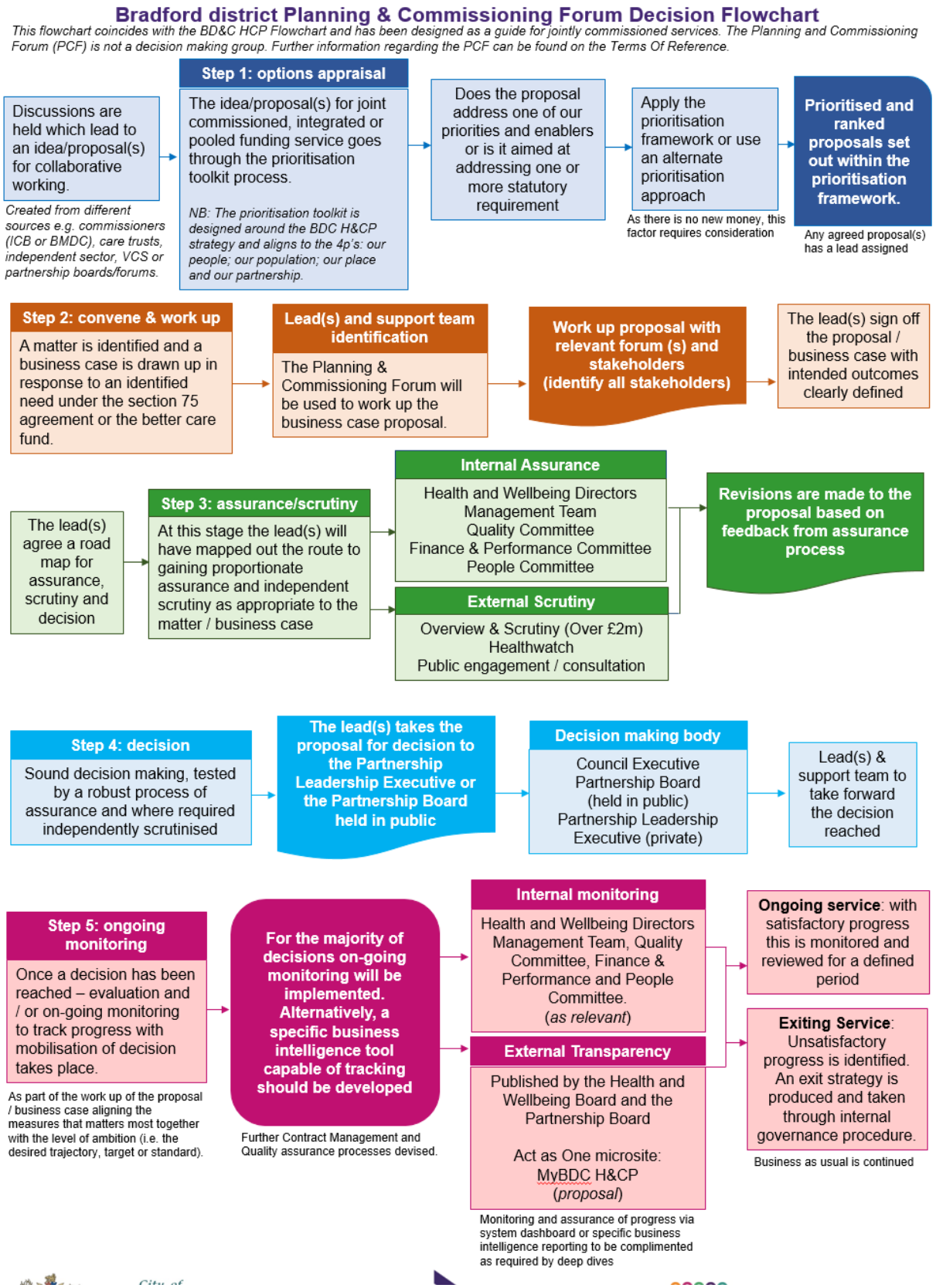
Governance of the Better Care Fund Programme is through the Bradford Health and Wellbeing Board, a statutory committee of Bradford Council.

The Planning and Commissioning Forum provides system leadership and strategic direction to the joint planning and collaborative commissioning arrangements within the Health and Care Partnership. This includes operational oversight of the Better Care Fund, its schemes and the joint commissioning arrangements made under Section 75 (S75) arrangements.

Figure 2, below, demonstrate some of the key groups involved in the BCF planning. These groups provide scrutiny of the BCF plans to ensure it is meetings its intended outcomes. These groups also support in the delivery of our partnership objectives and report to the PLE and Partnership Board.

Together, these arrangements provide assurance to the Partnership Leadership Executive and the Partnership Board.

Figure 2: Bodies involved strategically and operationally in preparing the BCF plan



3. Executive Summary

3.1 Priorities for 2023-25

Over the next 2 years, our ambitions are to enhance our existing BCF services and work towards a sustainable future. As a partnership, we will improve our services by developing our joint workforce and building our intermediate care services. We will continue to allocate resources more effectively with regular reviews of our BCF provision.

In 2022, a review of intermediate care (IMC) was carried out in Bradford, which has informed our plans for the next 2 years. The review considered the context for delivery of intermediate care, the national direction of travel, our local place delivery model and supporting infrastructure. A series of recommendations were accepted that support the ongoing delivery and improvement of intermediate care services based on our changing demographics, integration across community and mental health, how people use services, and the future affordability of the model.

The recommendations from the IMC review, alongside our response to the NHS Urgent and Emergency Care Plan, will be facilitated through the activity in our BCF plans for 2023-25. Our BCF services aim to keep people independent at home for longer (prevent hospital admission) and, where admission is required, help patients to return home with the right level of care and support as soon as possible.

During 2023-24, we will utilise the BCF funding to build on the preliminary recommendations in the IMC review to inform our collaborative plans for 2024-25.

The actions below describe some of our plans:

- Provide additional investment into therapy services to enable more timely assessments and support
- Increase and maximise the digital offer to promote greater independence for individuals
- Improve discharge processes aligned to the 5 key principles of the SAFER bundle with a ‘Home First Approach’
- Increase capacity and referrals into Urgent Community Response (UCR) services through targeted work with low referrers and enabling mechanisms for self-referral in 2023-24
- Improve referral processes for social care community support and reduce inappropriate referrals
- Manage health and social care community beds as a whole, with Trusted Assessors and our MAIDT leading the approach for all beds.
- Enhance the skills of independent sector workers across Home Support and Care Home services to better meet the needs of individuals by adopting reablement approaches across services
- Expand Virtual Ward capacity from 95 beds to 155 beds by April 2024

- Partner with the VCSE sector to support people on pathway 0, 0+ and agree Place objectives to reduce the need for pathways 1, 2 and 3.
- Develop a community single point of access to support care navigation
- Integrate a holistic mental health offer into our community services
- Improve data flows and interpretation of local data to ensure service improvements are data driven and prioritised based on local need.

We will further strengthen our joint working through enhancements to our existing BCF services and the alignment of our budgets to promote further integration within Bradford's health and care services.

We recognise that our collective workforce is invaluable to achieving our goals. Our forward plan prioritises the upskilling of staff and maximising collaborative working. We will break down organisational barriers and promote cohesion through joint commissioning.

During 2024-25 of our BCF plan, we aim to implement the recommendations of the IMC review and be more creative in how we address our system challenges. We will capitalise on the funding streams available to reduce delayed hospital discharges, develop Urgent Community Response services, and workforce recruitment and retention challenges. We will continue to offer versatile services that are responsive to, and reflective of, a wider population than before. This includes dedicated services for older people, those with mental ill health, and people with a learning disability.

3.2 Supporting people to remain at home

Our jointly commissioned BCF services continue to:

- work with communities to build on resources to support people outside of council funded support
- reduce the need for ongoing support from adult social care
- ensure our support builds on the strengths and abilities of people, their families and their local communities
- tailor the on-going support we provide to individuals through personal budgets, creative support planning and building on people's strengths and resources
- reduce waiting times for people contacting adult care and support

The focus in our BCF services remain in line with the BCF policy objectives through the delivery of enablement, home support and intermediate care. We have expanded our Tech Enabled Care (TEC) offer and invested in equipment services which has enabled people to be independent at home for longer.

We also offer direct payments as part of our personalised commissioning initiatives. Direct payments offer flexibility and choice to service users by meeting their needs through a bespoke package of care delivered by a provider of their choice.

We also offer a range of daytime activities which are available for people living in the community. 139 community activity groups are funded in local community centres. Of those there are 36 who cater for a specific BAME community of older people and have language skills and cultural awareness to support older people to stay independent, active and linked with their communities. Many are gender specific groups. In addition, there are 'Men's Sheds', and three groups for the older LGBTQ community, again gender specific.

3.3 Key changes since the previous BCF Plan

There are a number of changes to our jointly commissioned services that will meet the demand on hospital and community services.

Bradford Enablement Support Team (BEST) is our enablement service. It has expanded to incorporate multiple teams that assess patients in the hospitals as well as in the community. It is an integrated service that provides an assessment period for up to 6 weeks. Where long term needs are identified, the service works with the independent sector to provide a smooth transition of care from hospital to the person's usual place of residence or support with the transition to a long -erm domiciliary care provider. This allows us to respond to the demand for home support from hospitals and within the community.

Enhancements within BEST include the introduction of 'KIT bags' which are small parcels of basic assistive equipment which aid in promoting independence, for example long-handled sponges, shoehorns, long-handled brushes, sock aids etc. Enablement Co-ordinators can offer these kits to people to promote independence and help reduce/end reliance on packages of care. Currently 60% of the individuals using these kits have become fully independent and no longer require support. The remaining 40% have had a reduction in care. This reduces the number of 'low level' packages by promoting independence in people homes.

We have seen a rise in the number of patients with complex care needs, which has impacted system flow. Despite these challenges, in 2022-23 63% of people in receipt of BEST were discharged either without the need for a long term care package or with a reduced package of care. In the same period the average length of stay in BEST was 3.7 weeks.

We have trained and upskilled our front line care staff in BEST and in our residential settings to undertake some lower level nursing tasks. This enables high quality support alongside timely assessments, which in turn reduces prolonged care placements. This also reduces the reliance on community nurses who can attend to more complex needs. As a result, we have seen a positive impact on system flow along with an increase of people remaining independent for longer.

We have enhanced the **Home Support Reviewing Team (HSRT)** functions to include annual reviews of long term placements sector placements. In 2022-23 the HSRT completed over 1400 Care Act assessments, a 40% increase from 2021/22. Additional staffing and training has strengthened the HSRT with co-ordinators now having basic OT training to overcome the challenge of recruiting occupational therapists. The HSRT continue to work with social workers and community nurses to assess the needs of all people discharged with a package of care. The HSRT have an agreed pathway to screen and refer for CHC assessments.

To optimise BEST, we have increased the remit of our **Support Options Team**. Support Options are responsible for the brokerage of all care placements across BEST and the independent sector. This has had a positive impact across the system through strengthening our links with the independent sector providers while ensuring a smooth transition is achieved from hospital to home.

We plan to enhance our **residential care setting** by allocating more therapists and social workers to our residential beds. This ensures more effective rehabilitation/reablement for people in these bedded settings and reduces the wait for social work assessments. This will also reduce the impact of prolonged stays at a bedded setting which have proven to hinder people's recovery. We expanded the Tele-med system across all of our residential settings including the independent sector. We plan to continue this offer alongside other assistive technology such as the digital hub to support service users to remain safe at home. The Digital Hub, based at Airedale Hospital, provides a video link between health professionals to aid in speedy intervention and support that reduces the number of admissions to hospital.

We have boosted the resources within both acute trusts, through increasing the number of **Trusted Assessors** (TAs). We now have over 20 trusted assessors and seven administrative staff. TAs are working with patients on the wards to assess their long term needs and preparing them for discharge. This facilitates quicker discharges by engaging with patients from the earliest point of admission. The TAs have helped target patients in the Emergency Department. This includes providing a KIT bag where appropriate and introducing a higher level domiciliary care packages to reduce hospital admission.

Carer Navigators commissioned from the VCS and part of the jointly funded Carers Resource Service have worked with TAs and social workers to support unpaid carers of people receiving short term support or being transferred from hospital. These teams within the hospital form the MAIDT team, a critical service that has been enhanced through the BCF.

We have seen great performance from our **Multi-Agency Social Team** (MAST) which was jointly commissioned from the VCS. MAST screen, assess and signpost people who attend A&E to appropriate support services. MAST continues to provide support for substance misuse support and social prescribing, linking people to services in their communities. MAST has developed more mental health support services and links with our Wellbeing Hubs to offer bespoke advice and guidance to patients.

The **Wellbeing Hubs** are a new development in the last 12 months and operate out of 6 areas in our community where we identified specific needs based on data analysis. They provide a range of out of hours provision from a number of different locations in the district. They are now working with Family Hubs, Community Partnerships and other support services to ensure our service offer is joined up. As part of their ongoing development, they have been supported to create Digital Champions and become designated digital hubs in their communities to support people who experience digital exclusion in a variety of ways

The aims of the Wellbeing Hub are to help people to manage a range of issues including domestic abuse, welfare benefits, mental health, and substance misuse etc. They support individuals to stay well physically and mentally, remain independent and build resilience by supporting them to receive the right care, at the right time at the right place. Feedback

indicates that 42% of people in receipt of the service said they would have accessed an NHS service if the Wellbeing Hubs didn't exist. By directing people with complex social issues to the Wellbeing Hubs following discharge they are supported to access the services to keep them out of hospital. Welfare benefits, fuel and food anti-poverty initiatives are included in the Wellbeing Hubs along with a range of other services commissioned from the VCS.

Our **dementia assessment beds** which provide specialist support for MH service users have been enhanced. We have over 36 dementia beds available across two in-house care homes. The beds provide a short term assessment facility for a period of usually up to 6-8 weeks (meeting the Care Act Criteria). This workers from the community mental health teams to provide a full assessment of the patient's cognitive and physical abilities. The units also refer people with dementia on to diagnostic and support services.

A key change in our BCF plan includes our investment in the **supported living** for people with care and support needs, such as those with a learning disability, experience mental health problems and people who are neuro-divergent. These are services have been included in the BCF to reflect our commitment to widening our services. Many of our supported living homes offer a therapeutic space as an alternative to hospital admission working in partnership with VCS and linking up with existing provision. They also work as step-down facility from residential care to enable individuals experiencing mental distress to live more independently. We are aligning our accommodation offer to a Community Led Social Work approach implemented across all other client groups; ensuring that all Care Act assessments and support plans that are compliant with the Care Act 2014.

We are undergoing a full review of our **equipment provision** including our community equipment service (BACES) and aim to enhance Council **occupational therapy provision**. We have extended core hours within BACES to work more flexibly across 6 days per week. This includes a plan to build a central equipment store including a moving and handling suite, as well as a clinic where people could be assessed. We have also upped our offer of **assistive technology** and the team have moved to electronic care records which help identify patients' needs more effectively and efficiently.

We have continued to expand our health and social care **Urgent Community Response** (UCR) service to people in crisis requiring a 2hr urgent health or social care related response in the community. Referrals into this service have increased significantly during 2022-23 resulting in more people being supported in their own home or a Care Home.

We plan to expand and develop our **Virtual Ward** (VW) to facilitate early supported discharge or avoid a hospital admission. To date we have increased the VW bed base from 55 to 95 beds and these beds are being well utilised. We have expanded the range of pathways on offer, which now includes frailty and multi-specialty pathways including general surgery, acute infections, respiratory conditions and palliative and end of life care.

We will develop our **integrated community response service** in line with the IMC review recommendations, building a partnership between BEST, Rapid response, Virtual Ward Airedale Collaborative Care Team. This relates to TAs working in ED to facilitate discharge and avoid hospital admission. We aim to be more responsive by linking in with community support workers to provide a service that meets the lower level social care needs of people within ED. The 2-hour social care response services (which includes the falls response

service) has been brought under the management of BEST. During 2022-23, a comprehensive review of falls service provision identified areas for improvement to support equity of access to timely evidence-based frailty, falls prevention and bone health assessment across the system. The findings from the review are due to be published in early June 2023.

We have invested in our **Safe and Sound** team who offer a range of assistive technology to help optimise our collaborative work with the telemedicine hub and ambulance services. Work is ongoing to upskill care staff to deliver tasks delegated from nurses and therapists, supported by the telemedicine hub.

We have developed a place level model around the delivery of **Proactive Care** across communities. This involves proactive identification of individuals with complex needs, for example frailty, multiple long terms conditions etc. Individuals have a comprehensive assessment, MDT review, and development of personalised care and support plans resulting in the delivery of a range of health and social care interventions to support them to remain well and maintain their independence.

A review of the **Enhanced Health in Care Homes** (EHCH) framework across our place resulted in a series of recommendations to deliver improved outcomes for people living in Care Homes.

Several projects are already being delivered during 2023-24 including:

- Nutrition training and dedicated dietetic support for people at risk of malnutrition;
- Establishment of a pathway for all Care Home ambulance category 3 and 4 calls to be directed to the Telemedicine Service for initial triage and support to reduce ambulance conveyance and support people to remain in their place of residence;
- Support to better manage distressed behaviour through delivery of CLEAR training and development of local antipsychotic prescribing guidance;
- Development and introduction of a standardised medicines management policy and training for to support medicine administration and improve safety; and
- Implementation of a project between Care Homes and local VCSE organisations to build upon existing work within communities and strengthen community integration to increase understanding of local community assets and support individuals living in Care Homes to live more fulfilling lives.

4. National Condition 1

Overall BCF plan and approach to integration

4.1 Joint Priorities for 2023-25

As a Partnership, our ambitions are to work more cohesively across our respective organisations while maintaining our ‘home first’ strategy when jointly commissioning services. We will centre our plans on reviewing existing services and pooling resources better over the coming years.

This begins with the implementation of the IMC review recommendations to help optimise our discharge to assess pathways, including the improvement of our preventative services to reduce the number of admissions to hospital. We will focus on building our Community Response Service provision to offer more bespoke and tailored support to people.

The IMC review acknowledges that a key strength for Bradford is the wealth of resources available to meet the demand faced in the acute trusts to discharging patients. We will build the capacity and uptake of home based support (Pathway 1) to maintain our success in aiding hospital discharge and flow. This includes expanding on our hospital teams as well as community resources to ensure support is available for service users and their carers. We will also invest in our Pathway 0 services to provide support both in and out of hospital.

Our priorities will also include the enhancement of our intermediate care beds. The IMC review suggests that people who have appropriate levels of support following their discharge from hospital are less likely to require support long term. In 2023-25, the BCF is being used to enhance our bedded settings to deliver rehabilitation and enablement to enhance people’s outcomes. This will provide an opportunity for people to regain their independence following discharge from hospital.

Following on from this, our priority for 2023-25 is to establish the effective use of the Adult Social Care Discharge Fund. In 2022-23, funding was provided to purchase additional step down beds (£200m) which we observed to have unintended consequences to our service users. One of the challenges we faced with this funding was that not all pathway 2 discharges had access to comprehensive re-ablement and therapy which is offered in the Council residential homes. This led to less favourable outcomes including an increase in long term needs for patients discharged to independent sector providers. Another challenge involved service users who wanted to remain with the same providers but the providers charge a top up rate above the LA standard rate. This resulted in the LA having to accept the longer term placement remaining in the care home at a higher rate, thus putting increase pressure on the social care budgets. Outside of the funding, we focused on working with providers on fair cost of care exercises and the consequences of this funding may have distorted the market funding expectations. We will reflect on our experiences to ensure the effective use of our 2023-25 plans. We will continue to regularly study the impact of our jointly commissioned services and recognise strengths/limitations. These will help influence how we adapt our plans throughout 2023-25 to make the most the resources available.

4.2 How BCF funded Services are supporting our approach to continued integration of health and Social Care.

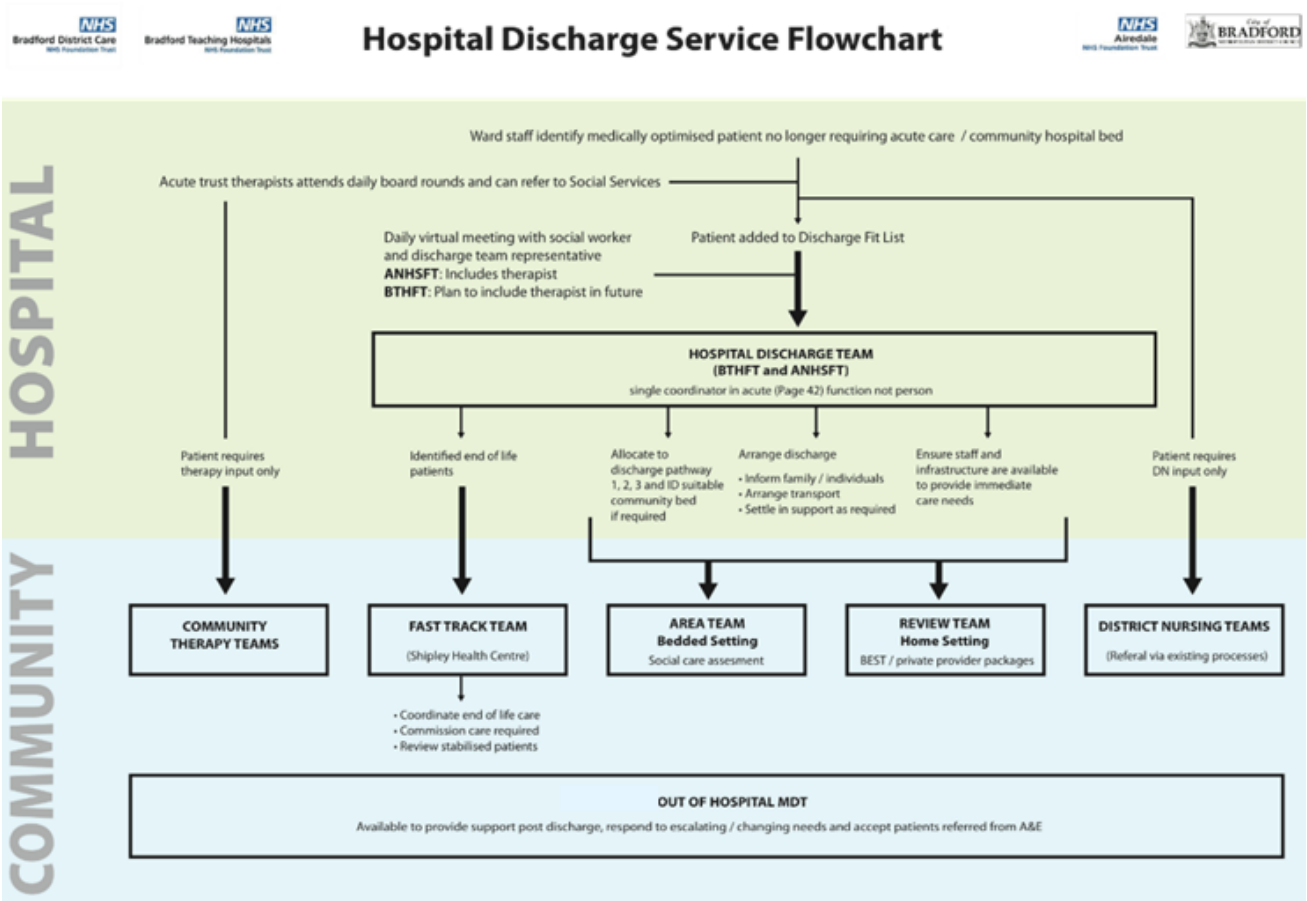
Please refer to section 5 to find details of the key changes and enhancements made to services within the BCF that are supporting our continued approach to the integration of health and care.

5. National Condition 2

How we meet BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer.

The Discharge to Assess model was implemented in Bradford in March 2020, with the intention to support more people to be discharged to their own home or normal place of residence. A range of out of hospital service have been funded through the Better Care Fund since 2017, and these have been grown and strengthened over the last few years. Figure 3 shows the interface between these services at a hospital and community level.

Figure 3: Hospital Discharge Flow Chart



The planning template sets out several schemes funded through the BCF, which helps achieve policy objective 1.

Development of a single point of access in our Hospitals is vital to allow more efficient management of demand coming in from other professionals. It turns unplanned care into planned and allows for the better utilisation of assessment and Same Day Emergency Care areas, hot clinics and direct access to advice and admission to specialties rather than these presenting directly to Emergency Departments (ED) either via ambulance or with a GP letter.

See section 5 for an overview of our local services, all supporting people to stay well at home.

5.2 Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community

We have used our primary adult social care management systems as sources of data to forecast capacity and demand within the community, based on our historical trends. To understand the capacity and demand in the hospitals, we used the NHS Operational Plan estimates along with the internal database to understand the levels of activity we aim to achieve. We work closely as a system to meet the demand on our hospital services by creating the capacity within the community (and equally for our hospitals). A breakdown of the expected numbers on a monthly basis can be found on the planning template.

Our MAST service data suggests that we will have on average 330 service users who require social support in the hospitals and at the point of discharge. MAST is a growing service, aiding timely discharge and supporting people in the community (to remain independent at home). The service is working alongside the Wellbeing Hubs to create the capacity to meet the demand in the community. As MAST continues to expand, we plan to build their scope of work in the community to aid in reducing hospital admissions.

Throughout 2022-23, we have enhanced our UCR provision to tackle the high volumes of people accessing our services and to prevent further hospital admissions where possible. The data proposes we are discharging patients quickly but equally we have higher numbers of people being admitted. Consequently, there is more demand on our UCR services to reduce the number of admissions and help people to remain independent at home. Through further BCF investment, we will ensure we have the capacity within our services to meet the demand and develop our provision to safeguard people to remain at home.

Capacity and demand on the reablement/domiciliary care services remain consistent to last years. Our community data management system shows that there will be a slight increase each month as the service will grow and the capacity will increase. There are multiple recruitment drives to secure additional workforce within the BEST services. Consequently, we have estimated more capacity to be created in the community to meet the demand we have seen throughout 2022-23.

Our management systems helped to identify the number of people receiving enablement in a bedded setting (short term intermediate care in our in-house homes). This was a new field and not explored in the 2022-23 capacity and demand plans. We have used the data from the past 12 months to establish a trend of referrals to these beds. The data shows a rise in the amount of referrals during the winter period which then dips back to normality in spring. We expect to meet the demands through the existing beds we have on offer. We aim to enhance the beds to include therapists which will have an impact in 2024-25 of the BCF plans.

5.3 Describe how BCF funded activity will support delivery of this objective with reference to changes or new schemes for 2023-25 and how they will impact the following metrics

Unplanned admissions to hospital for chronic ambulatory care sensitive conditions.

We have a range of services as part of our Access to Care programme, which are commissioned to contribute towards admission avoidance. Virtual wards have been commissioned to provide appropriate intervention to avoid unnecessary hospital admissions. The service includes remote monitoring using apps, technology platforms, wearables and medical devices such as pulse oximeters. This allows service users to receive the support they need at home instead of being admitted to hospital.

We have a number of initiatives delivered within Primary Care in combination with the VCS services and Community Partnerships. We have well established programmes of work around diabetes, CVD and respiratory all part of our Act as One Access Priority programme. There are initiatives going on in communities around high blood pressure and similarly with asthma. Our primary care Health Inequalities premium and Community Partnerships Core20+5 work is also focussing on these areas.

Emergency hospital admissions following a fall for people over the age of 65

Undertaking the falls scoping work has allowed us to start raising awareness of the services that we have available across the many teams addressing falls. We plan to have more joined up working, better information sharing, making every contact count.

The Telemedicine Service is a clinical advice and support service that is available 24/7 to all Care Homes. Falls is the single largest reason for calls from Care Homes into the Telemedicine Service with 24% of all call being related to falls. Last year, 88% of all falls related calls did not require any onward conveyance to hospital so people were able to remain at home. This service also offers a training package to Care Home around falls prevention and management. Further development of this service includes all Category 3 and 4 Ambulance calls from Care Homes will be sent to the Telemedicine Service for an additional triage and assessment to try and reduce ambulance conveyance.

The quantity of hospital admissions following a fall was at its highest in 2021/22. In recognising this, we expanded BEST to incorporate a falls team alongside its rapid response services. The falls team were integrated within BEST in 2022 and its main responsibility is to attend to people who have had a fall, pick them up safely, and ensure they are safe in their home. The team is linked to Safe and Sound who can refer fallers.

Our Pro-active Care Team (PACT) and the VCSE are working closely together to help reduce ambulance wait times due to falls response. The rapid response service is commissioned through the BCF to attend to service users that may require urgent intervention through a package of care to avoid hospital admission. By introducing these services, carers are able to meet the needs of the service user and aid their recovery.

3. The number of people aged 65 and over whose long term needs were met by admission to residential and nursing care homes per 100,000 populations.

The BCF 2023-25 activity for our residential and nursing homes have been identified in Section 5. We have several enhancements to empower people to be independent at home for longer, such as specialist input to aid rehabilitation, tele-hubs to communicate with health professionals where required and social work input to provide comprehensive assessment and delivery of care needs. These enhancements will help people to remain at home for longer while promoting their independence.

6. National Condition 3

How we meet Policy Objective 2: Provide the right care in the right place at the right time.

6.1 Describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge.

A range of schemes have been commissioned to help avoid unnecessary admissions to hospital. The **MAID Team** continues to flex home-based services within the community, provide rehabilitation or admit to a 'flexi-bed' within a care home or nursing setting to directly avoid admission to hospital. In addition to the services described in section 5, we have other programmes of work designed to keep people at home and ensure safe discharge can be achieved. These are outlined below.

The **High Intensity User** (HIU) programme is a VCS lead initiative that builds on our hospital HIU programme. It supports people at home via an assertive, social outreach programme. The service works intensively, building up a trusted relationship and working through any issues that are driving the frequent use of services. It supports people to access a range of services as well as working through more general life skills and problems.

The project aims to build towards reductions of around 70% for attendances, admissions, conveyances and 111/999 calls as well as further impacts on social care and police contacts for each HIU. Working with just the top 100 HIUs at would give yearly reductions of 1,950 attendances, 780 conveyances and 260 admissions compared to current levels as well as similar % reductions in ambulance calls. The reduction in attendances and admissions will have a further impact on bed occupancy and the Emergency Care Standard.

Despite workforce challenges, our **independent care sector** has, on average, supported 40 people a week out of hospital or to short-term home support. Our BCF commissioned services (detailed in the planning report) ensure that people do not remain in hospital longer than necessary and are discharged promptly. Where possible we promote discharge back to patient's normal place of residence and offer support to recover following discharge.

Additionally, we have a **Rapid Response** service that attends within 2 hours to people in crisis support in the community. Referrals into this service have increased significantly during 2022-23 resulting in more people being supported in their own home or a Care Home. Where required, we implement a package a care through our enablement service or independent sector domiciliary providers.

Residential and nursing placements are only used where the persons needs are such that they cannot be supported in an alternative setting. Where required, social workers within the community complete full Care Act assessment and refer to these settings to support hospital discharge. We have several in-house intermediate care beds where further assessment and rehabilitation can be provided before a long term placement Is considered. We continue to offer the maximum level of support to people to promote their independence before hospital admission.

6.2 Rationale for our estimates of demand and capacity for intermediate care to support discharge from hospital.

We have used different sources to accumulate the capacity and demand estimates for 2023-24. Further details on the assumptions made and the breakdown for each area can be found on the planning template. We have studied the data from the previous year to implement changes 2023-25 including our recent Intermediate Care Review.

Throughout 2023-25, we anticipate increased demand on our acute trusts. The estimates within our capacity and demand can be found on the planning template. These estimates are based on the annual NHS Operational Plan requirements, which sets out the expectations across our services throughout 2023-24.

We will manage this by investing in our **Community Recovery Services**. These services provide interventional support to reduce the likelihood of admission. We will also utilise the adult social care discharge fund to tackle the pressures faced in discharging patients who do not meet the criteria to reside. We are focused on increasing the enablement team and our home support offer which are both integral to aiding hospital discharge. We will continue to work with health partners to expand these core services which reduce bed occupancy by people that do not meet the criteria to reside and facilitate timely discharge.

Over the last 12 months, we have observed continuous pressure on our acute trusts to provide intermediate care services. In 2022-23, we estimated an average of 115 people per month across both hospitals to be discharged on **Pathway 1** (enablement services). We have seen an increase in the amount of people requiring enablement support at the point of discharge. We expect this demand will continue across the hospital and community with the number of service users increasing through winter 2023-24 (similar to previous year). We are using the BCF funding to meet this demand and enhance our enablement services through a number of methods described in detail in section 5. This includes a number of recruitment drives to enhance staffing levels, increased training for staff to deliver lower level nursing support, basic occupational therapy input and introducing more assistive technology such as KIT bags that encourage safe discharges while promoting independence at home. This will enable us to meet the demand and create the capacity under each pathway as **described in section 5**.

We have seen increased demand under **Pathway 2** with more patients requiring intermediate care in a bedded setting. In 2022-23, an average of 40 patients per month were discharged on Pathway 2. This has since increased between 45-50 patients per month. We have utilised the BCF to enhance our bedded setting to incorporate Virtual Ward and provide therapeutic input. This provides patients with the best chance at recovery and allows us to free up more capacity in our homes. As a result, this will discharge patients who do not meet the criteria to reside as well as reduce the amount of people who require long term support.

For short term residential and nursing support on **Pathway 3**, we estimate a fluctuation in the demand on these services. Data from 2022-23 suggested that an average of 60 people per month were discharged under pathway 3. We expect the demand on these services to reduce due to the enhancements across our services, in particular within our bedded settings. We will maintain our current level of activity, which will meet the demand we expect to see throughout 2023-24, while we implement alternatives.

Our VCSE continues to support people on **Pathway 0 and Pathway0+** through the expansion of services. Throughout 2024-25, we will widen our offer and integrate these services to reduce the amount of people requiring Pathway 1 support. This includes initiatives to support carers to reduce the reliance on domiciliary care services.

6.3 Set out how BCF activity will support delivery of this objective, with reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

Discharge to usual place of residence.

Please refer to section 5 for an in-depth narrative of the key changes/improvements made in this year's BCF plans.

We have enhanced our in-house enablement service **BEST**, which supports people to remain independent by delivering packages of care that meet their needs. Through the BCF, the team has grown to 170 enablement assistants (carers), 22 resource planners and over 20 reviewing officers. This has grown significantly since 2022-23.

BEST has 25 **Trusted Assessors** (TAs) working across both acute trusts who complete bespoke functional assessments of service users in the wards. They have been trained to work with patients from the earliest point of admission through to discharging them with the appropriate level of care. Where support is required, the TAs make referrals to the appropriate team to ensure that support is available at each stage of recovery. The majority of referrals from the TAs are referred to the enablement team that offer a package of care for up to 6 weeks. During this period, the Home Support Reviewing Team complete a Care Act assessment and signpost to relevant services to promote independence.

The **Wellbeing Hubs** (WBH) are also key in ensuring patients can be discharge to their usual place of residence. People often present to the wellbeing hubs with complex mental health needs or with single issues where further triage uncovers multiple challenges. The WBHs support people to meet and overcome these challenges by ensuring they access the right services, manage their conditions and social issues, maintain independence and build resilience. This service is offered to patients during their stay at hospitals to help build confidence in returning home.

Similarly, our **Multi-Agency Support Team** is created through input from various VCS organisations that aid in discharging patients on Pathway 0. MAST has offered comprehensive advice and support to service users to build confidence in remaining at home. MAST are able to make community referrals where necessary once a person has been discharged in order to help patients remain independent at home.

6.4 Set out the progress in implementing the High impact change model for managing transfers of care, any areas of improvement identified and planned work to address these.

The Discharge to Assess working group aims to ensure a more integrated health, social care, and wellbeing offer. The group works to improve flow and support our strategic vision of 'Home First' for all people. The group is chaired by Council social care colleagues and consists of key partners from our hospital trusts, Bradford District Care Trust, North Yorkshire County Council and the VCSE.

Priorities of the Discharge to Assess working group

- Education and awareness raising of Pathways 0-3
- Developing a system wide dashboard
- Identifying gaps/pressures and creating opportunities for shared learning
- Utilising the Service Development Fund to support flow and prepare for winter
- Ensuring alignment to national guidance

A review of the **High Impact Change Model** for managing transfers of care has been undertaken in May 2023. An action plan for improvement has been agreed and is in being implemented. A summary of each change is highlighted in Appendix A.

6.5 How we have used the BCF funding, including the iBCF and ASC Discharge Fund to ensure duties under the Care Act are being delivered?

The Adult Social Care Discharge Fund helps sustain flow in our acute trusts by focusing on returning patients to their usual place of residence. Investment in **Bradford Enablement Support Team** (enablement services) allowed capacity to be increased so that patients who do not meet the criteria to reside are discharged with a period of enablement and are provided an assessment period to help identify their long terms needs.

The **Home Support Reviewing Team** complete the Care Act assessment where they signpost and use specialist training to help individuals become as independent as possible. This includes the introduction of equipment and assistive technology along with basic occupational therapy training, preventing hospital readmission following the enablement period. Increased capacity and investment within BEST has reduced the number of people waiting in hospital for support. We have invested in upskilling the workforce and recruiting staff to expand the enablement team to support patients with a mental health diagnosis. This includes working with social workers and community officers to complete the Care Act / Capacity Assessment and identify support needs.

We have also invested in our **Home Support** offer. This relates to individuals who have identified care needs (as per the Care Act criteria) but there is no capacity within BEST or their needs cannot be met by the enablement services. This funding has enabled us to commission the **independent sector** to help individuals remain at home and maintain their independence. This results in more efficient discharges by enabling re-starts to patients care packages and allows hospitals to facilitate small changes to care packages in order to encourage discharge. Patients are discharged to their usual place of residence without causing blockages to hospital beds and the number of people waiting for enablement services is reduced.

We have invested in our **Pathway 3 (residential care) beds**. This relates to the in-house, 24-hour, care beds designed to meet advanced health and care needs. We have an increasing number of services users with complex nursing needs that cannot be met in the community. This model safeguards patients with more timely assessments and reduces the number of people occupying beds waiting for social work input.

7. Supporting unpaid Carers

According to census data, approximately 9.6% of the resident population of Bradford (over 52,000) are carers. Around 3.1% of people provide more than 50 hours of unpaid care a week. As a partnership, we recognise that carers play a vital role in ensuring that individuals in need of care continue to experience a good quality of life. Therefore, we continue to commission a range of additional schemes through the BCF that are specifically aimed towards supporting carers.

7.1 BCF schemes supporting carers

Bradford commissions a carers service which is jointly funded through the BCF and delivered by **Carers' Resource**. The service supports more than 3,000 adults by providing help and support for unpaid carers to have a life of their own along with their caring role. The carers resource service offers support for isolated carers, assesses carer's wellbeing to identify the help available, providing carer information tailored to individual needs and circumstances.

A **carer wellbeing grant** is also offered, which provides a small one-off payment to carers to promote their own wellbeing. The service delivers 160 peer support and worker led support groups, and gives out £120,000 in carers wellbeing grants per year. This provides support mechanisms to be established for carers who have eligible needs (as per the Care Act) to continue their important caring role. This funding can be used flexibly to support carers in having a break from their role and support their own health and wellbeing where and when they feel needed.

The BCF is used for other services that support carers, including the **Carer Navigator** service which supports friends and families who have a cared-for person admitted to Airedale Hospital and Bradford Hospitals. This service provides support in meetings regarding discharge from hospital, help to organise social and personal care, supports emergency planning, and connects with other Carers' Resource services. This ensures that Carers are provided the right level of support to help them continue their caring role.

We plan to use the BCF to promote further partnership working with the Carers' Resource to deliver a **Carer Care Act Assessment** pilot. Through working with the carers' service on assessments we aim to increase the quantity and quality of assessments and ensure offers of support are joined-up with other provision. This will enable us to assess service users in conjunction with their carers., We can then build a holistic view of assessed needs and utilise our existing services to offer bespoke advice, potential grants and offer respite services where appropriate.

In addition, the **Carers Emergency Planning Service** aims to provide reassurance to carers about who will take on their caring role in the event of an emergency. The service works with carers to make contingency plans, regarding how the person they care for would be supported if the carer were unable to do so.

8. Disabled Facilities Grant and Wider Services

The Disabled Facilities Grant (DFG) continues to be pooled within the Better Care Fund and aligns to the strategic intentions of the fund. In 2022/23, DFGs in Bradford supported 381 people through the completion of adaptations to significantly improve people's health and wellbeing while aiding hospital discharge and admission avoidance. We have increased our joint working with housing colleagues to better understand some of the challenges and successes to delivering DFG's. This includes more involvement of housing representatives at our PCF meetings (detailed in governance section) and shared intentions to improve the lives of our population.

The DFG remains a statutory duty upon the council to enable disabled people to live independently in their own homes and implement creative measures to promote safety and independence in the community. Minor adaptations are provided by BACES which work alongside BEST and our community social work and occupational therapy teams (assess the need for adaptations) which are teams also funded through the BCF. These services sit alongside the delivery of the DFG to ensure people remain safe in their homes and are as independent as possible through various adaptations.

The use of the DFG is aligned to **Bradford's Housing Strategy** (2020-2030) which details our approach and sets the priorities for meeting the housing needs of our population. A key objective of the strategy is 'Homes for All' and to ensure provision of sufficient housing to meet the needs of people with disabilities through adaptations, and the provision of more homes with level access and homes that are able to be adapted. Our priorities include how we contribute to a more productive and inclusive economy, addressing health and social inequalities, tackling climate change and helping to build stronger communities.

The DFG in Bradford includes an array of activity for major adaptations made by our department of place. **The Housing team** receives on average between 45 and 50 new referrals for DFGs each month, with as high as 70 some months. We continue to see high levels of demand for assistance with adaptation. At the end of March 2023, there were 755 cases (total cases at different stages of the DFG process) with an estimated total value of £9.54m. These cases are at various stages of DFG application, from receipt of initial referral to approved and awaiting completion of work. Of the total cases in the process of DFG application, 235 were approved where funding is committed (at a value of £3,295,610) and applicants can proceed with the work. Some cases are very complex and longstanding, hence we have a high number of cases but we are confident there are no delays or barriers to delivering DFGs. We will stay consistent in our work with longstanding cases while continuing to accept new referrals within our current budgets. We continue to meet the demand of DFG cases through utilising the BCF and additional funding to meet our statutory duties.

There are several factors that impact the process times for the grants including contractor supply, availability of materials, increase in costs of materials and labour and increasingly complex cases where clients have multiple needs. The Council also offers applicants the opportunity to use the Council's **'Agency Service'** in order to deliver their adaptation. This is a project management service which provides a contractor from a framework and a clerk of works to oversee the work. Approximately 80% of completed DFGs are delivered through the Council's Agency Service.

Some of the key challenges faced in recent times include:

- There are over 30 groups in need of support and assistance representing the breadth of challenges facing support services.
- We have an ageing population with increasing needs. Service users are living longer and their needs are increasing which poses challenges in the number of referrals and pressure on the system.
- Recruitment of Occupational Therapists is a national issue which is vital in the delivery of DFG
- Poverty associated with unemployment and low skills levels represent a major challenge when attempting to address access to suitable accommodation for many of our households

Our approach to tackling these challenges:

- Policy makers and planners will have regard to size, location, and quality of homes needed for future needs of older people and other needs groups, in order to allow them to live independently and safely in their own home, and, if and when the need develops, to enable them to move into more suitable accommodation.
- A wide choice of housing options will be made available by the sector including Extra Care, adapted housing, shared housing and self-contained units with the necessary care and support to maintain a good quality of life.
- We will ensure provision of sufficient housing to meet the needs of people with disabilities through adaptations, and the provision of more homes with level access and homes that are able to be adapted.
- We will encourage developers to provide dementia friendly and “Lifetime Homes”.
- The Council and the Housing Partnership will work with the health sector to minimise the impact of poor housing on health including impacts of fuel poverty.
- We have several recruitment drives to aid in tackling the resources in occupational therapy. This includes more collaborative working with health and wider colleagues to optimise resources.

A number of housing options are available for individuals whose care and support needs have increased. This aligns with the strategy and providing having a proactive approach to meeting housing needs. We have Extra Care Housing schemes that support the needs of people over 55 and younger people with disabilities. There are 7 different schemes provided by 5 housing providers. The schemes provide a community based alternative to residential care for older people who value their independence, by providing a range of self-contained housing with support and care onsite. One of these schemes are located at Fletcher court which is designed to be dementia friendly and is intended to support people to live happy healthy lives behind their own front door, with care support.

Within each scheme are dedicated units providing support for people whose needs have increased following an acute hospital stay, or where their own home may not meet their needs upon discharge. This allows people a period of reablement, rehabilitation and confidence building before they return back to their own home.

We have **Extra Care Housing** schemes that support the needs of people over 55 and younger people with disabilities. There are seven different schemes provided by five housing providers. The schemes provide a community-based alternative to residential care for older people who value their independence, by providing a range of self-contained housing with support and care onsite. One of these schemes, our newest Extra Care Housing development, is designed to be dementia friendly.

Have we made use of the regulatory reform (housing assistance) (England and Wales) order 2002 (RRO) to use a portion of DFG funding for discretionary services (Y/N)

In order to use the powers provided in the RRO the Council must approve and publish its own **Housing Renewal Policy**. The Council's Comprehensive Housing Renewal Policy achieves this and the Local Authority uses a proportion of its housing budget for the provision of discretionary DFG assistance. This amount is subject to need and resources being available from the Housing budget. Discretionary assistance is only available where the cost of the recommended works exceeds the maximum mandatory grant and where the grant applicant is assessed as being unable to fund the cost of the works or the additional costs themselves. In 2022/23 a total of £384K was provided in discretionary assistance. In addition to this, where applicants were assessed as being able to afford excess costs using their own funds (equity in their property), £35K was provided through Home Appreciation Loans (equity loan).

The amount of discretionary assistance is based upon need and the service responds on a case by case basis.

9. Equality and Health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics?

Our Equality Objectives and Equality Plan sets out how we work with wider groups as a partnership to tackle inequalities and establishes our core objectives. The Plan describes how we will create a new cross partnership, multi-agency, equality group that will work to promote an equal and inclusive approach across the whole of the District.

In any service we review, develop or commission, it is done with an inequalities lens on it and focused on how we can improve both the access and care in those communities who need it the most. We undertake Equality Impact Assessments to ensure we don't disadvantage anyone and our community partnerships and locality teams are embedded within the communities they serve. Due to the establishment of our Reducing Inequalities in Communities team a number of years ago, our default position is to put inequalities front and centre of all that we do. More recently with the development of the Alliance and establishing project managers solely focused on the Core20Plus5 priorities within our community partnerships, this will strengthen and embed our focus.

Health Inequalities are prevalent across the district. Starting in the least deprived area, Wharfedale, life expectancy is 87 years for women and 84 years for men. Moving into central Bradford, this dramatically reduces. In the most deprived area, Manningham, people's life expectancy here is around 10 years less than Wharfedale.

It is not just about how long people live, it is how well they live too. If we take away the time people are living with poor mental wellbeing and ill health we see healthy life expectancy. On this measure the gap gets bigger with people living in central Bradford experiencing 20 years less healthy life expectancy than those in Wharfedale.

Tackling health inequalities in Bradford is a key strand in all programmes. Our Reducing Inequalities in Communities (RIC) programme is a movement of people and projects who are working together to reduce health inequalities and close the health gap in Central Bradford; so everyone can live healthier, happier and longer lives.

9.1 Population health management approach

Our Population Health Management (PHM) programme was created to improve our PHM approach across the district. This inspires all key partners across the system to collaborate, bringing data processing and analytical capabilities together in order to generate better questions, intelligence and hypotheses for action, interventions. Ultimately with the goal to have a bigger collective impact upon the health and wellbeing of our population. The PHM programme aims is to facilitate the PHM approach at place and neighbourhood levels, building on existing networks and a shared commitment to reduce health inequalities.

Our approach to PHM recognises that PHM is '10% data and 90% engagement, leadership and culture'. A core function of this enabling programme of work is to facilitate the interpretation of that data by presenting it in ways that are appropriate for multiple users in our system, each of which will have their own requirements in terms of presentation. What they will have in common, is a need for the system to generate intelligence.

Our approach is to build from intelligence, identify effective, evidence-based interventions and implement them. It is not necessarily about making wholesale changes to the local health and care environment, but rather seeing where existing services, system and community assets could be adapted or tweaked so they are more relevant and useful for the population and to re-balance services in favour of prevention and long-term wellbeing.

The Bradford VCS Alliance (BVCSA) works closely with local VCS Organisations, the importance of local and grassroots organisations and their role in understanding and being known to (trusted by) local communities. This ensures that projects are delivered in an appropriate manner for the communities they serve.

9.2 Reducing Inequalities Alliance

The Reducing Inequalities Alliance (RIA) is a new function which was established in Bradford District and Craven in July 2022. It has been established to support and coordinate action to reduce inequalities across our local place. The role of RIA is to connect, co-ordinate, facilitate, and support the delivery of the work streams and job cards prioritised by the alliance, including drawing together evaluations and learning from initiatives to reduce inequalities such as the Reducing Inequalities in Communities (RIC) programme.

We will do this by:

- Setting the vision: for reducing inequalities in health (and the determinants of health)
- Building confidence and skills: in our staff and leadership to reduce inequalities on many fronts
- Supporting best practice: in the ways we work, the skills we use and the evidence we draw on to reduce inequalities
- Creating opportunities: for evaluation and learning from our approach

A particular focus of the RIA is bringing people together from the interfaces between large civic programmes, service interventions and transformation, and the community sector. In this way the alliance as a whole can become more than the sum of its parts.

To be successful we need to adopt a ‘Health in all policies’ approach. This requires a collaborative approach to link to tackle linked problems. Addressing them requires innovative solutions, a new way of thinking about policy, and structures that break down the ‘siloed’ nature of local systems.

9.3 Reducing Inequalities in Communities (RIC) Programme

RIC is a movement of people and projects who are working together to reduce health inequalities and close the health gap in central Bradford. It is a five-year programme, running from 2019/20 through to 2023/24, and is made up of a range of projects which aim to improve people’s health and tackle inequalities at different stages of life. It is a collaboration of system partners who are committed to reducing health inequalities in our place. It has been, and continues to be, an ambitious programme of work that involves the implementation and delivery of 21 projects, and over 50 delivery partners.

RIC was designed to be a test bed of innovation in our local place. Working together we have identified a range of projects that we feel will help reduce health inequalities, or the impact of health inequalities, for their respective cohorts. Through implementing these projects, we are building local evidence base of what works, and contribute to the growing research base around health inequalities.

The RIC projects are a group of interventions that range from completely new services, such as Young People's Social Prescribing; to extensions of existing projects or services, such as BEEP exercise referral; to projects that project specific training or support to our workforce or communities, such as new approaches for raising awareness of increased genetic risk in close relative marriage.

9.3 Core20Plus5

Key support for our inequalities programme has this year come from the Core20PLUS5 national strategy and funding. The Core20Plus5 has a number of key priorities which include:

- Reducing premature mortality for respiratory illness, CVD, cancer, infant mortality, and for people with serious mental illness
- Working harder on groups that are excluded/marginalised from the NHS
- Focusing on the most deprived 20% of areas as identified by the National Index of Multiple Deprivation (IMD)

Our local place has agreed an approach and principles to allocate the funding:

- We will employ an equity based approach (using proportionate universalism across health and the wider determinants of health)
- We will focus on subsidiarity and decision making down to Community Partnership level where appropriate
- We will undertake intervention evaluation of funded services
- We will support, rather than replace or supersede, wider system efforts to local inequalities.

Core20PLUS5 operating model - Three tier

1. Support: establishment of a small Core20PLUS5 support team for data, evidence, guidance, evaluation, prioritisation providing strategic oversight for the HCP;
2. Delivery: 6 Locality Models matching Council footprints as key tiers for delivery within an integrated model between NHS, Council and VCS partners; and
3. Focus: 12 Community Partnerships and 13 Primary Care Networks focusing on the six most deprived partnership areas allocated Core20pLUS5 specialist posts and additional budget, working with existing Primary Care services.

9.4 Reducing Health inequalities through the BCF

To ensure we are making a real difference to our population, we work closely with Born in Bradford (BiB), the University of York and Queen Mary University of London to create the Bradford Inequalities Research Unit (BIRU). BIRU helps us to:

- understand the causes of ill health and inequalities in central Bradford
- identify areas to prioritise
- build an evidence base of what works

As part of this approach, BIRU is also exploring 'community readiness' in different projects to make sure interventions are as effective as possible. As a partnership, we will work towards our key priorities to reduce health inequalities for our population as described in the Equality Act and within our joint working strategy.

The BCF plan cements our health inequality work in strategic and operational planning. The Director of Public Health is a key member of the Planning and Commissioning Forum, which operationally oversees the Better Care Fund Plan. One of our key commissioning principles as a system is Reducing Inequalities through ensuring services and interventions are designed to align uptake with the distribution of need. This include removing barriers to access; distributing resources and intervention proportionately to address need. This will allow us to achieve more equal outcomes; recognising the earlier onset of conditions in deprived areas compared to the least deprived areas.

This means that there is a robust connection between decision making and subsequent allocation of BCF funds to address inequalities. We are continuing to make the connections across the system, as well as seeing the benefits in the process of flexible commissioning activity to reduce inequalities.

Our BCF funded services are underpinned by key priorities and objectives that focus on reducing health inequalities. These priorities include:

- mitigating against digital exclusion
- ensuring datasets are complete and timely
- accelerating preventative programmes
- strengthening leadership and accountability
- restoring NHS services inclusively

We will continue to work as a partnership to ensure that advancing equality and diversity is central to how we jointly commissioned services through the BCF.

END

Impact Change	Where are we?	Update on implementation – including gaps
Change 1: **Early discharge planning EDD** **Elective & Non elective**	Established.	**What have we done so far?** Continued work at both hospitals to improve joined up operating DTA models which includes EDD and planning for discharge. As part of our strategy Happy, Healthy and at Home we have a Home First joint document being used in the MAIDTs (Multiagency Integrated Discharge Teams) and implementation of the 5 principles within the SAFER bundle. There is strong focus on a strength based, community led support approach to reduce the over prescribing of care and support in discharge planning. Tech enabled care and support is also part of our plans to reduce the need for care and support. This is intended to reduce the need for care/ support on discharge. CTR, CTD and LOS are closely monitored via MAIDTs at both hospitals. Expansion of our Virtual Ward offer from 95 to 155 beds by 2024 will support early discharge **Next Steps** A joint Moving on Policy across both hospitals is being reviewed and developed. This will be rolled out alongside a series of training sessions to support strength based 'moving on' conversations (co-designed by health and social care colleagues). Implementation of a revised Home Support contract which will support same day discharges via utilisation of the independent sector with an aim to pick up packages of care in a timely manner. Ongoing improvement work to reduce variation between EDD and ADD Internal work to be done within each Trust to avoid delays caused by take home medication (TTO)
Change 2: **Monitoring and responding to system demand and capacity (joint analysis of current capacity,** **Pathways 0-3, market shaping, optimum run rate to maintain flow)**	Established	**What have we done so far?** Undertaken a review of our Intermediate Care services across BD&C with recommendations to be taken forward by the Integrated Health and Care work stream (see next steps). BTHFT have a Command Centre and a wall of analytics, with the MAIDT adjacent – the data drives the response from MAIDT and other services. ANHST have developed a dashboard to support their MAIDT meetings and are working together to also have one version of the truth, significant progress has been made. Performance and flow through adult social care services is measured and reported throughout the day, seven days a week. **Next Steps** Implement recommendations from the IMC review to include consistency in data between health and social care, reduced number of people on bedded pathways 2 & 3, increased therapy input in the community and improved integration between community response services such as UCR and Virtual Ward.

		Manage health and social care community beds, with Trusted Assessors and MAIDT leading the approach for all beds. Deliver a local pilot to offer geriatrician input/support across all community beds. Home support contracts with the independent sector have been reviewed and are out to tender with new contracts expected end of October 2023. This will support flow out of hospital and through the BEST service.
Change 3: **Multi-disciplinary working, Transfer of Care hubs, System Co-Coordinator /leadership**	Mature	**What have we done so far?** Both hospitals have MAIDTs (community nurses are included in the MAIDT) with joint health and social care triage models - the VCS, housing pathway providers also operate within the model. VCS input from MAST into both hospitals to support those on pathway 0 (and where required pathway 1) providing mental health, housing, drug and alcohol support. Adult social care has a single point of access via trusted assessors for all restarts of home support, enablement and short- term beds managed by the LA. **Next Steps** Ongoing work to manage and respond to increase in complexity of discharges and PoC required. Improved system leadership and co-ordination of discharge and flow to be implemented.
Change 4: **Home first D2A reference to the Principles**	Mature	**What have we done so far?** Happy Healthy and at Home Strategy and Act as One approach clear in our joint operations. Home First document being used as assess to transfer out of hospital. Trusted assessors for home support and short-term beds work with discharge nurses/therapists. Relationship with care sector managed via single point of access in adult social care. CHC assessments are undertaken out of hospital other than on rehabilitation units in hospital. Pilot between BDCT and BTHFT to trial an electronic discharge form at Westwood Park which improved communication and efficiencies in processes. Wider roll out to take place at Westbourne Green & St Lukes. **Next Steps** Explore challenges around capacity within home support / BEST to reduce number of people going to a short-term bed whilst resource within BEST or Home Support can be sourced Increase therapy input within the community More focus on the home first model - earlier consideration of self-care and promoting patient involvement- especially around medication and continuing with health-related tasks they have performed prior to admission. Explore ways of reviewing / governance for when discharges don't go well so there is learning and effort to rectify and learn from issues.

Change 5: **Flexible working patterns 7 Day Discharge**	Established	**What have we done so far?** The MAIDT in BTHFT and ANHSFT operates 7 days a week and transfers take place 7 days a week. Discharge support services such as housing, transport, social care also operate 7 days a week. **Next Steps** More work to be done with internal processes within each Trust to improve weekend flow, especially on pathway 0 Staffing resource remains a challenge
Change 6: **Trusted assessment**	Mature	**What have we done so far?** Trusted assessors embedded within MAIDTS and social workers have been focused on care act assessments out of hospital in line with DTA guidance Trusted Assessors trained in strength-based conversations **Next Steps** We have plans to further optimize TEC enabled support and VCS services to increase pathway 0.
Change 7: **Engagement and choice, Community and Voluntary sector involvement**	Mature	**What have we done so far?** Voluntary sector has contracts in place funded by the BCF, LA and ICB - Carer Navigators, MAST, home from hospital, homeless pathway – all embedded within the MAIDTs. Six Wellbeing Hubs (WBH) were established by the Voluntary Community Sector (VCS) in 2022/23 and operate across all of BDC and are located in some of our most deprived areas. They help people to manage a range of issues for example domestic abuse, welfare benefits, mental health, and substance misuse etc. By directing people with complex social issues to the WBH following discharge it can allow them to access the right services to keep them out of hospital in the future and remain in their usual place of residence. **Next Steps** Developing a Leaving Hospital folder which will include information about the different voluntary and community services someone might receive once back at home Increase partnering with the Voluntary Community Sector to support people on pathway 0, 0+ and have a set of clear place objectives to reduce the need for pathways 1, 2 and 3.
Change 8: **Improved discharge to care homes** **Anticipatory Care for residence**	Established	**What have we done so far?** We have the Telemedicine service (TMS) delivered by Immedicare in place across all Care Homes providing clinical advice and support as well as referring into other services such as UCR and Virtual Wards. Enhanced primary care and alignment to GP Clinical Lead. A scoping exercise of the Enhanced Health in Care Homes framework has been undertaken by the Integrated Health & Care work stream identifying current provision and gaps. Established relationships and communication within the system – input into Care Homes forums and Resource Pack to raise awareness of different services that

		can reduce avoidable admissions. REACT service in place to identify and support those within their last year of life, reducing A&E admissions and bed days for PEoLC. Includes regular A&E attendances from Care Homes. Next Steps Prioritise and agree a set of actions to take forward from the EHCH scoping exercise. Capacity within Care Home Liaison teams to support increase in complex/distress behaviours amongst residents. Work being undertaken to review therapy offer into care homes – capacity within therapy teams and expectations around the environment that Care Homes can offer to support rehab/reablement to take place. Improved consistency of access to reablement services.
Change 9: Housing and related services- equipment	Established	What have we done so far? Homeless pathway in place, with short term enablement/supported housing post transfer out of hospital funded by adult social care. Healthcare funded by health (Bevan healthcare) Safe and Sound service promotes independence at home via remote monitoring to support falls pick up, dementia/delirium – 'walking with purpose', medication reminders etc. Innovation sites established with independent sector to explore how HCSW can support more TEC and equipment. VCS support with the increased demand for house clearance (hoarding) to reduce delays in discharge Next Steps Improved processes for early identification of home environment and acting early on support needs to avoid delayed discharge. Increased awareness of DFG to support with home adaptations. Improved timely access to equipment.

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Bradford
Completed by:	Javeid Karim
E-mail:	Javeid.karim@bradford.gov.uk
Contact number:	7974599221
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Susan	Hinchcliffe	susan.hinchcliffe@bradford.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Mel	Pickup	Mel.Pickup@bthft.nhs.uk
	Additional ICB(s) contacts if relevant		Robert Helen	Maden Farmer	robert.maden@bradford.nhs.uk
	Local Authority Chief Executive		Kerstan	Engalnd	Kersten.England@bradford.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Iain	MacBeath	Iain.Macbeath@bradford.gov.uk
	Better Care Fund Lead Official		Jane	Wood	Jane.Wood@bradford.gov.uk
	LA Section 151 Officer		Chris	Kinsella	Chris.Kinsella@bradford.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

#NAME?

	Complete:
2. Cover	Yes
4. Capacity&Demand	#NAME?
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Bradford

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£5,137,133	£5,137,133	£5,137,133	£5,137,133	£0
Minimum NHS Contribution	£46,835,641	£49,486,538	£46,835,641	£49,486,538	£0
iBCF	£23,388,296	£23,388,296	£23,388,296	£23,388,296	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£3,279,003	£5,443,145	£3,279,003	£5,443,145	£0
ICB Discharge Funding	£3,443,000	£5,342,000	£3,443,000	£5,342,000	£0
Total	**£82,083,073**	**£88,797,112**	**£82,083,073**	**£88,797,112**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£13,288,808	£14,040,954
Planned spend	£21,820,231	£23,055,256

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£25,015,410	£26,431,282
Planned spend	£25,015,410	£26,431,282

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	215.5	205.2	217.3	189.1

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,697.2	1,663.7
	Count	1417	1389
	Population	83489	83489

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.0%	94.0%	94.0%	94.0%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	512	439

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	79.5%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes

	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Bradford

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from e
The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should inpu
number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then th
many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Res split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then th take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Furt Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23
AIREDALE NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	114	114	114
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST		116	116	116
AIREDALE NHS FOUNDATION TRUST	Reablement at home (pathway 1)	29	29	29
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST		86	86	86
AIREDALE NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)			
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST				

AIREDALE NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)			
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST				
AIREDALE NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	7	7	7
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST		21	21	21
AIREDALE NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	5	5	5
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST		14	14	14
AIREDALE NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	11	11	11
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST		32	32	32

3.2 Demand - Community

Demand - Intermediate Care			
Service Type	Apr-23	May-23	Jun-23
Social support (including VCS)	178	178	178
Urgent Community Response	324	324	324
Reablement at home	127	161	132
Rehabilitation at home			
Reablement in a bedded setting	20	37	33
Rehabilitation in a bedded setting	5	5	5
Other short-term social care			

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge				
Service Area	Metric	Apr-23	May-23	Jun-23
Social support (including VCS)	Monthly capacity. Number of new clients.	329	329	329
Reablement at Home	Monthly capacity. Number of new clients.	137	172	141
Rehabilitation at home	Monthly capacity. Number of new clients.			
Short term domiciliary care	Monthly capacity. Number of new clients.			
Reablement in a bedded setting	Monthly capacity. Number of new clients.	24	24	24
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	11	22	16
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	43	43	43

3.4 Capacity - Community

Capacity - Community				
Service Area	Metric	Apr-23	May-23	Jun-23

Social support (including VCS)	Monthly capacity. Number of new clients.	330	330	330
Urgent Community Response	Monthly capacity. Number of new clients.	324	324	324
Reablement at Home	Monthly capacity. Number of new clients.	127	161	132
Rehabilitation at home	Monthly capacity. Number of new clients.			
Reablement in a bedded setting	Monthly capacity. Number of new clients.	20	37	33
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	5	5	5
Other short-term social care	Monthly capacity. Number of new clients.			

ɛach trust by Pathway for each month.
ɹt an overall estimate each month for the
ıis would need to take into account how

sponse and VCS support. The template is

his would need to

her guidance on all sections is available in

	Complete:
3.1	#NAME?
3.2	#NAME?
3.3	#NAME?
3.4	#NAME?

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
114	114	114	114	114	114	114	114	114
116	116	116	116	116	116	116	116	116
29	29	29	29	29	29	29	29	29
86	86	86	86	86	86	86	86	86

7	7	7	7	7	7	7	7	7
21	21	21	21	21	21	21	21	21
5	5	5	5	5	5	5	5	5
14	14	14	14	14	14	14	14	14
11	11	11	11	11	11	11	11	11
32	32	32	32	32	32	32	32	32

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
178	178	178	178	178	178	178	178	178
340	340	340	357	357	357	373	373	373
117	128	141	137	136	114	171	147	142
27	38	29	32	39	34	22	20	16
5	5	5	5	5	5	5	5	5

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
329	329	329	329	329	329	329	329	329
126	138	152	148	145	122	184	157	153
17	36	30	19	28	23	12	11	10
9	15	16	19	8	20	6	11	11
43	43	43	43	43	43	43	43	43

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
	100%	
	100%	
	100%	
	100%	

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint

330	330	330	330	330	330	330	330	330
340	340	340	357	357	357	373	373	373
117	128	141	137	136	114	171	147	142
27	38	29	32	39	34	22	20	16
5	5	5	5	5	5	5	5	5

	100%	
100%		
	100%	
	100%	
	100%	

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Bradford

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Bradford	£5,137,133	£5,137,133
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£5,137,133**	**£5,137,133**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Bradford	£3,279,003	£5,443,145

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS West Yorkshire ICB	£3,443,000	£5,342,000
Total ICB Discharge Fund Contribution	£3,443,000	£5,342,000

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Bradford	£23,388,296	£23,388,296
Total iBCF Contribution	**£23,388,296**	**£23,388,296**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding

Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS West Yorkshire ICB	£46,835,641	£49,486,538
Total NHS Minimum Contribution	**£46,835,641**	**£49,486,538**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£46,835,641**	**£49,486,538**	

	2023-24	2024-25
Total BCF Pooled Budget	**£82,083,073**	**£88,797,112**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

As advised, we have presumed the iBCF will remain the same for 24-25.
We have multiplied the ASC DF 23-24 by 1.66 to provide an estimate for 24-25.
We have also presumed the DFG element will remain the same for 24-25

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Bradford

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£5,137,133	£5,137,133	£0	£5,137,133	£5,137,133	£0
Minimum NHS Contribution	£46,835,641	£46,835,641	£0	£49,486,538	£49,486,538	£0
iBCF	£23,388,296	£23,388,296	£0	£23,388,296	£23,388,296	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£3,279,003	£3,279,003	£0	£5,443,145	£5,443,145	£0
ICB Discharge Funding	£3,443,000	£3,443,000		£5,342,000	£5,342,000	£0
Total	**£82,083,073**	**£82,083,073**	**£0**	**£88,797,112**	**£88,797,112**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£13,288,808	£21,820,231	£0	£14,040,954	£23,055,256	£0
Adult Social Care services spend from the minimum ICB allocations	£25,015,410	£25,015,410	£0	£26,431,282	£26,431,282	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):

#NAME?

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
S4ICT01	Virtual Ward	Continued support to patients after discharge home from hospital	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
S1PS02	Community Equipment	Providing equipment to patients at home	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Private Sector	Minimum NHS Contribution
S1PS03	Local Schemes	Primary care and community based services	Assistive Technologies and Equipment	Community based equipment		16683	16683	Number of beneficiaries	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
S1PS04	Nursing support to care homes	Nursing support to care homes	Residential Placements	Nursing home		45	45	Number of beds/Placements	Continuing Care		NHS			Private Sector	Minimum NHS Contribution
S3R01	Early Supported Discharge	Support to patients to allow early discharge home	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
S3R02	Re-ablement Services	Support to patients in own home to improve confidence and ability to live as	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		558	558	Packages	Community Health		NHS			Private Sector	Minimum NHS Contribution
S3R04	Collaborative care Team	Community Support Schemes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
S3R05	Intermediate Care Beds	Short-term intervention to preserve the independence of people who might otherwise	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support admission		3938	3938	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution

9	Equipment (part a)	Equipment to facilitate hospital discharge and maintain independence	Assistive Technologies and Equipment	Community based equipment		16683	16961	Number of beneficiaries	Social Care		LA			Local Authority	iBCF
10	Equipment (part b)	Equipment to facilitate hospital discharge and maintain independence	Assistive Technologies and Equipment	Community based equipment		16683	16961	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
11	Care Act Assessment (part a)	Social workers to implement care act duties	Care Act Implementation Related Duties	Other	Social work support				Social Care		LA			Local Authority	iBCF
12	Care Act Assessment (part b)	Social workers to implement care act duties	Care Act Implementation Related Duties	Other	Social work support				Social Care		LA			Local Authority	Minimum NHS Contribution
13	Carers	Support to Carers	Carers Services	Carer advice and support related to Care Act duties		6948	6951	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
13	Carers	Support to Carers - Time Out Service	Carers Services	Respite services		115	117	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
14	Maintaining Social Services (part b)	Working in partnership with Local Authority to maintain and support social services	Residential Placements	Care home		1688	1688	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
15	Maintaining Social Services (part a)	Working in partnership with Local Authority to maintain and support social services	Residential Placements	Nursing home		540	540	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
15	Maintaining Social Services (part a)	Personlised Budgets for Direct payments	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	iBCF
16	Enablement (part a)	in-house enablement service delivering support in own home to improve confidence	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		1074	1091	Number of Placements	Social Care		LA			Local Authority	iBCF
16	Enablement (part a)	in-house enablement service delivering support in own home to improve confidence	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		1074	1091	Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
17	Enablement (part b)	Support to patients in own home to improve confidence and ability to live as	Home-based intermediate care services	Reablement at home (to support discharge)		3505	3571	Packages	Social Care		LA			Local Authority	iBCF
17	Enablement (part b)	Support to patients in own home to improve confidence and ability to live as	Home-based intermediate care services	Reablement at home (to support discharge)		3505	3571	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
18	Disabled Facilities Grant	Adaptations via the Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		380	380	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
15	Maintaining Social Services (part a)	Working in partnership with Local Authority to maintain and support social services	Residential Placements	Learning disability		492	516	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
15	Maintaining Social Services (part a)	Working in partnership with Local Authority to maintain and support social services	Home Care or Domiciliary Care	Domiciliary care packages		1895950	2000227	Hours of care	Social Care		LA			Local Authority	iBCF
19	Maintaining Social Services (part b)	MAST	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
19	Maintaining Social Services (part b)	Working in partnership with Local Authority to maintain and support social services	Residential Placements	Nursing home		540	540	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
19	Maintaining Social Services (part b)	Working in partnership with Local Authority to maintain and support social services	Home Care or Domiciliary Care	Domiciliary care packages		1895950	2000227	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution
19	Maintaining Social Services (part b)	Working in partnership with Local Authority to maintain and support social services	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution
20	Home Support	Additional spend on Home Care services to enable timely discharge from	Home Care or Domiciliary Care	Domiciliary care packages		1895950	2000227	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge

21	Pathway 3	To fund short term nursing beds for nursing care to enable hospital discharge and	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		107	110	Number of Placements	Social Care		LA			Local Authority	ICB Discharge Funding
22	North Yorkshire County Council	Bradford ICB contribution to North Yorkshire County Council.	Other								LA			Local Authority	ICB Discharge Funding
23	Reablement Services	To support investment in the reablement service which supports with timely	Home-based intermediate care services	Reablement at home (to support discharge)		3505	3571	Packages	Social Care		LA			Local Authority	ICB Discharge Funding

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other

5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other
9	Housing Related Schemes	

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other
13	Urgent Community Response	

14	Personalised Budgeting and Commissioning	
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other
19	Other	

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.

Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Bradford

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	216.0	216.8	223.1	1,174.0	Local data FOT uplifted by 3% to reflect variance from BCF numbers. 2% reduction applied based on historical performance and profiled quarterly based on 2021/22 delivery. NOTE we can't calculate a directly age standardised rate so the figures are crude rates using the populations provided in the	We have well established programmes of work around diabetes, CVD and respiratory as part of our Act as One Access Priority programme. There are initiatives going on in communities around high blood pressure and similarly with asthma. Our primary care Health Inequalities premium and Community Partnerships Core20+5
	Number of Admissions	1,127	1,131	1,164	-		
	Population	539,776	539,776	539,776	539,776		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	215.54	205.16	217.26	189.09		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,933.2	1,697.2	1,663.7	Admission rates have been falling over recent years. Local data 22/23 FOT uplifted by 4% to reflect variance from BCF numbers. A further 2% reduction is felt to be achievable in 2023/24 based in the current work underway NOTE we can't calculate a directly age standardised rate so the figures are crude rates using the populations provided in the	Increased awareness around falls due to the scoping exercise putting falls prevention back on everyone's radar and the work being done by teams such as RIC PACT re proactive prevention ads well as UCR suggesting people sign up to the safe and sound pick up off the floor service due to ambulance wait times.
	Count	1,600	1417	1389		
	Population	83,489	83489	83489		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	94.5%	94.6%	94.7%	94.0%	Aligned with the 2023/24 NHS operational plan trajectory. Maintains current 94%	• 100 Day Discharge Challenge - Focussed work on early identification of those with Complex needs – posters developed to raise awareness of importance of early identifications and immediate actions to take • Work undertaken within Carers Resource to address the increase in hoarding which is delaying people from being discharged from hospital as their home is not suitable
	Numerator	11,148	11,231	11,310	10,143		
	Denominator	11,803	11,870	11,938	10,785		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	94.0%	94.0%	94.0%	94.0%		
	Numerator	11,266	11,266	11,266	11,266		
	Denominator	11,985	11,985	11,985	11,985		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	512.1	502.4	438.7	438.6	We aim to reduce the number of people that are dependent on longer term support. We have accomplished this during 22-23. We aim to continue this performance across 23-24.	Improved data capture and reporting will be developed to improve understanding of demand for new admissions to care homes. We have enhanced a number of services and reviewed our intermediate care services. We have increased the
	Numerator	419	426	372	379		
	Denominator	81,814	84,801	84,801	86,413		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	69.8%	79.1%	79.5%	79.5%	We aim to achieve above 79% across our enablement/rehab services. In previous years, Covid has had an impact on the number of people that were able to remain at home. As services have returned to normility, we estimate that we will be	We will continue to invest in our enablement and rehab services uses the funding available. This includes enhancing the teams and the workforce to ensure we are able to meet the demand on services. Furthermore, we aim to expand our
	Numerator	250	283	159	159		
	Denominator	358	358	200	200		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan