Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Bradford District and Craven Partnership Board

6 September 2024
10:00 – 13:00
Rendezvous Hotel, Skipton BD23 2TA

AGENDA

Item	Lead	Purpose	Time	Mins
1. Welcome, introductions and apologies	Chair	Information	10:00	10
2. Conflicts of interest A register of Board members can be found on our website – Declarations (mydeclarations.co.uk)	Chair	Assurance	10:10	0
3. a. Minutes of the meeting held on 17 May 2024 b. Action log c. Partnership Leadership Executive approved minutes and previous triple A report d. matters arising	Chair	Approve and to note	10:10	10
4. Public questions	Chair	Information	10:20	5
5. Listen in	Victoria Simmons/Shak Rafiq	Information	10:25	30
6. Place Lead's update	Therese Patten	Information	10:55	25
7. Reports from committees and fora	Committee and Forum Chairs	Information/approval	11:20	15
Break 11:35-11:45				
8. Partnership high level risk update	Carrie Haywood	Assurance	11:45	10
9. Closing the Gap Update	Mike Woodhead	Information	11:55	25
10. North Yorkshire Council Wellbeing strategy and Better Care Fund	Victoria Turner	Information	12:20	10
11. Bradford District and Craven Joint Forward Plan – Refresh 2024/25	Kerry Weir	Information	12:30	10
12. Any other business	All	Information	12:40	10
13. Reports/escalations to WY ICB and review of meeting	Chair	Information	12:50	10

Date and time of next meeting –
Friday 15 November
10:00 – 13:00
Scorex House

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

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	BDC Partnership Board
Agenda item no:	3
Meeting date:	6 September 2024
Report title:	BDC Partnership Board Meeting Business Items
Report presented by:	Elaine Appelbee, Independent Chair of the BDC Partnership Board
Report approved by:	Carrie Haywood, Governance Manager, WY ICB
Report prepared by:	Carrie Haywood, Governance Manager, WY ICB

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

Previous considerations and any resulting action:

PLE: June, July and August 2024 – approve previous meeting minutes
WY ICB Board: June 2024 – BDC Partnership Board Triple A Report

Executive summary and points for discussion:

This report contains BDC Partnership Board business items for information and approval:

- Minutes of the BDC Partnership Board formal public meeting held on 17 May 2024
- BDC Partnership Board Action log
- BDC Partnership Board Triple A report submitted to the WY ICB Board meeting in June 2024
- Partnership Leadership Executive approved minutes from May, June and July 2024

Outline how this supports our partnership vision and strategy

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

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

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

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

Recommendation(s)

The BDC Partnership Board is asked to:

1. **APPROVE** the draft minutes from the meeting held on the 17 May 2024
2. **DISCUSS** any open actions on the action log

3.	**RECEIVE** the previous triple A report for information
4.	**RECEIVE** the PLE minutes from May, June and July for information

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. Minutes of the BDC Partnership Board formal public meeting held on 17 May 2024
2. BDC Partnership Board Action log
3. BDC Partnership Board Triple A report submitted to the WY ICB Board meeting in June 2024
4. Partnership Leadership Executive approved minutes from May, June and July 2024

Acronyms and Abbreviations explained

- BDC: Bradford District and Craven
- WY ICB: West Yorkshire Integrated Care Board
- PLE: Partnership Leadership Executive

Minutes of the Bradford District and Craven Partnership Board
Friday 17 May 2024
10:00 – 13:00
G7/G8, Scorex House, 1 Bolton Road, Bradford, BD1 4AS

Present:

Elaine Appelbee	Independent Chair of Bradford District and Craven Health and Care Partnership (BD&C H&CP)
Therese Patten	Chief Executive, Bradford District Care NHS Foundation Trust/ BD&C Partnership Place Lead
Mel Pickup	Chief Executive, Bradford Teaching Hospitals NHS FT
Melanie Hudson	Non-executive chair of the People Committee of the BD&C H&CP
David Crampsey	Chair of Clinical Forum/Executive Medical Director, Airedale NHS Foundation Trust
Andy Withers	Non-executive chair of the Quality Committee of the BD&C H&CP
Julie Lawreniuk	Non-executive chair of the Finance and Performance Committee of the BD&C H&CP
Foluke Ajayi	Chief Executive of Airedale NHS Foundation Trust
Sarah Jones	Independent Chair, Bradford Teaching Hospitals NHS FT
Danielle Hann	Deputy Chair, Bradford and Airedale Branch of YORLMC
Iain Macbeath	Strategic Director – Health and Wellbeing, City of Bradford MDC
Jonathan Kerr	Chief Officer, Age UK North Craven
Sam Keighley	CEO, VCS Alliance
Helen Rushworth	Chair of Citizen's Forum/Chief Executive, Healthwatch Bradford District
Victoria Turner	Public Health Consultant, North Yorkshire Council (deputising for Louise Wallace)
Marium Haque	Strategic Director – Children, City of Bradford MDC
Richard Haddad	Chair of the Clinical Advisory Board (CAB)
Prof Marina Bloj	Professor of Health Research/Associate Dean (Research and Innovation) Faculty of Health Studies University of Bradford
Sarah Muckle	Director of Public Health, City of Bradford MDC

In Attendance:

Lesley Tillotson	Associate Director (people, patients & resilience), BD&C H&CP
Victoria Simmons	Senior Head of Communications and Involvement, BD&C H&CP
Shak Rafiq	Associate Director Communications and Involvement
Mike Woodhead	Director of Finance, Contracting and Estates, Bradford District Care NHS Foundation Trust/BD&C Partnership lead Finance Director (from 11am)
Sally Napper	Non – executive Director, Bradford District Care NHS Foundation Trust
Sohail Abbas	Director of Population Health and Inequalities, BD&C H&CP
Sue Baxter	Head of Partnership Governance, NHS West Yorkshire Integrated Care Board (deputising for Linda Patterson)
Phillipa Hubbard	Director of Nursing, Professions and Care Standards, DIPC, Deputy Chief Executive, Director of Nursing and Quality for BD&C H&CP
Carrie Haywood	Governance Manager, NHS West Yorkshire Integrated Care Board

Apologies:

Nancy O'Neill	Chief Operating Officer, BD&C H&CP

Draft

Andrew Gold	Chair of Airedale NHS Foundation Trust
Karen Siennicki	Assistant Director of Adult Social Care, North Yorkshire Council
John Pattinson	Chief Executive, Independent Care Group
Louise Wallace	Director of Public Health, North Yorkshire County Council
Richard Webb	Corporate Director, Health and Adult Services, North Yorkshire Council
Karen Dawber	Chief Nurse, Bradford Teaching Hospitals NHS FT/ BD&C Partnership Quality Director
Lorraine O'Donnell	Chief Executive, City of Bradford MDC
Ashley Green	Chief Executive, Healthwatch North Yorkshire
Linda Patterson	Chair of Bradford District Care NHS Foundation Trust
Louise Bestwick	Chief Executive, Bradford Care Association

Members of the public: 2

1 Welcome and introductions

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

It was highlighted that item ten, relating to the deep dive focus on 'workforce wellbeing' - staff/staff retention had been deferred to the Partnership Board Development Session on 21 June 2024; due to unavoidable reasons.

2 Conflicts of Interest

The members register of interest was noted and declarations of interest were made against item eight regarding the tenure of the Bradford District and Craven non- executive directors. Declarations were made by; Elaine Appelbee, Andy Withers, Julie Lawreniuk, Melanie Hudson, and Sally Napper who had direct financial interests.

It was agreed that those members who had declared an interest with item eight would not participate in the discussion or the decision and could remain present at the board for the duration of the item.

3 Minutes of the meeting held on 08 March 2024/action log/matters arising

The chair highlighted that the last formal Partnership Board meeting was not quorate and asked members to ratify any decisions or recommendations that were noted in the previous minutes. The board agreed that the minutes of the last meeting were an accurate record of the discussion and ratified all decisions and recommendations.

The board noted that there were no actions to update or discuss.

The chair highlighted that the previous Triple A report submitted to the NHS West Yorkshire ICB Board was included in Partnership Board papers for information and will continue to be included for future meetings.

DRAFT

The Partnership Board:
RECEIVED and **APPROVED** the minutes from the previous meeting held on the 8 March 2024

4 Public questions

No questions were received from the public for this meeting.

5 Listen in – inclusion health groups

Victoria Simmons presented the Listen in report which described the second cycle in the second year of the 'Listen in' programme which focused on inclusion health groups. During the cycle throughout February to May 2024 a range of meetings, activities or visits to groups took place across Bradford district and Craven The team worked closely with the Reducing Inequalities Alliance (RIA), their expertise and insight identified a gap in the understanding of people who are in contact with the justice system and their health needs, it was highlighted that this was the most challenging cycle to date.

Key themes were highlighted as; mental health and substance use, access to healthcare services, support for families of prisoners, stability and consistency in support services, community engagement and peer support and housing and reintegration challenges such as digital exclusion and disengagement to society.

Victoria Shared a patient experience with members through a discussion at the 'Together Women Project', who was on probation and had a long history of complex needs including domestic abuse, care system experience, mental health, substance use and alcohol addiction with multiple admissions to Bradford Royal Infirmary over the last year. It was noted that the patient had since joined a clinical research trial after receiving compassionate care following the last admission and was discharged with a full rehabilitation offer.

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

Mel Pickup identified that the Chief Executive of Timpson's has a strong commitment to employ prison leavers which had proven successful for them. She asked the board to think about the partnership's ability as employers to look at that cohort of people as part of their rehabilitation. The board noted that there was an opportunity to make a societal contribution within the workforce arena as the VCSE has evidenced when employing those from marginalised communities.

The board discussed developing the Listen in report to show the translation of the information into a change or outcome within the community. It was felt that strengthening the feedback about what changes and actions have been made would allow the board to hold themselves to account on the previous identified insights. The board agreed that deliberative events could be used to bring members of the board and senior managers together on key topics to develop exposure which will

be influenced by the Chief Listen in Officer. Connectivity across the partnership would be strengthened via the priority programme boards.

The Partnership Board:
considered the ideas and insights from the 'Listen in' cycle and made the following recommendations:

- The Listen in Programme to include an action plan in future cycle
- Agreed to host deliberative events

6 Place Lead's update

Therese Patten presented a report which summarised key activities and points to note arising from the activity of the Bradford District and Craven Health and Care Partnership and the wider West Yorkshire Health and Care System.

Therese Patten highlighted a report published regarding health foundation research that predicted 700,000 more workers projected to be living with major illness by 2040 and that 80% of the increase would be within the most deprived areas of the UK that would exacerbate health inequalities further in areas such as Bradford District and Craven. It was highlighted that this has been confirmed as a priority for partner organisations who have committed to support staff to reduce inequalities as much as possible.

It was highlighted that staff across various parts of the partnership had received awards, Therese Patten recognised those receiving as; myHappymind Bradford District and Craven shortlisted for the HSJ Digital Awards, Safe Spaces won the Third Sector Care Award for collaboration, Staying Put won Bronze at the Smiley Awards, Airedale healthcare support worker received a national award for compassion and commitment to care and Bradford hospital colleagues won Skills for Health Our Health Heroes award.

Therese Patten highlighted that Airedale NHS Foundation Trust and City of Bradford Metropolitan Council have been working in collaboration to deliver a Home First Assessment Support Team (Home FAST!) pilot that has seen delays in discharge reduced by 50% in five weeks. It was highlighted that the current model using the Bradford Enablement Support Team (BEST) was overwhelmed with care being purchased from the independent sector. Therese Patten confirmed that the Home FAST! service would be established at Bradford Teaching Hospitals Foundation Trust, following training on the methodology to apply further efficiencies across the district and to allow patients to return and remain at home.

Foluke Ajayi confirmed that the pilot has proved that the model has been successful and confirmed that the North Yorkshire Council will be engaged to implement this model of care in the future, in line with City of Bradford Metropolitan District Council.

The Bradford District and Craven Partnership Board:
RECEIVED and **NOTED** the Place lead's update

DRAFT

7 Reports from committee and fora

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

- The chair of the People Committee offered support following the Listen in item to strengthen the workforce element within inclusion health groups challenge with integration
- The chair of the Clinical and Professional Forum offered support following the Listen in item to work with those patients who are remote to area and new to area to strengthen integration to those in inclusion health groups. The chair also highlighted that work should be done to widen access to health records taking into consideration safeguarding issues and any risks to third parties.
- The chair of the Quality Committee highlighted that the Committee had met following submission of the triple A report and noted the key items the Committee had discussed included:
    - Cygnet at Wyke had been rated inadequate by the CQC and
    - confirmed that the Quality Group within the ICS had provided ongoing support and Low vaccination rates consistently reported across the district and confirmed that a risk had been identified as an emerging risk
- The chair of the Finance and Performance Committee highlighted that the Committee had held an extraordinary meeting alongside partner executives to prepare for the financial peer review.

The Partnership Board:
RECEIVED the Bradford District and Craven Sub – Committee and Fora Triple A Reports

Mike Woodhead joined the meeting

8 Partnership governance effectiveness & efficiency – proposal for longer-term partnership governance arrangements

The chair highlighted that the work presented within the item had been contributed to by three nominated board members via the Governance Efficiency Steering Group.

8.1 Partnership Governance Effectiveness

Sue Baxter presented the item on committee effectiveness and highlighted that each of the members and attendees of the Partnership Board and all groups in the formal governance structure were asked to complete the committee effectiveness survey. The partnership board results were shared at the 17 May Partnership Board Development session. It was noted that participation numbers were low for two of the sub-committees of the Partnership Board and as a result were not included in the report. Members expressed concerns on the low engagement and requested a review of the methodology to increase engagement in the next cycle.

8.2 Committee Annual reports for 2023/24 and review of Terms of Reference

DRAFT

The board approved the committee annual reports for the Partnership Board and all groups in the formal governance with the exception of the Citizen's Forum.

The board agreed to approve the terms of reference for the Partnership Board and all groups in the formal governance with the caveat that the wording will be amended to reflect a change to the timing of publication of draft minutes for each group in the quarterly cycle.

Members requested more clarity on the mechanism that the Partnership Leadership Executive (PLE) makes decisions within the terms of reference and noted that it has not been clear what decisions have been made from the shared minutes at each meeting.

ACTION: The board agreed that any decisions made by the PLE should be made clear as part of the Place Lead report.

RESOLVED: The Partnership Board approved the annual reports and terms of reference for the Partnership Board, Partnership Leadership Executive, Finance and Performance Committee, Quality Committee, People Committee and the Clinical and Professional Forum

8.3 Partnership governance effectiveness and efficiency review report

The chair highlighted the declarations of interest made against this item by Elaine Applebee, Andy Withers, Julie Lawreniuk, Melanie Hudson, and Sally Napper who had direct financial interests regarding the tenure of the Bradford District and Craven non-executive directors and Melanie Hudson stated an interest in regard to the recommendation for disestablishment of the People Committee. It was agreed that those members who had declared an interest with item eight would not participate in the discussion or the decision, and could remain present at the board for the duration of the item.

Sue Baxter introduced the item and highlighted that the Board Development Session on the 25 April 2024 provided key feedback from members to enable progression of the review.

It was highlighted that the proposal to reduce the formal board cycle to four meetings per year had been removed as this had been agreed in a previous meeting. Members noted the progress of the governance effectiveness and efficiency steering group and approved the proposed recommendations.

RESOLVED: The Partnership Board:

1. **APPROVED** the preferred option as option two to stand down the People Committee and re-distribute responsibilities to other boards, committees and groups
2. **NOTED** that Sarah Jones (chair of BTHFT) will become the Partnership Board 'chief listening officer'
3. **NOTED** the timeline for the new CoBMDC district plan and the delayed review for the PLE and WBE
4. **NOTED** the interim arrangement to proactively manage the PLE and WBE meeting forward planners, to mitigate overlap where it is appropriate to do so

5. **NOTED** the development of the Adults Joint Commissioning Group and the shared learning with CoBMDC colleagues
6. **NOTED** the further work to explore equivalent mechanism for NYC children's to be taken forward into 2024/25
7. **AGREED** to the additional Closing the Gap Programme Board (management group), which will report into the Partnership Leadership Executive and
8. **AGREED** to the changes to the Strategic Partnering Agreement Financial Governance Framework, reflecting the new closing the gap programme board responsibilities in relation to business cases
9. **NOTED** the changes to the decision flowchart
10. **APPROVED** the reform and re-establishment of the Primary Care Strategy and Assurance Group
11. **APPROVED** the reduction of Trust Non-Executives from six down to two and alignment of tenure with individuals Trust tenure, and tenure of independent chair to 30 June 2025
12. **NOTED** that the refreshed Strategic Partnering Agreement and update Governance Handbook will be submitted for approval in September 2024 Partnership Board meeting
13. **AGREED** that all future roles to be overseen by the reconstituted partnership vacancy control panel
14. **AGREED** to consider learning from the Welsh Health Board and liaise with WY Governance arrangements and partnership governance leads to inform improvements in connectivity with audit and assurance
15. **APPROVED** the Associate Director of Communications and Involvement to lead the publication on act-as-one partnership website the partnership's contribution to the NHS West Yorkshire ICB annual report for 2023/24
16. **NOTED** the Quality Committee approach to the Thirlwall inquiry
17. **NOTED** the pausing of the ambition to delegate budget and decision making to priority boards and
18. **REVIEWED** lessons learnt from the review of distributed leadership

9. Partnership high level risk update

Carrie Haywood presented a report which detailed the high-level risks (scoring 15 and above) on the Bradford District and Craven Health and Care Partnership risk register during cycle one of 2024/25. The report included the NHS West Yorkshire ICB risk register and information on the common risks across West Yorkshire places.

It was highlighted that the risk score that related to the CoBMDC financial position (2173) had lowered from 25 to 20 due to receiving extraordinary funding. The risk score related to the sustainability of the voluntary sector (2386) had lowered from 25 to 16 due to a moderation exercise of scores to ensure proportionate scores are assigned in relation to the other high-level risks on the risk register. It was confirmed that this risk remained high and will maintain the same

level of board oversight. It was highlighted that North Yorkshire Voluntary services were not impacted by this risk and confirmed that this would be made clear in the next report.

It was highlighted that a risk related to the vaccination programme has been developed with Public Health colleagues focused on the low uptake of vaccines in particular MMR, COVID – 19 and Flu alongside community circulation of pathogens, this would be added to the risk register in cycle two.

It was noted that the paper included a summary of the 17 high level risks on the WY ICB risk register and links to similar risks on the partnership risk register were highlighted, to encourage place consideration of risks on the ICB risk register and how the partnership could mitigate these risks. The common risks across the five places were provided to encourage consideration of any potential gaps in the partnership risk register.

The Partnership Board:

1. **RECEIVED** the BDC H&CP cycle one risk report and noted assurance on the critical and serious risks scoring above 15.
2. **DISCUSSED** and identified risks that were not currently recorded on the risk report and signposted the partnership governance team to the relevant risk owners for liaison in preparation for cycle one.
3. **RECEIVED** the ICB risk register for consideration and noted assurance on the BDC H&CP risks captured in the ICB risk register.

10 Deep dive focus on 'workforce wellbeing' - staff/staff retention

Deferred to the Partnership Board Development Session on 21 June 2024.

11 Financial and Operational Planning Update

11.1 Financial Planning 2024/25

Mike Woodhead presented the financial planning update and confirmed that an aggregate place plan was submitted on the 2 May 2024 following a peer review session with colleagues across the ICB on the 26 April 2024, the session provided challenge and scrutiny on plans to close the gap and it was confirmed that the £47.6m deficit plan would move towards £40m as more risk had been introduced to the plans.

Mike highlighted the governance arrangements that had been developed to implement the closing the gap programme board and will report into the Partnership Leadership Executive (PLE) and would share responsibility for delivery with the priority programmes.

The Partnership board agreed that when service changes were being considered the impact on health inequalities of the population, the impact on quality and equality and the statutory involvement duty of NHS organisations needed to be considered and understood on an individual business case basis. It was noted that a deliberative event including local citizens, was being developed to address the closing the gap work. (to involve the population.)

Draft

Philippa Hubbard and Andy Withers confirmed that the System Quality Committee had agreed a process for oversight of business case full and partial Quality and Equality Impact Assessments. Andy highlighted that it was preferable to review this without causing delay the process to have assurance on the safety of services without dropping below the agreed safety threshold.

It was highlighted that objective to agree the top opportunities for improving productivity and tackling waste and objective to identify and prioritise services that could be stopped / slowed, paused, and scaled down were identifying the largest opportunities for reducing spend across Place; work has also started with the acute trusts to develop new ways of delivering services.

Mike confirmed that a three-year aggregated plan would be developed in June, as breakeven would not be reached by year one. He noted that the West Yorkshire ICS deficit plan of £50m would likely become a control total, however confirmation has not yet been received.

The Partnership board recognised that a reduced deficit plan had been submitted due to the Closing the Gap Programme and collaboration through PLE. It was recognised that there was an increased risk into each organisation stretch target plan. The board were given the opportunity to request the detailed plan that was scrutinised at the peer review in April for further information.

The Partnership Board

1. **NOTED** the reduced deficit plans
2. **DISCUSSED** the challenges in further closing the gap
3. were **ASSURED** regarding the work being undertaken to further close the gap

11.2 Operational planning 2024 / 25

Mike Woodhead introduced the paper regarding the operational planning update and highlighted three key areas of focus that related to: recovery of core services; support for the workforce; and improved productivity.

It was recognised that the plans would deliver the national requirements with four exceptions; bed occupancy that remains slightly above requirements; ambulance category two response times which remains slightly above requirements; the impact on activity due to the roll out of electronic patient records at Airedale NHS Foundation Trust; and variances in patient diagnostic test across all specialties. Mike confirmed that plans submitted showed no overall growth in staff.

The Partnership board:

- **NOTED** the update on the 2024/25 Operational Plan

14 Better Care Fund – Sign off

DRAFT

Iain Macbeath presented the item as an update on the Better Care Fund refresh submission, along with the draft updated capacity and demand (C&D) plan required for 2024-25. It was highlighted that the C&D plan will align to the NHS operational plan where possible.

The Partnership Board agreed to delegate the approval of the Better Care Fund to the Place Lead due to timings of the deadline for submission. It was highlighted that PLE will be sighted on the plans on 24 May 2024 and a Better Care Fund refresh submission will then be presented to the Health and Wellbeing Board for approval of the plans on 11 June 2024. It was noted that the plans will continue to evolve throughout the year to drive better outcomes.

It was highlighted that the North Yorkshire Better Care Fund updated plan will be received by the Partnership Board in the formal meeting on 6 September 2024.

The Partnership Board

RESOLVED; The Partnership Board delegated the approval of the Better Care Fund to the Place Lead for the updated capacity and demand plan 2024 – 2025.

13 Any other business

Members, led by the chair and Sam Keighley gave formal thanks to Mel Pick up for the work carried out during her Place Lead tenure and welcomed Therese Patten as the new Place Lead.

Helen Rushworth shared a concern that there have been no public questions brought to members for this meeting and the previous two meetings. The board agreed to explore how the public would like to engage with the board., There is potential to use the planned deliberative events, and the wider outreach involved to facilitate an increase public questions.

The Partnership Board

ACTION The Communication and Engagement Team to review process for public questions and propose next steps

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

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

Date and time of next meeting:

Friday 6 September 2024
10:00-13:00
Craven venue to be confirmed

Draft

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven Partnership Board

Date of meeting: 17 May 2024

Report to: WY ICB Board

Report completed by: Carrie Haywood for Elaine Appelbee (chair) & Therese Patten (place lead)

Date: 28 May 2024

Key escalation and discussion points from the meeting
Alert:
• **Financial position** – members received an update on the significant financial challenges faced by the Health and Care Partnership. It was highlighted that a peer review with colleagues from across WY ICB had taken place on the 26 April 2024 to provide challenge and scrutiny on the financial plans to close the financial gap. It was highlighted that BDC Place is submitting a £47.6m deficit plan for 2024-25 on 2 May 2024. This has reduced considerably since the first planning submission on 22 February (£83.7m deficit) however, it was noted that the plans contain significant risks and high savings targets, BDC has a disproportionately large deficit compared to other WY Places and BDC is under continued scrutiny and pressure to further close the gap. • Related risks on the partnership risk register include in-year financial performance - risk 2433 - and underlying financial deficit - risk 2337.
Advise:
• The Chair and members of the Place Committee formally thanked Mel Pickup for the work carried out during her **Place Lead** tenure and welcomed Therese Patten as the new Place Lead. • **BDC governance efficiency review –** the Place Committee approved the eighteen governance efficiency review recommendations to support the progression of a longer term and more streamlined governance plan for the partnership. Key areas approved were: o the People Committee to be disestablished and responsibilities re-distribute to BDC people development priority board, assurance committees and other groups o the Partnership Board 'chief listening officer' has been taken up by the chair of Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) o the Closing the Gap Programme Board (management group) with responsibilities including approval of business cases, will be established and will report to the Partnership Leadership Executive (PLE) o agreement to reduce the number of Trust Non-Executives from six down to two, with tenure extended to align with their Trust tenure. In addition, the tenure of the independent chair was extended to 30 June 2025 to align with independent chairs in the four other West Yorkshire places o the ambition to delegate budget and decision making to priority boards was agreed to be paused

- The distributed leadership model has been reviewed with key learning and recommendations to be incorporated into future arrangements

- **Operational planning update –** members received an operational plan update that showed that activity and performance trajectories deliver all national requirements with the following exceptions:
  - Bed occupancy plans are above the national 92% target
  - Yorkshire Ambulance Service (YAS) Category 2 Response times plan is above the 30-minute target
  - Airedale NHS Foundation Trusts (ANHSFT) activity plans are impacted by reduced capacity during implementation of the new Electronic Patient Record (EPR) and
  - 95% or above of patients will be seen within 6 weeks for all diagnostic specialties, with the exception of audiology (90% by March 25) due to the current significant backlog

It was noted that triangulation with finance, workforce and activity, plans now show no growth in staff. Plans still assume reductions in temporary staffing across the year, no further industrial action in 2024/25, a continued reduction in bank / agency use, and that recruitment plans will deliver temporary staffing reductions.

Assure:

- **Listen in -** members received a report following the second cycle which focused on inclusion health groups. The key themes from the cycle included mental health and substance use, access to healthcare services, support for families of prisoners, stability and consistency in support services, community engagement and peer support and housing and reintegration challenges. It was noted that the information gathered from this cycle would feed into a new project to improve cancer screening uptake among inclusion health groups, with an event taking place in May 2024, with outcomes being worked on in conjunction with the Clinical and Professional Forum.
- **End of year process -** members received the annual report for the BDC Health and Care Partnership Board and its Sub–Committees and Fora, including an annual review of the terms of reference. It was highlighted that there is to be amended wording within the terms of reference to reflect support arrangements in line with the NHS West Yorkshire ICB.
- **Better Care Fund sign off –** an update was provided regarding the capacity and demand (C&D) plan required for 2024-25. It was highlighted that the C&D plan will align to the NHS operational plan where possible. The Partnership Board agreed to delegate approval of the Better Care Fund to the Place Lead due to timings of the deadline of submission. It was highlighted that PLE will be sighted on the plans on 24 May 2024 and a paper will then be presented to the Health and Wellbeing Board for approval of the plans on 11 June 2024.
- Members received an update regarding awards received by staff across various parts of the **partnership** and gave recognition to those receiving them; “myHappymind Bradford district and Craven”, was shortlisted for the HSJ Digital Awards, “Safe Spaces”, won the Third Sector Care Award for collaboration, “Staying Put”, won Bronze at the Smiley Awards, “Airedale healthcare support worker”, received a national award for compassion and commitment to care and “Bradford hospital colleagues”, won Skills for Health Our Health Heroes awards.

Partnership Leadership Executive

Friday 24 May 2024

9am – 12pm

MS Teams

Present:	
Therese Patten *(TP)*	CEO, Bradford District Care Foundation Trust (BDCFT) ***(Chair)***
Mel Pickup *(MP)*	CEO, Bradford Teaching Hospitals Foundation Trust (BTHFT)
Iain Macbeath *(IMB)*	Strategic Director of Health and Wellbeing, City of Bradford Metropolitan District Council (CBMDC)
Phillipa Hubbard *(PH)*	Director of Nursing and Quality (Distributed leadership) Bradford District and Craven Health and Care Partnership (BdC HCP)
Mike Woodhead *(MW)*	System Lead Director of Finance/Chief Finance Officer (BDCFT)
Louise Bestwick *(LB)*	CEO, Bradford Care Association
Marium Haque *(MH)*	Strategic Director for Children's Services, (CBMDC)
David Crampsey *(DC)*	Medical Director Airedale NHS Foundation Trust (on behalf of Foluke Ajayi)
Charlotte Ramsden (CR)	CEO, Childrens Trust
In Attendance:	
Nancy O'Neill *(NoN)*	Chief Operating Officer/Director of Partnership Delivery, Bradford District and Craven Health and Care Partnership (BdC HCP)
John Hartley *(JH)*	Assistant Director Quality and SEND (BdC HCP) ***item 3***
Stu Barrett *(SB)*	Head of Send Services (CMBMDC) ***item 3***
Nagina Javaid *(NJ)*	Programme Director for Children, Young People and Families (BdC HCP) ***item 3***
Clare Smart *(CS)*	Associate Director of Strategy (BdC HCP) ***item 7/8***
Sasha Bhat *(SBh)*	Priority Director - Healthy Minds/Deputy Director of Integration and Transformation (BdC HCP) ***item 8***
Shak Rafiq (*SR)*	Associate Director Communications and Involvement (BdC HCP)
Alison Bullock*, (AB)*	Partnership manager (BdC HCP)

1. Welcome and apologies for absence Declarations of Interest	Foluke Ajayi, Sohail Abbas, Sam Keighley, Danielle Hann, Richard Haddad, Sarah Muckle, Lorraine O' Donnell. MW declared an interest in item 8: Business Case Appraisal Panel – Recommendations to PLE. BDCFT are a provider of the services, MW remained present for the conversation.
Actions:	***None***
2. Notes from 23 February 2024 2 (b) Action log	The minutes of the last meeting were accepted as an accurate record. Actions have been updated on the action log. <u>Matters Arising:</u> None
Actions:	***None***

3. Special Education Needs and or Disabilities (SEND) Health & ICB responsibilities and update	In March 2022, Ofsted, and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Bradford, as a result of this inspection, five Written Statement of Action were produced to address five areas of weakness. In March 2024, the Department for Education (DfE) and NHS England agreed to release Bradford from formal monitoring under the Written Statement of Action due to the progress made towards the actions. As of April 2024, Bradford is now back in the SEND Inspection window. An inspection could happen at any time but is likely to be towards the end of the year. There are ten evaluation criteria that the Inspection Team will use to judge the Local Area SEND Partnership. During the next inspection, BdC will be judged both on the progress since the last inspection (under the old framework) and the criteria under the new framework. The Inspection will be making a judgment on the lived experience of children and young people with SEND and how well partners within the district work together to ensure good outcomes for children and young people (CYP). The Local Authority will co-ordinate on behalf of partnership, there are three potential outcomes: • consistent and effective • inconsistent and ineffective • Serious widespread failings Whilst it is recognised that BdC have made good progress in this area, there are also some key areas of weakness (stock issues) which have been ongoing for some time that we need to, as a partnership, commit to a way forward to resolve these. These areas include: • Waiting list: attention deficit hyperactivity disorder (ADHD)/Autism • Quality of Early Health Care Plans • Joint Commissioning this is underdeveloped, we need to demonstrate this is being developed by the next inspection. The recent North Yorkshire inspection has provided some insight into new inspection framework. Feedback has suggested that that there may be more scrutiny than previous inspections. It is anticipated there will be between six and eight people conducting the inspection, they will focus on how we work together as a partnership/are we listening to CYP/families, there will be a strong focus on impact and triangulation on what we say with CYP/Families. They will look at six cases in-depth, there is a concern that Bradford has around 7000 cases and they will not be able to form a reasonable judgement on such a small number of cases. When a case is chosen all information will need to be shared, it is important that this request is prioritised by all partners. Bradford has supported other areas under inspection and have demonstrated outstanding practice in some areas of SEND. We have

	a good knowledge due to our local complexities, but it is felt this could lead to additional scrutiny. There are clear roles and responsibilities in terms of SEND for Health and the Local Authority. The significant progress made in the last two years, due to the work of all the teams involved was recognised, particularly Sally Skipper, Matthew Elliott, Sarah Firth, Nigel Hammon and Caroline Taylor for the work they've been doing on co-production and then using that to further strengthen and improve our two-way communications and involvement in an open and transparent way. As a system, we are clearer around SEND governance structures and have good quality data. Regular meetings are held and SEND is a thread that runs through a number of areas. It was agreed the Childrens Trust needs to be more strategically involved in the process. In terms of finance, there was caution that we need to anchor our ambition for the next 6-12 months within the context of the current finance constraints. Any request for funding (around joint commissioning) will need to be submitted to the Business Case Appraisal Panel. Whilst acknowledging the current financial situation, it was felt that this is a priority area that we need to demonstrate we are making progress on. As partners we need to support and commit to improve this. It was suggested a shared narrative around supported waiting would be useful. Local Authority Councillors have been briefed on the position.
Actions:	***Update on progress of stock issues in Sept 24***
4. Better Care Fund 24-25 Plan update	A two-year plan for the Better Care Fund (BCF) 23-25 was approved in May 23. the BCF national team has now released the reporting guidelines for 2024-25. This includes a requirement for local areas to agree spend for 2024-25 and establish the use of the additional funding for Adult Social Care Discharge. The BCF for Bradford is fully committed and is contributing to core services. Partners are reviewing their 24-25 spend to ensure it meets the BCF national conditions. Finance and data leads from both organisations are working collaboratively to finalise the BCF report. It was noted that conversations will continue around how we get the best value from this funding and changes can be made to the plan during the year, correcting it in the quarterly submissions. It was agreed that the process for North Yorkshire BCF should mirror the Bradford one so can see both together and sign off at same time. The BdC Partnership Board on have delegated authority for Therese Patten to sign the BCF 24-25 plans. The Chair of the Health and Wellbeing Board will sign the BCF, and a paper will be presented to the Health and Wellbeing Board on 11th June 2024.
Actions:	***None***

5. Priorities and Enabler update	PLE were advised that the c£400k investment in asset-based community development (ABCD) referenced in the progress section of the report was potentially at risk because of the current financial position. This would impact both primary and community care and could be a reputational risk to the partnership as it is understood letters have already been sent to colleagues confirming financial agreements. It appeared this had not been through the panel for financial decisions process. It was clarified that the funding was part of the ICB budget and had been discussed at the ICB Executive as one of several unpalatable options to consider in terms of reducing the ICB deficit, but no decision had been made at this point, a piece of work was underway to understand what had been committed and any impact. It was suggested the c£400k investment in asset-based community development should sit alongside the process for financial decisions and PLE should have oversight. However, given there appeared to be some confusion around the funding and process, it was suggested that clarity was gained before any further discussions. Home First Assessment and Support Team (H-FAST) is going well and has been referenced in the Health Service Journal award application
Actions:	***£400k investment in asset-based community development: Clarify process that has been undertaken (fact find) and how it can fit with the financial business case panel process***
6. Finance update	At the last planning submission on 2 May the West Yorkshire ICS plan deficit was £99.1m. A technical private finance initiative (PFI) of £14.2m brings the deficit to £84.9m deficit, £46m of this relates to BdC ICB. Since the submission on 2 May, ANHSFT have improved their plan position by £3m, and BTHFT by £5m, it was reported this is by taking on additional risks, but it will allow some extra time to work on plans to prevent the need for regulatory intervention. The place position of just under £40 million deficit for BdC, is largely in the two acute providers and represents 3% of our funding allocation (the highest in West Yorkshire). Progress against the programme delivery objectives was shared: Objective 1: Agree the top opportunities for improving productivity and tackling waste. - Work is ongoing to ensure we are delivering against our cost improvement programmes. Objective 2: identify and prioritise services that could be stopped, slowed, paused, or scaled down. - During June the three trusts are reviewing all services that they deliver to see if these could be delivered in a more rationalised collaborative way, in both the short and long term. This will be discussed at the System Finance and Performance Committee on 27/06/24. Objective 3: progress our system population health approach.

	Objective 4: progress immediate system priorities with CBMDC and Childrens Trust - In terms of closer working with the Children's Trust and the Local Authority and Health around strategic estates, housing for health, CYP out of area placements and complex cases, Intermediate care services. This work is ongoing, the leader of the council has received an update from each of the Senior Responsible Officers Progress was reported around a process for shared funding for CYP with disabilities and the Home-First Assessment Team (H-FAST) pilot at ANHSFT is proving to be a success. It is important that all System leaders continue to commit to what is in the plans, they are responsible for leading this within their own organisations.
Actions:	***None***
7. Closing the Gap Programme Board Priorities	The five priority programme boards: Healthy Communities, Access to Care, Healthy Minds, Healthy Children and Families, and Workforce were asked to review their programmes with a view to re-focusing work to help close the financial gap in 2024/25 and beyond. Summary of outcome from this piece of work: <u>Healthy Communities</u> • Intermediate Care reform • Community Partnerships and the development of Integrated Neighbourhood Teams <u>Access to Care</u> • Outpatient transformation • Evidence based interventions and value for money reviews. <u>Healthy Minds</u> • Out of area placements, complex packages of care, admissions avoidance and reducing bed days, and length of stay for adults and children. • Workforce and productivity and aligning to health delivery only. <u>Healthy Children and Families</u> • Every child has the best start to life, thrives, and gets the support they need. <u>Workforce</u> • Reduction in temporary staffing expenditure The Programme Boards now need to be more explicit in delivery savings targets. It was noted that the programme boards were at different stages of development and maturity. Programme Boards do not currently have delegated budgets with the exception of Healthy Minds. This is a vision we are working to, looking at totality of programme budget and operating like a service unit. Currently there is senior finance representation on each of the boards to provide advice and guidance.

	It is anticipated that program boards will develop proposals for investment (but more likely for disinvestment due to the current financial situation). These will then be considered by the Business Case Appraisal Panel before coming to PLE for approval. A service line review is underway due to complete mid-June this will inform some of the work needed to be undertaken by the programme boards. Dependent on the outcome of the service review, specialist support may be required to come in and help us progress some things at pace. CS will meet with programme directors after Service Line Review meeting in June
Actions:	***Provide progress update at next meeting.***
8. Business Case Appraisal Panel – Recommendations to PLE	MW declared a DOI as Finance Director of BDCFT, a provider of these services. MW remained in the meeting for the conversations. <u>Children in Care Review Health Assessment Capacity</u> Review health assessments are a mandated service commissioned by ICBs. Review Health Assessments are undertaken annually. The assessments are an opportunity to assess a child's physical and mental health status. The number of children requiring an assessment is increasing. A proposal was presented which recommended funding nursing capacity above the current funded establishment to increase capacity for Review Health Assessments for 24/25. In 2023/24 BDCFT used non-recurrent budget flexibilities to support an additional capacity of nine whole time equivalent nurses, the recommended standard for the ratio of nurses to children would be ten additional nurses. The panel considered options of zero, five, or nine additional nurses to the funded establishment. Nine additional nurses were supported at a cost of £493,109. BDCFT plan to use vacancies in adult unplanned care services for match funding at £190,000, therefore the recommendation was that the remaining amount was match funded by the Partnership, a total of £303,000. This will be an unidentified increased risk to the ICB savings plan. It was noted that the service would not meet the recommended nurse to child ratios, but that compliance levels would remain in line with the SEND Written Statement of Action improvement trajectory. Going forward this growth is unsustainable, and a new model and approach is needed. It is expected that this piece of work will be taken up by the Healthy Children and Families Programme Board and through the work with the Children's Trust. The proposal was supported by PLE. It was acknowledged that this demonstrated the maturity of the partnership, recognising that to fund this service, something else in the system would need to stop or pause. It was noted that as the waiting list reduces the need for additional staff will also reduce. <u>Children and Young People's Autism and ADHD Assessment Capacity</u>

	The Autism and ADHD assessment services are delivered collaboratively by ANHSFT, BDCFT and BTHFT. The services are funded £1,889,920 for 1,078 assessments. Referrals in 2023/34 were 2,337. The average diagnosis rate is 91%. Some of the remaining 9%, are diagnosed with Delayed Language Disorder or may require assessment for a learning disability. There has been a continual increase in demand for CYP Autism and ADHD assessments, resulting in long waits across BdC. There are 3,936 children waiting on the NHS list. The waiting time for NHS services for children not fast-tracked due to risk, is now at four years in BdC. The volume of referrals means by December our children will face a wait of five years. Wait times in the private sector range between one and three years, averaging 2.2 years. This does not include shared care arrangements for medication support. It was noted that a 91% conversion rate demonstrated the significant level of need in BdC. Whilst Families that exercise *'choice'* have shorter waiting times they are no shared care arrangements in place for medication support. Following an extensive discussion, the Business Case Appraisal Panel concluded that there is a need to create a sustainable service that does not seek budget increases to match the 25% year on year growth and asked PLE to confirm acceptance of a wait time of 3-years for new referrals for Children and Young People's Autism and ADHD assessments whilst a new model of care was developed. Alongside this moving away from NICE Guidelines and developing a pathway and model of care that is right for us at Place. It was noted the model has not changed since 2019 and non-recurrent money has been used in the past to support the service in crisis times whilst the service was transformed but this had not happened. Given the predicted growth it was felt this was now urgent. It was noted there are several successful models that BdC could benchmark against/take some learning and adapt. There were significant concerns raised by PLE members around agreeing a three year wait for referral would be acceptable as suggested in the recommendations. As an area of focus of the SEND inspection, we need to demonstrate progress as a partnership. Alongside this, a nine-week timescale to develop a new model would increase waiting list times for an already pressured service. However, given the current financial situation it was acknowledged that PLE could not agree to an unfunded spending commitment. A proposal to invest for the long term needs some consideration. It was agreed that to make the right decision on a long-term solution PLE would support the Healthy Minds Programme Board to develop a business case for a new model of care which would provide long term sustainability for the service. The Business case would be submitted to the Business Case Appraisal Panel before coming back to PLE in

	July 2024, ensuring it has support from the relevant governance forums. e.g., System Quality Committee PLE members committed to free the relevant staff from their organisations to be able to fully focus on this work to ensure it is completed within the timescales. Noting that the business case to develop a new model would likely increase our deficit, it should include what can be decommissioned to support this. In terms of moving away from NICE guidance on staffing, the business case should highlight any impact of this and ensure that it is evidenced Clinical input has been part of the decision. In terms of communication to families, it will be important that we communicate to them, that we recognise a three-year wait is not acceptable and we are working on developing an improved model of care which will reduce this. How families are supported whilst waiting will need consideration.
Actions:	***Fully developed business case for Autism and ADHD assessment services to be brought back to PLE in July 2024***
9. Any other business/ Key messages	SEND update. Better Care Fund update. Business Case Appraisal Panel – Recommendations.
Actions:	***None***
Date and time of next meeting	28 June 2024 MS Teams

Partnership Leadership Executive

Friday 28 June 2024

9am – 12pm

MS Teams

Present:	
Therese Patten *(TP)*	CEO, Bradford District Care Foundation Trust (BDCFT) ***(Chair)***
Mel Pickup *(MP)*	CEO, Bradford Teaching Hospitals Foundation Trust (BTHFT)
Iain Macbeath *(IMB)*	Strategic Director of Health and Wellbeing, City of Bradford Metropolitan District Council (CBMDC)
Phillipa Hubbard *(PH)*	Director of Nursing and Quality (Distributed leadership) Bradford District and Craven Health and Care Partnership (BdC HCP)
Mike Woodhead *(MW)*	System Lead Director of Finance/Chief Finance Officer (BDCFT)
Louise Bestwick *(LB)*	CEO, Bradford Care Association
Marium Haque *(MH)*	Strategic Director for Children's Services, (CBMDC)
David Crampsey *(DC)*	Medical Director Airedale NHS Foundation Trust (ANHSFT)
Sam Keighley *(SK)*	VCSE Sector Lead and CEO of VCS Alliance
Richard Haddad *(RH)*	CEO, Bradford Care Alliance
Foluke Ajayi *(FA)*	CEO, Airedale NHS Foundation Trust (ANHSFT)
Sohail Abbas (*SA)*	Director – Population Health and Inequalities (BdC HCP)
Sarah Muckle *(SM)*	Director of Public Health
In Attendance:	
Nancy O'Neill *(NoN)*	Chief Operating Officer/Director of Partnership Delivery, Bradford District and Craven Health and Care Partnership (BdC HCP)
Shak Rafiq (*SR)*	Associate Director Communications and Involvement (BdC HCP)
Sasha Bhat *(SB)*	Priority Director - Healthy Minds/Deputy Director of Integration and Transformation (BdC HCP) ***item 6***
Helen Farmer *(HF)*	Programme Director – Access to Care (BdC HCP) ***item 7***
Louise Keighley *(LK)*	Senior Head of Integrated Health and Care (BdC HCP) ***item 7***
Alison Bullock*, (AB)*	Partnership manager (BdC HCP)

1. Welcome and apologies for absence Declarations of Interest	Danielle Hann, Lorraine O' Donnell, Charlotte Ramsden
Actions:	***None***
2. Notes from 24 May 2024 2 (b) Action log	The minutes of the last meeting were accepted as an accurate record. Actions have been updated on the action log. <u>Matters Arising:</u> None Items 8 and 9 were taken before item 7.
Actions:	***None***

3. Finance update/closing the gap	MW updated on the Month 2 position for the System. BdC are officially reporting on plan for this year (as are other West Yorkshire places) but this is severely at risk. The three Trusts are off plan by £3m. PLE were reminded that the plan submission had included significant risk, therefore this was not unexpected. The Trusts are looking at mitigations to get back on track. It was noted other places were experiencing the same pressures. The focus at the System Finance & Performance Committee (27/06/34) was on the closing the gap work: Objective 1: Trusts maximising their Cost Improvement plans: The first quarterly check and challenge session will be held in the next few weeks. Objective 3: Population segmentation, it was noted there had been a lot of good work being undertaken around this, but it was felt it was not being used effectively. Each programme board has been asked to ensure this is discussed as a priority to understand what is being done. It was agreed a session with all programme leads was needed to understand what they are all doing around population health. Objective 4: Work with NHS, Local Authority, Childrens Trust. MH questioned progress around the CYP Autism waiting list which had been discussed at the May PLE and agreed to be a significant risk to the system as this will be a focus of the SEND inspection. It was reported a business case was going through the Business Investment process before coming to PLE in July.
Actions:	***Session with programme leads to be arranged to discuss what they are doing around population segmentation to be arranged.***
4. NHS Trust's line by line speciality work update	Close the gap Objective 2: Service Level Review across the three Trusts. This is looking at a detailed review of all services, mapping out what we would a service to look like if starting from scratch and looking for tactical and strategic opportunities to transform and rationalise the way services are being delivered and highlight any duplications. The first part of the work has been completed, there are some gaps to fill, a follow up meeting with Chief Operating Officers is planned to complete this part of the work. It was reported that each Trust felt there were some opportunities that could be explored. TP/MW have been asked to give some thought to who could help facilitate a workshop to scrutinise and challenge us (not external support, this would be NHSE/ICS colleagues. The workshop will be held in September, ICB colleagues will be invited to attend. MP advised that West Yorkshire Association of Acute Trusts (WYATT) have commissioned PricewaterhouseCoopers to do a piece of work in Trusts, looking at opportunities for Trusts to look at system opportunities. It was not thought this work would help our system

	organise our services better, but it would be good to compare with their work. MW would ensure there was no duplication of work . It was suggested the System Quality and Finance and Performance committees come together in Sept to look at outcomes of this work. MH asked for progress on the Autism/ADHD business case, it was reported this was in the stages of being updated and would need to be considered by the Finance investment panel before coming back to PLE in July.
Actions:	***None***
5. Update on State of the VCSE in BDC and maximising the role of the sector in supporting people to be happy healthy at home	It was noted this was not a request for funding but a commitment to work together collaboratively to ensure stability for the VCSE so they can continue to support the system. Stability of the VCSE sector remains a key challenge across our BdC footprint. The Local Authority's decision to terminate the existing Infrastructure Support Contract (SIP) and reduce its investment in such going forward adds a further risk to sustainability of the VCSE sector. One of the key risks because of this is: • Reduction in support for grassroots organisations falling. The Interim Activation Contract which has been codesigned and runs between 01/07/24 and 30th 30/06/25 has mitigated this risk a little, but some of these services which support the most diverse and vulnerable, sit outside the scope of contract. It is important that we work more effectively together to create the capacity to support these services. In May, West Yorkshire Health and Care Partnership made a commitment to work in close partnership with the VCSE. The West Yorkshire actions align with the ambitions set out in the VCSE Health and Care System, Bradford Council & VCSE Joint Sustainability action plan. It was reported that since the last update several actions which were agreed have not progressed. • Expand public sector training to VCSE staff, this would help VCSE staff provide better services for the population. • In terms of contracting, look at how quickly we can communicate termination of contracts, how quickly we get contracts in place. • the importance of being able to and pay in advance up front for services. • Annual uplifts. These are not consistent across the system. Consistency in contracting. It is difficult for VCSE services as services are commissioned differently by the Local Authority and ICB. Specifically, it was noted whilst the Wellbeing network funding has been agreed, a three-month interim arrangement has been communicated but a grant agreement is not yet in place therefore the VCSE are unable to invoice. There is a danger the VCSE will start to

	lose staff due to the uncertainties, this will put the service at risk. It was thought the issue may be at a West Yorkshire level. RH echoed the issues expressed around commissioning processes as these are also experienced by the BCA in terms of finalising contracts, this impacts on the ability to do financial planning. It was questioned whether there was any visibility of what other places provide in in terms of non-financial support to VCSE, are we doing more, less, or equal and whether there were any other approaches in terms of support we could consider. It was suggested there may be opportunities for VCSE staff to join the training that is available to adult social care providers, this would help with consistency of care for patients. Noting that a lot of training is available online, it was suggested it would not be too onerous for VCSE colleagues to join and we could consider an 'Act as One' passport for learning and development, this will need picking up through the workforce priority. It was reported the new Programme Manager for Workforce is looking at process of grant signing so we can be more proactive going forward. FA referred to online learning training noting there have been issues in the past with data sharing which will need exploring. TP advised she was not aware of contracting delay issues and requested more information so she could escalate at West Yorkshire if required. PLE supported adding the risk of grassroots organisations not receiving support required to deliver services to marginalised groups as a fifth component to VCSE stability risk. SK will provide a further update in 6 months' time
Actions:	***1. FA to explore extending training to VCSE as part of workforce priority.*** ***2. SK to brief TP on contracting delay issues***
6. West Yorkshire CYP Mental health overnight crisis support/line provision - Night Owls	This service has been in place since July 2021. It commenced in pilot form and runs from 8pm to 8am every night providing multiple routes to access support. The service is delivered by the voluntary sector but has clinical input via nurse practitioners. The service model was co-produced with young people and parent/carers and specifically designed with neurodiverse families in mind. Any young person up to the age of 25 can access the service, as well as parent/carers. Individuals are also able to access the service anonymously. The service has been continued via a tender waiver process in recognition of some of the changes that 111 might have on the service and due to limited contracting support as the ICB operating model was restructured. It was proposed that a two-year contract

	through Direct Award process C be enacted, this would also allow time to decide whether to move towards a full 24/7 all age crisis offer in the future. The proposal has been supported by the Healthy Minds Board, and fits with one of our priorities around our population segmentation of children, young people and around crisis provision. It fits within the new Provider Selection Regime. It was noted that funding was within budget for this year. It was felt this sat well with place base support and meets BdC intended objectives. In terms of efficiencies, it was noted these have been made in terms of what was commissioned through covid (this was a larger budget). It will be important that we have oversight of activity to ensure that Bradford has proportionally got equity of access. In terms of achieving efficiencies, it was felt that if the services work well, it would reduce pressure on other areas e.g., presentation at A&E. It was suggested that having metrics would demonstrate this. SK advised that as part of developing the activation contract, it was agreed a single set of metrics to measure the impact of the VCSE sector on taking pressure off front line services would be developed. PLE gave their support to the proposal
Actions:	***None***
7. Intermediate Care Beds	LK provided a progress update on the work ongoing around Intermediate Care services (IMC) and developing a blueprint that will transform the services. The IMC blueprint includes, step up processes, wrap around support for community services and primary care and the wider adult social care services. In March 2024 PLE supported eight key projects that would deliver the work. It was also agreed as a partnership to *'mothball beds'* at Norman Lodge. In terms of the bedded model, the partnership agreed we need to have an operational 24/7 rehabilitation, recovery, reablement, intermediate care model, with a consistent offer across the health and social intermediate care bed base. It is recognised there will be some variance because of a health need or a social care need and wraparounds support. Currently there are 132 beds open across the partnership this includes 71 health intermediate care beds and 61 local authority. 20 beds at Valley View remain closed. The blueprint in January stated that we needed 152 beds. Since then, the project team has looked at developing a Standard Operating Process, negotiated with BTHFT. to take over 18's (previously over 65's), looked at admission and discharge processes and standardised communications across all beds. It was noted that Castleberg is not included at this time but will be included going forward.

	In March CBDMC raised a concern around staffing ratios at Valley View/Beckfield. This was due to increasing acuity and complexity of patients and needing to deliver the intermediate care model. In May CBDMC submitted a business case to address staffing levels at Valley View, it was noted this would require an additional £1.2m. A piece of work was then undertaken to look at capacity and demand. This identified a reduced demand for pathway 2 patients (capacity since then has gone up slightly). Further conversations have taken place around what we could deliver within our current financial envelope, particularly local authority beds, this would be around 48 beds. It is felt that this would not be good value for money. It was reported that the HFAST service for Pathway 1, supporting people to be discharged from ANHSFT which went live in March, is achieving good outcomes for patients, reducing demand on pathway 2 and has saved bed days. This will go live at BTHFT in July. It has raised a question around the proposal for a 50 bedded intermediate care unit at Saltaire and whether there would be a demand for this now if demand is likely to reduce. PLE were asked to note that following the closure of Norman, it has become evident that there is a gap around access to step up beds for people with complex dementia and complex need who are living in the community, this is mainly a workforce issue but will need addressing. It was suggested we now need to review our therapy support, nursing funding implications, workforce requirements, Saltaire new build, success of HFAST, maintaining the improved flow around Pathway 2 and access to step up beds in community. IMB acknowledged that demand for intermediate care has shifted since the blueprint was developed. Referring to the staffing issues at Valley View he advised that this has had CQC implications, and it had been rated inadequate, CBDMC have had to increase staff to safe levels at a cost and are waiting for the CQC revisit Valley View. IMB suggested that a review of the health IMC beds was needed to ensure they the right model. Alongside this a review of patients at Beckfield and Valley View to determine whether they have a social or health need. In terms of the blueprint, it will be important we consider future demand (next 5-10 years) as it could be anticipated that there will be more complex patients and demand could increase. Saltaire build: IMB advised that CBDMC have agreed £13m to build this unit and already committed £400k for groundworks. If a decision is made that this build would be no longer viable, notice will need to be given by the end July. Assurance would also be needed that beds would be closed somewhere else, and an integrated model would be created.

	It was agreed it is important that all IMC services in their entirety are included in this work. It was felt the terminology now should be integrated care not intermediate, as this was a better description of services. It was suggested that links with Virtual Ward /Proactive care/bedded facilities were explored along with primary care opportunities. LB noted the gap in care for complex dementia patients is likely to increase and they will need support, currently outcomes are poor for these patients. It was suggested that we should not assume that HFAST will have same success in BTHFT as AHNSFT. We will also need to evaluate HFAST effectively if this is demonstrating that the new build at Saltaire is not needed. PLE supported further IMC summit meetings. For the summit to be effective, it will require information and data from partners, PLE members were asked to make sure this is made available when requested. It was noted a decision on whether to proceed with the Saltaire build will be needed before end July 24.
Actions:	***LK to arrange an IMC summit***
8. A strategic alliance to promote career openings for University of Bradford students	SR talked through a proposal which described how the partnership could further our ambition of supporting students from the University of Bradford in securing work-based experience to support their future careers. It was noted this proposal was for non-clinical placements., with a focus on where students have struggled to find placements within non-clinical and wider administrative and managerial functions. This approach would support our ambition to 'grow our own' workforce from our communities. A small and recurrent investment of £10,000 p.a. would allow us to create a flexible range of options that provide mutual benefits. In terms on numbers of students it was suggested no more than 4 at any one time. The University of Bradford offers the following short-term work placement opportunities to students including: A Summer Experience internship, Bradford Graduate internship Programme and Brad-Attain internship programme. The options available range from zero to relatively low cost for shorter term work placements. It was proposed that funding would come from existing non pay budgets therefore not adding to running costs. It was noted this offer would be open to all partners, costs for VCSE and the independent care sector, would be supported by existing programme non pay budgets. The university has offered internship this year at no cost, this person will work with the communications team.

	It was highlighted that several conversations were happening with the University in various forums and felt it would be beneficial to engage with the university in a more strategic way. It was noted the University does have a seat at the BdC Partnership Board but does not currently send a representative. PLE supported the proposal.
Actions:	***SA to speak to colleagues at Bradford university re strategic engagement***
9. Priorities and Enabler update	• Charlotte Ramsden will take on the Exec lead for healthy children and families. • HSJ award entries are being finalised before submission, this includes one for place-based partnership. • Developing a communications and engagement plan for intermediate care to support blueprint roll out. • A new role has been created which is the Creative health manager role, this is an important link between the work we do cross health and care and the impact of arts culture on wellbeing. • Progressing developing a co-design process to support the revised specification for VCSE citizen activation and delivery. • Menopause awareness work with GPs, alongside planned information videos to support wider population: Filming is due to be completed by mid-October. This will form part of a wider Women's Health movement. The women's health movement is looking to do a soft launch in January 25 and then having the first ever Women's Health Conference at the end of February. Any suggestions for a speaker for the conference would be welcome. • There is a wider roll out of infant health campaign, targeting people who have English as a second language or are relatively new to this country and don't understand their healthcare interventions that are available. • A new sensory room has opened in The Broadway shopping centre. The room is available during the centre's usual opening times, with no booking needed. SK advised she has been working with a wider group looking at shared care records and data sharing. The group have developed some prototypes of what our shared care records/patient held record need to look like. These will be refined over the next two months. A paper will be coming back to PLE later in the year which sets out a model to take forward, it was noted there may be a small investment needed to do this, but this would improve outcomes for our patients and across the system. It was felt that we should be feeding back nationally how much not having a shared care record impacts on patients care and is a blocker to progressing new ways of working. It was agreed this was a good time to have a conversation around priorities. Are they still right, do we need to refocus and do things differently.

Actions:	***Arrange a session in September to discuss if a refocus on priorities is needed***
10.Any other business	PLT received a presentation from colleagues at CMBDC around development of the next District Strategy. This was around streamlining the district plan under the Wellbeing Board to allow focus key priorities. This will be discussed at PLE.
Actions:	***None***
11. Key messages	Finance update/closing the gap. West Yorkshire CYP Mental health overnight crisis support/line provision - Night Owls Intermediate Care progress update Update on State of the VCSE in BDC and maximising the role of the sector in supporting people to be happy healthy at home
Date and time of next meeting	26 July 2024 MS Teams

Partnership Leadership Executive

Friday 25 July 2024

9am – 10.30am

MS Teams

Present:	
Mel Pickup *(MP)*	CEO, Bradford Teaching Hospitals Foundation Trust (BTHFT) ***(Chair)***
Phillipa Hubbard *(PH)*	Director of Nursing and Quality (Distributed leadership) Bradford District and Craven Health and Care Partnership (BdC HCP)
Mike Woodhead *(MW)*	System Lead Director of Finance/Chief Finance Officer (BDCFT)
David Crampsey *(DC)*	Medical Director Airedale NHS Foundation Trust (ANHSFT)
Richard Haddad *(RH)*	CEO, Bradford Care Alliance
Foluke Ajayi *(FA)*	CEO, Airedale NHS Foundation Trust (ANHSFT)
Sarah Muckle *(SM)*	Director of Public Health
Danielle Hann *(DH)*	Medical Director and Deputy Chair, LMC
In Attendance:	
Sasha Bhat *(SBh)*	Priority Director - Healthy Minds/Deputy Director of Integration and Transformation (BdC HCP) ***item 3***
Fazeela Hafejee *(FH)*	AD for adults with disabilities ***item 3***
Sadia Hussain (SH)	Health and Wellbeing Partnership Manager ***item 4***
Alison Bullock, *(AB)*	Partnership manager , Bradford District and Craven Health and Care Partnership (BdC HCP)

1. Welcome and apologies for absence	Lorraine O' Donnell, Charlotte Ramsden, Richard Webb Therese Patten, Sohail Abbas, Sam Keighley, Shak Rafiq, Nancy O'Neill, Marium Haque, Louise Bestwick, Iain Macbeath
Declarations of Interest	MW and PH declared an interest in item 3 as BDCFT is a provider of the service. Item was for information only no action was required.
Actions:	***None***
2. Notes from 28 June 2024 2 (b) Action log	The minutes of the last meeting were accepted as an accurate record. Actions have been updated on the action log. <u>Matters Arising:</u> None
Actions:	***None***
3. Redesign of Autism and ADHD support services	The waiting lists Autism and ADHD in BdC have been high for some time now (current waiting times are approximately four years). In the past non-recurrent funding has been used to purchase additional capacity through the independent sector, with the aim of reducing the backlog. Unfortunately, this has not impacted on the growing numbers on the waiting list, and it continues to grow. Therefore, it was recognised the current model was not fit for purpose and needed transforming.

	PLE received a business case in May 2024, which aimed to increase capacity to the existing model and maintain waiting times at 3 years indefinitely. Whilst PLE agreed that they would not be comfortable agreeing a 3-year wait was acceptable, they recognised that given the current financial situation, there is a duty to make sure the resources that are invested in services are appropriate and demonstrate value for money. As a result, the team were asked to review national models and redesign the service, developing a transformed model that was evidence based, demonstrated value for money and clearly set out to improve the experience of children and families. During the past two months a rapid review of the national models was undertaken, this included the Northeast London Foundation trust model and Portsmouth model along with how BdC benchmark against local partners. The proposed model has been coproduced with families, clinical staff, and stakeholders, and is built on the principles of our Act as One ethos. It will make use of all the provision currently existing within the system to bring this together under one service '*A Centre of Excellence for Children and Young people's Neurodiversity.'* There will be a number of benefits using this approach, including, efficiency savings and consistency. The proposal is to create a needs led service which extracts the current service from the three providers and independent from CAMHS support. The referral pathway will remain the same, as the conversion rate from this is high. The support offer will ensure that any pre diagnostic support and statutory requirements are considered at the outset. This proposal would move the currently heavy clinical model to a multidisciplinary skill mixed model. This new Centre of Excellence ambition would aim to clear the waiting list to within NICE guidelines within 3.2 years. In terms of the finances, the current baseline funding is £1.8m. There is a c£1.9m additional request of resource for this new model. A phased approach (using a prioritisation framework) to this resource is suggested. MW advised that the paper had been discussed at the System Finance and Performance Committee on 24/07/24 and at an extraordinary meeting of the Business Case Appraisal Panel. It was reported there was strong support in principle and agreement that this felt to be a sustainable model but recognition that the financial investment required will be a significant challenge. In terms of clinical pathways, referrals and prescribing there was a request that Primary Care was engaged in these discussions. In response to a suggestion that involvement from education needed

	to be strengthened and embedded into the model. It was noted that the Local Authority are committed to a partnership approach which included education. It was suggested there may be an opportunity to use (BDCFT) educational psychologists. It would be good to understand what we have already got in post in terms of existing workforce. Referring to the capital comparisons with other systems in terms of our spend, it was suggested we are underinvesting. It was suggested that as the backlog reduced, if the model is right, the need for investment should also reduce, it would be good to understand what longer term projections (3 to 5) years would look like. DC advised caution around using the term '*Centre of Excellence'* which could suggest a single organisation is responsible for these assessments. The model describes a complex matrix of assessment and support. With regards around having a consistent offer across place, it was reported that West Yorkshire have been clear that place-based waiting lists were the responsibility of place, and they would not be taking any lead on that, though it was noted Leeds are interested in the new model. Noting there was further work to do to refine the model particularly finances, understanding and in year savings, PLE: • Agreed the approach of the future model as presented. • Confirmed support for the team to mobilise. • Agreed to receive a full business at PLE with detailed finance and investment plan
Actions:	***SBh to present full business case at PLE (date TBC)***
4. Finance update/closing the gap	Whilst it was noted all parts of the system are currently reporting they are on target to plan. There is a is a significant amount of risk attached to this and the position is likely to deteriorate. There are ongoing conversations at a West Yorkshire level around the position. It was noted there is a danger that regulatory intervention may be needed. MW advised that the West Yorkshire Association of Acute Trusts (WYATT) commissioned PricewaterhouseCoopers (PwC) to undertake a piece of work to help with closing the gap. The reports have just been finalised. It may be proposed that a similar piece of work is extended to the whole system rather than just to the acute Trusts. MW extending thanks to all parts of the system for contributing towards the capital pot to resolve the primary care infrastructure which in need of replacement.

	A peer review challenge session has been arranged for the 1st of August. The aim of the session is to undertake a robust peer-to-peer review and challenge session of our Q1 financial and savings performance. All trusts have shared their baselining information on this now and a systemwide workshop will be arranged (in September) to challenge us as a whole system to make sure we are exploring every option and making sure organisational barriers are not getting in the way in terms of what we could and should consider. Mike Farrar will help with facilitation of the workshop and in preparation he will be requesting one to ones with some members of PLE. It was reported Programme Boards are now receiving the population health segmentation data. All trusts and the ICB in line with national timetables are currently working on five-year medium term financial strategy.
Actions:	***None***
5. Development of the next District Strategy	The current version of the District Plan will expire in 2025. The document operates as the Place-based high-level strategic focus for the district's organisations and the district's strategic partnerships. It also operates as the statutorily required Health & Wellbeing Strategy for the district and to this end will now be called a District Strategy. The ambition is to realign partnership structures to reflect the new strategy framework. The District Strategy will provide consistency across our strategic approach. An appraisal of engagement sessions which have taken place in the last 12 months/Professional questionnaire and feedback from the Annual Partnership Development event have helped develop the proposal. A proposal for four strategies that will sit underneath the Health and Wellbeing Board are below: 1. Children and young people strategy 2. Inclusive communities strategies 3. Bradford and Craven Health and Care Partnership 4. Inclusive & Resilient Communities Partnership. There are some cross cutting themes across the high-level ambitions; reducing Inequalities, Living Well and sustainability and enablers; EDI, Intelligence, research & insight, and Social Value. It was agreed this was a good opportunity for closer alignment with the Health and Wellbeing Board and more streamlined governance. A request was made that SH worked with Duncan Cooper (and priority leads) around setting the strategic actions and metrics related to health.

Actions:	***None***
6. . Priorities and Enabler update	The report was noted for information.
Actions:	***None***
7.Any other business	***None***
8. Key messages	Supported the approach for redesign of Autism and ADHD support services. PLE supported the approach to development of District Plan, requesting that BdC are involved in setting strategic actions and metrics related to health.
Date and time of next meeting	23 August 2024 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:	6 September 2024
Report title:	Listen in – what are we hearing?
Report presented by:	Victoria Simmons, Senior head of communications and involvement
Report approved by:	Shak Rafiq, Associate director of communications and involvement
Report prepared by:	Victoria Simmons, Senior head of communications and involvement

Purpose and Action

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

Previous considerations:

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

Executive summary and points for discussion:

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

At each Partnership Board meeting since December 2022, we have presented insight from Listen in; this report reflects on how our partnership is acting on what we hear from communities.

An important part of the Listen in programme is that senior leaders, decision-makers, and partnership colleagues can take part in visits, hearing directly from our communities. The report includes responses from a recent internal survey gathering reflections on the Listen in programme to demonstrate how the programme is shaping our way of working, influencing ideas, and offering new perspectives to colleagues who take part.

Across our partnership, there is lots of work underway linked to what we are hearing from our communities, some of these projects pre-date our Listen in programme rather than being a direct response to community feedback.

This report highlights some of the most common or significant themes that have emerged through Listen in cycles since October 2022, and some of the key actions being taken in each priority area that addresses issues raised. The report has been compiled with input from colleagues in our five priority areas.

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. Reflect on how insights from Listen in are being acted on by the 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. Listen in, so what? How we act on what we hear
Acronyms and Abbreviations explained
n/a

What are the implications for?

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

Citizen and Stakeholder Engagement	The Listen in programme is a core part of our partnership approach to citizen engagement. Local stakeholders are actively involved in planning and taking part in the programme.

Bradford District and Craven
Health and Care Partnership

ACTasONE

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

Listen in So what?

How we act on what we hear

August 2024

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

19 August 2024

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

What is Listen in?

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

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

Our first year of Listen in activity rotated across the six localities of our place and has built or strengthened our relationships with communities and organisations.

This was our discovery phase – finding out about our communities and their assets, hearing about what matters to them, and generating insights about people's experiences.

We produced in-depth reports from each of the six cycles that highlight the common themes and unique attributes or challenges in each locality: Listen in | Engage Bradford District & Craven (engagebdc.com)

We are now in our second year of Listen in cycles focusing on reaching into communities of interest and understanding the differing experiences of groups of our population to provide insight to drive forward our partnership's priorities:

- Children and young people – report published on engagebdc.com
- Inclusion health groups – report published on engagebdc.com
- Disabled people and their carers – report expected September 2024
- LGBTQ+ communities – activity complete, report expected October 2024
- *Racial minority communities – activity planned November 2024*
- *Men (particularly unemployed or low-income white, working class) – activity planned January 2025*
- *Women (particularly in areas of deprivation) – activity planned February 2025*

What did we hear in 2022-2023?

What are we hearing from communities?	Shipley	Bradford East	Bradford West	Keighley	Bradford South	Craven
Getting GP appointments is a significant challenge	✓	✓	✓	✓	✓	✓
Positive impact of community support & VCSE	✓	✓		✓	✓	✓
Cost of living crisis impacting wellbeing		✓	✓	✓	✓	✓
Once people are 'in the system' care is generally good	✓			✓		✓
Poor communication about delays or changes	✓		✓		✓	✓
Primary care is a 'blocked gateway' in the system		✓	✓	✓	✓	✓
Travel and transport is a challenge	✓	✓			✓	✓
Long waits for mental health support leads to crisis		✓	✓	✓	✓	✓
Improve consistency of care and sharing information	✓		✓	✓		✓
Mainstream services don't meet needs		✓		✓		✓
Information and support needed on entry-level roles		✓		✓	✓	
Concern about staff shortages	✓				✓	✓
Negative experience of working in health or care		✓	✓	✓		
Health visitor support is lacking	✓			✓		
Not enough mental health support for teenagers	✓	✓	✓	✓	✓	✓
Impact of C-19 on children & young people	✓			✓	✓	✓

This table gives a snapshot of headline themes from locality-focused cycles in year one. Themes from our year two cycles are included for each priority area in the relevant sections that follow in this report.

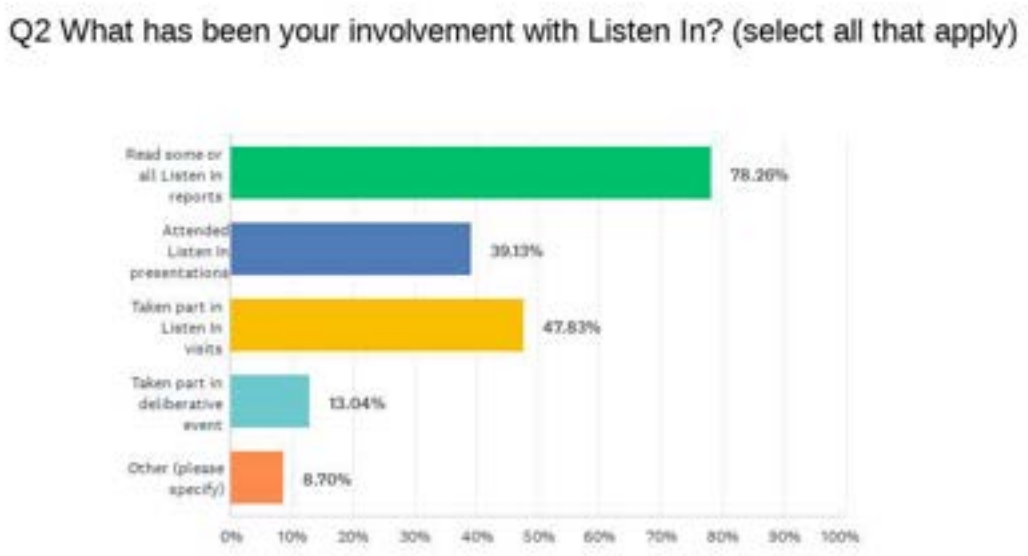
How we report on what we hear

After each Listen in cycle, a detailed report is produced highlighting key themes and potential actions. These reports are published on our website and presented at our Partnership Board (a committee of NHS West Yorkshire Integrated Care Board) meetings held in public.

Reports are shared widely with colleagues across our partnership and insights shared through presentation to relevant programme boards or working groups.

An important part of the Listen in programme is that senior leaders, decision-makers, and partnership colleagues can take part in visits, hearing directly from our communities. This has a powerful impact, influencing people's thinking and potentially leading to change being implemented through less formal routes.

A recent internal survey gathered reflections on the Listen in programme from colleagues as follows.



Colleagues also gave examples of where they had used or shared data from the Listen in programme.

- *"Listen in with people in contact with criminal justice was shared with regional ICB, NHS England and Office of Health Improvement and Disparities (OHID) colleagues, to highlight what works well and what challenges/gaps need to be explored and tackled."*
- *"Discussed Listen in reports at two Community Partnerships and considered how it aligned with local priorities and intelligence."*
- *"Collated themes from all reports relating to financial hardship and reported to Bradford Council Anti-Poverty group."*

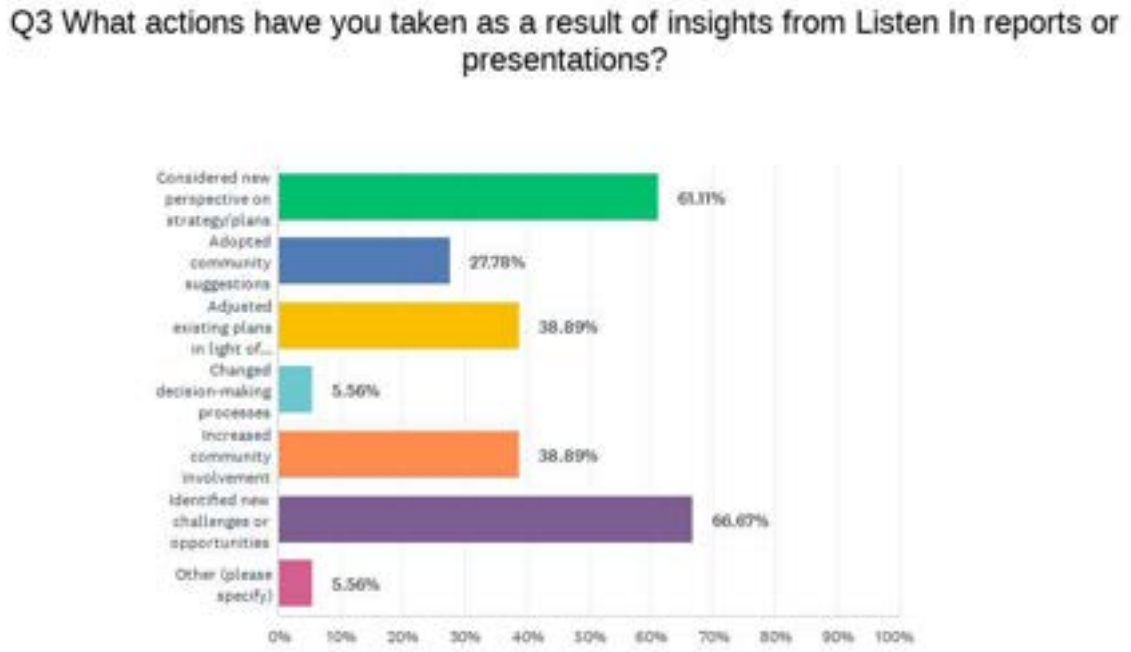
How we act on what we hear

This report highlights some of the most common or significant themes that have emerged through Listen in cycles since October 2022, and some of the key actions undertaken in each priority area to tackle issues raised – it is not exhaustive. The report has been compiled with input from colleagues in our five priority areas.

Across our partnership, there is lots of work underway linked to what we are hearing from our communities, some of these projects pre-date our Listen in programme rather than being a direct response to community feedback. Having an ongoing approach to listening to our communities is useful to enable us to ensure that we continue to focus on what matters most and are connected to the people we serve.

- *"Listen in reinforces what we already know."*
- *"It keeps the work real from a communities' perspective and reminds us of why we are doing this work in the NHS."*
- *"Discussions in Craven at SELFA reinforced our intentions to work on improving cancer screening for people with learning disabilities."*

Insight from people we meet through Listen in helps us consider issues from the point of view of our diverse communities and enables us to adapt existing plans to better meet the needs of our population.



In addition to understanding the specific examples in this report where our partnership is acting on what we hear through the Listen in programme, it is important to understand how the programme is shaping our way of working, influencing ideas, and offering new perspectives to colleagues who take part.

Reflections from colleagues included,

- *“It just opens your mind, look at things more creatively and not to assume we have all the answers.”*
- *“It had a direct influence on how we describe the challenges of access to a GP.”*
- *“The session gave me in depth understanding of the challenges disabled face when services change.”*
- *“After listening to mums that were struggling with health advice and mental health. I learnt more about the system & where I could sign post them when the conversation next came up. Also having a better understanding of what is going on across the health and care system that could benefit communities who didn't know.”*
- *“People are happy and open to discussing what is going on, we need to listen and go out more to hear what is happening in people's lives. Not to go into a place with a preconception or a judgement of where you are or who you will speak with. Not everyone wants to moan & complain they have useful ideas and ways in which health and care could be improved for the public.”*

Access to care - what are we hearing?

Long waiting times

- A significant concern was the lengthy waiting times in hospital settings, particularly in Accident & Emergency (A&E) departments.
- Many patients reported feeling frustrated and anxious due to the long delays in receiving care.

Communication breakdowns

- There were frequent reports of poor communication between hospital departments and other parts of the NHS.
- This led to patients feeling confused, abandoned, and concerned about not receiving the necessary follow-up care after discharge from inpatient or outpatient services.
- Some people felt that women's health is not always taken seriously, with long waits to receive appropriate treatment for painful conditions like fibroids – people's experiences are worsened when different services push patients 'from pillar to post' instead of solving their problem.

Challenges for vulnerable people

- Hospital environments, especially in A&E, were noted to be poorly adapted to the needs of people with learning disabilities, neurodevelopmental conditions, or dementia.
- This lack of appropriate environments made health appointments particularly difficult for these patients, which was seen as potentially contributing to poorer health outcomes.
- Inadequate communication adaptations and misattribution of symptoms could lead to misunderstandings and misdiagnoses, hindering proper treatment for people with learning disabilities or neurodivergence.

Travel and transport issues

- Accessing hospital care was problematic for some people, especially for those living in remote areas like Craven or on poorly connected housing estates.
- Long travel distances, the cost of transport, and the frequent need for hospital visits, particularly for children with long-term health conditions, posed significant challenges for patients and their families.

Community support

- Community groups played a crucial role in supporting residents with long-term conditions or complex health needs. VCSE organisations provide social support and help with navigating the healthcare system, but we heard from some organisations who hosted our Listen in visits that they are facing challenges around resources and sustainability leading to concern that vital support may be lost, increasing pressure on health and care services.

Access to care – how are we acting?

Access to care for people with learning disabilities

Reports from year one of the Listen in programme highlighted the unique challenges faced by people with learning disabilities in accessing mainstream healthcare services. During visits to community groups, concerns were raised about the misdiagnosis of conditions like dementia and menopause, with symptoms misattributed to learning disabilities. Additionally, communication needs were frequently overlooked, further complicating access to care.

In response, the Bradford District and Craven Health and Care Partnership is implementing a programme focused on improving access and making reasonable adjustments for cancer screening in primary care for people with learning disabilities and autism. Furthermore, Bradford District Care NHS Foundation Trust is closely monitoring Learning Disability Annual Health Checks, which play a crucial role in promoting healthy lifestyles, supporting wellbeing, and enabling early detection of illnesses such as cancer and diabetes.

To enhance screening uptake, new resources from the West Yorkshire Cancer Alliance have been promoted, including three accessible videos created in collaboration with Bradford Talking Media, which guide people with learning disabilities and their carers through the screening process for bowel, breast, and cervical cancer. Learning disability cancer screening videos: West Yorkshire Cancer Alliance (wyhpartnership.co.uk)

Interface between secondary and primary/community care

Community feedback highlighted concerns about communication breakdowns between different parts of the NHS, particularly after inpatient or outpatient experiences. In response, focused work is underway to understand and improve the interface between secondary care and primary/community services. Our Access to Care team is working to establish clear communication routes and shared understanding of where responsibilities lie so that patients don't feel like they are being passed from pillar to post. A written agreement has been developed between primary and secondary care, and a public-facing version is being prepared which will help people understand where responsibilities lie and reduce confusion.

Urgent and emergency care

Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) has implemented streamlined services such as the Urgent Care Centre (UCC) and Ambulatory Emergency Care Unit (AECU), which have not only alleviated pressure on Emergency Departments (ED) but also ensured better coordination of care after a hospital admission. This approach helps reduce confusion, improves communication, and ensures patients receive timely follow-up, contributing to improved performance.

Both hospital trusts – Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust - have focused on expanding their capacity and improving patient flow through initiatives like the Home First Assessment Support Team and enhanced Same

Day Emergency Care services. The introduction of Patient Flow Facilitators further supports these improvements, ensuring that patients feel seen, heard, and cared for during their time in A&E. Enhancements at the ‘front door’ mean that patients flow through all hospital departments more quickly, reducing delays and cancellations.

Travel and transport impacts on access to care

Travel and transport challenges, especially for families in Craven and those with children who have long-term health conditions, have been a significant concern. Both hospital trusts have expanded their Same Day Emergency Care services, reducing the need for frequent hospital visits and long journeys.

Additionally, the development of Virtual Wards and the setting up of Urgent Treatment Centres aim to bring care closer to home, thereby minimising travel for patients and ensuring that care is accessible when needed.

The Access to Care team is working closely with secondary care providers to develop opportunities to deliver outpatient clinics from community settings to improve experience for patients and improve efficiency, for example clinics for dermatology and ophthalmology where patients can be seen by specialists without needing a visit to hospital. These pilots are showing good outcomes for patients and reducing pressure on hospital clinics.

We are currently working with the West Yorkshire Combined Authority to explore ways to reduce the cost of public transport for people travelling to health care services.

Enhancing services for children with complex needs

Feedback pointed to the difficulties faced by children with complex needs who must access different services in different locations – this theme came through particularly clearly in Craven. To address this, Airedale NHS Foundation Trust has invested in the expansion of its Paediatric Assessment Unit and the direct streaming from the ED to the assessment unit, making it easier for children to receive the care they need in one location. This approach helps in consolidating services, thereby reducing the burden on families, and ensuring more integrated care for these children.

We are working with both acute trusts to explore opportunities to improve the experiences of families waiting in A&E departments with children who have additional needs. Although space constraints have prevented creation of a dedicated quiet space or sensory-adapted environment, we are considering alternative solutions such as enabling families to take children off-site while waiting to be seen.

Taking women's health seriously

As part of our work to implement the national Women's Health Strategy we are delivering education sessions for GPs to raise awareness of women's health issues, covering a range of conditions, symptoms, and treatment options. Initially, these sessions have focused on menopause and sessions are planned to cover other conditions.

We are working with our clinical lead for women's health to create a suite of information films, giving advice and information about a range of conditions such as endometriosis, fibroids, and painful periods. These resources will be shared through communications channels and embedded in the GP Assist pathway making it easy for health care professionals to provide people with reliable information in an accessible format.

Information and signposting resources will continue to be developed as we rollout a campaign focusing on women's health towards the end of 2024, which will culminate in a women's health conference scheduled for February 2025. To improve women's health in Bradford District and Craven, a multi-faceted campaign strategy will reach both women and healthcare workers, with messaging tailored as needed but centred on a strong, unifying message. We will partner with respected local figures to promote open conversations about women's health, reduce stigma, and encourage behaviour change. The early campaign development has been shaped by the insight collected to develop the national women's health strategy, the ongoing engagement with VCSE and community groups and additional information collected through our Listen in reports. This will be a community-led initiative to address healthcare mistrust, empower women in preventative care, and reduce NHS pressure by building on existing community dynamics and support networks.

Healthy children and families - what are we hearing?

Mental health support for children and young people

- Access to mental health support for children and young people was a significant concern. Long waiting times for mental health services were a common issue.
- Parents expressed frustration over the lack of timely support, which they felt led to worsening mental health conditions for their children. The lack of culturally appropriate mental health services was also highlighted, particularly for children from South Asian backgrounds.
- The overwhelming demand on CAMHS and the resulting delays and compromised care quality were major concerns. People expressed a need for CAMHS to better adapt to the needs of neurodivergent young people and improve the transition to adult services.

Partnering with schools

- The school environment was often mentioned as a significant factor affecting mental health. Some young people found school stressful and anxiety-inducing, especially neurodivergent individuals who face challenges such as sensory overload.
- The role of schools in supporting children's health was discussed, with school staff feeling insufficiently supported to handle mental health needs and a lack of clear responsibility for health services within the educational environment.

Advice and support for parents

- There was a clear need for more support for parents, especially new mothers, in managing their children's health and development.
- Parents reported difficulties in accessing health visitor services, which left them without essential guidance on child development, nutrition, and general health concerns. The absence of regular check-ups and advice impacted the wellbeing of both children and their parents.

Communication issues

- Communication barriers also impacted children and their families, particularly in understanding health information and services.
- Families with limited English proficiency struggled to understand appointment letters and health advice, which affected their ability to make informed decisions about their children's health.

Impact of COVID-19 on child development

- Parents expressed worries about the impact of the COVID-19 pandemic on their children's development, particularly in areas such as speech and communication.

Healthy children and families - how are we acting?

Infant health

During visits to Keighley, families voiced difficulties in accessing health visiting services, which impacted their ability to get their babies weighed and receive essential developmental advice. Responding to these insights, the Bradford District and Craven Health and Care Partnership supported Modality to launch and promote baby wellbeing events, including new clinics focused on providing routine immunisations and parental support. This initiative exemplifies how the Listen in programme translates community feedback into tangible actions, improving service accessibility and health outcomes.

Read more on our website: Routine immunisation uptake boost for babies and children in Keighley thanks to new baby wellbeing clinic - Bradford District and Craven Health and Care Partnership (bdcpartnership.co.uk)

Throughout our Listen in cycles, we have heard that when people start a family they are often overwhelmed with information and advice from different sources – not all of which are reliable. We saw that within certain populations, such as our European Roma community and migrants newly arrived in the UK, there is a much lower level of awareness or use of support available.

This insight was valuable and some of our relationships developing during Listen in has helped in developing our infant health communications campaign, Help for You and Baby. The campaign materials provide clear and accessible information to families in a bright and engaging style about all things they can expect from pregnancy, until their child is aged two years old. This includes encouraging uptake of several key infant vaccinations in line with the national ambition for 95% of children to be vaccinated to stop the spread of preventable diseases.

A suite of information, including animations voiced by community members in their native languages, offers reliable information around the pregnancy and parenting journey, such as advice around antenatal care, what to expect in hospital when you have your baby, and post-natal care – to normalise the antenatal and postnatal journey.

Some of the communities who hosted Listen in visits have codesigned the campaign with us, taking part in focus groups, testing design concepts, providing voiceovers in different languages, and even starring as models in the campaign. In addition, through the campaign we established new relationships, such as with providers of English as Second Language (ESOL) courses, that will support our ongoing efforts to gather insight from a wider group of communities.

School health hubs

Bradford District and Craven Health and Care Partnership responded to insights - from our existing community networks as well as Listen in - about the barriers children and families face in accessing healthcare by launching a School Health Hub pilot. This initiative, developed in collaboration with health and education partners, created a "one-stop health shop" within schools to provide easier access to physical and mental health services. The hub aims to address challenges such as travel, cost, and awareness by bringing services directly to students and families, focusing on prevention and early intervention to improve overall health outcomes in the community.

> *"I'm here with my wife and family. We met the SEND nurses and found out about CAMHS, injections and toothbrushing. It's really helpful that everything's in one place – we wouldn't have got all that information otherwise because you're not going to google it. We've not got this type of thing with everything in one place in the community yet but having it here in school is brilliant because they understand us, and we know they're trustworthy."*

The Access to Care team is exploring potential for secondary care clinics to be brought into the school health hubs in the future.

Read more on our website: https://bdcpartnership.co.uk/one-stop-health-shop-for-schools-a-partnership-school-health-hub-pilot/

A recent Reducing Inequalities Alliance short film highlights the work of a mental health coordinator who works in local schools to promote emotional well-being, build resilience, and provide high-quality, evidence-based interventions for young people. George's story - nurture environments - Bradford District and Craven Health and Care Partnership (bdcpartnership.co.uk)

Speech, language, and communication needs

The Talking Bradford guide and campaign was developed in response to concerns raised by parents and carers about the impact of the COVID-19 pandemic on their children's speech and language development, and the resulting increased demand on services. This followed feedback from parents and carers through our existing SEND parent and carers forum. It aims to equip all parents with information to support their child at different stages of development, potentially addressing issues earlier and preventing the need for interventions or supporting families while they wait for specialist support.

A task and finish group, comprising experts from Bradford Council, NHS providers, Better Start Bradford, FYI Bradford, and PPL: People Places Lives, led the campaign's development. Using insights from co-production and engagement activities within the Bradford district and the Family Hubs and Start for Life programme, the campaign was designed to provide a comprehensive guide for parents. The Talking Bradford Speech and Language Pathway serves as a resource to help parents support their children's communication skills, offering practical tips, videos, and guidance. The campaign aims to ensure that every child under the age of five in the Bradford district can become the best communicator they can be, giving them a strong start in life.

Find out more about the campaign at Speech and Language Pathways | Bradford Families and Young Persons Information Service

Our partnership has also successfully bid for Bradford District to be one of nine national Pathfinders for Early Language Support for Every Child (ELSEC). This has secured around £1millon over two school years to fund the ELSEC Programme which will launch in September 2024. A team has been recruited, and ten schools have been selected to take part in this evaluated learning programme that will enhance provision across Bradford. The aims include, improving early identification of children with speech, language and communication needs, reducing the rate of specialist referrals by providing earlier support, and improving collaboration between health and education.

Mental health support for children and young people

Our Children and Young People (CYP) Mental Health Programme is guided by a Leadership and Programme Group, which seeks to actively improve mental health support for children and young people by responding to community feedback and aligning our efforts with the needs and priorities identified by those we serve. The leadership of the programme includes the voices of young people through our Healthy Minds Apprentices.

Our actions are driven by a locally established evidence base, including insights from the CYP Listen In events, system-wide reviews, and needs assessments. These findings directly inform our work plans, ensuring that we address the most pressing issues identified by children, young people, and their families.

Key concerns such as access to timely mental health support, cultural appropriateness of services, and long waiting times have been addressed through several initiatives. These include developing a coordinated early help and prevention approach, enhancing community-based support through the Youth in Mind partnership, and expanding Mental Health Support Teams in schools.

Despite the ongoing challenges, especially with the demand on specialist services like CAMHS, we have made progress in streamlining processes, reducing waiting times, and improving transition pathways for neurodivergent young people.

Waiting times for CYP mental health support are monitored routinely, we are developing an enhanced community-based offer through our Youth in Mind partnership for people who may need short-term outcome-focused individual or group-based support, with a streamlined referral process to make it easier for professionals, families, and young people themselves to ask for help and support when they need it. During 2023/24, over 3,000 referrals were made to the Youth in Mind partnership alone, on average young people currently wait three weeks from referral to first contact and just over five weeks from their initial referral to their second contact with the service.

We acknowledge that since the pandemic, both locally and nationally, the increased demand on specialist mental health services for children and young people has been significant and we are continuing to see high numbers of referrals to CAMHS each month. Bradford District Care NHS Foundation Trust have introduced new processes and pathways to streamline the triage process for mental health support, with new approaches to support quicker access and effective signposting to enable people to ‘wait well’.

The Bradford SEND improvement plan target is that 90% of CYP will wait no longer than 18 weeks between referral and commencement of treatment for mental health support from CAMHS. In June 2024, 86.1% of CYP referred had commenced treatment within 18 weeks and we are continuing to strive for improvements against our target.

Currently, a new needs-based model for neurodivergent children and young people is in the process of being agreed, it is hoped this will bring much needed help and support to CYP and families who may be referred for an Autism and/or ADHD diagnosis.

Healthy communities - what are we hearing?

Access to primary care

- Difficulty in accessing GP appointments is a recurring issue across all areas, leading to frustration and disillusionment with the healthcare system. This frustration is shared by people working in primary care.
- Many residents face lengthy waits, language barriers, and a lack of alternative care options, which can lead to them seeking emergency care instead.
- Low digital literacy often results in confusion and frustration when trying to navigate online healthcare systems. For some, this means that even if digital services are available, they are not fully accessible or useful.
- Our deliberative event developed ideas to improve experiences of accessing primary care, such as integrating broader wellbeing and social support into general practice to meet non-medical needs more effectively without patients feeling “fobbed off”.

Better integration between community and healthcare services

- There is a call for better integration between community support and formal health or social care services. Listen in sessions showed that community groups are filling gaps left by statutory services, especially in addressing social determinants of health. However, the variation between experiences in different localities and communities of interest highlights fragmentation and a need for more coordinated approaches.

Trust in health and care services

- In some communities we heard a worrying lack of trust in the NHS, especially among marginalised communities. This distrust is fuelled by poor communication, cultural misunderstandings, and a sense of not being listened to by healthcare providers.

Social determinants of health

- Financial concerns and housing instability are major factors impacting health. These issues often take precedence over health concerns, affecting both mental and physical well-being.
- Community support systems are sometimes strained, with limited resources to address these wider social issues.

Community support for wellbeing

- Community groups play a crucial role in providing social support, combating isolation, and offering a range of advice and information.
- During Listen in visits, we saw community-based services being effectively used for healthcare purposes, such as hosting information sessions or offering health checks. We heard clearly that there is potential and appetite to strengthen integrated care by further embedding healthcare services within trusted community venues.

Healthy communities – how are we acting?

Focused efforts on primary care access

Our practices are delivering more appointments than ever as demand for primary care services continues to rise. For example, in May 2023 376,296 appointments were delivered within general practice across Bradford District and Craven (572 per 1000 patients). By May 2024 this had risen to 419,736 appointments (629 per 1000 patients).

As well as increasing the numbers of appointments, we are also working to improve the overall experience for the public. Over the past year, we have been actively working with general practices on a range of improvements as part of NHS England's Primary Care Access Recovery Plan. This includes offering improved telephony when people call their local practice – which should reduce people getting an engaged tone and includes an option to request a call-back, plus better online access for patients who prefer to use digital routes for booking appointments or requesting repeat prescriptions.

In October 2023, we hosted the 'Listen in So What?' event. This event brought together citizens, workforce members, and leaders to collaboratively consider how we might address challenges in accessing primary care, particularly GP services. Groups discussed and developed potential solutions that were narrowed down through participant voting to create a set of ideas that should be taken forward. Details of the event and ideas generated have been captured in a report: https://engagebdc.com/28455/widgets/81677/documents/49707

As our Listen In insight demonstrates that primary care access is the most important issue for local people, we have influenced the BDC Innovation Hub to focus its efforts on helping

address the challenges of primary care access. The Innovation Hub team will facilitate testing of ideas generated from our deliberative process by using quality improvement methodologies and robust evaluation.

The Innovation Hub has engaged with PCNs to understand the support they may need and identify existing projects that can be adopted and spread across place. We have begun work on a pilot project with Five Parks PCN, which was selected based on Listen in insight alongside other readiness factors.

Interventions that the Innovation Hub team will support the PCN to deliver include:

- bringing colleagues from different sectors into GP settings to enable integration and deliver social support and wellbeing services
- optimising existing assets and working relationships between PCN and wider stakeholders in the neighbourhood (focusing on quality of provision, establishing trust, developing Integrated Neighbourhood Teams)
- enable better information sharing between partners to enable hyperlocal integration (inclusive of Information Governance requirements)

You can read more about the BDC Innovation Hub on our website: Innovation Hub - Bradford District and Craven Health and Care Partnership (bdcpartnership.co.uk)

Primary care access project to support multi-generational households

To enable easier access to preventative healthcare services and health education for our most vulnerable communities, we have launched a pilot project bringing primary care into people's homes in Little Horton, Manningham and parts of Keighley.

The service supports families where different generations live together, focusing on families where NHS data tells us there is greater risk of poorer health. We are offering all family members tailored support from a GP, nurse practitioner, or social prescriber. Healthcare professionals from a local GP practice are organising home visits to build trust and provide culturally competent, safe support with the time to engage and answer questions.

The pilot is enabling us to carry out targeted health checks and we are providing advice on a broad range of issues. We are offering vaccinations and immunisations that have been missed to babies and young children to protect them from childhood diseases, such as measles, mumps, and rubella. We are ensuring eligible family members have had cancer screening and reviews.

Read more about the project on our website: New NHS home visiting service available to households in Bradford - Bradford District and Craven Health and Care Partnership (bdcpartnership.co.uk)

Integrated Neighbourhood Teams

Over the last decade, in Bradford District and Craven we have developed various models to create an integrated team delivery system across primary care, community health services, secondary care, social care, and the VCSE sector. There is renewed national interest and specific mandates from NHS England for Integrated Care Boards (ICBs) to advance the development of Integrated Neighbourhood Teams (INTs). However, there is not a unified delivery model, either national or local, to drive this work forward.

To fast-track the implementation of INTs in Bradford District and Craven, the healthy Communities Board has initiated a rapid review over summer 2024, to better understand insights and intelligence from ongoing services, projects, and initiatives across our Partnership. This review will help us identify what to stop, pause, and focus on to accelerate and transform the development of an effective INT delivery model.

It will result in a comprehensive, collectively owned delivery plan, building on existing neighbourhood models rather than imposing a top-down structure. This approach is particularly focused on avoiding fragmented services for our population, focusing on where intelligence is telling us we are likely to have the biggest impact, wrapping services around communities, and creating a flexible model that can be adapted to local needs.

Supporting grassroots community groups

In our thirteen Community Partnerships, a total of £473,689 in small grants has been distributed to support over 200 community-led initiatives to address wellbeing and improve health outcomes for local populations over the past year.

These projects include targeted approaches to build trust, provide culturally competent support, offer individualised and group support addressing the wider social determinants of health, increase primary care access and reduce health inequalities. Outcomes being reported include:

- **Enhanced mental wellbeing**: Programs focused on mental health support, such as social prescribing and community-led wellness initiatives, have fostered stronger community ties and provided safe spaces for individuals to engage in activities that reduce stress and improve emotional well-being.
- **Increased physical activity**: Initiatives promoting physical activity, particularly among groups with historically low participation rates, have contributed to better physical health outcomes, reduced risk of chronic diseases, and increased social cohesion through shared activities.
- **Social cohesion and inclusion**: Projects that bring together diverse community members, including refugees and marginalised groups, have built stronger social networks, reduced cultural barriers, and promoted understanding and inclusivity within the community.
- **Support for disadvantaged populations**: Efforts to address food insecurity and provide necessities have directly improved the quality of life for vulnerable individuals and families.

These examples highlight the Community Partnerships' roles in addressing both immediate needs and long-term determinants of health, ultimately contributing to a healthier, more resilient community.

Core20PLUS5 – our hyperlocal approach

Core20PLUS5 is a national programme that provides funding for local systems to reduce health inequalities for those living in the 20% most deprived areas; to support those in the nationally defined inclusion health groups; and to work towards five national clinical priorities.

In Bradford District and Craven, one of the ways we do this through supporting our thirteen Community Partnerships to have access to and interpret NHS local data and intelligence. We have 'inverted the power to act' and have enabled them to make decisions on how £1.19m of community investment is to be spent. Resource has been distributed among the Community Partnerships proportionately according to need using deprivation indices. We have 46 projects up and running; they are listed in our 'at a glance' summary of the projects in each locality Core20PLUS5: Our hyperlocal approach - Bradford District and Craven Health and Care Partnership (bdcpartnership.co.uk)

As well as an emerging Community of Practice around NHS community health checks, there is a joint Reducing Inequalities Alliance and Healthy Communities initiative which supports community conversations about the winter vaccination programme and resources delivery of winter vaccination clinics at trusted VCSE venues.

Healthy minds - what are we hearing?

Mental health access challenges

- Long waiting times for mental health services and a perceived lack of crisis support, were a significant concern.
- Access to mental health and wellbeing services was a particular problem for Craven residents due to the additional challenge of rurality and having to travel for support.

Neurodiversity

- Prolonged waiting periods for neurodevelopmental diagnoses are common, which causes emotional distress and delays in accessing appropriate support.
- The challenges in accessing mental health services and the prolonged diagnostic processes also impact neurodivergent individuals, exacerbating their conditions without proper support.

Mainstream services not meeting the needs of marginalised communities

- In some communities, stigma surrounding mental health issues prevents individuals from seeking the help they need – this was especially noted in Listen in visits to South Asian or Black communities.
- Neurodivergent people described challenges with talking therapies not being adapted to their specific needs. This was also a challenge for other communities who felt their experiences weren't reflected in the services offered - including d/Deaf people and those with learning disabilities.
- People recovering from addiction struggle to receive mental health support, falling into a trap of using alcohol or substances to alleviate mental health symptoms while being refused access to mental health services until their addiction is managed.
- People with experience of the justice system and people experiencing homelessness also described difficulties in accessing mental health support due to the instability they are facing in their lives.

Healthy minds – how are we acting?

Specialist mental health support for diverse communities

The specialist mental health support for ethnically and culturally diverse communities (ECDC) is a new provision which will develop culturally sensitive and appropriate mental health support. The new ECDC mental health service in Bradford District and Craven directly addresses issues of stigma, trust, and cultural competency highlighted by an independent review that was carried out by the Centre for Mental Health. Some of the findings from this review also reflect what we heard through the Listen in programme.

The ECDC service provision is jointly funded by Bradford Council and the ICB at place. Mind in Bradford has been awarded the contract to lead a delivery partnership includes a wide range of VCSE organisations including Staying Put, Girlington Community Association, Roshni Ghar, Inspired Neighbourhood and African Caribbean Achievement Project.

- Strategic Function: The service promotes leadership and advocacy for ethnic and culturally diverse groups, ensuring mental health services are culturally sensitive, which helps reduce stigma and build trust. It also focuses on training the workforce to enhance cultural competency across all ages.
- Delivery Function: It provides tailored mental health support, using culturally appropriate methods and peer support to manage distress. This approach aligns with the lived experiences of diverse communities, improving trust and service effectiveness.
- Service Integration: The service aims to transform and expand its reach through co-produced, culturally responsive interventions, ensuring more communities are supported within the mental health pathways.

In essence, the ECDC service is designed to break down barriers, build trust, and provide culturally competent mental health support to diverse communities.

Neurodiversity

Work is underway to co-design a new needs-led model for autism. This will be starting with children and will then be adapted to the adult service to address waiting lists. This new approach will shift towards a dimensional approach that considers an individual's unique needs, rather than determining whether the individual fits certain diagnostic criteria and providing support only if these diagnostic criteria are met. This approach creates a formulation-based assessment and management plan, whether an individual fits neatly into diagnostic criteria or not. The key areas of challenge for that individual are identified with respect to their current social and physical environment and appropriate, holistic support is provided. In the short-term, additional diagnostic capacity has been brought into the system through South West Yorkshire NHS Foundation Trust in order to manage demand for diagnostic services.

Access to mental health and wellbeing support in Craven

During Listen in visits we heard about poorer access to mental health support in Craven than in other areas of our place, and we have worked with partners to address this through the Community Mental Health and Crisis Transformation work. This has included: creation of new Mental Health Practitioner ARRS roles in PCNs covering AWC; improved connection between primary care and community-led support; new health engagement roles in PCN footprints to increase the physical health checks for people with severe mental illness (SMI); safe space crisis cafe outreach provision delivered by VCSE providers; and supporting development of the Craven Mental Health and Wellbeing Hub Network.

Craven Mental Health and Wellbeing Hub Network is a partnership of eight local organisations across Craven offering adult mental health and wellbeing support in the community that is consistent, accessible, and local. The network is led by local creative health charity Pioneer Projects, with support from specialist mental health providers in the VCSE, North Yorkshire Council, Bradford District Care Trust, and the Modality, WACA, and Western Dales PCNs.

Crisis services

A review of mental health crisis services has resulted in new services, including Safe Spaces. Safe Spaces offers same-day support for anyone aged seven and over from Bradford District and Craven who needs urgent help with their emotional and mental wellbeing. This could include experiencing severe anxiety, panic attacks, suicidal thoughts, intense depression or feelings of disassociation. The service is led by mental health charities The Cellar Trust and Mind in Bradford and replaces former safer space services Sanctuary, Haven and the children's overnight service, Towerhurst. An expanded VCSE partnership means that the provision is extended across Bradford District and Craven by working with ten other local charities to enable access for more people close to home and to draw on specialist support for people with specific needs such as addiction or perinatal mental health.

Healthy minds website

The Healthy Minds website (www.healthyminds.services) was re-launched on World Mental Health Day in October 2023 after a significant redesign to improve the quality of information and ease of use. We redeveloped the website after a series of workshops with service users, members of the public and health professionals, which was supported by insight gathered through Listen in about people's experiences of trying to access mental health support. The website includes a Support Finder tool to help people find the best services for them and a directory of more than 280 local services, apps and guides. Based on insight about the impact of financial pressures on people's mental health, the site also includes information about the cost-of-living crisis.

The co-design process included working with diverse communities including those with additional communication needs, and the site has been built to meet latest accessibility guidance.

People development: what are we hearing?

Interest in health and care professions

- Despite the challenges, there is notable interest in health and care professions from various communities. However, communities need proper engagement and support to pursue such careers.
- Our most marginalised communities, such as people with experience of the justice system, refugees, or care-leavers, experience additional barriers to entering the workforce.
- There is a perception that young people are not adequately informed about careers in care, which could affect future workforce development.
- People of all ages talked specifically about needing more information about entry-level roles in the health and care system.

Perceptions of our workforce

- Local people are aware of staffing shortages in health and care sectors. People are concerned about experienced professionals leaving their roles and the impact this may have for patients.
- People feel our workforce is not representative of their community and this impacts their trust in health and care services.

People development: how are we acting?

Promoting health and care careers

With a focus on breaking down barriers to employment, the ‘Generation Medics Bradford’ initiative has garnered attention for its innovative strategies and tangible outcomes in addressing unemployment and local healthcare workforce challenges, while enhancing the overall quality of life for Bradford District and Craven residents. This aligns with the NHS’s commitment to not only providing healthcare services but also contributing to the socio-economic development of communities.

The employment project is a collaborative effort between the award-winning social enterprise Generation Medics and Bradford District and Craven Health and Care Partnership. The project was presented to Sir Stephen Powis, National Medical Director of NHS England and other key healthcare leaders at the ‘NHS Big Pitch’ event in March 2024. Read more on our website: [Empowering employment initiatives: Bradford project showcased by NHS - Bradford District and Craven Health and Care Partnership (bdcpartnership.co.uk)]

Entry-level recruitment project

In response to insight about a lack of understanding of routes into health and social care, the Entry-Level Recruitment Project has been launched. This project offers a single, streamlined route into these roles through the SkillsHouse Service. Local Job Coaches provide personalised support within communities, helping individuals secure employment in the sector.

A recent short film from the Reducing Inequalities Alliance showcased the impact that job coaches can have in the local community. Watch Nadia and Yuma's story: https://youtu.be/Lmflpo5Vok8?si=hl6zZ_rMQ4VYwfKl

Building a representative workforce

The Pathways into Health and Social Care Programme seeks to address concerns about our workforce not reflecting the diversity of the communities we serve. By enhancing recruitment from local communities, particularly in areas of high deprivation, this programme aims to create a sustainable, local workforce that is representative of our place. Efforts include expanding clinical placements and leveraging apprenticeships. Providers are also prioritising staff retention by improving well-being support, offering flexible working, and enhancing career development opportunities.

The Career Ambassadors project promotes awareness of health and social care careers, ensuring equal opportunities across the district, and inspiring young people to explore a future in our sector. Our ambassadors have a range of different experiences and perspectives, role modelling and truly representing our communities. Ambassadors act as champions for the health and care partnership, taking part in a calendar of events including assemblies, classroom talks, local career fairs and employability days. We also continue to put people forward for the range of fellowship programmes now available through the West Yorkshire Health and Care Partnership.

Volunteer to Career

Volunteer to Career provides high quality impactful volunteer opportunities alongside development support including training, coaching, skill development and access to job opportunities which enable people, whatever their starting point, to progress in their personal journey to a career within health and care. Volunteer to Career supports anyone over the age of 16/18 and in particular those who would not have seen health and care as an employment/career opportunity previously, to gain valuable experience, skills and training which supports them to gain employment in/start an education program which will enable them to have a career in health and care.

60% of the volunteers on our Maternity Pathways project live within one of the three most deprived postcodes in Bradford. The women reflect the diversity of our communities with many different backgrounds and stories, including women who have trained in India and Pakistan and now want to join the NHS workforce, people who have never worked, and domestic abuse survivors. 23 people have gained employment following the programme: 15

into health and social care roles. 16 people went on to vocation-related education, including 15 into health and social care courses.

Barriers for marginalised communities

We are tackling employment challenges faced by marginalised groups through initiatives like Project Hope, which offers care-experienced young people tailored support and paid placements in health and care environments. The project provides young people that are care experienced with career development opportunities through a 12-month programme that has been informed through the National Care Leaver Covenant. Project Hope includes paid placements across the health and care sector, tailored pastoral support that is trauma informed, and support with education and employment skills.

Read more about Project Hope on the West Yorkshire Health and Care Partnership website: New project gives hope to care leavers in West Yorkshire :: West Yorkshire Health & Care Partnership (wypartnership.co.uk)

Listen in, so what?

The Listen In programme has provided critical insights that directly inform our strategy for transforming health and care services across Bradford District and Craven.

By capturing the authentic voices of our communities, we are not just listening but actively shaping a more equitable and responsive system. This process ensures that the changes we implement are grounded in real experiences and are poised to make a tangible difference in addressing health inequalities, building trust, and enhancing the quality of care for all.

Across our partnership, there is lots of work already happening that echoes what we are hearing from our communities, some of this is happening independent of our Listen in programme.

Our Listen in cycles offer the opportunity to demonstrate what we are already doing as well as how feedback from our communities makes a difference. This allows us to have a more structured way of sharing updates with communities, community groups and our colleagues.

Having a new board-level ‘Chief Listening Officer’ acting as champion for the Listen in programme and our Citizen Voice structures across the partnership is a significant step toward ensuring accountability across all partners that the insights and concerns raised by the community are not only heard but acted upon.

As the programme develops, we will continue to use our ‘call for evidence’ process to ensure we are making use of what communities have already told us, as well as reporting on our findings after each cycle, and closing the feedback loop with communities.

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Health and Care Partnership Board
Agenda item no:	6
Meeting date:	6 September 2024
Report title:	Place Lead's Update
Report presented by:	Therese Patten, Place Lead
Report approved by:	Therese Patten, Place Lead,
Report prepared by:	Shak Rafiq and Lesley Tillotson

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

Previous considerations:

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

Executive summary and points for discussion:

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

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

Outline how this supports our partnership vision and strategy

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

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

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

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

Recommendation(s)

The BD&C Partnership Board is asked to

1) receive and note the Place Lead's Update

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
This report provides an overview of the partnership context, recent highlights, and forthcoming activities. As such it touches on several areas of the BAF but does not seek to provide assurance on any specific risks.
Appendices
n/a
Acronyms and Abbreviations explained
1. DHSC Department of Health and Social Care 2. GP General Practitioner 3. BMA British Medical Association 4. ICB integrated care board 5. WYCHS West Yorkshire Community Health Services provider Collaborative 6. NHSE NHS England (NHS Commissioning Board) 7. HCP health and care partnership 8. BD&C Bradford District and Craven 9. WY West Yorkshire 10. VCSE voluntary, community and social enterprise sector 11. CQC Care Quality Commission 12. UKHSA United Kingdom Health Security Agency

1. We stand united against all racism and Islamophobia

I want to start my place lead report by saying how shocked, saddened and appalled I have been by the open displays of racism – primarily driven by anti-migrant and anti-Muslim hate – across our country. It is simply intolerable that in 2024 people think it is acceptable to not only harbour these views but use them to unjustifiably attack others on the basis of their ethnicity, religion or a perception that they are somehow not part of our country.

We have been strong in our condemnation and in our show of solidarity here in Bradford District and Craven, across West Yorkshire and through national bodies including NHS England, Local Government Association and the National Council for Voluntary Organisations.

I have been heartened and been given hope by the stories of human kindness throughout these challenging times. I will continue to support those affected, ask that they are ok and encourage them to seek any support they need.

I am sure the Board will join me in saying we are here for you and every single person living or working in our place belongs here.

2. National context and policy development

New ministers at DHSC
Following the General Election on Thursday 4 July, we have a new government and this includes a new ministerial team for the Department for Health and Social Care. You can see details of the appointments below and their areas of responsibility.

- Wes Streeting MP; Secretary of State for Health and Social Care
- Stephen Kinnock MP, Minister of State (Minister for Social Care)
- Karin Smyth MP, Minister of State for Health (Secondary Care)
- Andrew Gwynne MP, Secretary of State for Public Health and Prevention
- Baroness Merron, Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health

Other key cabinet members include:
- Rachel Reeves as Chancellor
- Angela Rayner as Deputy Prime Minister
- Yvette Cooper as Home Secretary
- David Lammy as Foreign Secretary
- Liz Kendall as Secretary of State for Work and Pensions

Collective action by GPs
Following a non-statutory ballot, organised by the British Medical Association (BMA) of its GP contractor/partner members in England that concluded on 29 July, GP partners/contractors

members voted, with 98.3% of members voting yes, indicating that they are willing to take action. Since the result of the ballot was announced, plans have been set in place nationally, regionally and locally in response to the collective action.

The ICB is working through situations and potential risk, impacts and implications of GP collective action. The action will be different to previous industrial action by junior doctors, as the level of activity can vary by place, practice and timeline when GPs may wish to act. At place, intelligence to date suggests there has been very minimal disruption across our GP practices with system partners working through contingency plans including dealing with any surge in activity such as at local emergency departments.

Care Quality Commission (CQC) Review
In May 2024, Dr Penny Dash was asked to conduct a review into the operational effectiveness of the Care Quality Commission (CQC). The purpose of the review was to examine the suitability of CQC's new single assessment framework methodology for inspections and ratings of health and care providers.

This interim report provides a high-level summary of the emerging findings of the review in order to inform the changes needed to start the process of improving CQC. It makes 5 recommendations and is aimed at health professionals, health and social care services, academic and professional institutions and the general public.

New chief nurse for England
NHS England has announced that Duncan Burton has been appointed as Chief Nursing Officer for England. A nurse of more than 25 years, Duncan was most recently Deputy Chief Nursing Officer where he led national work on the maternity and neonatal programme, workforce policies and the children and young people's transformation programme.

NHS England appoints first medical director for mental health and neurodiversity
Dr Adrian James has been appointed by NHS England to a new role supporting the transformation of services for people with mental health needs, autism, a learning disability and those who are neurodiverse.

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

Welcome to Shaukat Ali Khan
Welcome to Shaukat Ali Khan to the new role of ICB Chief Digital Information Officer who joins us this month and will be an NHS West Yorkshire ICB employee. He will be working with digital information colleagues and business intelligence teams across West Yorkshire. Shaukat brings a wealth of experience from his current role as the Global Chief Information Officer at the Aga Khan University and Hospitals in Asia, Africa and United Kingdom, where he's been driving digital strategies on a

global scale. His background includes leadership roles at the University of 14 Central Asia and Novo Nordisk A/S, where he led digital transformation initiatives.

Programme director appointed for community health services provider collaborative
Becca Spavin has been appointed as the new Programme Director of the West Yorkshire Community Health Services provider Collaborative (WYCHS). Becca had been working as WYCHS Director on secondment basis over the last 18 months, but following a successful interview process, Becca will now lead the provider collaborative as its new director.

The West Yorkshire ICB People Board
The West Yorkshire ICB People Board, met on the 20 June 2024 to review and refresh the purpose of the Board together with key principles and strategic priorities. The People Board recognised the importance of the upcoming publication of the national Social Care Strategy as a key enabler to system wide workforce planning and transformation across the Partnership and the outcome of that strategy will signal priorities for the Board. There will also be a focus on the mental health workforce in delivering the ambitions of the Partnership and tackling inequalities.

The ICB's Director of People and members of the People Board, following consultation across sectors, are establishing a Strategic Workforce Forum to lead with the following purpose:

a) Oversee and drive the growth and sustainability of a health and care workforce for tomorrow, capable of meeting the needs of the population of West Yorkshire.
b) Provide leadership and consensus on determining system wide workforce transformation priorities, interventions and projects.
c) Enable strategic collaboration between partners.
d) Provide governance / assurance to the WY Health and Care Partnership.
e) Oversee the system's ability to expand and maximise placement quality and capacity across all partnership sectors.

The priorities will be set out in the West Yorkshire People Plan which will be refreshed over the forthcoming 12 months.

NHSE Regional Director, Richard Barker
Cathy Elliot Chair for NHS West Yorkshire Integrated Care Board offered thanks to Richard on behalf of the NHS West Yorkshire ICB Board in recognition of his contribution and commitment to the NHS. Richard retired at the end of June 2024 after a 40-year career in the NHS.

A recruitment process has begun to appoint a successor, with Robert Connell taking on the role as Interim in the meantime.

West Yorkshire Combined Authority
On 4 May 2024, Tracy Brabin was re-elected as Mayor of West Yorkshire and has set out her plans to create a more prosperous region by putting local growth at the heart of her vision to give children the best possible start in life and to support parents to retrain and get back into work creating a 'region of learning'.

In addition to improving public transport, reducing violent crime, and building thousands of affordable homes, Mayor Brabin will work with councils to redesign public services including early years, adult skills and employment support.

Alison Lowe was confirmed on 14 June 2024 as West Yorkshire's Deputy Mayor for another four years, to support the Mayor to improve policing and tackle crime across the region

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

Thanks to Andrew Gold
I would like to thank Andrew Gold, Chair of Airedale NHS Foundation Trust for his contribution to the work we have been doing across our health and care partnership for Bradford District and Craven. Andrew will be stepping down as Chair for Airedale NHS Foundation Trust from 30 September 2024.

Thanks to David Crampsey
We are proud and delighted that David Crampsey has been offered and accepted the position of Chief Executive for Royal Free London Hospital. Many of you will know David and his inclusive leadership style both through his role as Medical Director and Deputy Chief Executive for Airedale NHS Foundation Trust, as well as his role as chair of our place-based clinical forum. I know that all of you will join me in wishing David every success, we are sorry to see you go and know that your new colleagues are very lucky to have you.

Bradford 2025 update
We are getting closer and closer to 2025, which brings the excitement of Bradford taking on the mantle of UK City of Culture. On 12 September, the programme for City of Culture will be announced and we know that arts and culture bring positive impacts to people's wellbeing. The BBC has confirmed that it will be the broadcast partner for Bradford 2025, and if you didn't know already Bradford's very own Zayn Malik is the brand ambassador. Keep up to date by visiting www.bradford2025.co.uk where you can also sign up for the newsletter.

Social worker recruitment campaign
Bradford Council and Bradford Care Association have launched a recruitment campaign, aimed at inspiring people across the city to embark on a rewarding career in adult social care. Titled, "Be Someone's…" this campaign highlights the crucial role social care workers play in supporting individuals in need across Bradford - because, when you work in social care, you become something to someone. We want to encourage wider sharing of this, so that we can attract people to our local health and care workforce, please do get involved.

Breastfeeding friendly scheme launched
Bradford District Care NHS Foundation Trust's Community Infant Feeding Team is launching the new Bradford District Breastfeeding Friendly scheme to support local

mums to breastfeed ‘here, there and everywhere’. Local organisations from cafes and restaurants, to hairdressers, shopping centres, Family Hubs, transport hubs and leisure facilities, are being encouraged to sign up to the Breastfeeding Friendly initiative, by ensuring their staff understand the importance of breastfeeding, providing a warm welcome for breastfeeding mums and displaying the Breastfeeding Friendly sign on their premises.

South Asian Heritage Month (18 July – 17 Aug)
We are pleased to have marked South Asian Heritage Month, a time to commemorate, mark and celebrate South Asian cultures, histories and communities. Mind in Bradford have led on developing resources for all partners to use. This includes stories shared in blogs and videos as well as recommendations on how you can experience South Asian culture through film, TV, recipes and books.

Pioneering research project on wellbeing into later life secures funding
Researchers from the Bradford Institute for Health Research (BIHR) have been awarded a major grant of £892,518 from the Nuffield Foundation to establish the ‘Wellbeing in Later Life in Bradford’ cohort study. The research team aims to produce new findings on factors that improve or reduce wellbeing in later life, focusing on frailty, care transitions, care needs, and care networks. I look forward to hearing more about the outcomes and learnings that can help support our wider system working.

Bradford independent care providers score top marks
Independent care providers, that are CQC registered, across Bradford District and Craven have topped the national table for complying with the Data Security and Protection Toolkit (DSPT). National colleagues have congratulated local care providers as we achieved a compliance rate of 93% against the national target of 70%. This means we have topped the June league table in terms of overall percentage of compliant providers! Congratulations to all teams involved, I know this has been a true partnership effort – thank you.

Awards news
I’d like to say good luck to the below teams and partner organisations who have been shortlisted for awards as shared below.

- Four teams from Bradford Teaching Hospitals NHS Foundation Trust have been shortlisted in prestigious national healthcare awards. The maternity parent education team, along with additional needs navigator Naomi Hargreaves, Bradford Royal Infirmary’s ward 31 and the Trust’s early innovation team are all nominees in this year’s Health Service Journal’s Patient Safety Awards 2024. The awards ceremony is on Monday 16 September.
- Congratulations to the teams at Safe Spaces and the Multi-Agency-Support-Team (MAST). Both have been shortlisted for the Charity Times Awards under the 'Collaboration of the year' category. The winners will be announced on Wednesday 25 September.

5. Partnership Leadership Executive Discussions – May to July 2024

At the Partnership Board meeting in May 2024, I agreed to include more detail on the discussions that take place at our Partnership Leadership Executive Meetings, which are held on a monthly basis within my report. These are noted below.

PLE received the following updates at their meeting held on 24 May 2024:

- Special Education Needs and/or Disabilities (SEND) Health and ICB responsibilities update. PLE requested an update on progress in areas including Waiting list for attention deficit hyperactivity disorder (ADHD) and autism; the quality of Early Health Care Plans; and joint commissioning for their meeting in September 2024.

- Better Care Fund 2024-2025 plan update. PLE heard that conversations continue to ensure best value is achieved from this funding, and that amendments can be made in-year, with updates via the mandatory quarterly submissions. Following final sign off of the Plan for 2024-2025, this was to be presented to the Health and Wellbeing Board in June 2024.

- Finance Update: progress against each of the programme delivery objectives was shared, with work ongoing to ensure delivery against the Partnership cost improvement programmes. System leaders confirmed their on-going commitment to the plans and ensuring work continues within individual organisations. PLE will continue to receive regular updates at their monthly meetings.

- Children in Care Review Health Assessments: PLE supported a proposal recommending funding nursing capacity above the currently funded establishment to increase capacity for Children in Care Review Health Assessments for 2024-2025.

PLE received the following updates at their meeting held on 28 June 2024:

- Closing the Gap Update: PLE received an update on the Partnership work to close the financial gap and requested a session be arranged with programme leads to discuss population segmentation. They also received an update on the Service Level Review work that has been undertaken across the three NHS Trusts by Directors of Finance and Chief Operating Officers.

- VCSE Health and Care System, Bradford Council and VCSE Joint Sustainability action plan update: PLE recognised that stability of the VCSE sector remains a key challenge for the Partnership, and confirmed their commitment to continue to work together collaboratively to ensure stability for the VCSE so they can continue to support people to be happy healthy at home. PLE agreed to add the risk of grassroots organisations not receiving support required to deliver services to marginalised groups as a fifth component of the existing VCSE stability Partnership risk.

- West Yorkshire CYP Mental health overnight crisis support/line provision – Night Owls: PLE heard that this provision, which has been in place since July 2021, is available for any young person to the age of 25 and runs between 2000 and 0800 every night, providing multiple routes to access support for individuals and their parents or carers. PLE supported the proposal made by the Healthy Minds Board for a two-year contract through the Direct Award process C to allow time to determine whether a move towards a full 24/7 all age crisis service in the future was appropriate.

- Intermediate Care Beds Update: PLE received a progress update on the ongoing work around intermediate care services and the development of a blueprint to transform the service and supported further IMC summit meetings – agreeing to prioritise any meeting requests in their diaries.

- Strategic alliance to promote career openings for University of Bradford Students: PLE supported a proposal to work more strategically with Bradford university around hosting non-clinical placements (26/06/2024).

PLE received the following updates at their meeting held on 26 July 2024:

- Redesign of Autism and ADHD support services: PLE received an update on the work to date, noting that the proposed model has been coproduced with families, clinical staff and stakeholders, building on the Partnership's Act as One ethos. PLE noted there was further work required to refine the model but agreed to the approach of the future model as presented. They confirmed their support for the team to mobilise and agreed to receive a full business case at PLE, along with a detailed finance and investment plan, later in the year.

- Development of the next Bradford District Strategy: the current version of the Bradford District Plan will expire in 2025. PLE recognised that the document operates as the Place-based high-level strategic focus for the district's organisations and strategic partnerships and that it also operates as the statutory Health and Wellbeing Strategy for the district, hence the new title of District Strategy. PLE agreed this will provide consistency across the partnership's strategic approach. PLE supported the approach to development of the District Strategy and requested that Bradford District and Craven are involved in setting the strategic actions and metrics related to Health.

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	7
Meeting date:	6 September 2024
Report title:	Sub – Committee and Fora Triple A Reports
Report presented by:	Sub – Committee and Fora Chairs
Report approved by:	Sub – Committee and Fora Chairs
Report prepared by:	Carrie Haywood, Governance Manager, West Yorkshire ICB

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

- System Quality Committee Triple A report links to risk 2248: Vaccination Programme
- Finance and Performance Triple A report links to risks; 2266, 2039, 2227: ADHD and Autism; 2168: Performance against national standards; 2433 and 2337: in year finances and financial deficit

Appendices

1. System Quality Committee Triple A Report
2. Clinical Forum Triple A Report
3. Finance and Performance Committee Triple A Report

Acronyms and Abbreviations explained

1. BDC: Bradford District and Craven

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 SQC meeting: 13th June 2024, 11th July 2024 (No meeting in August due to summer break)

Report to: Bradford district and Craven Partnership Board

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

Date of Partnership Board: 6th September 2024

Key escalation and discussion points from the meeting
Alert:

Bradford District Care NHS Foundation Trust

- **Admission into 136 Suite-** Children continue to be admitted into 136 suite in relation to the continued use of out of area beds and was being replicated nationally

Bradford Metropolitan District Council

- **Elms nursing home-** Notice of decision issued by CQC in relation to The Elms (Associated Wellbeing) on 7th June. A Bradford based Independent Service with no Bradford young people placed within the facility. Seven out of area young people were placed there. Multi agency meetings held between commissioners, social care, health, CQC and placing LAs. Learning events held to understand how similar situations may be avoided in the future.
- Significant issues at **CQC** nationally, which is impacting locally. This includes issues with IT the systems, implementation of a new structure which has included a reduction in staff impacting on the number of visits that can be undertaken. As an example Only four assessment visits have been made to Bradford services since February this year.

Airedale NHS Foundation Trust

- **Bradford and Airedale Stroke Service** - ongoing challenges facing the service across both Airedale Foundation Trust and Bradford Teaching Hospital. Concerns raised about the lack of improvement and the fact that the Sentinel Stroke National Audit Programme SSNAP score remains at a D. It was agreed that a comprehensive stroke action plan was needed at a place level with clarity about the responsibility of the partners involved and clear timescales for improvement/investment, In addition, delays in referrals from Accident & Emergency Department (AED) to stroke services have been identified as a recurring theme at Bradford Teaching Hospital Foundation Trust (BTHFT)

Bradford Teaching Hospitals NHS Foundation Trust

- A **peer led review** of Health Services for People with Haemoglobin disorders raised concerns regarding commissioning and delivery of local haemoglobin

disorders services. A meeting is planned to include CQC representation, to discuss the context of the review and the issues raised.

- **Quality Improvement Group (QIG**)-BTHFT QIG ongoing investigations into aspects of the board, still awaiting the outcome of their CQC core and well led visit

Primary care

- **GP ballot-** a ballot is underway with the potential outcome of industrial action undertaken by GPs including the withholding of services. The LMC have advised that they will not be directing members, and that any decision remains with individual GP practices.

Cygnet Wyke

- **Quality Improvement Group-** following recent CQC inspection at cygnet wyke, overall rating reported as 'inadequate', Quality Improvement Group has been implemented to monitor action plan

Advise:

Primary Care

- **Vaccinations & Immunisations –**
  - Limited supply of **Sanofi vaccines** in relation to Flu vaccines, guidance about alternatives available.
  - **Covid19 and flu campaigns**, Providers have been advised to work on basis that Covid19 and adult flu programmes will commence in early October 2024.
  - **MMR**- There has been one confirmed case in Bradford since March 2024 through community transmission. Notable small clusters in other areas in West Yorkshire. Further national communications campaign to begin in August 2024.
- **Immunisation- (Childhood and Travel Vaccinations**) – Practice nurse at Modality discovered administering childhood and travel booster vaccinations out of prescribed schedule. Discussion with NHSE West Yorkshire Screening & Immunisations (WYSI) initiated. Audit of Practice Nurse vaccination history over 18 months revealed 10 additional incorrect vaccinations. No harm to the patients has been identified, and the patients have been informed.
- **Human normal immunoglobulin** (**HNIG)-** Measures are in place to improve vaccination levels. Bradford Metropolitan District Council (BMDC) Memorandum of Understanding to be shared with NHS ICB colleagues and to include work to identify issues noted regarding the lack of a confirmed or agreed pathway to administer HNIG.
- **TB** - ongoing work with the UK Health Security Agency (UKSHA) following 9 reported TB cases in Bradford. Concerns raised regarding staff safety and patient engagement in the community. Plans in place in ward 1 (BTHFT) to open TB beds.
- **Patient Safety Incident Response Framework (PSIRF) -** training for GP practices being developed and rolled out. System Quality Insight Assurance &

Improvement Group (SQIAIG) meeting will have oversight of the PSIRF process in primary care.

- **CQC inspections**-
  - Thornbury/ Farrow CQC inspections concluded.
  - Modality - CQC draft report has been submitted to the provider to review for factual accuracy ahead of the publication of the final report.
- **Practice Plus Patient Incident:** This is being investigated and ongoing discussions with Manchester and Rochdale continue.

Bradford District Care NHS Foundation Trust

- **Increase use in out of areas beds**- A person-centred approach has been proposed to balance increased bed demands and financial pressures. April data is suggesting a small reduction in numbers of out of areas placements.

Bradford Metropolitan District Council

- **Closure of homes**- Following the announcement in April of the intention to close a large residential care home in Wibsey, all residents have now moved to new accommodation at various local care homes. The service intends to renovate and potentially re-open. The owners will continue to engage with the Contract, Quality and Commissioning teams in respect of any future decisions.
- **Managed Closure of Bradford South Residential Home** –19 residents will be rehoused, not all Bradford patients.
- **New Mental Health Specialist Enablement and Recovery Service Contract**- commenced on 1 April 2024 and offers accommodation and support, working as part of Community Rehabilitation Team's wider service.
- Following a whistleblowing report concern has been raised in relation to a supported living provider operating across Leeds & Bradford. A joint response and strategy meeting taking place led by Leeds. Discussion has taken place between contract management teams, social work and health regarding response. Joint provider communication has taken place and joint quality assurance activity is planned. Health colleagues are part of the review process including the provision of intelligence relating to service provision and outcomes.
- The Home Support Locality Contracts introduced the final stage of the implementation plan with the introduction of the agreed **Placement Timescales**. This, along with the new contract process has already resulted in a significant reduction of people awaiting support.
- A Bradford residential care home in Shipley has now closed. All residents have been safely relocated to new accommodation in local care homes.

Airedale NHS Foundation Trust

- Patient at Airedale who continues to reside at ANHST -19 months with complex health needs, legal support has been identified and the BDC HCP DON is supporting ANHST
- **Clostridium Difficile** - increasing numbers, Airedale report they are decluttering and using Infection Prevention Control (IPC) measures to improve service provision, and several actions have been undertaken to mitigate risks, the situation is also being monitored through the Trust board and an IPC 'rapid

improvement' event has been held with the aim of further improving the situation and identifying potential further funding / investment.

- **Electronic Patient Records (EPR)-** Readiness for EPR rollout in September 2024- a request has been made for a completed QEIA and an update to SQC in September 2024 re rollout. The Trust have paused the roll out of EPR due to concerns raised by Health Care Partnership.
- **Palliative and End of Life Care Annual Report**. - was noted that the demographics of referrals to the service do not reflect the population served and there is ongoing work to understand and address this. Long-term aspiration to co-locate Manorlands with the hospital site to improve patient experience and address potential imbalance in the ethnicity of users of the service.
- **Maternity, quality and safety and performance reports.** - ANHSFT quality committee received its regular suite of reports; it was noted that the new formats were much clearer and enabled a more detailed focus on areas of success, challenge and improvement. In particular the committee were updated following the recent LMNS visit to the Unit on 20th June, where positive feedback was given in relation to progress against the recommendations which had been made at the previous visit, as well as against the CQC "must do actions". The committee noted the ongoing challenges across the obstetric workforce due to staff vacancies and the risk and impact of this is recorded on the risk register.

Bradford Teaching Hospitals NHS Foundation Trust

- **Bronchitis-** The 13 data points presented actually correspond to 24 months-worth of data from February 2022 up to and including January 2024. The data shows both in-hospital deaths and deaths up to 30 days post-discharge. The "Acute Bronchitis" CCS groups refers to patients who died following a diagnosis of acute bronchitis, not necessarily from acute bronchitis. This is because SHMI data uses primary diagnosis to group patients together, not their actual cause of death. Only one patient within the dataset actually had acute bronchitis as a cause of death.
- Junior Doctors industrial action took place with limited cancellation of non-urgent activity, however the covering of Junior Doctor activity by consultants has had a detrimental impact on costs
- High Emergency Department attendances during the reporting period of the SQC, however performance was maintained.
- Crude mortality rates continue to drop (currently the lowest rate in West Yorkshire). Summary Hospital-level Mortality Indicator (SHMI) is still high, however analysis of the data has been carried out in relation to the reasons for the outlier status, this includes ongoing work around the accuracy of clinical coding.
- The Trust still awaits the CQC report from inspections carried out in March, April and May.

Assure:

Primary Care

- **Provision of oxygen contract**- the contract has been allocated to Baywater Healthcare Ltd, and is now enabled. Due to concerns with previously reported

data the service currently in a 6-month review period however to date no safety concerns or negative outcomes have been reported.

Airedale NHS Foundation Trust

- **Safeguarding annual report-** The system quality committee reviewed the Annual Safeguarding Report, assessing the Trust's efforts to protect children, young people, adults, and their families. They noted the rise in mental health needs and challenges with the new EPR system. A plan in place for 24/25 includes mandatory training for staff.

Bradford Metropolitan District Council

- Development of children's Contract & Quality function continues. Regular Quality Assurance visits and monitoring of improvement action plans in response to concerns. Further developing process for professional feedback to identify and respond to lower-level concerns as early as possible.
- Further developing process for professional feedback to identify and respond to lower-level concerns as early as possible. Monthly meeting established between Contract & Quality Manager working with Children's Trust and Deputy Delegated Nurse for Safeguarding Children to respond to any concerns.

Bradford Teaching Hospitals NHS Foundation Trust

- Patient Safety Incident Response Framework PSIRF - Monitoring of reported incidents continues to occur through weekly Quality Oversight meetings.
- Emerging themes - Increase in pressure ulcers (Improvement programme in place), Readmissions of > 65years (silver trauma) with injuries not identified on first Emergency Department visit. A scoping exercise is being completed with regards to completing a full review of the issues identified.
- Recent feedback received (June 2024) highlighted potential issues with SHMI reported data specifically relating to deaths from bronchitis. Following investigation by the Trust, assurance has been received from BTHFT that this report is due to reporting anomalies rather than a clinical issue.

Primary care

- Pilot project work with Quality team to work with BDCT Childhood immunisation team in primary care to look at feasibility of working on GP premises.

LeDeR

- WY Latest figures for the 6-month KPI at 74%. This has been facilitated by an increase in performance of 20% within month ending June 2024
- LeDeR annual report has been completed and signed off- shared with NHSE.

Integrated Care Board (Bradford Place):

- **Quality Accounts**- all Quality Accounts have been updated, signed off and submitted back to providers within timescales.
- **Quality Equality Impact Assessments (QEIA)**- rollout of process within ICB transformation programmes ongoing, with the process agreed and communicated to colleagues within the transformational programmes

- **Peri-natal mental health-** Acute providers and BDCFT will collaborate to review the last five maternal deaths by suicide to reflect on lessons learned and inform future practice.

Items presented to the Bradford district and Craven SQC

Since the last update the Bradford district and Craven System Quality Committee (SQC) has received updates on

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

In addition, the committee received.

- An update on the Children & Young People Priority Programme
- An update on the BD&C People Committee responsibilities – with agreement regarding the responsibilities of the committee which will be amalgamated into the SQC terms of reference following the stepping down of the People Committee
- An update on the Airedale Paediatric Audiology Service Review and progress towards completion of the action plan at ANHSFT
- Update on SEND – including the 2024 / 2025 priority areas.
- An update on the BDC QEIA process and the rollout of process within BDC transformation programme

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

Dates of meetings: 13th August 2024 (11th June 2024 & 10th July 2024- meetings cancelled)

Report to: Bradford district and Craven Partnership Board

Report completed by: Jaspreet Sohal / John Hartley/ Iram Amin

Date of Partnership Board: 6th September 2024

Key escalation and discussion points from the meeting
Alert:
There are currently no issues specific to the Clinical Forum to escalate to the Board.
Advise:
Structured Judgement Reviews: update provided on structured judgement reviews and death of a patient where multiple agencies involved and how to navigate patients care when there are so many different agencies involved. Discussed how this is a significant challenge for clinicians across the system and raising awareness is not enough. **GP Assist Tool**: The Forum agreed this should be promoted as something that could be used across the whole system to help with referrals, especially in mental health care. There was also a challenge in not knowing all the options that were available in terms of referring people. It was ascertained that certain barriers needed to be crossed regarding the GP Assist Tool. Forum has requested Simon Wilson as ICB Associate Director of Digital to attend a future meeting to discuss. **Future items** planned for discussion include. • Community Pressures and Self Care promotion would be an agenda item in September. • The Forum agreed to hold a development session in October due to changes in arrangements. • The Forum agreed to develop standard regular agenda items for future meetings. • Noted the Clinical Forum chair Dr David Crampsey has been appointed CEO at Royal Free Hospital. Jaspreet Sohal is interim chair, however a formal process of appointing a new chair will need to be undertaken. Clinical and Professional Leadership development remains a priority for the Forum
Assure:
The Clinical Forum would update the BD&C Partnership Board on the following.

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

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: System Finance and Performance Committee

Date of meeting: 25 July 2024

Report to: Health and Care Partnership Board

Report completed by: Mike Woodhead

Date: 2024

Key escalation and discussion points from the meeting
Alert:
Regarding Childrens ADHD and Autism, we considered a draft business case and discussed: • Need for action to clear 3-4 year waiting lists (and growing) • No funding source for investment currently identified Regarding system performance: • Significant number of 65+ week waits in T&O service at BTH (improvement plans being enacted but some risk around it) • Elevated Mental Health Out of Area Placements and impact of closure of national secure unit beds on PICU & risks re early release of prisoners • Neurodiversity waits (see Autism & ADHD case) • Risk of GP industrial action Regarding month 3 finance report: • Although reporting on plan with forecast, significant risk of being materially off plan by year end.
Advise:
Regarding Childrens ADHD and Autism we considered a draft proposal for a new service model, requiring c£1.8m recurrent investment over 3 years to deliver sustainable services and bring waits down to NICE guidelines, noting: • Needs some more modelling around finance, workforce and phasing. And how the Lead Provider model would work. • Will then go through Business Case Assessment Panel for recommendation to Place Leadership Executive • Will still need to identify source of funding (see above) • Support in principle for the model and development of business case • COOs to discuss preferences re who should be Lead Provider (with support from ICB contracting team) Regarding system performance:

- Diagnostic performance is improving but still not at target. More Community Diagnostic Centre capacity now online which should see continued improvement and reduced spend with 3rd parties.

Regarding month 3 finance report:

- WYATT PWC reviews landed with Trusts this week with some useful recommendations (to be shared with system partners
- ANHSFT have requested and received revenue cash support for July

Regarding the Closing the Gap (CtG) programme:

- Q1 peer review and challenge session scheduled for 1 Aug (objective 1 of CtG mandate)
- Service review (part of objective 2 of CtG mandate):
    - Baselines shared
    - COOs in discussion about emerging opportunities, with engagement form Programme Directors
    - 1 Aug session scheduled on this with CFOs, COOs and PDs.
    - External support and brief agreed for Sept workshop
- Programme Boards all received support and presentation on population health and segmentation in July, to inform their priorities / work programme for the next 12 months. (objective 3 of CtG mandate)
- All working on a Medium Term Financial Plan for November 2024.

Assure:

We considered the presentation from the People Committee, discussing the following:

- Disestablished the People Committee
- Reviewed Terms of Reference to ensure all responsibilities appropriately redistributed across revised governance groups
- FPC specifically agreed to pick up responsibilities re
    - Assurance re sufficiency of workforce in line with other strategic place plans and objectives
    - Assurance re place based workforce metrics
    - Identify any areas where there are wider implications/trends of workforce risks, where additional assurance is required
    - Oversight and assurance re workforce elements of system planning process
- Agreed to incorporate these into FPC ToR (for next meeting) and revise the workplan accordingly.
- To include workforce metrics into Integrated Performance Report
- Have People responsibilities on agenda quarterly (might be more at planning stage) and have appropriate HR rep for those meetings.
- We will also hold 2 workshops per year with the "old" people committee reps

Regarding system performance:

- Waiting times ***generally*** better than trajectory
- ANHST achieved all cancer standards for 5th consecutive month, and BTH's 2-week wait performance is expected to improve and be above target it June.

- June performance against the A&E 4-hour target was 64% and 83.3% at ANHSFT and BTHFT respectively, with performance for both Trusts remaining above their 2024/25 trajectory. The development of the co-located urgent treatment centre (UTC) at ANHSFT was handed over

from the lead contractor in July and is due to open on the 25th

Regarding month 3 finance report:

- Thanks from ICB colleagues for system contributions to primary care capital to address urgent infrastructure needs
- Direct access from GPs - Helen Farmer supporting workshops between AGH and GPs.

Meeting name:	BDC Partnership Board
Agenda item no:	8
Meeting date:	6 September 2024
Report title:	Partnership risk update (risk report – cycle 2)
Report presented by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB
Report approved by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB
Report prepared by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations:			
Partnership Leadership Team: 08.08.2024			
Executive summary and points for discussion:			

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

BDCH&CP Risk Register

This report provides details of all high-level risks (scoring 15 or above, or risks escalated from committee review) on the BDCH&CP Health and Care Partnership Risk Register, together with details of risks aligned to each committee.

ICB Risk Register and Board Assurance Framework (BAF)

The ICB risk register and BAF are included in this report for consideration.

Outline how this supports our partnership vision and strategy

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

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

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

Our Partnership – Greater value through the best use of our collective resources, minimising duplication and waste.
Recommendation(s)
The BDC Partnership Board is asked to: 1. To **RECEIVE** the BDCH&CP cycle 2 risk report and confirm assurance on the critical and serious risks scoring above 15. 2. To **DISCUSS** any identified risks that are not currently recorded on the risk report and signpost the partnership governance team to the relevant risk owners for liaison in preparation of cycle 3 3. To **RECEIVE** the ICB risk register and BAF for consideration and confirm assurance on the BDCH&CP risks captured in the ICB Risk Register
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
The report includes details of the current risks on the partnership risk register and those on the ICB corporate risk register for information
Appendices
1. Risk scoring matrices 2. Bradford District and Craven Health and Care Partnership risk log 3. BdC Risks on a Page Report 4. West Yorkshire ICB risk log 5. West Yorkshire ICB mapped common risks 6. West Yorkshire Board Assurance Framework summary and heat map 7. West Yorkshire Board Assurance Framework BDC Action Plan
Acronyms and Abbreviations explained
1. H&CP – Bradford District and Craven Health and Care Partnership 2. ICB – NHS West Yorkshire Integrated Care Board 3. BAF – Board Assurance Framework

What are the implications for?

Residents and Communities	Any implications relating to specific risks are set out within the risk register
Quality and Safety	Any implications relating to specific risks are set out within the risk register

Equality, Diversity and Inclusion	Any implications relating to specific risks are set out within the risk register
Finances and Use of Resources	Any implications relating to specific risks are set out within the risk register
Regulation and Legal Requirements	Any implications relating to specific risks are set out within the risk register
Conflicts of Interest	Any implications relating to specific risks are set out within the risk register
Data Protection	Any implications relating to specific risks are set out within the risk register
Transformation and Innovation	Any implications relating to specific risks are set out within the risk register
Environmental and Climate Change	Any implications relating to specific risks are set out within the risk register
Future Decisions and Policy Making	Any implications relating to specific risks are set out within the risk register
Citizen and Stakeholder Engagement	Any implications relating to specific risks are set out within the risk register

Partnership Risk Register Cycle 2 2024 – 2025 (26.06.24 – 24.09.2024)

1. Introduction

1.1 The Bradford District and Craven Health and Care Partnership (the Partnership) via the West Yorkshire Integrated Care Board (as a publicly accountable organisation), needs to take many informed, transparent and complex decisions and manage the risks associated with these decisions. As part of this risk management arrangement Partnership therefore needs to engage with this overarching approach and thereby ensure that the partnership has a sound system of internal control.

1.2 Effective risk management processes are central to providing assurance that all required activities are taking place to ensure the delivery of the Partnership's priorities and compliance with all legislation, regulatory frameworks and risk management standards.

2. BDC H&CP risk register

2.1 Effective risk management processes are central to providing assurance that all required activities are taking place to ensure the delivery of the Partnership's priorities and compliance with all legislation, regulatory frameworks and risk management standards.

2.2 To support the reporting throughout the Partnership, all risks are aligned to appropriate BDC H&CP Committees for oversight – with risks categorised as People, Primary Care, Quality, Finance, and Performance, or a combination.

2.3 There are 12 high level risks for review (Appendix two). Of these:

- 4 (33%) are identified as only finance and performance risks
- 0 (0%) are identified as only quality risks
- 7 (59%) are identified as being both finance, performance and quality risks
- 1 (8%) are identified as risks to planning and commissioning and the priority programmes

The below table shows a summary of these risks along with any associated actions. Full risk details can be found in appendix two.

Ref	Committee	Risk Description	Current Score	Target Score
2447	FPC and QC	**New:** Renal Services Capacity - Renal Services Capacity There is a risk that as the demand for haemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity that it will not be possible to provide timely dialysis for some patients. Due to increasing demand within the local demographic and an aging and limited footprint, which has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the patient group. There is a high risk of increasing down time at the St Luke's site and the satellite unit at Skipton because of the aging infrastructure. Loss of either facility for an extended period would be unsustainable without seeking support from organisations both within and without the region.	**20 (I4xL5)**	**12 (I3xL4)**
2433	FPC	**Decreasing** IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc.) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	**20 (I5XL4)**	**16 (I4XL4)**
2173	FPC and PCF	BMDC FINANCIAL POSITION	**20 (I5XL4)**	**12 (I4XL3)**

Ref	Committee	Risk Description	Current Score	Target Score
		There is a risk that the measures taken to control expenditure by BMDC, and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures.		
2337	FPC	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	**20 (I4XL5)**	**9 (I3XL3)**
2314	FPC/QC/PC/PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL There is a risk of long-term disruption of service provision at Airedale General Hospital due to building component failure, 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	**20 (I5XL4)**	**15 (I3XL5)**

Ref	Committee	Risk Description	Current Score	Target Score
		Airedale General Hospital site and a transfer for the continuing provision of services without this facility for months or years. In the event of catastrophic failure of the AGH could result in damage to the partnership's reputation, legal proceedings, claims for compensation and regulatory intervention (implications for AFT and also the NHS WY ICB due to vicarious liability). This links to risk number 2312 (risk that AFT is unsuccessful in securing funding from the new hospitals programme).		
2312	FPC/QC/PC/PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - Although Airedale NHS Foundation Trust has been successful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030, there is a risk that the funds do not flow as quickly as required, resulting in a failure to open the new hospital before the current one ceases to be viable (engineers estimate 2030) (or earlier if a significant RAAC incident occurs - see related risk number 2314). Further, Airedale NHS Foundation Trust must submit a new application for funds in 2024/25, relating to the next Comprehensive Spending Review and there is a risk that this process may result in a hiatus mid-programme.	**20 (I5XL4)**	**15 (I3XL5)**
2215	FPC/QC	LYNFIELD MOUNT HOSPITAL - There is a risk of delivering poor quality health care with a negative impact on patient safety including infection prevention and control, service user experience including privacy and dignity, additional costs for out of area bed usage and negative impact on staff wellbeing, recruitment and retention and on	**20 (I4XL5)**	**2 (I2XL1)**

Ref	Committee	Risk Description	Current Score	Target Score
		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.		
2386	FPC/QC/PCF/PLE/PB	There is a strong and increasing risk to the sustainability of the VCSE sector. This includes the risk of VCSE organisations and services across Bradford District and Craven closing or reducing their delivery or activities. The risks centre around financial sustainability, ability to recruit and retain staff (especially due to employment uncertainty and cost of living) and the decision to withdraw the VCSE infrastructure contract due to local authority budget pressures. All these issues ultimately decrease the sector's resilience and sustainability and would decrease its capacity to engage with the system. This in turn has a knock-on effect on the wider health and care system, both in terms of increase usage of statutory services and a reduction in proactive preventative work to tackle inequalities.	**16 (I4xL4)**	**12 (I4xL3)**
2266	BDC PLT and PCF	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to	**16 (I4xL4)**	**4 (I2XL2)**

Ref	Committee	Risk Description	Current Score	Target Score
		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.		
2039	FPC/QC/PCF	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. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.	**16 (I4XL4)**	**6 (I3XL2)**
2227	FPC/QC/PCF	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	**15 (I3XL5)**	**6 (I3XL2)**

Ref	Committee	Risk Description	Current Score	Target Score
		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.		
2168	FPC and PCF	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place-based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	**15 (I3XL5)**	**4 (I2XL2)**

2.4 Of the 12 risks, there are:

- 1 newly identified risks
- 0 closed risks
- 0 risks increasing in score
- 1 risk decreasing in score

2.5 Of the 12 Risks:

- 9 were reviewed by the risk owner
- 9 were reviewed by senior risk managers
- 8 have had a static score for more than 4 cycles

3. Emerging risks and Committee Discussion

3.1 At the time of writing the report, no new risks had been highlighted as part of horizon scanning or through meetings of key groups and committees

3.2 A Discussion at the Partnership Leadership Team identified that risks 2266, 2039 and 2227 relating to both children's and adults' autism and ADHD required further review and development considering national challenges and operating model changes. This work is due to commence throughout September and October 2024 with colleagues from Healthy Minds and Healthy Children's and Families Priority Programmes.

3.3 The Partnership Leadership Executive confirmed that the risk relating to Renal Services Capacity (risk 2447) has also been reported through the West Yorkshire Association of Acute Trusts (WYAAT) as this also impacts Leeds Place.

4. BdC Risks on a Page Report

4.1 This document provides an overview of all BdC risks and is starting to show trends and flag areas that the Partnership Board and its committees may wish to consider.

4.2 Please see appendix three with Information that can be found that 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.

- Static risks, 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.

5. ICB Risk log

5.1 The ICB corporate risk log has been provided for assurance of what is being reported to the ICB Board on behalf of each place. The ICB Board report includes risks with a score of 15 plus and place risks with a residual score of 15 plus that have been identified as being common to more than one place, having the potential to impact multiple places, or requiring active management by a number of organisations.

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

- There were 49 risks on the ICB risk register
- There were 18 risks scoring 15 and above on the ICB risk register

A summary of the ICB high level risks are shown in the table below with a full log provided in appendix four:

Risk Ref:	Score	Risk Wording
2036 (Quality)	**20 (I4 x L5)**	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.
2166 (FIPC)	**20 (I4 x L5)**	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.
2309 (Quality)	**20 (I4xL5)**	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
2308 (Quality)	**20 (I4xL5)**	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.
2202 (FIPC)	**20 (I4 x L5)**	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures.
2432 (FIPC)	**20 (I5 x L4)**	PANDEMIC There is a risk that a pandemic will occur due to a novel pathogen (such as viruses, bacteria, fungi, uni and multicellular eukaryotes) and due to a lack of population immunity this will result in the pandemic spreading quickly around the world. This could result in a reasonable worst-case scenario (RWCS) (taken from the National Risk Register) of an unmitigated pandemic with an unassumed transmission route and a high attack rate, with 4% of symptomatic infections requiring hospital care and a case fatality ratio of 2.5%. The RWCS assumes 50% of the UK's population fall ill during the whole course of the pandemic, with around 1.34 million people requiring hospital treatment and approximately 840,000 deaths.
2430 (FIPC)	**20 (I4 X I5)**	There is a risk that the ICS will not deliver the 2024/25 financial requirement of breakeven. On 21 March the ICS submitted a deficit plan to NHS England of £153.7m. Whilst work continues to reduce this deficit plan, it is unlikely a break-even plan will be submitted for the final deadline of 2 May. UPDATE 11/7/24: A revised financial plan was submitted on 12 June which was a system deficit of £50m, predicated on delivering efficiencies of £434m of efficiencies (7.7% of allocation). Failure to deliver a break-even position will resulting in reputational damage to the ICS/ICB, additional scrutiny from NHS England, and a requirement to make good deficits incurred in future year.

2437 (Quality)	**20 (I4 X I5)** ⬆	There is a risk to patient care and safety due to GP Collective Action from 1st August 24, resulting in disruption to service delivery, reduced access to core provision and some enhanced service provision, impacting; Health Inequalities; Resilience and pressure on wider service provision, including, Urgent and Emergency Care - A&E, 111 and out of Hours; Secondary Care elective; Public health programmes, Immunisations and Vaccinations; Community Pharmacy
2451 (Quality)	**16 (I4xL4) NEW**	There is a risk that changes in the national Gender identity providers and associated, increasing waits, result in more support for CYP/Families at a local level.
2400 (Quality)	**16 (I4xL4)**	There is a risk that initial health assessments and review health assessments will not be completed within the statutory time frames due to resource issues, increased demand and complexity within the Children in Care (CIC) Teams across West Yorkshire. This could result in health needs assessments of CiC being delayed and out of area children placed in West Yorkshire area being significantly delayed. This could result in the health needs of these vulnerable children not being met.
2391 (Quality)	**16 (I4xL4)**	There is a risk that increasing numbers of people seeking asylum placed in WY and the Home Office Policy decision to implement double occupancy for contingency accommodation, will place significant demand on services and add additional pressure onto service providers. This could result in an increased risk safety and safeguarding concerns, potentially resulting in poor experience, increased harm and poor outcomes
2232 (Both FPC and QC)	**16 (I4xL4)**	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.
2176 (Quality)	**16 (I4xL4)**	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.
2175 (Both FPC and QC)	**16 (I4xL4)**	There is a risk that the increasing number of patients in WYAAT hospitals who are ready to be discharged but unable to leave due to capacity issues in social care and community services, will add extra pressure on the workforce and reduce elective activity due to inadequate bed capacity. This could result in increased backlogs, delays to patient care, reduced functioning / deconditioning of patients, and reputational damage across WYAAT members.
2120 (Both FPC and QC)	**16 (I4xL4)**	There is an increasing risk of a widening of health inequalities and poorer health outcomes across West Yorkshire due to the reduction or loss of VCSE services and aggregated impact of disinvestment in the VCSE. VCSE organisations are facing significant cuts - and in some cases closure - including infrastructure organisations which enable sector involvement across the ICB. This is likely to result in increased demand on already overstretched mainstream NHS services and impact transformation work across health and care.
2109 (Both FPC and QC)	**16 (I4xL4)**	Clinical Outcomes: Cancer Risk - There is a risk that the ambition to deliver the national ambition in early-stage cancer diagnosis (reflected in ICS Ambition 3) will not be achieved due to workforce, capacity, technological, and other resourcing constraints - including the direct impacts of the Covid-19 pandemic, secondary mortality factors and delays to new asset investments such as Community Diagnostic Centres (CDCs). This would mean that one- and five-year survival rates for patients affected by cancer would not improve at the pace expected towards European comparators.
2313 (Both FPC and QC)	**15 (I3xL5)**	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.
2194 (Both FPC and QC)	**15 (I3xL5)**	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.

6. West Yorkshire ICB Common Risks

6.1 The West Yorkshire Risk Operational Group meets to identify common risks emerging from the place risk registers. This reports bi-monthly to the West Yorkshire ICB Board and quarterly to the West Yorkshire ICB Audit Committee with a request to report at each of the five places. The detail of these risks is set out at appendix five – common risks are highlighted in 'orange'.

6.2 Common risks are defined as place risks with a score of 15+ that have been identified as being common to more than one place, having the potential to impact multiple places, or requiring active management by a number of organisations.

7. West Yorkshire ICB Board Assurance Framework (BAF)

7.1 The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meeting its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks.

7.2 The ICB received an Internal Audit report that concluded with a 'limited assurance' rating, and made a number of recommendations for action, all of which have been approved by the ICB Audit Committee and Board. Each Place will contribute to the recommendations made which will form part of a full developmental review of the BAF over the coming months.

7.3 The BAF summary, heat map and Bradford District and Craven Health and Care Partnership Action Plan has been appended to this report (appendices six and seven) as information for the current position of the BAF.

8. Next steps

8.1 Following review by the Partnership Leadership Executive, the BDCH&CP Partnership Risk Register will be presented at the Partnership Sub Committees before concluding the second risk cycle at the BDC Partnership Board on the 6 September 2024. Any closed risks will be archived, open risks

carried forward to the next risk review cycle and this report will be escalated to the West Yorkshire ICB Board.

APPENDIX 1: Risk Scoring Matrices (Qualitative Measures of Consequence)

Consequence ▸	1. Insignificant	2. Minor	3. Moderate	4. Major	5. Catastrophic
Financial	£1k - £10k	Up to £50k	Up to £250k	Up to £1M	Over £1M
Harm	Minor bruises/ discomfort/ affects wellbeing.	Some minor injuries/ ill-health - minor. <3 days absence	Many minor injuries/ ill-health – temporarily incapacitating. RIDDOR reportable.	Some major injuries/ ill-health - permanently incapacitating	Multiple injuries/infections Unexpected Death
Disruption	One day Service disruption/1 or 2 staff absent.	One week Service disruption/<5 staff absent.	One month Service disruption/5-10 staff absent.	Up to 6 months Service disruption/11-20 staff absent.	6 months to 1 year Service disruption/21-50 staff absent.
Litigation	Replacement of property.	Replacement of property and finances.	Minor out-of-court settlement.	Civil action – no defence.	Criminal prosecution.
Damage	Minor property damage/ no environmental impacts.	Slight property damage/ impacts on internal environment.	Moderate property damage/impacts on local environment.	Severe property damage/impacts on local environment.	Loss of whole department/impacts on regional environment.
Reputation/ Confidentiality/Data Loss	Damage to individual's reputation. Minor breach of confidentiality. Minor complaint resolved within team.	Damage to team reputation. Temporary loss of information. Minor complaint resolved by local management.	Damage to Service reputation/local media coverage on day. Loss of information/ records. Some complaints resolved by Senior management.	Damage to Trust reputation/local media coverage <3 days. Irrecoverable loss of vital records/information. Complaints resolved by Chief Officer.	Damage to Health Authority reputation/ national media coverage <3 days. Prosecution under Data Protection legislation. Complaints resolved by Ombudsman or Healthcare Commission
Clinical care	No significant effect on quality of care provided	Noticeable effect on quality of care provided	Significant effect on quality of care provided	Patient care significantly impaired	Patient care impossible

Quality	Negligible negative impact on access, experience and /or outcomes for people with this protected characteristic. Negligible increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minimal injury requiring no/minimal intervention or treatment, peripheral element of treatment suboptimal and/or informal complaint/inquiry	Minor negative impact on access, experience and /or outcomes for people with this protected characteristic. Minor increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minor injury or illness, requiring minor intervention and overall treatment suboptimal"	Moderate negative impact on access, experience and /or outcomes for people with this protected characteristic. Moderate increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in moderate injury requiring professional intervention.	Major negative impact on access, experience and /or outcomes for people with this protected characteristic. Major increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to lead to major injury leading to long-term incapacity/disability	Catastrophic negative impact on access, experience and /or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, an event which impacts on a large number of patients, totally unacceptable level or effectiveness of treatment, gross failure of experience and does not meet required standards

Performance		Internal Standards not achievable	Repeated failure to meet internal standards	National Performance not achievable (Intermittent)	National Performance not achievable (Continuous)
Enforcing action	Audit non-conformance/advice from enforcers.	Breach of procedure/ Directive from enforcers.	Improvement Notice.	Prohibition Notice.	Government Investigation.

Qualitative Measures of Likelihood

LEVEL	DESCRIPTOR	DESCRIPTION
1	Rare	The event may occur only in exceptional circumstances
2	Unlikely	The event could occur at some time
3	Possible	The event should occur at some time.
4	Likely	The event will probably occur in most circumstances.
5	Almost Certain	The event is expected to occur.

Qualitative Risk Grading Matrix; Level of Risk = Consequences x Likelihood

Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
Insignificant 1	1	2	3	4	5

Score	Risk Level
1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-16	Serious risk
20-25	Critical risk

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
2447	25/07/2024	Both FPC and QC	Improve healthcare outcomes for residents	20	(I4xL5)	12	(I3xL4)	Ray Smith	Phillipa Hubbard	Renal Services Capacity - Renal Services Capacity There is a risk that as the demand for haemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity that it will not be possible to provide timely dialysis for some patients. Due to increasing demand within the local demographic and an aging and limited footprint, which has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the patient group. There is a high risk of increasing down time at the St Luke's site and the satellite unit at Skipton because of the aging infrastructure. Loss of either facility for an extended period would be unsustainable without seeking support from organisations both within and without the region.	Patients who cannot be dialysed in a timely way are monitored and clinically managed on a daily basis. BTHFT are providing twice weekly dialysis (instead of 3 sessions) where it is clinically appropriate. Patients who require urgent care through lack of timely dialysis can be brought to BTHFT for treatment as acute patients, however capacity to deliver this is very limited, and emergency/ reactive dialysis carries a high degree of risk of adverse outcomes and would place severe unsustainable stress our on call emergency dialysis service which should be reserved for acutely ill inpatients. Specialist nurse staffing is augmented by TNR and agency staff. Additional staffing capacity has been built into the rota using existing staff. Patients are encouraged to take up peritoneal dialysis where clinically appropriate and where possible with the restricted theatre availability. Additional resource has been put into our home therapies services to maximise opportunities for home haemodialysis and PD. We have introduced a fluoroscopic PD catheter insertion service and are strongly promoting home-based renal replacement therapies, including renal transplantation. Provision of an HD service requires specialist nursing skills which can be augmented by agency or TNR nurses. In the event of a sustained loss of facility, further mitigation would be implemented (but our staffing is also stretched and this would compromise the following additional steps): Services extended into overnight/out of hours 6 or 7 days a week. Further reduced dialysis sessions. Displacement of patients to other facilities potentially at some distance of travel. 03/05/24 - Skipton twilight shifts (Monday, Wednesday and Fridav) are now open.	The additional capacity which has been created at Skipton by opening twilight sessions is predicted to be filled within 6 months.	Reporting progress through System Quality Committee. Reporting through Executive Team meetings and Quality and Patient Safety Academy at BTHFT.	Reporting progress through System Quality Committee. Reporting through Executive Team meetings and Quality and Patient Safety Academy at BTHFT.	N/A			New - Open
2433	29/04/2024	F&P Comm	Enhance productivity and value for money	20	(I5xL4)	16	(I4xL4)	Mike Woodhead	Robert Maden	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	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. - Additional financial controls implemented across the NHS system in line with NHSE requirements. - Closing the Gap Programme Board established with clear mandate reporting into PLE and FPC. - Business Case Appraisal Panel established with a clear appraisal and scoring process for considering cases for investment/disinvestment.	Savings not fully identified. No contingency reserves to manage in-year pressures. National pressures outside local control, e.g strike action. System wider review of allocative efficiency and value not yet completed.	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. - Closing the Gap Programme Board reports to FPC, PLE and the Partnership Board to provide assurance on the recommendations made from the Business Case Appraisal Panel.	Quarter 1 system wide check and challenge session scheduled for the 1st of August 24. Phase 1 of the system wide service review complete and externally facilitated workshop scheduled for Sept 24.	N/A			Decreasing
2337	28/06/2023	PCF/FPC	Enhance productivity and value for money	20	(I4xL5)	9	(I3xL3)	Mike Woodhead	Robert Maden	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	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. Additional financial controls implemented across the NHS system in line with NHSE requirements. Closing the Gap Programme Board established with clear mandate reporting into PLE and FPC. Business Case Appraisal Panel established with a clear appraisal and scoring process for considering cases for investment/disinvestment.	Development of a medium term strategic financial plan to demonstrate the path to recurrent balance. Development of 5 year plan is underway in line with national timelines. 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 wider review of allocative efficiency and value not yet completed.	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. Quarter 1 system wide check and challenge session scheduled for the 1st of August 24. Phase 1 of the system wide service review complete and externally facilitated workshop scheduled for Sept 24.	Insufficient recurrent waste reduction / savings plans in place. Follows the control gap in relation to clarity on the outcomes of priority programme's transformation work which once achieved will enable reporting on the impact of priority programme work.			Static - 6 Archive(s)
2314	05/06/2023	FPC/QC/PCF/PLE/PB	Improve healthcare outcomes for residents	20	(I5xL4)	15	(I3xL5)	Nancy O'Neill	Therese Patten	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).	SRO for new hospital Director of Strategy, Planning & Partnerships; and SRO for Estates including RAAC Chief Operating Officer. Management groups established: - Securing the future committee; Security the future Programme Board; and Securing the future delivery group with responsibility for the planning and co-ordination building the new hospital and management of RAAC remedial works. External groups: - 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. Other controls: 1. Remedial works funding with NHSE approval for £15m in 2024/25 to address structural works. 2. 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. 3. Business continuity plan has been developed which describes the transfer of activity to other trusts in WYH to maintain patient safety and services. Patient safety plans developed via EPRR to transfer activity to other WYAAT Trusts. 4. Process in place for monitoring the prevalence of deterioration over time and reporting to NHSE 5. Process in place for escalating new risks relating to deterioration and call-off contract with structural engineers to seek advice on most appropriate structural solutions. 6. Active participation in the regional RAAC Quality and Risk Summits to identify themes and trends over time and escalate as required. 7. Regular Site Insoections	1. Identification of medium term (potentially years) of continuity of service provision plan. How to provide the service without viable estate at the AGH site. 2. Structural engineers have advised that the hospital needs to be replaced no later than 2030. 3. The multi-agency RAAC emergency evacuation response protocol has been approved by the WY Resilience Forum and the Local Health Resilience Partnership. 4. The draft NEY Regional Hospital Evacuation Framework has been shared for comment in Feb 2024 and this will be used to inform the development of the WY hospital evacuation plan and so the date fot that WY plan to be completed has been extended beyond Q4 2023/24. 5. Unable to ferro scan all of the building. Update - November 23 - emerging industry scanning available - moved from Gaps to Assurances 6. Situation extends beyond RAAC panels as deterioration in structural frame, corbels. This is now a routine process. 7. Operations director for RAAC (this role also interfaces with new hosptial programme) not yet appointed to 8. Business case process for national funding beyond 2024/25 for remedial work and maintenance of RAAC has not yet been notified	- 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 held on the multi-agency RAAC protocol (6 June 2023). A further exercise to be scheduled, but date not yet agreed. - Protocol for the identification and management of RAAC which is approved by independent engineers. - 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. - Reports to Executive RAAC assurance group - Risk summit discussions - Meeting with NHS England national RAAC team - Update - November 23 - emerging industry scanning available - moved from Gaps to Assurances - Update Nov 23 - guidance on degregation of panels published. We are compliant - 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.	- Emergency planning exercise 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. - Latest national research programme guidance was published in the spring of 2023 and AFT are applying the learning from this guidance. - Deterioration in line with previous baseline 2021/22 comparison with 2022/23 5/7% deterioration with 37% of planks with defect.	The national RAAC maintenance allocation is for three years (2023/24 is year 2). For years 2 and 3 there is insufficient funding to meet the maintenance requirements. For 2023/24 (year 2) the shortfall is £3m. However, a further £2m has been secured from NHSE to progress with structural work, this leaves a shortfall of £1m. For 2024/25 is the final year of funding allocation and there is uncertainty beyond March 2025 with the expectation of a need for further bids. 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.			Static - 4 Archive(s)

2312	05/06/2023	FPC/QC/PCF/PLE/PB	Improve healthcare outcomes for residents	20	(5xL4)	15	(3xL5)	Lesley Tillotson	Nancy O'Neill	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - Although Airedale NHS Foundation Trust has been successful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030, there is a risk that the funds do not flow as quickly as required, resulting in a failure to open the new hospital before the current one ceases to be viable (engineers estimate 2030) (or earlier if a significant RAAC incident occurs - see related risk number 2314). Further, Airedale NHS Foundation Trust must submit a new application for funds in 2024/25, relating to the next Comprehensive Spending Review and there is a risk that this process may result in a hiatus mid-programme.	1. Programme team has secured the future for the new hospitals programme. With the New Hospital Programme committing to complete the Airedale project by 2030. 2. Securing the Future Committee and Programme Board to oversee New Hospital Programme and remedial RAAC works established from November 2023 3. SRO Role for new hospital has been appointed in April 24, Securing the Future Programme Director (umbrella title for both RAAC and NHP) 4. Liaison with National NHP	1. Structural engineers have advised that the hospital needs to be replaced no later than 2030. 2. Long term programme approach to be developed 3. Clarity on exact funding settlement 4. Clarity on full Hospital 2.0 requirements 5. 2024 will be an election year and uncertainty in relation to how the election may impact on the New Hospitals Programme	1. 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. 2. Place on NHP 3. Programme support funding and Enabling Works submission show programme is progressing forward 5. Securing the Future board reports to programme board and committee 6. Execs RAAC reports 7. ANHSFT BAF links to risk register to provide assurance	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.	N/A		There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to delivery consistently high quality care.	Static - 5 Archive(s)
2215	13/01/2023	PCF/FPC/QC	Tackle inequalities in access, experience, outcome	20	(4xL5)	2	(2xL1)	Mike Woodhead	Robert Maden	LYNFIELD MOUNT HOSPITAL - There is a risk of delivering poor quality health care with a negative impact on patient safety including infection prevention and control, service user experience including privacy and dignity, additional costs for out of area bed usage and negative impact on staff wellbeing, recruitment and retention and on the organisation's reputation. This is due to the deteriorating and failing physical condition of Lynfield Mount Hospital building with £68m backlog maintenance as well being an estate requiring redevelopment this out-of-date estate has insufficient therapeutic space, large ward sizes and a lack of ensuite bathrooms. This is resulting in poor quality environment of care, issues with sewage flooding, heating systems, escalating maintenance costs and impacts on recovery leading to an increased average LOS consistently 60 days which is double than the national average of 30 days.	Outline Business Care updated. Expression of interest for £90m NHP scheme submitted (but not approved in the latest round and no foreseeable change in that position). Joint Expression of Interest for NHP funding submitted with AGH and BTHFT (but not approved in the latest round and no foreseeable change in that position). 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. Limited enabling works on the car park have commenced on the main site.	Uncertainty regarding NHS funding available nationally, & locally. No funding approved in latest NHP round. No ICS funding available under current arrangements (though this is being challenged). This has been challenged. An ICS capital workshop in July saw most organisations in favour of distributing some ICB capital funding for smaller strategic projects like LMH, but WYATT Chief Executives have since blocked that. WY SOAG meeting considered the issue but, without a consensus, we are stuck with the status quo. We will continue to challenge this and push for a system-wide prioritisation approach. In the meantime, we will work with ICS partners to make sure LMH is featured as a pri 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; *Improving inpatient flow	- 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. 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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; *Improving inpatient flow	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 (e.g. contributing >£10m p.a. in pressures re agency staff, OAPs and excess reactive maintenance costs; wasting a further c£3m p.a. (capital) on short-term planned maintenance solutions; and risking tens of £ms in further OAP costs if wards need to close). Additional pressures that are unsustainable. Additional pressures on workforce that are unsustainable.			Static - 9 Archive(s)
2173	17/10/2022	PCF/FPC	Enhance productivity and value for money	20	(5xL4)	12	(4xL3)	Mike Woodhead	Iain MacBeath	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures.	Working with BMDC and the Children's Trust 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. BMDC are in discussions with the Department for Levelling Up and Communities. an independent Advisory Panel has been established to oversee any major budget decisions and strategies and progress against the government best value notice, the first meeting is scheduled for the 7 Aug 24. Exceptional Financial Support has been received from the government and so a section 114 notice will not be issued. Agreement on financial assistance from Department for Levelling Up and Communities has been received. CIPFA external review on the 12 August.	Clarity on Health flexibilities for system support. Medium term financial term financial plan agreed at executive in July 24 that brings the Council back to a sustainable balanced budget (£40M out of £120M identified).	System Finance and Performance Committee review of options and system impact. BDC HCP Partnership Board PLE and FPC have sight of position. Internal governance processes within BMDC.	Initial session held by system DoFs to understand BMDC position and options already considered to manage the position. Follow-up session was on 25th October, oversight is now maintained. Winter Plan was finalised to help manage system pressures. Better Care Fund for 24/25 agreed between partners inclusive of the national discharge funding.	Meeting to commence to discuss financial interfaces between the NHS and Local Authority.			Static - 1 Archive(s)
2386	09/10/2023	FPC/QC/PCF/PLE/PB	Improve healthcare outcomes for residents	16	(4xL4)	12	(4xL3)	Sam Keighley	Sam Keighley	There is a strong and increasing risk to the sustainability of the VCSE sector. This includes the risk of VCSE organisations and services across Bradford District and Craven closing or reducing their delivery or activities. The risks centre around financial sustainability, ability to recruit and retain staff (especially due to employment uncertainty and cost of living) and the decision to withdraw the VCSE infrastructure contract due to local authority budget pressures. All these issues ultimately decrease the sector's resilience and sustainability and would decrease its capacity to engage with the system. This in turn has a knock-on effect on the wider health and care system, both in terms of increase usage of statutory services and a reduction in proactive preventative work to tackle inequalities.	• VCSE voices in key decision making arenas and partnerships • VCSE system lead post holder involved in Wellbeing Board, priority boards, ICB, PLE, PLT and other key decision making bodies including Adult Social Care commissioning strategy • VCSE and commissioner forum in place with a remit to develop and conversations in place about shared approaches to commissioning • Development of a refocused activation contract to strengthen a new way of working due to changes in infrastructure, this includes an interim arrangement being co-designed so we retain staff in the sector • VCSE Representation on the 'Business Case Approval Panel' and 'Closing the Gap Programme', ensuring decisions consider the views and impact on all partners	• An annual programme (4 – 6 days a year) of visits to VCSE organisations so public sector staff better understand the value, pressures and circumstances of VCSE organisations across the BDC footprint (building on successful pilot. To be established in 2024) • System wide commissioning strategy (to be developed from or replacing Adult social care one) • System support to enable VCSE organisations delivering health and care services to ensure they have robust and effective IG systems. • Priority workstreams shift mainstream funding to the VCSE (Modelling Healthy Minds) • Comprehensive forward plan of investment in the sector • PLE Sponsor identified to champion / hold accountability for the early achievement of the 4 financial VCSE sustainability conditions agreed in December 2022 • PLE Sponsor identified to support / hold accountability for the acceleration of conversations about creating a system wide shared set of data to measure VCSE impact. • While controls are in place, the cut to the infrastructure contract has and will continue to impact our VCSE sector and our health and care partnership with the potential of reduced input at key strategic meetings due to VCSE sector capacity restraints	• Infrastructure contract monitoring and evaluation • Assurance activities at key system meetings (e.g. Reports from VCS system lead / advocates; deep dive events at ICB/PLE/PLT) • VSCE leaders network and associated network • Recruitment of Insight, Data and Learning manager to have oversight of sustainability of the sector risk	• Collaborative conversations have begun between council and health commissioners and VCSE ho's to look at co-designing a reduced and repurposed contract that focuses specifically on reducing pressure on services and achieving priorities. • Mapping is still in process to allow for mitigation of this risk. • Development of a refocused activation contract to strengthen a new way of working due to changes in infrastructure, this includes an interim arrangement being co-designed so we retain staff in the sector	• Lack of reliable real time information on the organisational and financial sustainability of the sector. • The reduction in the Bradford infrastructure contract is likely to impact on the assurance activities and active involvement of the VCSE in all strategic meetings due to reduced financial and human resource			Static - 1 Archive(s)
2266	03/04/2023	BDC PLT/ PCF	Tackle inequalities in access, experience, outcome	16	(4xL4)	4	(2xL2)	Walter O'Neil	Sasha Bhat	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	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. Business case has been completed and has gone through the Healthy Minds Board and PLT and is due to go to the Finance and Performance and Quality Committees and PLE in February 2024. Right to Choose project group has been formed, reporting to the WY Neurodiversity program, with a focus on developing a WY accreditation process for prospective RTC ADHD services	A sustainable model of delivery of ND assessments across children and adults being worked up at West Yorkshire level. Furthering health inequalities by not being transparent to the population's constitutional Right to Choose and making sure this route is accessible to all. Shared care agreements between private providers and GPs remain problematic and inconsistent and quality assurance from private providers around assessment is an issue, leading to duplication in some cases.	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 September 23 - advice to be sought on if this is corporate risk. WY programme being developed, specifically around Right to Choose, AQP and shared care. Depending on the outcome of the business case work might be needed to address the gap with health inequalities and advertise Right to Choose with our population.	All invoices are checked to ensure no VAT added and to ensure on NHS framework	An uncontrolled cost- this is arranged via GP and provider with no ICB oversight until assessment is completed. This is a national issue.			Static - 7 Archive(s)

2039	11/07/2022	PCF/FPC/QC	Improve healthcare outcomes for residents	16	(I4xL4)	6	(I3xL2)	Emma Hughes	Sasha Bhat	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. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.	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 Business case has been completed and has gone through the Healthy Minds board and PLT and is due to go to the Finance and Performance and Quality Committees and PLE in February 2024.	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. Supply issues with ADHD medication which has impacted on increasing ADHD medication backlogs. Medication expected to be available again in April 2024 which means there will need to be a programme of catch up. .			Static - 11 Archive(s)
2227	02/02/2023	PCF/FPC/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 quality and outcomes between NHS and IS providers of ADHD Assessment/Diagnosis services.	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 2023/24; BDCFT have allocated additional non-recurrent financial resource to increase BANDS ADHD capacity. Uncertainty as to whether the funding will continue into 24/25. If additional funding is not sourced an EQIA would be needed to understand the impact.	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 April 24 The CYP business case is due to be heard at closing the gap in May.	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. Nov/Dec 2023; Costed business plan with revised Adult ADHD pathway to be presented to Healty Minds Board. Dec 2023 Draft business plan with revised Adult ADHD pathway has been prepared and further work needs to be undertaken.	Briefing on current state of BANDS adult ADHD to PLT. Briefing and initial proposals have been presented to Healthy Minds PB. Monthly data reporting to commissioners. Dec 2023 Project team meetings were held in Dec 2023 to develop new Partnership Adult ADHD Pathway. Some improvement in service capacity from August 2023 due to additional investment from BDCFT. Medium to long term mitigation of risk dependent on securing additional investment to manage growing demand. If additional funding is not sourced an EQIA would be needed to understand the impact.	KPIs for the service are being revised and reporting will be improved. Project group under the Healthy Minds PB to be established.			Static - 8 Archive(s)
2168	17/10/2022	PCF/FPC	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.	ystem 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 Recovery plans submitted as part of 2023/24 operational planning process. Delivery will be monitored via SF&P Recovery plans being built into SF&P dashboard. 16.04.24: The system dashboard has been aligned to each of the priority programmes to demonstrate delivery of programme objectives and contribution towards national targets. July - 2024 Operational plan for 202425 finalised and signed off at the end of May 2024.	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 A detailed quality metrics dashboard is being developed for the system	Recovery plans submitted Dashboard showing good progress against plans July 2024 - Additional CDC diagnostics capacity now available which will improve wait times performance. Co-located UTC in operation from the 25th July to support improvement in A&E waiting times.	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. The current financial position and plans to close the financial gap will impact on the delivery of national targets July 2024 - risk score remains unchanged as whilst recovery plans are in the main on track, performance is below key NHS constitution standards in some areas. Potential adverse performance impact if GP industrial action proceeds (separate risk to cross reference to).			Static - 10 Archive(s)

Risks Report Summary

CCG: Bradford District and Craven Health and Care Partn

Archive Deadline: 25/09/2024

New Risks: 2

Total Risks: 27

Old Risks: 25

Marked for Closure: 2

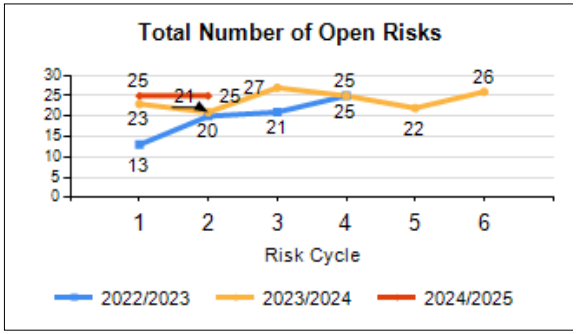
Risk Cycle 2 – June – September 2024

Bradford District and Craven Health and Care Partnership
Corporate Risk on a Page Report

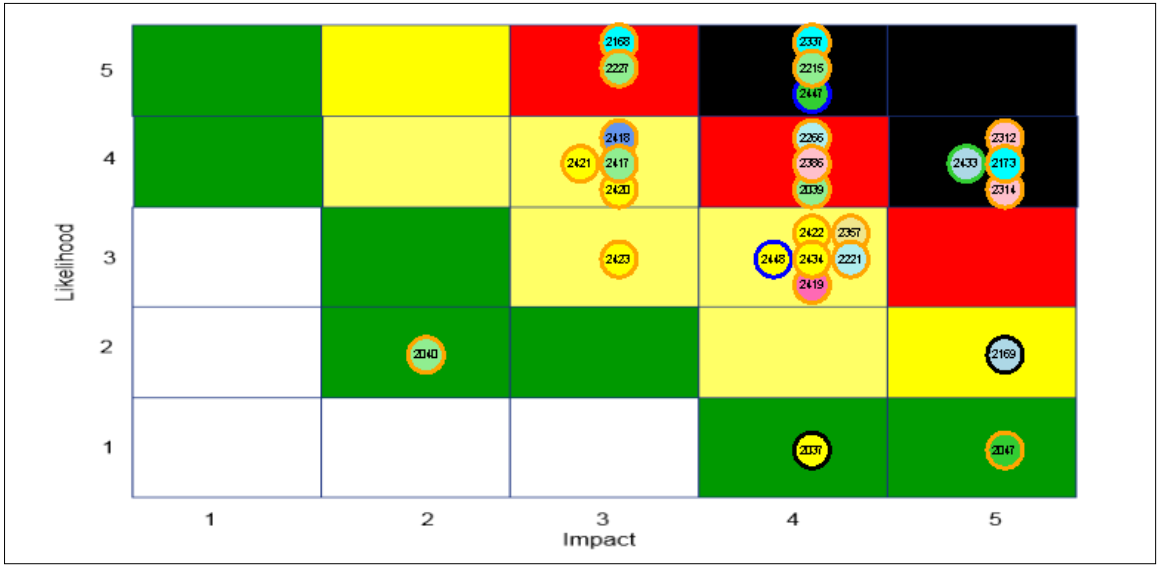
NHS West Yorkshire Integrated Care Board

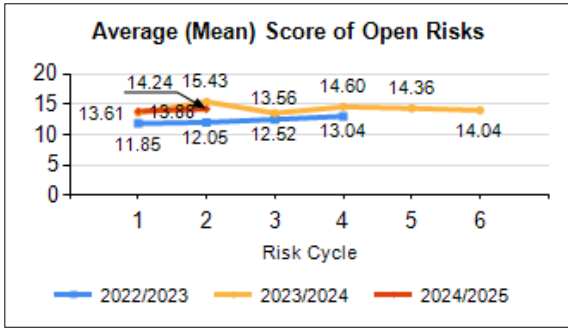
Total Risks		27
finance and performance		2
Quality		5
Finance, performance and quality		7
Other (including commissioning and priority programmes		13

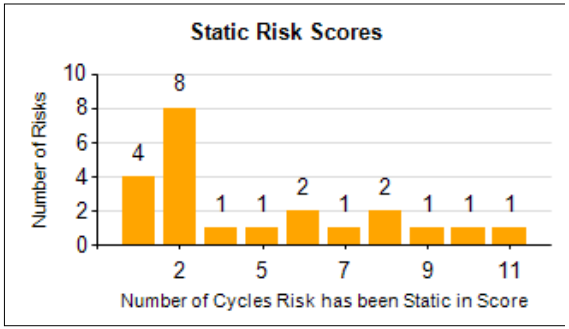
Movement of Risks		Risk score increasing	0
New	2	Risk score static	22
Marked for closure	2	Risk score decreasing	1



Risk Overview







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	Risk Status
2437	10/05/2024	Quality	Tackle inequalities in access, experience, outcomes	20	(I4xL5)	16	(I4xL4)	Kathryn Giles	Ian Holmes	There is a risk to patient care and safety due to GP Collective Action from 1st August 24, resulting in disruption to service delivery, reduced access to core provision and some enhanced service provision, impacting; Health Inequalities Resilience and pressure on wider service provision, including, Urgent and Emergency Care - A&E, 111 and out of Hours Secondary Care elective Public health programmes, Immunisations and Vaccinations Community Pharmacy	Scenario Planning led by the Director of Planning and Performance has been undertaken to support preparation, assess system risks and detail mitigating actions. Continued place engagement with LMCs to be kept informed and to understand local GP practice actions. Regular WY system touch point meetings to report and share key risks, weekly GP Action calls, fortnightly regional collective action touchpoint calls. Work to support place consistent messages, approach and actions when appropriate. - Acceleration of actions to ensure OPEL consistency to support reporting and action. SDF agreed to support Resilience Links through NHSE region to NEY ICBs - share approaches and protocols Communications to public and key stakeholders - toolkit developed	This action is different to Industrial action, and more difficult to plan for. Practices can agree which and how many actions to implement out of 10 actions published by the BMA. Practices do not have to inform commissioners which actions are being implemented.	We continue to work closely with NHSE and primary care leads across places and LMCs to maintain oversight and gather any intelligence we can. We are connecting with NHS Confederation nationally to share intelligence with other systems.	Routine monitoring - OPEL	Understanding the knock on consequences on all parts of the system and the full impact on service provision and service users.	Increasing
2432	24/04/2024	Finance, Investment and Performance	Improve healthcare outcomes for residents	20	(I5xL4)	20	(I5xL4)	Laura Siddall	Anthony Kealy	PANDEMIC There is a risk that a pandemic will occur due to a novel pathogen (such as viruses, bacteria, fungi, uni and multicellular eukaryotes) and due to a lack of population immunity this will result in the pandemic spreading quickly around the world. This could result in a reasonable worst-case scenario (RWCS) (taken from the National Risk Register) of an unmitigated pandemic with an unassumed transmission route and a high attack rate, with 4% of symptomatic infections requiring hospital care and a case fatality ratio of 2.5%. The RWCS assumes 50% of the UK's population fall ill during the whole course of the pandemic, with around 1.34 million people requiring hospital treatment and approximately 840,000 deaths.	# A YH working group is being established to review the YH pandemic plan. # Global disease surveillance and early warning system for emerging zoonoses, including early detection system in UK # Tiered plans in place (national, regional, county, health economy) e.g. UK Health Security Agency Pandemic Influenza Response Plan # LRF plans: fuel plans, management of excess deaths, mass casualties, mass fatalities, temporary mortuaries # Organisational business continuity plans # Health service and social service capacity plans # National plans for prioritising distribution of anti-viral drugs # Vaccine programme - longer term measure # Public awareness - mechanisms in place for informing public and professionals through joint media plans, NHS111, TV and advertising campaigns # Mass medication protocol # Personal Protective Equipment (PPE) purchased for health professionals and local authority care providers # Testing and tracing arrangements for COVID-19 could be resurrected # COVID-19 experience of social distancing practice in general population and capability to work at home where possible	# Local and national debriefs following COVID-19 # Up to date Y&H Pandemic Influenza Plan # Review of local authority outbreak plans required	# UKHSA surveillance: Real time syndromic surveillance such as admissions, Primary care, ambulance service. # UKHSA surveillance systems for monitoring vaccine preventable diseases. # National flu and COVID-19 surveillance reports. # Weekly all-cause mortality via EuroMoMo # Reporting from providers, such as acute trusts, community providers, GPs, voluntary organisations and local authority	# Reporting by WHO, UKHSA and local authority level health protection committees # Response to managing recent measles outbreaks.	# Exercising of regional and local outbreak plans required.	Closed - Moved to BAF
2430	22/04/2024	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	12	(I4xL3)	Adrian North	Jonathan Webb	There is a risk that the ICS will not deliver the 2024/25 financial requirement of breakeven. On 21 March the ICS submitted a deficit plan to NHS England of £153.7m. Whilst work continues to reduce this deficit plan, it is unlikely a break even plan will be submitted for the final deadline of 2 May. UPDATE 11/7/24: A revised financial plan was submitted on 12 June which was a system deficit of £50m, predicated on delivering efficiencies of £434m of efficiencies (7.7% of allocation). Failure to deliver a break even position will resulting in reputational damage to the ICS/ICB , additional scrutiny from NHS England, and a requirement to make good deficits incurred in future year.	1. Agreement of West Yorkshire ICS 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. Working to reintroduce the transformation and efficiency group within the ICB to focus on key strategic and system efficiency opportunities; UPDATE 11/7/24: Currently refreshing ToR in advance of relaunch of TEG. 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 System Oversight and Assurance Group 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 3. All plan submissions approved via each individual organisational governance routes.	1. Further review of risks and mitigations leading to additional unmitigated risk with no formal route to address	Static - 1 Archive(s)
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. There is now increased focus on developing a new model, including potential day-hospital provision for eating disorders between the provider collaborative and WY places.	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. Variation in some of the community support available to CYP with Complex Needs has been highlighted in recent escalation cases	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. We have seen new services open such as The Croft in Wakefield that is supporting CYP within OFSTED registered premises, reducing the need to consider inpatient referral. CYPMH Thematic Reviews based on admissions into Red Kite View are identifying circumstances that result in an inpatient admission to drive further learning for the whole system. This has identified the need for a focus on eating disorder provision. EMT recognise the impact of the risk but the likelihood is smaller than previously thought due to low numbers of CYP likely to be affected	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.	Static - 6 Archive(s)
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. We are also supporting the NEY region in considering more consistent approaches to pressures specifically within ADHD services.	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. There remain a range of views across both services, commissioners and people with lived experience regarding where WY focus should be in supporting Neurodivergence which we continue to work through following the summits but gaining consensus is not easy.	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. ICB Board confirmed that prioritisation of funding for Neurodiversity will be considered as part of Medium-term financial planning Neurodiversity Summits held to bring a range of system partners together to discuss collective challenges and identify a vision for the future. Prioritisation of actions from the summits have been discussed via the ND Steering Group and MHLDA Partnership Board but there is not yet consensus on how to proceed between priorities at place and priorities at system level, therefore a further exercise is taking place to finalise.	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.	Static - 6 Archive(s)

2202	01/12/2022	Finance, Investment and Performance	Enhance productivity and value for money	20 (I4xL5)	6 (I3xL2)	Adrian North	Jonathan Webb	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures.	1. Working with councils in ICB places to understand the issues, options being considered and the potential impact on system partners. 2. Review use of intermediate care capacity 3. System leadership oversight and consideration of options to minimise impact	1. WY councils are separate statutory organisations with no NHS oversight 2. Lack of clarity on funding options	1. System oversight of wider health and care financial position	1. Close working relationships between the NHS and councils in place and representation of councils on system partnership board 2. Additional government funding to support social care pressures - £500m national discharge / socil care funding recently announced 3. Establishment of ICS discharge group considering all options across the system	1. Potential pre-commitments in councils and in the NHS on the use of additional funding unclear.	Static - 2 Archive(s)
2166	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	20 (I4xL5)	12 (I4xL3)	Nichola Stephens	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 was 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. Bi-monthly WY cyber network meetings are now in place to develop a WY strategy and progress the action plan.	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. Annual war games activities for digital and business colleagues to review plans around business continuity in the event of a cyber attack. WY cyber network has now been established to share best practice examples and enable more strategic approaches to cyber assurance. WY cyber funding allocation has been notified. Awaiting approval of funding.	No funding allocation for ICS cyber resources	Static - 7 Archive(s)
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 and offices so that patients and staff can be decanted out of RAAC areas while repair work takes place and can be used if areas need to be evacuated. * NHS England NEY published a draft NEY Evacuation Framework for comment, which sets out how the evacuation of any hospital in NEY would be managed. * National funding to build a new hospital for ANSHFT by 2030 was confirmed in May 2023.	* Once the NEY Evacuation Framework is finalised it will provide additional information such as the numbers of patients to be dispersed to each hospital if an evacuation takes place. * 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. * 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. * In the recent EPRR annual assurance, WY ICB was marked as partially compliant for the evacuation and shelter standard and so further work is needed to increase compliance.	08/07/24 - NHSE NEY has asked ICBs to undertake an exercise in Q2 and Q3 2024/25 to test mass casualty arrangements and inform the update of the NEY Mass Casualty Framework. This will strengthen arrangements needed if hospitals need to rapidly create capacity within their hospital to accept patients that have been evacuated from Airedale Hospital. Update (10/04/24) The multi-agency RAAC protocol has been signed off by the WY Resilience Forum Interoperability Subgroup and the WY Local Health Resilience Partnership. Update (29/01/24) Latest version of the multi-agency RAAC protocol is due to be signed off at the WYRF Interoperability Subgroup in Feb 2024. Update (25/09/23) Nationally, all NHS organisations have been asked to implement the findings from the East of England RAAC exercise. A new report is expected from East of England and ANHSFT, WY ICB and NHSE will review the findings from the new report. Update (22/08/23) An exercise to test the multi-agency RAAC response protocol was held on 6 June 2023, involving Airedale NHS FT, NHS England, WY ICB, local authorities, police, fire, YAS and other agencies. Learning from this exercise is being used to enhance plans. 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.	- 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 - 11 Archive(s)
2451	05/08/2024	Quality	Improve healthcare outcomes for residents	16 (I4xL4)	9 (I3xL3)	Keir Shillaker	James Thomas	There is a risk that changes in the national Gender identity providers and associated, increasing waits, result in more support for CYP/Families at a local level.	CAMHS providers are working together to ensure consistency of approach in supporting requests from NHSE to risk assess local CYP. Prescribing leads engaged in process to ensure clarity of approach in terms of use of puberty blockers/ hormone therapy (if previously prescribed). Working with Barnardo's to ensure CYP and services aware of Positive Identities service to ensure "waiting well"	Lack of detail from ARDGEM referral unit in terms of numbers of CYP needing local support. Lack of information about how waiting times are going to be managed at national level eg phase 2 services in each region, how CYP "aged out" will be supported when adult services have long waits too, and role of primary care and other services. Waiting NHSE guidance on new referral policy where referrals will need to go through CAMHS or Paediatrics. Current referral rates into CYPMH look low - only 11 cases being badged as WY ICB cases and we are asking the referral unit to review this as we know there are 250 individuals that have consented across NEY and neighbouring ICBs have between 65-85 each	Connections made across local services to ensure consistency. Activity and requests for support will be monitored	Barnardo's service seeing an increase in referrals (including self referrals) since promotion of their Positive identities service. Healthier together resources are being pulled together to help both professionals and parent/carers.	Request to support CYP currently waiting and £9k award to each CAMHS provider only for this year 24/25 but waits likely to be much longer than this. Need to keep monitoring what level of support is being asked for locally and whether we can fulfil this request	New - Open
2400	27/12/2023	Quality	Tackle inequalities in access, experience, outcomes	16 (I4xL4)	6 (I3xL2)	Louise Fletcher	Beverley Geary	There is a risk that initial health assessments and review health assessments will not be completed within the statutory time frames due to resource issues, increased demand and complexity within the Children in Care (CIC) Teams across West Yorkshire. This could result in health needs assessments of CiC being delayed and out of area children placed in West Yorkshire area being significantly delayed. This could result in the health needs of these vulnerable children not being met.	CIC Teams across West Yorkshire have produced *Standing Operating Procedures (SOP's) in place across West Yorkshire *Teams are using Banks Nurses to support. *Currently service review processes in place to consider efficiencies and business cases have been submitted in Leeds and Bradford. *Hybrid models currently in use. *Each place is reviewing all outstanding statutory reviews to enable prioritisation *There is an increased reliance on other services to inform of health issues and signpost accordingly.	*A review of the commissioning arrangements in each area * Demand and capacity assessment to be undertaken to look at improving resources. *Outstanding business cases need actioning. * in some places there is a lack of staff to meet statutory requirements compounded by long term sickness. *Combined Designated nurse role for Safeguarding and Children looked after does not provide the strategic oversight required *Consider a Single Point of Contact (SPOC) into health provision. *Lack of capacity to attend to wider strategic and operational work.	The West Yorkshire CIC Group is : *looking at ways a standardised approach to reduce unwarranted variation *Connects with Regional and National Groups *Ensuring robust processes and procedures are in place. * Review Performance Monitoring is undertaken at each place *West Yorkshire Thematic CIC review completed *Reports into place provider Safeguarding Committees, Corporate Parenting Boards and Safeguarding Oversight and Assurance Partnership Regular 'place' Triage Meetings of caseloads and oversight of those children waiting for assessment *Written Statement Of Action in response to SEND inspection and improvements to date.	None identified at this stage	Fluidity of assurance due to changing circumstances	Static - 3 Archive(s)
2391	08/11/2023	Quality	Tackle inequalities in access, experience, outcomes	16 (I4xL4)	9 (I3xL3)	Sarah Smith	Beverley Geary	There is a risk that increasing numbers of people seeking asylum placed in WY and the Home Office Policy decision to implement double occupancy for contingency accommodation, will place significant demand on services and add additional pressure onto service providers. This could result in an increased risk safety and safeguarding concerns, potentially resulting in poor experience, increased harm and poor outcomes .	WY oversight on risks and issues to be reported at SQG and escalated to appropriate forum, if applicable. Place based groups established to manage local service challenges. Regional Board NE&Y with WY representation. Following SOAG discussion a WY group is being established to provide oversight on emerging population and system risks. Once the group has met a clearer plan for mitigation will be established.	Engagement with Home office/MEARS as immigration provider in managing the number; nature and timing of migrants brought into hotel accommodation. Formal reporting structures being enacted between Immigration Services and Health and Social Care Providers.	Recent IMT - strong health and social care partnership arrangements to support health and care needs of migrants. Correspondence to Mears/ Home office	None identified	Home Office relationships and engagement. Shared health information to effectively manage the services.	Static - 4 Archive(s)

2232	09/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	9	(I3xL3)	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 5. Work to develop an infrastructure strategy for West Yorkshire (due to complete March 2024)	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 3. Confirmation that Airedale and Leeds schemes are both within national hospitals programme.	Robust assurance not yet fully provided through WY FIPC.	Static - 3 Archive(s)
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. First round of international recruitment unsuccessful, alternative routes now being pursued. 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.	Work on model is progressing well; intention to bring into full business case Engagement events undertaken	None identified	Static - 10 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 who are ready to be discharged but unable to leave due to capacity issues in social care and community services, will add extra pressure on the workforce and reduce 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 no longer meeting the Criteria to Reside. Participation in the West Yorkshire ICS Discharge programme development and implementation. WYAAT group established as part of UEC programme to share best practice to support flow and ensure consistent definitions / data. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Plans for protected elective hub sites due for implementation in 24/25 to enable continuation of elective activity during periods of significant non - elective activity.	Workforce capacity gaps in social care services remain high. Despite mitigations, there continue to be high numbers of patients in hospitals with who no longer meet the criteria to reside. Some improvements in bed occupancy during summer months but risk remains high in winter. Financial pressures in local authorities remains a risk to non - statutory services such as intermediate care provision being decommissioned.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified	Static - 10 Archive(s)
2120	07/09/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	16	(I4xL4)	Jo-Anne Baker	Ian Holmes	There is an increasing risk of a widening of health inequalities and poorer health outcomes across West Yorkshire due to the reduction or loss of VCSE services and aggregated impact of disinvestment in the VCSE. VCSE organisations are facing significant cuts - and in some cases closure - including infrastructure organisations which enable sector involvement across the ICB. This us likely to result in increased demand on already overstretched mainstream NHS services and impact transformation work across health and care.	- VCSE procurement framework clearly set out in new ICB Procurement Policy - Keep it Local – actively applying the 6 priorities of being a Keep it Local ICS; keep it local delivery plan - VCSE finance lead (Karen Parkin) now in place to ensure oversight and scrutiny of VCSE investment - Analysis of current funding at place and WY level underway – but data is proving inconsistent and analysis inaccurate	- Lack of a long term sustainable VCSE investment model - No clear plan to deliver on the ICBs commitment to a shift to investment in prevention and community based service models - Ensuring all place based VCSE infrastructure organisations have adequate, long term funding - Inconsistency and inaccuracies in VCSE investment data at system and place levels	- Power of Communities (PoC) Board intelligence and feedback - ICB oversight of investment levels in VCSE - VCSE research and surveys - Monitoring and oversight of Keep It Local delivery plan - PoC governance structures also provide the space to be sighted on and responsive to changes at place and system level, including VCSE representation on the WY ICB and Place Committees of the WY ICB	- Clear commitment to VCSE in ICB Strategy and refreshed JFP - ICB commitment to Keep it Local principles and embedding these across the system - Letter from Jonathon Webb and Kim Shutler to Accountable Officers requesting a position update on VCSE (including disinvestment) - responses due August 24 SOAG meeting to inform September ICB Board meeting	- Lack of clarity re aggravated disinvestment in VCSE across West Yorkshire - Lack of insight and data leading to an inability to understand and respond to changes that may impact sustainability of the sector, increased demand on statutory services, and consequent impact on communities.	Static - 5 Archive(s)
2109	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	6	(I2xL3)	Jason Pawluk	James Thomas	Clinical Outcomes: Cancer Risk - There is a risk that the ambition to deliver the national ambition in early stage cancer diagnosis (reflected in ICS Ambition 3) will not be achieved due to workforce, capacity, technological, and other resourcing constraints - including the direct impacts of the Covid-19 pandemic, secondary mortality factors and delays to new asset investments such as Community Diagnostic Centres (CDCs). This would mean that one and five year survival rates for patients affected by cancer would not improve at the pace expected towards European comparators.	The Cancer Alliance receives Service Development Funding to support a range of initiatives seeking to promote earlier presentation and diagnosis of cancer, associated with improved prognosis - this includes a whole-pathway prospectus. This complements funding made available to places for core service delivery and funds accessible from the research and third sectors. Section 7a commissioners receive funding to deliver the national cancer screening programmes, which are associated with facilitating earlier presentation and diagnosis of cancer in breast, bowel and cervical. The Targeted Lung Health Checks programme is also being rolled out in particular WY&H geographies based on health inequalities. A liver cancer surveillance programme is under development and local trials under consideration for kidney cancer. Data from NHSE indicates that referrals have recovered to the level expected notwithstanding the pandemic, however services remain challenged due to the concurrent impacts of managing elective recovery measures alongside cancer. Opportunities for multi-cancer blood tests (asymptomatic cancer screening tools) are being developed in local cancer policy development for local application.	NHSE planning processes and distributions of funding have been delayed in 24/25 arising from the slippage on the publication of the Planning Guidance and the completion of the planning process. This has meant that a Funding Agreement covering the use of the SDF as described in the key controls has not materialised in Q1. This particular issue is managed by NHSE NEY and has been escalated via this route. Discussions on SDF also form part of ICB Oversight and Review meetings. Some elements of funding which are relevant to the control of the risk were re-profiled arising from the implementation of the ICB Operating Model, which has been managed by the Cancer Alliance and through its Board, in conjunction with the ICB. In 24/25, the re-prioritization of uncommitted funds for deployment against operational performance requirements may continue to impact on the streaming of finances for early stage diagnosis, linked to the performance tiering system. Change in tariff arrangements for targeted lung health checks have delayed mobilization in Bradford and make distribution of this activity and benefit across WY more challenging and this remains a gap in key control which has been escalated nationally. Phasing and delivery schedule of assets such as CDCs, linked to capital investment plans affects the key risk. Sourcing of capital for investment in linear accelerator capacity in West Yorkshire also affects the principal risk. Reporting interface for COSD data linked to Cancer Information Solutions in providers may also impact on	Actively exploring research for evidence that additional interventions will have the desired impact, including applied national policy in local conditions. This is part of an early diagnosis strategy. Completion of H2 financial reset process and advice on the outcomes of the same discussed at Cancer Alliance Board, results communicated to WY ICB. Effective planning of 24/25 resource scheduling. Review of rapid staging data to track and monitor impact and review of metrics as part of Joint Forward Plan refresh. Risk escalations relating to the gaps identified in key controls section.	Most recent Rapid Registration data from national data sources suggests a modest improvement in cancer stage of presentation. This has been reviewed against the ambition set out in the ICB ambition - namely the cumulative number of additional people diagnosed at stages 1 and 2 by the end of the 2023/24 financial year, contrasted with 2017/19, including the impact of the pandemic. This figure shows that the ICB ambition for the reference period has been achieved, although the trajectory set out in the NHS LTP is not being met across England and an interim goal has been noted in the JFP. For this reason, the risk threshold has been retained.	None identified.	Static - 2 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 have issued consistent communication to Primary Care relating to the Right to Choose agenda including clarity on those providers who do hold contracts with WY commissioners 3 working groups are now underway and consist of: - Co-producing information and resources for professionals and the public - Shared Care/Prescribing (amber drugs) - Provider Framework (Commissioning/accreditation/contracts/AQP) Draft quality standards for autism and ADHD assessments are being worked on collectively with all 5 places. The aim is to provide consistency and quality to support contracts with all providers, reduce the need for re-assessments and support GP's having confidence to enter shared care with providers who have contracts with WY. This work is taking place in the WY ND professional's forum with input from the medical optimisation team and WY LMC. The new consolidated ICB contracting function is now supporting the work and governance associated with making a decision in the next few months.	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	Static - 6 Archive(s)
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	Static - 6 Archive(s)
2436	09/05/2024	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Debi Gibson	Beverley Geary	There is a risk to the delivery of safer maternity and neonatal care due to staff sickness / absence levels, vacancies and increased training requirements, resulting in reduced capacity to provide clinical care, reduced capacity to ensure staff are adequately trained, limited ability to deliver enhanced continuity of carer impacting the most in need, reduced ability to deliver maternity transformation and reduced offer of choice of place of birth.	Trust daily operational management of staffing and resources Recruitment and retention strategies PMA support LMNS workforce strategy LMNS daily SitRep and staffing huddle LMNS assured training plans Maternity Incentive Scheme Continuity of carer working group Collaborative working with MNVP Student midwife attrition data deep dive by NHSE	Staff resilience due to prolonged periods of reduced staffing levels Ability to provide staff with opportunities for well-being support and additional training opportunities other than mandatory Staffing uplift for training is varied and is not adequate to cover the increased maternity training programme	LMNS Daily SitRep Monthly reporting at LMNS workforce steering group Trusts reporting to own board Bi-monthly reporting to LMNS board Trust compliance with maternity incentive scheme year 5 Trust compliance with implementation of Saving Babies Lives Care Bundle v3 LMNS assurance visits Perinatal quality surveillance model	Midwifery vacancy rates have reduced from 144 WTE to 34 WTE; Trust attrition rates stabilising	Student midwife attrition rates high No approved tool for measuring obstetric and neonatal medical staffing requirements	Static - 1 Archive(s)
2427	14/04/2024	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	3	(I3xL1)	Debi Gibson	Beverley Geary	There is a risk that the LMNS will not be able to deliver their ambitions, key deliverables and fulfill their assurance and oversight role due to absence in the core LMNS team, due to long term absence and recruitment delays.	Perinatal pelvic health project manager now in post Project manager backfill appointed Director of Midwifery Appointed Progressing to advert for Quality & Safety Lead Midwife; Health Inequalities Programme Lead and MNVP Strategic Lead roles The core team review and prioritise work regularly Attendance at local quality surveillance continues when possible, reporting to ICB and region continues	Due to the ICB restructure there are significant delays in recruitment Multiple documents overdue for updating including guidelines and policies, equity & equality plan, LMNS plan (reflecting 3 year delivery plan), learning needs analysis.	The core LMNS team meet weekly to prioritise work The lead midwife has direct support from the ICB director of nursing Essential meetings are continuing The LMNS plan for 2024/25 has now been drafted and is being finalised. Task & finish groups set up for updating equity and equality plans.	The LMNS assurance visits were completed The LMNS has completed oversight and assurance of the saving babies lives care bundle v3 and the maternity incentive scheme year 5.	The LMNS team are acting reactively more than being proactive Unable to progress work on trauma informed care, unit escalation and mutual aid, key actions from multiple working groups	Static - 1 Archive(s)
2407	08/02/2024	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	6	(I3xL2)	David Smith	James Thomas	There is a risk that patients may deteriorate and or receive suboptimal treatment resulting from a growing number of medicine shortages across the system	National, regional and local shortages system put in place alerting organisations to potential shortages and updating on when lines will come back into stock. Regional and national contracting strategies to try to ensure plurality of supply for each product. Regional and national contracting strategies to assist new market entry. System of price concessions to help reduce the risk of pharmacies and dispensing doctors dispensing medicines at a loss.	No further actions need to be taken or can be taken at the current time to reduce the risk lower than the target rating of 6.	There are national assurance controls with shortages monitored by colleagues from NHSE's Specialist Pharmacy Services and overseen by a national shortages group. Regional reporting and assurance through the Regional Medicines Optimisation and Procurement Committee Chaired by Trust Chief Pharmacist / WYICS Chief Pharmacist. Pharmacy Silver Group established, Chaired by the WYICS Chief Pharmacist, which has had oversight of the recent Scarbies Treatment Shortage, The Group A Streptococcal Antibiotics (GAS) shortage and the more recent ADHD treatment shortages.	The actions of the Pharmacy Silver group helped manage the shortages of scabies treatments and GAS antibiotics with no reported adverse effects. The ADHD shortages were more complex but the group again worked well to minimise adverse effects	No current gaps identified	Static - 2 Archive(s)
2402	30/01/2024	Both FPC and QC	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	6	(I3xL2)	Kathryn Giles	Ian Holmes	There is a risk that timely access to general practice services fails to improve due to financial and workforce pressures facing the sector. This will result in failure to deliver our objectives to improve outcomes and tackle inequalities.	General practice commissioning is delegated to the place committees of the board. These place arrangements are responsible for working with general practice and other providers to join up services and improve access. The national primary care access recovery plan sets out specific requirements of ICBs - delivery is overseen by WY and place primary care teams. The Fuller Delivery Board provides oversight of the delivery of integrated primary care in place. We will look at opportunities to invest SDF funding to support general practice resilience. Work continues on building capacity through the development of retention strategies We will continue to assess resilience through regular General Practice Pressures reporting.	Further to the development of the ICS strategy and ICB joint forward plan, there is a need to refresh and crystalize our primary care vision for West Yorkshire. This will be developed over the spring and summer - and co-produced with clinical leadership and service users.	Place committee AAA reports to the Board and Place Committee Dashboards. Reports to the Board of the ICB - covering progress via the Fuller Delivery Board. . Board integrated dashboard (recognising the gaps below) Focus on sessions to the Board of the ICB (Nov 22 and Nov 23)	Key milestones for delivery of the national access recovery plan have been met - including face to face and virtual appointments available and number of staff in 'ARRS' roles. Place leads reporting positive progress in developing integrated models of primary care. Public satisfaction with general practice in WY remains above the national average.	There is a lack of routinely available data to fully track inequalities in access to and satisfaction with primary care across different communities and population groups.	Static - 2 Archive(s)

2399	22/12/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that incidence of respiratory viruses and urgent and emergency care pressures will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	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. Plans for protected elective hub sites due for implementation in 24/25 to enable continuation of elective activity during periods of significant non-elective active activity. WYAAT has established a UEC group aligned to the approach in planned care, working closely with the SCC (established by the ICB) to agree SOPs and escalation plans, supported by the roll-out of the RAIDr app. 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'.	Workforce and capacity challenges in primary care, community services and social care which cannot be further mitigated, resulting in additional demand on secondary care services.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified	Decreasing
2398	22/12/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to 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. Revised planning exercise in November 22 has identified local mitigations to increase capacity to support treating the longest waiting patients. Independent Sector group and approach established across WYAAT to maximise independent sector activity. National agreement has now been reached with consultant workforce, and an offer made to junior doctors.	Further industrial action for junior doctors subject to national negotiations. Potential for other staff groups to re-ballot for industrial action. Operational plans for 24/25 are based on a nationally directed assumption of no further industrial action.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified	Static - 1 Archive(s)
2350	03/08/2023	Quality	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Debi Gibson	Beverley Geary	There is a risk of not meeting the 2025 national ambition to reduce the stillbirth, neonatal and maternal death rates by 50 per cent due to gaps in personalised care, triage care, holistic risk assessment, escalation and embedded learning; resulting in adverse outcomes and poor experiences for women and families, poor LMNS reputation and substantial financial impact for injury and harm sustained to neonates.	LMNS has 4 key workstreams and steering groups: Safer Maternity Care, Personalised Care, Workforce and Addressing Inequalities each with subgroups addressing specific aspects of care to improve outcomes. All trusts are implementing the saving babies lives care bundle v3 with LMNS oversight and assurance. LMNS data is reviewed through the working groups and is presented to LMNS board for scrutiny and identification of priorities for action. Deep dive of neonatal death data being undertaken. NHSE asked to commission review into maternal deaths.	Data sources are not always reliable and definitions in relation to some data varies. Audit tools used for compliance with saving babies lives vary between trusts.	LMNS Quality and Safety Report presented to LMNS Board; System Quality Group; Regional Perinatal Quality Surveillance Oversight Group; Local Perinatal Quality Groups	The stillbirth rate has fallen for 6 consecutive quarters Smoking at time of birth rates have decreased A deep dive of neonatal death rates is being completed	Smoking data requires further analysis to identify impact of interventions The in unit neonatal death rate appears to be rising based on available date.	Static - 5 Archive(s)
2296	04/05/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Sarah Brewer	Ian Holmes	There is a risk that YAS will not be able to fully implement the plans which would deliver the Operational Planning target of a 30 mean response time for CAT 2 999 calls due to the high level of recruitment required to grow capacity within YAS and also full implementation of actions across the WY system which would contribute to delivery of the CAT 2 target	WY system plans being agreed to support YAS delivery of CAT 2 which includes a focus on expanding alternative pathways and reducing hospital handover delays WYAAT UEC Recovery Group maintaining a focus on SDEC and hospital handovers Additional national funding for YAS to increase capacity to support delivery of the CAT2 30min mean target Enhanced monitoring and reporting through monthly Executive Leadership Board	ICB system plans to support CAT 2 have yet to be delivered - these will be monitored through monthly ELB meetings YAS performance trajectories to deliver below 30min mean CAT 2 response have yet to be delivered - these will be monitored through monthly ELB	Monthly assurance of delivery against operational plan through Y&H ELB which include progress against workforce recruitment trajectories Monthly oversight of delivery of WY system plans to support delivery of CAT2 through the WY UEC Programme Board National NHS assurance through monthly report by YAS on performance against plan	The mean CAT2 response time across Yorkshire and Humber at the end of June was 30min 43seconds which was an improvement from May of 38 seconds. As part of the ongoing planning for 2024/25, trajectories have been agreed for 2024/25 and collective actions agreed that YAS and the system can deliver to support delivery of the CAT2 30 min target which includes additional national funding to increase crew 'time on the road'.	The Executive Leadership Board is now meeting monthly and is chaired by the CEO of WY ICB and provides opportunity for greater executive oversight and to ensure opportunities for ICB actions to support delivery of CAT2 are maximised. In addition the YAS Quality Oversight Group will have a role to oversee clinical and quality risks associated with hospital handover delays and delays in CAT2 response. Acute Trusts across WY need to maintain a focus on reducing hospital handover delays.	Static - 7 Archive(s)
2267	04/04/2023	Quality	Tackle inequalities in access, experience, outcomes	12	(I3xL4)	6	(I3xL2)	Debi Gibson	Beverley Geary	There is a risk of adverse outcomes for women and babies due to the impact of health inequalities and levels of deprivation as women are risk assessed mainly on clinical need not social complexity, resulting in women not receiving enhanced care and not fully accessing maternity services or providing their own self care.	The LMNS Health Inequalities steering group are working on key priorities including working with VCSE and public health partners, developing trauma informed approach, early booking campaign, utilising the LMNS Inequalities Dashboard to identify priorities. The LMNS equity & equality plan identifies current and future priorities Barriers to care in relation to deprivation are considered at all patient safety incident reviews Some trusts have implemented strategies to support women attending including food parcels and bus fares. Service user representatives engaged with LMNS steering groups via MNVP	The voices of service user groups in greatest need are seldom heard and require focused work to ensure engagement The equity and equality plan requires updating Social complexity is not clearly defined	Review of data and outcomes through a health inequalities lens is embedded through all LMNS steering groups	None identified	TBD	Static - 5 Archive(s)
2234	17/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	9	(I3xL3)	Caroline Squires	Laura Ellis	There is a risk to key services of the ICB and commissioned services due to a successful cyber-attack, hack or data breach of a commissioned Provider or supplier to the ICB, resulting in disruption of ICB services, potential for damage and distress to individuals, reputational damage to the organisation and regulatory action under data protection legislation.	ICB in hours and oncall escalation arrangements Assurance from providers/suppliers that business continuity plans are in place in the event of a prolonged IT system issue. Procurement including information security/cyber security due diligence, DTAC (Digital Technology Assessment Criteria) Contractual levers, NHS Standard Contract Terms and Conditions, Data Protection Protocol Terms and Conditions, contract monitoring arrangements Dedicated cyber security resource/expertise utilising national alerting and reporting. ICB EPRR expertise and resource. Cyber Security Network	1. Review of business continuity arrangements 2. Testing/simulation of business continuity arrangements specifically in relation to cyber-attack (including ransomware attacks) experienced by commissioned Providers or suppliers to the ICB. 3. Limited understanding of supplier enforcement of Multifactor Authentication (MFA) 4. Assurance that supplier IG due diligence provides indicator of cyber security maturity.	Contract monitoring arrangements (links to mandatory requirements of Standard 10 of the DSPT 2023-24) Together with Contracting Team, review existing approach to DSPT Standard 10 supplier IG due diligence checks, to ensure fit for purpose. MFA policy incorporated directly within DSPT version 6 (2023-24). NB. MFA policy published as guidance under s3(3)(b) of the Network and Information Systems (NIS) Regulations 2018. ICBs are now designated under the Regulations as operators of essential services for the health sector and have a statutory obligation under s10(4) to have regard to such guidance. Sharing learning via Cyber Security Network	None identified	1. Clarity on data controller / data processor relationship on a number of contracts is still required.	Static - 3 Archive(s)
2165	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Nichola Stephens	James Thomas	There is a risk that place IT teams have insufficient capacity to implement regional solutions. Due to increasing demands for digital solutions and the prioritisation of local vs regional projects. Resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement regional solutions at scale	Ensuring organisational IT teams are provided with sufficient notice to plan for regional implementations. Seeking additional funding for resources to bring in additional capacity or to backfill key resources.	Digital investment to be increased within individual organisational budgets to enable increase capacity in the in-house teams, with dedicated time allocated to regional programmes	Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.	WY CDIO has been recruited and due to commence. The CDIO will support delivery of the strategy and agree up front the strategic schemes to work on collectively, ensuring funding is sought for delivery, which would increase capacity for delivery in organisational IT teams.	None identified	Static - 9 Archive(s)

2111	25/08/2022	Both FPC and QC	Tackle inequalities in access, experience, outcomes	12	(I3xL4)	6	(I2xL3)	Keir Shillaker	James Thomas	There is a risk that there is reduced effectiveness of delivery due to the scale of the programme ambition and volume of possible workstreams. This would result in a dilution of improvement in the areas that most need it. This includes the tension of delivering national LTP targets, against known quality improvement initiatives (ie Ederfield response) and other locally determined priorities (such as Neurodiversity Deep Dive, new work on Older People's Mental Health) The impact of this would be to contribute to a delay in achievement of the ICB mission and will probably occur in most circumstances	Agreed permanent funding for the core WY team via the ICB. Utilising maximum available non-recurrent funding sources (including NHSE, HEE and legacy ICS funds) to appoint to non-recurrent project roles Process for identification of WY priorities remains by agreement with all WY places to ensure they are necessary Development of new responsibility agreement between the MHLDA collaborative and the ICB to support the process by which priorities are agreed and business as usual tasks are undertaken	There is no formal process for either places or the system to prioritise which initiatives take precedence over another, or an agreed framework for doing so No comprehensive mechanism for understanding totality of the WY staffing offer to know whether capacity can be moved around to support agreed priorities - either between places and system or between/within programmes Whilst there is agreement within both the ICB and the Provider Collaborative that there is support to prioritise the reality is that asks on the WY team are greater now than ever through a combination of place queries about commissioning (ie High Cost Placements, S117 arrangements), business as usual responsibilities around FOIs/ complaints, MPs enquiries and media enquiries and the identification of new areas of pressure such as Gender ID Services, CFS/ME, Dementia Disease Modifying Drigs alongside new expectations to coordinate workforce returns, work through newly identified Transformation Priorities and oversee place performance (ie on MHSTs, EIP in Leeds etc) The restrictions on utilisation of SDF funding and/or recruitment freezes within providers will also impact the ability to replace capacity lost as a result of the operating model (ie LD support) or increase temporary capacity in priority areas (ie previous non-recurrent roles in Acute Mental Health & OPMH not replaced)	MHLDA Partnership Board maintains oversight of all WY priorities, as does the NEY Regional Programme Board. The MHLDA collaborative Committees in Common oversees specific responsibilities delegated to that collaborative and wider arrangements for collaboration between the Trusts	ICB leadership and the Provider Collaborative are supportive of the WY Programme Team pushing back on areas that are not priorities, however work to determine clarity around priorities still needs to happen, particularly given ongoing discussions regarding the financial challenge	The MHLDA Partnership Board or local place committees do not regularly review capacity allocated to each priority or workstream. As part of developing the MHLDA plan for 24/25 we only committed to priorities we felt the capacity in the WY core team had to deliver. However, new areas like Dementia Disease Modifying Treatments, Gender Dysphoria response, expanding apprenticeships and developing CeTR processes have already landed as additional asks in the first month.	Static - 3 Archive(s)
2107	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I3xL2)	Jason Pawluk	James Thomas	Constitutional Access Standards - Cancer Performance Risk: There is a risk that patients in WY&H will not receive cancer care in accordance with the access standards set out in the national cancer strategy and NHS Constitution. Significant failure to deliver the access standards risks clinical harm, regulatory intervention, loss of funding, and significant reputational damage.	-- Provider trusts deliver pathway improvement work collaboratively through WYAAT forums. This includes work on mutual aid, effective capacity expansion measures, role of independent sector. -- Places have also developed proposals for community diagnostic centres which will support longer-term growth of capacity. -- Development of place-level workforce plans to support the delivery of the cancer standards. -- Oversight/support of Cancer Alliance - reviewing areas of best practice and also stimulating pathway improvement work in defined areas, based on operational priorities. -- Provision of service development funding for operational performance recovery and sustainability.	Due to performance against the 62 day standard, services at Leeds Cancer Centre have been escalated to Tier 2 performance review status and this position has been maintained in successive reviews. This involves additional assurance at a Regional level of NHS England. Performance against reviewed measures has improved, although headline 62 day performance is still significantly below threshold.	-- Develop system wide plan, pathway analysis work, use of Transformation Funds and Diagnostic Capacity and Demand programme. -- Also ongoing and close planning with WYAAT Leadership. -- Continued development of Cancer Performance Recovery Group and identification of financial resources to support performance sustainability and recovery. -- Relevant discussion at ICB forums such as Clinical Forum.	Fortnightly performance meetings commenced focused on 62 day backlog working through mitigations, finance and mutual aid chaired by WYAAT Cancer COO. Good performance standard achieved in some WY trusts but variation in position, favourable performance nationally. Positive plans developed by providers for pathway improvements in 24/25, which have been maintained in to Q1 actuals.	Impact of industrial action; seasonal factors; awareness raising campaigns and referral displacement (elective to cancer in lower risk cases) have all resulted in a reduction in cancer waiting times performance against the faster diagnosis standard and an increase in the cancer care backlog. This reflects a national position. The position is mitigated by provider trusts, but current performance means that the out-turn position, which was the target set at the beginning of the year, will now be more challenging to achieve. Target of 597 across the WY system was achieved but must be sustained - focus on 70% 62 day position next year. Radiotherapy 31 day performance at Leeds declining.	Static - 1 Archive(s)
2106	23/08/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	4	(I2xL2)	Jason Pawluk	James Thomas	Cancer Health Inequalities: There is a risk that prevailing health inequalities for people affected by cancer will get worse unless place-based capacity and priority setting for cancer care is fully aligned to the ICB strategic priorities across all geographies in WY&H.	-- ICS coordination of plans across places and requirement to respond to the Planning Guidance. -- Work of the Cancer Alliance developing system level plans. -- Role of the acute provider collaborative. -- Provision of SDF to places to deliver cancer priorities. -- Collaboration between ICS partners and Cancer Alliance and Core20Plus5.	-- Reduction in resources available for place-based transformation of cancer care arising from operating model review and aggregation of cancer requirements alongside other long-term conditions. -- Gaps in direct application of financial resources to managing health inequalities for cancer in some local place-based plans for Core20Plus5 and challenges in aligning governance. Delays in funding agreement from NHSE for 24/25. -- Risks agreed with NEY Region relating to strategic/system level working on themes such as PET-CT, robotics, fragile and vulnerable services, Genomics and RT capacity to avoid health inequalities worsening associated with access and implementation of new service models and technologies. Delays in developing a resourced Region-led transformation plan for 24/25.	Design work for ICS provides opportunity to work differently across the Alliance with shared common aims and sharing of resource where appropriate to level up. Coordination of planning across the ICS. Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action.	Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action. Inequalities featured consistently as a consideration in Cancer Alliance Planning Pack for 24/25. Some evidence of disproportionate benefit of schemes such as lung health checks and NSO transformation programmes in mitigating health inequalities (access and outcomes). Planned further rollout of population targeted screening and case finding initiatives for kidney cancer.	Evidence of place-based investment profiles for cancer health inequalities, linked to Core20Plus5. Evidence of aligned national planning guidance requiring oversight of Core20Plus5 funding deployment for cancer health inequalities, linked to oversight by Cancer Alliances (unlikely to change in 2024/25). Assurance required that local resourcing patterns supporting cancer health inequalities management at place will be reserved through operating model review.	Static - 7 Archive(s)
2446	09/07/2024	Both FPC and QC	Improve healthcare outcomes for residents	9	(I3xL3)	1	(I1xL1)	Adam Cole	Anthony Kealy	There is a risk that Vocare and YAS are not passing patient details to LCD in a timely manner following patients being given a disposition which may impact patient safety and quality or care due to two hour dispositions not actioned in appropriate timescales; at times this can be up to 11 hours. In may 128 cases took 5 hours or more to be passed to LCD. This has been even higher in previous months.	1. Escalated by LCD to Urgent Emergency Care Commissioners across WY 2. Escalated internally by YAS who are analysing data with Vocare to see the extent of the issue and if it also affects GPOOH 3. Tripartite meeting arranged between YAS, Vocare and LCD supported by UEC commissioners (July 2024)	1. Yet to be identified - will understand the gaps following the tripartite meeting in July 2024	1. On-going monitoring by LCD as the WY Clinical Advice Service contract holder	TBC	TBC - to be identified following tripartite meeting in July 2024	New - Open
2444	04/07/2024	Both FPC and QC	Improve healthcare outcomes for residents	9	(I3xL3)	4	(I2xL2)	Yvonne Hoorman	Martin Pursey	There is a risk that the ICB fails to comply with patient choice requirements due to the absence of available single robust and consistent West Yorkshire service specifications for consultant-led services resulting in a potential legal challenge or referral, by an independent sector or private provider, to NHS England to investigate whether the ICB has failed or is likely to fail to comply with patient choice requirements under the NHS Standing Rules.	An accreditation process that is compliant with legislation has been published on the WYICB website. The accreditation criteria were signed off by the Finance, Investment and Performance Committee. Meetings between commissioning and contracting colleagues have been established and multiple consultant-led pathway and service specifications are in development.	The accreditation process does not include clear instructions for re-application/accreditation of providers who may have failed at first attempt. The accreditation process is lengthy (longer than the 6 weeks stipulated by NHSE) and takes up a lot of capacity from multiple teams. The accreditation process is not proportionate in the use for the re-accreditation of existing providers and services. The development of consistent service specifications is taking longer than the time available to respond to requests for new accreditation of providers (longer than the 6 weeks stipulated by NHSE). A revised process is in development alongside a Provider Accreditation Procedure expected to be completed in July 2024.	Any live and completed Provider Selection Regime (PSR) processes are reported through to Audit Committee (the Provider Accreditation Process falls under PSR direct award process B). A Provider Accreditation Process tracker is used to ensure deadlines set out in the process are met.	The accreditation process is live has been completed for two providers with numerous other providers going through the process at present. A formal complaint was received through NHSE and was closed/not upheld due to agreed pragmatic approach to re-application of providers that failed at first attempt.	Whilst the accreditation process is in operation, a number of learning points have been identified and need to be addressed.	New - Open
2435	01/05/2024	Quality	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a risk that the 'go live' for NHS111 first for Mental Health places significant additional demand upon local crisis teams who are already struggling with capacity and ability to respond in a safe and timely way, leading to an increase in call-drop out rates and people in MH crisis without the response they need.	WY is now live with 111 first for Mental Health including additional messages that state if someone is phoning 111 and there is an immediate risk to life, then they should instead phone 999. In addition, the MOU with crisis partners and YAS identifies the ability of crisis teams to request that the IVR model is turned off if demand becomes unsafe, reverting MH crisis calls back to the YAS 111 call-centre. Other elements of work with YAS such as piloting Early Help and improving collaborative discussions on the rollout of MHRVS do appear, in the early stages to be helping mitigate demand	NHSE has not provided additional funding to MH crisis teams to respond to any increase in demand driven by 111 first for MH, therefore providers are needing to do what they can locally to reprofile capacity. We are also seeing a transfer in demand from calls to YAS to the WY 24/7 Helpline provider which is not funded to meet this additional demand.	Given current performance in crisis line response is variable it is likely that any signficant increase in demand could lead to impact on service users. There is a need to continue monitoring the impact of 'go live' through the 111 Task & Finish group. We also do not intend to locally promote 111 First for MH until we are confident of capacity, and for this to be locally led alongside maintaining awareness of existing crisis line numbers	To date, whilst demand has increased into our crisis services it has not resulted in a need to reduce the offer and services have been able to add messaging to divert non-urgent calls to other sources of support where needed	NHSE KPIs regarding 111 First tend to focus on traditional 'call handling' metrics, rather than outcomes for service users and true service user experience measures. Many of these KPIs are not sensitive to the requirements of mental health and therefore will not tell the full story. Our ongoing monitoring of impact needs to pay close attention to what our providers are telling us, and the views of clinicians in the service, not just quantitative metrics	Static - 1 Archive(s)

2431	22/04/2024	Finance, Investment and Performance	Enhance productivity and value for money	9	(I3xL3)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS/ICB will not manage within the capital limits set by NHS England. Potential to exceed due to inflationary pressures and other demands, or undershoot due to lead times or delayed funding notifications leaving little time for procurement leading to non-delivery of one of the financial statutory targets and a reduction in the expected capital allocation in the next financial year. Underspend could result in increases in backlog maintenance requirements, detrimental impacts on NHS infrastructure, and lost funding as capital money cannot be carried into future years.	1. West Yorkshire wide capital plan with robust schemes which are designed to alleviate need fairly across the West Yorkshire service providers 2. Collective understanding and agreement across all WY providers that the over-commitment of 5% allowed in the planning process will need to be managed collectively by the end of the financial year. 3. Capital working group now well established which involves all WY NHS providers and the ICB, which meets monthly to oversee year-to-date expenditure, forecasts, risks ad opportunities 4. Oversight of capital position by WY ICS Finance Forum	1. Detailed plans which detail which elements of the capital plan can be reduced to live within capital allocation	1. NHS England oversight and management; 2. Review of capital plans in West Yorkshire Finance Forum between commissioner and providers; 3. ICB Finance, Investment and Performance Committee oversight; 4. ICB Board overview	System capital expenditure for the last financial year was managed within plan due to controls noted above, and at Month 1 no specific risks are yet identified and forecasts are at planned level	None identified	Static - 1 Archive(s)
2412	18/03/2024	Quality	Improve healthcare outcomes for residents	9	(I3xL3)	3	(I3xL1)	David Smith	David Smith	There is a risk that partners across the integrated care system may not be able to comply with the recent National Patient Safety Alert (NatPSA)– Valproate: Organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients. The NatPSA details that there is a significant risk of serious harm to a baby after exposure to valproate in pregnancy. The NatPSA details the following measures which aim to ensure valproate is only used if other treatments are ineffective or not tolerated, and that any use of valproate in women of childbearing potential who cannot be treated with other medicines is in accordance with the Pregnancy Prevention Programme. This means, resulting from a regulatory change mean that for oral valproate: - • Valproate must not be started in new patients (male or female) younger than 55 years of age, unless two specialists independently consider and document that there are compelling reasons that the reproductive risks do not apply. • At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialiser unless the patient's situation changes. The risk to the system is that: - • there may be insufficient specialist capacity across the system and or in each place to facilitate the review of existing women and girls of childbearing potential to facilitate a review and signature from a second specialist. • There may be women and girls of childbearing	Key Controls The following systems, processes and controls are in place to manage the risk? 1. A West Yorkshire ICS (WYICS) Valproate Coordination group (VCG) has been established to respond to the NatPSA and to seek assurance from organisations that they are compliant with the new regulations. 2. Sub-groups in each sector have been established to work through the NatPSA. 3. The NatPSA has been cascaded by the national team across the system so that colleagues, regardless of the actions of the WYICS VCG should have some knowledge of the alert. 4. The NatPSA comes on the back of previous alerts and mitigations aimed at improving the safe use of valproate.	Despite the key controls identified above there is a potential that women and girls of childbearing age may continue to take valproate. The following further actions are suggested. 1. A search of data should be undertaken to identify all people taking valproate to ensure that those affected by this alert can be referred to appropriate specialist support for review. 2. Local guidance and protocols need to be updated to reflect the new regulatory position. 3. Commissioning work may need to be done to understand the needs of the affected population, including those people most at risk of health inequalities. 4. Audits need to be implemented to provide assurance that the new regulations are being followed. 5. Local pathways of care for women of childbearing potential and girls in relation to the prescribing and review of valproate may need to be reviewed.	The WYICS VCG will oversee the response to the NatPSA and will seek assurance from organisations that they are following the new regulations. The WYICS VCG will report to both the WYICS Medicines Optimisation Committee and the System Quality Group to provide assurance of compliance with the new regulations.	Positive assurance of the system's response to the NatPSA is available from the minutes of the groups' meetings. Updates have also been provided to the MOC and SQG. Further assurance will be provided as the work of the WYICS VCG continues and completes.	There is some evidence to suggest that in the interim period some Risk Assessment Forms are coming through with only one signature on them. In cases where this does arise pharmacists, GP practices and other primary care colleagues are encouraged to refer the person requiring valproate back to the provider who initiated it.	Static - 2 Archive(s)
2351	07/08/2023	Both FPC and QC	Improve healthcare outcomes for residents	9	(I3xL3)	1	(I1xL1)	Vanessa Hails	James Thomas	A review of the original acute stroke pathway developed between Harrogate District Foundation Trust (HDFT) and Leeds Teaching Hospitals Trust (LTHT) did not occur primarily due to the impact and legacy of the Covid-19 pandemic. A risk now exists with regards to the effectiveness of the pathway and the possibility that there may be a small number of patients from the Harrogate area who are not accessing the appropriate hyperacute stroke care. The risk is shared across the Trusts, as there are capacity and workforce issues within both of the stroke services that contribute to the situation.	There are ongoing discussions between the services, hosted by HNY ISDN and involving the WYH ISDN Manager, Clinical Leads, consultants and staff. Key senior stakeholders have been identified across both ISDNs, York and Scarborough Foundation Trust (YSFT), HDFT, and Yorkshire Ambulance Service (YAS) and a working group established to develop viable solutions to the issues outlined.	Continuing discussions between the various stakeholders are required due to the complex nature of the pathway and the potential service reconfigurations being considered.	A risk report was presented as part of a paper to the LTCP Board in May 2023, and this has led to a further report, detailing the risk and mitigating actions, produced in collaboration with the HNY ISDN. Regular updates are being provided to the WY ICB MD, the regional/national team via quarterly highlight reports, and the monthly NEY Stroke Subgroup meetings. The risk and updates are provided at the ISDN Steering Group on a bi-monthly basis. The ISDN are hoping to establish a Diagnosis and Treatment task and finish group to work on standardising pre-alert pathways for all HASU trusts within WY, and this will include the Harrogate to Leeds pathway. There have been several meetings between the working group with good progress being made.	An initial action plan has been developed following the most recent meeting held at the end of September. Actions include: • YSFT to potentially accept Harrogate walk-in and in-house stroke patients at York Hospital (YH). • A division of the YAS cases to match the geography for LTHT and York Hospital. YAS will work with HDFT, YSFT, and LTHT to identify border postcode areas (Isochrones) and establish impact data with a view to amend the current pathway used by crews to provide clarity of HASU destination from specific Harrogate locations. This will help to rebalance the number of patients going to Leeds, and to York. • HDFT will continue to concentrate on achieving full ASU status and will continue to work with LTHT to repatriate patients in a timely manner whilst ensuring ESD is utilised directly for those who are suitable. • An initial draft model to be available and discussed via a MS Teams meeting in Mid-November, once data has been modelled using the Isochrones. • A pilot service will then be launched with the agreement of all key stakeholders, including both ISDNs. • The new pathway will then be reviewed in March 2024, at the earliest. Meeting between all stakeholders held on 23rd of November to discuss pathway review data and potential viable solutions. Agreement in principal to take forward a plan with revised pathways for self-presenters and inpatient strokes at HDFT, and for Harrogate stroke patients identified by YAS clinicians. Internal meetings / discussions within Trusts, and between COOs, are being arranged that will hopefully lead to approval of the plans and agreement on a start date for a 3-month pilot. Documentation to support	None identified.	Static - 4 Archive(s)
2295	03/05/2023	Quality	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I2xL3)	Laura Siddall	Anthony Kealy	There is a risk that the ICB does not have effective business continuity plans and arrangements in place due to this work being delayed until the organisational restructure was completed. This could result in a reduced ability to prevent, recover from, and deal with potential threats, which may disrupt business as usual.	# A WY business continuity plan has been approved by EMT. # An ICB EPRR policy has been agreed which includes BC arrangements # ICB on call system is fully operational # A business continuity exercise in relation to a remote working at the WY ICB was undertaken in March 2024.	# A multi-year testing and exercising plan has not yet been completed # Business impact analyses (BIAs) will need to be completed for each ICB function once the new ICB structure is in place from April 2024. # Recent annual EPRR assurance marked a number of the business continuity standards as partially compliant and so work is needed to increase compliance.	# Regular cycle of Internal Audit review of BC arrangements # Annual assessment against EPRR (including BC) core standards reported to the Board #Annual statement of EPRR (including BC) compliance # Annual review of Business Impact Assessments to be undertaken by ICB teams	# The EPRR team BIA has been completed and a contact directory has been developed to approach leads to complete BIAs. # Internal Audit review of BC arrangements with a view of Significant assurance following the audit in early 2023. # Successful continuity of services through prolonged period of industrial action in 2022 and 2023 # Evidence of successful BC exercises and tests	# Current business impact analyses (BIAs) are not yet developed and so cannot exercise or assess them.	Static - 7 Archive(s)
2294	03/05/2023	Both FPC and QC	Enhance productivity and value for money	9	(I3xL3)	6	(I3xL2)	Kate Sims	Kate Sims	There is a risk to the operational effectiveness and staff morale of the ICB and ICS programmes due to uncertainty, potential disruption and loss of capacity resulting from the review of the operating model and required reduction in the running cost allowance.	1) Committed to undertake in one year to minimise period of uncertainty 2) Dedicated SRO, Programme Board and Team established 3) Programme Plan in place 4) Capacity reductions spread across all operations rather than focussed just on running costs 5) Well established leadership and management structures in place 6) Weekly transparent all staff communication and monthly briefing 7) Wide engagement with all stakeholders 8) Formal consultation undertaken and implementation plan agreed with Staff Side. 9) OD plan being developed within agreed framework	None identified at this stage	Critical path and associated milestones for delivery regularly reviewed and updated	None identified at this stage	None identified at this stage	Static - 2 Archive(s)

2108	23/08/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I3xL2)	Jason Pawluk	James Thomas	Cancer Workforce Risk: There is a risk that the ambitions set out in the Cancer Workforce Plan will not be delivered in WY&H arising out of insufficient supply, retention, and training provision across key priority areas. Failure to deliver the Cancer Workforce Plan would likely have adverse effects on quality of care; delivery of access standards/performance; effective financial control; innovation priorities, and ICB reputational standing.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) -- Appointment of an HEE funded cancer workforce lead for WY&H and support team addition in January 2024. Close working relationship with Workforce team. -- Influencing application of the NHS People Plan through system relationships. -- Skill mix, transformation, and capacity building in key areas such as non surgical oncology and diagnostics. -- CNS workforce census activities. -- Development of ACCEND framework activities. -- Development of solutions for fragile service areas such as dermatology and link with elective. -- Integration with WYAAT improvement programmes for delivery, linking elective and cancer with workforce transformation angle. -- Support for diagnostic and treatment networks with focus on workforce transformation. -- Development of community models of support and investment in key lines such as social prescribers, primary care coordinators, primary care network facilitators, navigators and support staff to release clinical time. -- Development of place-based clinical and other service improvement leads in clinical leadership roles. -- Collaboration on fellowships and secondment activities for AHPs.	-- Pipeline activity for new roles in key professional groupings, including attraction and retention to training places in noted speciality areas. -- Pipeline activity strength may grow at a lower rate than loss of supply due to gaps in retention, age profiles of key areas of clinical workforce (primary and secondary care), and other factors such as reward. -- Outputs from ICB operating model for transformation/coordination resource, notably at Place level. -- Some evidence of the impact of establishment control and financial measures impacting on the capacities of provider and community organisations to respond to business planning activities.	Workforce census data provides assurance on key controls, review of CA resourcing for Places.	Delivery of key controls.	None identified.	Decreasing
2199	01/12/2022	Both FPC and QC	Improve healthcare outcomes for residents	8	(I2xL4)	4	(I2xL2)	Caroline Squires	Laura Ellis	There is a risk of confidential personal data and commercially sensitive information being sent by email and by paper based correspondence (from areas such as e.g. CHC, complaints, IFR, HR) to an incorrect recipient or recipients, resulting in a breach of confidentiality and potential for damage and distress to individuals, reputational damage to the organisation and regulatory action under data protection legislation.	1. NHS Mail supportive features: employing organisation detailed when picking from Address Book, additional details in 'Contact Card' to verify identity, Address Book filter by organisation. 2. Guidance included within 'Effective Use of Emails' guidance, part of NHS Mail user guidance on computer desktops as part of NHSMail implementation. 3. Annual Data Security training of all West Yorkshire Integrated Care Board (WY ICB) staff. 4. Staff awareness of the risk via policy level messages (IG Policies Book), IG staff handbook, bespoke communication reminders to staff. 5. Data flow mapping and mitigation of any risks, by IAOs. 6. Return to Sender sticker or markings on outgoing confidential patient/staff correspondence from the relevant departmental areas of the ICB (may vary in extent across functions and places of the ICB) 7. Local departmental verbal and written reminders of good record keeping and administrative process and checks of personal details against source (may vary in extent across functions and places of the ICB)	1. Programme of ongoing awareness to ensure all staff remain sighted on the risk, including enhanced practical guidance on alternatives to email, controls to keep data in transit secure and awareness of checking emails and attachments before sent. 2. Audit of data quality processes (focused on admin and record keeping processes that produce high volumes of patient or staff confidential correspondence) in place and subsequent recommendations on findings of the audit.	1. Monitoring of incident patterns and trends via Incident and Near Miss Process Reviews. 2. Monitoring of incidents reported via the Information Governance Steering Group and Integrated Governance Report to Audit Committee. 3. Report on findings and recommendations of data quality audit and subsequent monitoring of completion of actions, via WY ICB IG Steering Group.	1. No serious incidents relating to confidential personal data and commercially sensitive information being sent by email to an incorrect recipient or recipients reported to the Information Commissioners Office. 2. Ongoing awareness to ensure all staff remain sighted on the risk, e.g via West Yorkshire Shareboard and bulletins such as Christmas IG good practice reminder messages. 3. Data Quality Audit is a mandated requirement of the Data Security and Protection Toolkit 23/24.	None identified at this time.	Static - 3 Archive(s)
2406	08/02/2024	Finance, Investment and Performance	Tackle inequalities in access, experience, outcomes	6	(I3xL2)	6	(I3xL2)	David Smith	James Thomas	There is a risk of an insufficient number of qualified prescribing pharmacists to meet the national workforce transformation requirements due to a lack of allocated funding. From 2026 new pharmacy graduates will be expected to quality as independent prescribers (IP) with prescribing forming a core element of the syllabus. In order to achieve this, students are required to undertake training with the support of a Designated Prescribing Practitioner (DPP), with a mininmum of 90 hours supervision. There is currently no funding to support the payment / backfill for the DPP. Without the support and supervision of the DPP, pharmacy graduates will not be able to qualify as prescribers or pharmacists. This leaves West Yorkshire with a significant risk pharmacy workforce risk and the potential to see a shift in students leaving the area to qualify in areas that can support this as part of their qualification. Future delivery plans, including, but not limited to Recovering Access to Primary Care (PCARP) are dependent on sufficient prescribing pharmacists being available. There are already significant pharmacy workforce vacancies across the West Yorkshire (WY) system, with very limited IPs to act as DPPs, which is already causing pressure with the pharmacy system. Alongside this, WY is an outlier in that there is no dedicated WY Pharmacy Workforce Transformational lead as seen in other Integrated Care Systems across the country and this is adding additional pressure to colleagues managing this as an addition to their contracted roles.	Options scoped to look at new models to deliver DPP availability, including, but not limited to, teach and treat models utilising out of hours services e.g. LCD or primary care training hub. Escalation to regional and national colleagues Continued work across the system to close the gap.	No dedicated (permanent) WY Pharmacy Workforce Transformation lead to develop a full and comprehensive workforce strategy for Pharmacy. No funding streams identified to support payment for DPP time.	Workforce workstream of the WYICS Medicines Optimisation Committee provides regular updates to that committee of progress made.	There is limited positive assurance that the key controls are managing the issue. Further system, regional and national work is planed. Some short-term non-recurrent funding has been found to support the DPP work.	assurance controls provide limited assurance that the risk is being managed.	Decreasing
2405	05/02/2024	Both FPC and QC	Enhance productivity and value for money	6	(I3xL2)	6	(I3xL2)	Caroline Squires	Laura Ellis	There is a risk of key evidence that supports the Data Security and Protection Toolkit (DSPT) submission for 2023/24 not being in place/implemented, due in particular to compliance with a new mandatory evidence line having a dependency on the actions of a number of suppliers to the ICB to deliver successfully and on time; leading to an increased risk of non-compliance against that evidence line within the DSPT and a 'Standards Not Met' DSPT submission for the WY ICB for 2023/24.	1. DSPT workstream for 2023/24; identifying systems which are in scope of the relevant DSPT mandatory evidence line; liaising with relevant system suppliers in relation to their plans to meet the mandatory requirement and their associated timescales; linking with regional and national cyber security and policy leads to ensure the ICBs approach is in line with national expectations and approach being taken by other NHS organisations. 2. Co-ordination and overall programme management of the WY ICB DSPT submission by the IG Manager and ICB Heads of IT. ICB and THIS IT Working group closely monitoring the progress with the relevant mandatory evidence line. 3. SLA in place with The Health Informatics Service (part of Calderdale and Huddersfield NHS Foundation Trust) in relation to provision of IT and cyber security services. 4. Monitoring of the progress being made and completion of the relevant evidence line, being undertaken by regular reports to the SIRO, IG and Records Management Steering Group and Audit Committee.	None	1. Monitoring of progress and risk/emerging risk via IG and IT Team progress meetings with SIRO and IG and Records Management Steering Group. 2. Bi weekly progress monitoring meetings in diary between ICB Head of IM&T, IG Officer and THIS/IDS. 3. Scheduled DSPT progress reporting to Audit Committee (including exception reporting)	Toolkit submitted as standards met by 30 June 2024.	None at this time.	Closed - Reached tolerance

2363	21/08/2023	Quality	Improve healthcare outcomes for residents	6	(I3xL2)	6	(I3xL2)	Laura Ellis	Laura Ellis	There is a risk of the ICB being unable to provide a timely, comprehensive and quality response to complaints received in relation to primary care services (GP, pharmacy, optometry and dental) due to the volume of complaints being received being significantly in excess of that anticipated during the transfer of the function from NHS England to the ICB on 1 July 2023. This may result in a poorer patient experience for those wishing to raise complaints, reputational damage to the ICB, and unsustainable pressure on staff within the function.	- Weekly performance reports implemented - Additional resource being brought in from other teams - Additional information on the ICB's website for commonly raised concerns e.g. access to dental services - Task and Finish Group established - New operating model developed to bring additional resource and resilience	None identified	- Weekly performance reports to show improving position - Implementation of new operating model	- New operating model approved and implemented on 1 April 2024 - New head of service in post - Targeted work on outstanding complaints	- None identified	Closed - Reached tolerance
2339	07/07/2023	Both FPC and QC	Improve healthcare outcomes for residents	6	(I2xL3)	6	(I2xL3)	Simon Rowe	Ian Holmes	There is a risk of patients waiting to be contacted beyond the initially assessed period by Local Care Direct (out of hours delivery within West Yorkshire Urgent Care) due to high number of patient referrals resulting in a potential risk to patient safety and experience.	1. Embargo of appointments (peak times) to promote availability for the most urgent cases. 2. 'Refusal of Disposition' Standard Operating Procedure (SOP) utilised within the service to close referrals where the patient does not accept the offered appointment. This releases clinical capacity within the service. 3. 'Comfort calling' including 'worsening advice' provided by LCD. SMS usage for new referrals Acknowledging the referral, possible delay and provision of remote cancellation (if appropriate). Safety netting and 'worsening advice' also provided by the referring service (NHS 111). 4. Internal escalation - utilising OPEL - to manage actions according to misaligned capacity with demand. This incorporated linking with NHS 111. 5. Revised workforce model within the LCD Hub to support MDT remote review of incoming referrals / calls. 6. WYUC Service Review- will inform commissioning intentions for future service model with improved waiting times and outcomes for patients.	Potential future alterations to NHS Pathways are not managed by the service. NHS pathway changes can increase / decreases impact referral levels. The service is supported by sessional staff and operate within a wage competitive environment, this can effect staff availability.	QUALITY MONITORING a. West Yorkshire ICB UEC Clinical Quality Meeting monitors quality concerns related to the service. b. Escalation of performance / contractual issues via the Partner Relationship Management Team (Kirklees) c. Monitoring (via West Yorkshire ICB Clinical Quality Meeting) includes: - Review of Incidents (and Serious Incidents) - Patient Satisfaction via patient surveys. - Complaints - monitored and reported. - Care Quality Commission Visits / assessments - (Rated 'good' in the most recent inspection, and further positive commentary via the 'system review'. CONTRACTUAL MONITORING a. Contract Management - the service is also monitored in conjunction with the Partner Relationship Management Team (Kirklees) b. Easter and Christmas plans are produced by the provider. Summary of capacity requirements linked with anticipated demand. c. Demand and Performance - reported on a daily, weekly and monthly basis.	1. Incidents - the overall reporting levels remain stable 2. Complaints levels - remain stable. 3. Audit - following revised closure procedures for 12 and 24 hr dispositions (based upon OPEL), audits have demonstrated very limited system impact and appropriate actions (if any) taken by patients. Further audits to be reported to WY ICB UEC Clinical Quality Meeting. 4. CQC Report (May 2020) - all domains received a 'good' rating, with an overall 'good' rating. A further focused CQC inspection did not alter the original ratings. Further inspection reported August 2022 - no concerns identified. 5. West Yorkshire Urgent Care Service Review is underway with support from WY UEC leads through WY UEC Programme Board.	The service has reported continued large numbers of patients within the clinical queue (can be 500 plus). The current contract is coming to end 31st March 2023 however work is underway in conjunction with WYUC Service review to see options for future contractual arrangements.	Static - 1 Archive(s)
2197	30/11/2022	Quality	Tackle inequalities in access, experience, outcomes	6	(I2xL3)	4	(I2xL2)	Debi Gibson	Beverley Geary	There is a risk to patient experience and reputational damage due to the closure of the birth centres in Pontefract and Huddersfield, resulting in reduced choice of place of birth for women. These closures are due to the inability to safely staff the resource.	"Each of the Trusts offer midwifery led care in alongside birth centres at Calderdale and Pinderfields hospitals. Both services provide antenatal and postnatal care in the Kirkless footprint. The standalone birth centre in Dewsbury has reopened and 4 options for place of birth are now available for women within the Calderdale, Kirklees and Wakefield footprint. Equality Impact Assessments have been undertaken by the individual Trusts. Place Care Partnerships are aware of the situation. Ongoing work with the Maternity and Neonatal Voices Partnerships (MNVP) to ensure good communication with service users.	Until staffing levels increase further, no additional standalone birth centres will be able to reopen. Permanence of closures not yet confirmed, may require formal consultation but this will not be until after parliamentary elections due in 2024. Enhanced midwifery continuity of carer teams to be established	Situation monitored by ICB place and trusts, reporting to LMNS board and ICB.	The impact is on a small number of women. Each of the units offer midwifery led care in alongside units.	No gaps in assurance identified.	Static - 1 Archive(s)
2110	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	6	(I2xL3)	4	(I2xL2)	Jason Pawluk	James Thomas	Living with and Beyond Cancer (Strategic Focus Risk): There is a risk that the strategic outcomes from the Living with and Beyond Cancer transformation programme will not be fully delivered due to the approach taken by providers to prioritise the NHS Constitutional Waiting Time standards for cancer (see other risk). This would impact on the quality of care, delivery of the national cancer strategy, and risk significant reputational damage for the ICS.	The Cancer Alliance commissioned a report on options for a Digital Remote Monitoring System (DRMS) to deliver benefits for cancer follow up. Provider trusts were responsible for delivering the recommendations arising and providing a timeline as discussed with WYAAT CIOs. Data collections on other areas such as holistic needs assessments, personalised care support plans, and opportunities for effective pre-habilitation and rehabilitation following cancer treatment. Dedicated Steering Group set up. Provision of Implementation Project Managers to oversee trust responses. National quality of life metric developed. Cancer Alliance Board level oversight of National Cancer Patient Experience Survey.	The development of a milestone tracker has been useful in collecting data, but it has been difficult to complete and is done manually. IT support to make this process easier is required. COSD interface issue.	Supported by national data collection. Implementation managers to support the delivery in local providers. A national quality of life metric has been launched. Covid-19 recovery plans are in place to restart LWBC agenda, both locally and Alliance wide.	-- Cancer Alliance Project Managers in Acute Providers supporting LWBC programme delivery. -- Psychosocial support established as workstream and post holder began in July. -- Successful development of community model of support in two places, with early-stage plans for rollout, subject to strategic support and available finance.	-- Delays and gaps in assurance around DRMS implementation, impacting on benefits realization across the remainder of the programme. -- Recruitment delays have impacted on central delivery capacity for this programme and vacancy control processes have created additional gaps in assurance.	Decreasing
2324	06/06/2023	Finance, Investment and Performance	Enhance productivity and value for money	4	(I2xL2)	4	(I2xL2)	Suzie Tilburn	Kate Sims	There is a potential risk of increased turnover or wellbeing concerns for staff within NHS West Yorkshire ICB as a result of the cost reduction programme and new operating model review and potential organisational change. Whilst the new operating model is developed, some staff may experience a greater period of uncertainty which may result in matters of increased wellbeing concerns or in colleagues opting to leave the organisation for an alternative role and a loss of skills.	Results of the NHS Staff Survey Turnover data including feedback through exit interviews Indication of increased absence relating to work related issues and evidence of increased referrals/ access to occupational health provision and employee assistance programmes/ staff counselling.	None identified at this time.	Staff Briefings - focus on how colleagues are feeling and feedback Staff Engagement Group and Equality Staff Networks - future actions from Group/ Networks. Corporate People Team work programme - the aspects of which that support employee engagement and wellbeing etc. NHS Staff Survey results action plan Peer Support Network Sessions Organisatonal change support and training for people managers Establishment of orgnaisational change and wellbeing hub on Share Board	Staff Briefings - presentation and recordings are available Corporate People Team work programme	None identified at this time.	Static - 2 Archive(s)

Risks Report Summary

CCG: WY ICB - Corporate

Archive Deadline: 25/09/2024

New Risks: 3

Total Risks: 49

Old Risks: 46

Marked for Closure: 3

Mapping of risks –2nd risk cycle of 2024/25

COMMON RISKS

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Common Risk
Kirklees (2195)	There is a risk that the Kirklees Health & Social Care(H&SC) system organisations are unable to deliver comprehensive care. Due to multiple partners across the H&SC system declaring organisational OPEL 4 for sustained periods of time and pressure across the system partners continuing to escalate. Resulting in increased potential for patient care, safety and experience to be compromised.	3	3	6	Common risk re: impact across the system / OPEL 4
Wakefield (2429)	There is a risk that patient safety and experience is compromised due to the number of patients with no reason to reside remaining in the MYTT bed base due to delayed discharge arrangements. This can impact extended patient waits in the ED. In addition escalation beds may need to be opened across the Trust with the resultant impact on the workload for staff and quality of care of patients.	3	3	9	
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk. In combination with the risk of harm to those people who remain in hospital when they no longer have a reason to reside from hospital-related harms and deconditioning while they wait for ongoing services, where their wait is longer than 72h.	4	4	16	
Wakefield (2401)	Waiting times for Tier 4 beds for children and young people have increased, resulting in young people waiting on sections 3s in inappropriate settings.	4	3	12	Common risk re: CAMHS
Leeds (2243)	There is a risk of delay in accessing MH treatment due to the significant increase in referrals over the past years and a lack of capacity within MindMate SPA to deal with referral numbers, resulting in young peoples mental health deteriorating whilst they are waiting to be triaged by MindMate SPA.	3	4	12	

Calderdale (1977)	There is a risk that Children and Young People's (CYP) will be unable to access timely CHFT Community therapy due to:- a) increase in demand and acuity, b) existing high waiting times and c) inability for provider to recruit to vacant posts - (regional and national issue) In particular the risk relates to the legacy waiting times for speech and language (SLT) resulting from a significant increase in the number of referrals in 21/22 compared to previous year, not least to the increase in the number of CYP with Education, Health and Care Plans in Calderdale (consistent with regional and national picture). In January 2024 there were 2.431 on the SLT waiting list with an average wait of 336 days. CHFT Physio and Occupational therapy teams are working at 120% of job plans, so no flex in capacity. Issues remain with videofluroscopy offer from Leeds there were 1314 CYP waiting for a new appointment, 296 waiting for a follow-up with an average wait of 157 days (however, this picture has increased). During Covid-19 lockdown, therapy staff at CHFT were redeployed (as this was a f2f service). Once services reopened, staff returned and virtual/telehealth appointments were offered. Workforce remains a risk with vacancies across therapies which Provider are unable to recruit to (national picture).	3	3	9	
Kirklees (2196)	There is a risk of delays for Kirklees' Children & Young people (CYP) requiring mental health services, including access to tier 4 CAMHS when in crisis, Community therapeutic placements. Due to a significant increase in demand from pre pandemic levels & increased acuity. Resulting in patient care and safety to be compromised & CYP being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	3	3	9	
Calderdale (1864)	There is a risk that people with complex mental health needs will not receive the right level of support that they require to meet their needs This is due to current capacity within community mental health services both health and social care resulting in escalating crisis situations for people in the community and requests for out of area locked rehabilitation hospital placements; and delays in discharge for people who are ready to leave out of area locked rehabilitation hospital placements . This leads to an increased pressure upon CCP Specialist Care/CHC team and to potentially increased costs for CCP.	3	2	6	Common risk re: mental health services capacity and demand

Leeds (2018)	There is a risk of increased rates of avoidable deteriorations in mental health due to demand outstripping capacity to provide access to proactive community mental health intervention and support wider social determinant needs, exacerbated by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent increased lengths of stay and reduced system flow within LYPFT MH inpatient provision, resulting in increased utilisation of out of area placements for acute mental health beds that impacts quality, experience and service user recovery outcomes.	4	3	12	

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

Place	Risk	I	L	Score	Common risks
Calderdale (62)	That the system will not deliver the NHS Planning guidance ED target of 77% for the next quarter, due to pressures associated with; avoidable demand and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	Common risk re ED waits
Wakefield (2409)	There is a risk that the system will continue to see an unprecedented volume of patients attending A&E and therefore will not deliver the NHS Constitution 4-hour A&E target which has been raised from 76% to 78% for 2024/25 due to pressures associated with unavoidable demand, patient choice, capacity and flow out - resulting in long waits, over crowded ED, harm to patients and patient experience being compromised.	2	3	6	
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk. In combination with the risk of harm to those people who remain in hospital when they no longer have a reason to reside from hospital-related harms and deconditioning while they wait for ongoing services, where their wait is longer than 72h.	4	4	16	
Kirklees (2425)	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT & MYHT will result in; long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution	3	4	12	Common risk re: failure to meet Constitutional standards

Calderdale (2162)	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT will result in; long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution	3	4	12	
Calderdale (62)	That the system will not deliver the NHS Planning guidance ED target of 77% for the next quarter, due to pressures associated with; avoidable demand and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
Leeds (2016)	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	4	3	12	
Wakefield (2129)	There is a risk of delays in people accessing planned acute care due to more complex cases and in some cases higher demand and significant capacity issues due to inability to recruit into key clinical roles, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times.	4	3	12	
Kirklees (2049)	There is a risk that Kirklees 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 place.	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)	Demand for adult ADHD assessment exceeds capacity due to increased referrals and there is a waiting list. There is a risk that more people will exercise choice for private assessment where quality of assessments can vary. The overall risk may result in financial risk to the ICB.	3	2	6	Common risk re: adult ADHD assessment
Leeds (2354)	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which will cause impact to patient outcomes and significant financial impact	3	5	15	

BDC (2227)	There is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service. The gap between demand and capacity within BDCFT BANDS continues to grow month on month and referrals increase and capacity remains static. There is inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider. Concerns exist between differences in service quality and outcomes between NHS and IS providers of ADHD Assessment/Diagnosis services.	3	5	15	
BDC (2266)	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	4	4	16	
Kirklees (2180)	There is a risk of non-compliance with the Children & Families Act 2014 and the Health and Care Act 2022 relating to ICB responsibilities with regard to Children with Special Educational Needs and Disabilities (SEND). This is due to Education, Health and Care Plans not being completed within statutory timescales. A key factor is that Health information is not always provided by clinicians in a timely manner. 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	2	6	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	

Calderdale (2219)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints.	3	5	15	Common risk re: posture and mobility service
Kirklees (2218)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints. This could result in patient safety being compromised, and people's experience of the service could deteriorate in relation to waiting times.	3	5	15	

ICB Workforce Risks

Place	Risk	I	L	Score	Common Risk
Kirklees (2078)	There is an ongoing risk of a continual increase in overdue CHC/joint funding/FNC reviews due initially to business continuity arrangements during Q4 21/22 (when "low risk" reviewing activity was paused), but since, vacancies, recruitment challenges and sickness absence in the CHC clinical team, resulting in a poorer patient experience and a negative impact on the CHC activity and delivery.	3	4	12	Common risk re: continuing healthcare workforce challenges
Kirklees (2074)	There is the risk of delays to Continuing Care administration processes and workflows due to a staff shortage in the business support team, resulting in an impact to clinical workflows, the wellbeing of the team, patient experience and a potential impact to organisational reputation. It also has an impact on the financial position of the CHC team, with delays to invoices being paid and potential impact to NHSE mandated activity. June 2024 - the Team has been reduced by 3WTE as part of the Operating Model, which has further impacted upon the capacity of the Team.	3	3	9	
Wakefield (2181)	There is a risk of delayed response to changes in healthcare needs or discharge from hospital for children requiring Continuing Healthcare packages, due to MYTT not having capacity to provide Children's Continuing Healthcare packages under the Block Contract. The result of this is the additional costs to the ICB associated with commissioning of external providers.	3	3	9	

Calderdale (2092)	The Continuing Healthcare team is currently significantly short staffed due to vacancies, short and long term sickness. This is at a time where the team is experiencing high volumes of complex case management, increasing request to case manage crisis situations. There is a risk to the organisational effectiveness in the delivery and quality of the service provided, patient/carer dissatisfaction and increase in complaints leading to reputational damage to the organisation, non-compliance in meeting national assurance targets set by NHSE, and with regard to financial efficacy.	4	4	16	

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Common risk
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
Leeds (2272)	There is a risk to pregnant people of not achieving the preferred elements of care identified in individual personalised care plans, due to midwifery staffing issues (both recruitment and retention), resulting in a potential for poorer outcomes and experience of care	2	3	6	
Leeds (2269)	There is a risk of poor quality care to pregnant people and their families due to workforce short and long-term challenges (eg: industrial strike action across the maternity sector, recruitment challenges, sickness and absences, etc), resulting in poor patient experience, safety, and clinical effectiveness.	2	3	6	
Wakefield (2128)	Children and young people aged 0-19 years will be waiting between 46 to 52 weeks for their first ASD appointment following referral and 106 weeks for diagnosis outcome due to availability of workforce to manage the volume of referrals. The time taken for a full diagnostic assessment for ASD for children and young people is continuing to increase due to the exceptionally high and unpredicted number of referrals. The number of referrals remain much higher and above the capacity planning which was part of the business case for investment. Because of the increased waiting times and pressure/publicity in neighbouring areas the numbers of Patient Choice referrals for assessment has risen in the last 3 months which increases financial pressure on the organisation.	4	4	16	Common risk re: waits for CYP neurodiversity Also seek corporate risk

Calderdale (1338)	There has been an increase in the risk for ASD/ADHD in school age CYP and adult services. School Age CYP is provided by Northpoint (FPoC) and SWYPFT - In Dec 2023 the CCP were made aware of a backlog of 600 cases waiting to be defined as 'clinically appropriate' (pre assessment). The delay has been due to workforce vacancies and increase in referrals (this figure does not include new referrals being received for review). SWYPFT (adult ADHD) have also informed the CCP of c.1,000 people waiting for an assessment with waiting list time being excessive. There is a risk that children and young people (CYP) will be unable to access timely mental health services (in particular complex 'at risk' cases and Autism Spectrum Disorder/Attention Deficit Hypertension Disorder (ASD/DHD)). This is due to a) waiting times for ASD (approx. 14 months) b) lack of workforce locally and nationally to recruit into this service and c) appropriate services not being available for CYP as identified in SEND. Resulting in potential harm to patients and their families.	4	4	16
Kirklees (2240)	There is a risk of children being unable to access a timely diagnostic service for neurodevelopmental conditions. This is due to increased demand for the service and the impact of the Covid 19 pandemic on provision of the service. Waiting time at end of May 2024 was 91 weeks, 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. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.	4	4	16

Place	Risk	I	L	Score	Common Risk
Calderdale (2149)	There is a risk to the ability of care homes to be able to provide a safe, high quality, person centered quality lifestyle due to staffing capacity and gaps in knowledge resulting in poor quality care and experience.	2	3	6	
Wakefield (2138)	Due to the requirement to manage people with increased complexity there is a risk to quality, safety and experience in the independent care sector, rising costs and workforce supply challenges, resulting in insufficient capacity and delayed discharges.	2	3	6	Common risk re: social care workforce
BDC (2417)	There is a risk that there will be further closures to care and nursing homes, and reduced capacity due to a lack of registered managers (RMs) and registered nurses (RNs) causing delays to patient flow from hospital to community settings which would then be a system (Partnership) problem	3	4	12	
BDC (2434)	There is a risk of insufficient social care workforce, specifically care workers and senior care assistants, to deliver safe and quality care services due to a lack of interest/supply from potential domestic workforce. Care sector terms and conditions and pay are a primary reason for a lack of interest from the domestic workforce with workers often choosing higher paid roles in other sectors e.g. hospitality and retail where there has been a shift in some employers paying higher than the National Living Wage, resulting in a reduction of international recruits coming to UK working as care / senior care workers and an insufficiency of social care workforce, causing difficulty in maintaining safe services and delays in hospital discharges, particularly in domiciliary care	4	3	12	
Wakefield 2133	Due to the delay at a national level in implementing the requirements of the Adult Social Care Reform White Paper there is a risk of instability with providers which may result in insufficient resource to cover demand and quality, placing pressure on other services.	3	3	9	

Quality and Safety Risks

Place	Risk	I	L	Score	Common Risk
Kirklees (2179)	There is a risk of Looked After Children (LAC) not receiving an Initial Health Assessment (IHA) or Review Health Assessment (RHA) within statutory timescales. This is due to an increase in the complexity of individual cases and increasing numbers of LAC from outside the area living in private children's homes Kirklees. This includes an increase in Unaccompanied Asylum Seeking Children (USAC), resulting non achievement of mandatory timescales Resulting in performance targets not being met and assessments being carried out late. Health needs may not be identified early enough to ensure that support is put in place promptly.	2	3	6	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	Common Risk
Wakefield (2329)	There is a risk that the high level of risk within the collective ICS financial plan 2024/25 and more specifically the impact of that within the Wakefield Place will mean that transformation schemes and investment decisions will be severely limited. The ICB and in particular within Wakefield has significant cost pressures in Prescribing, Independent Sector Activity, Continuing Healthcare Packages, complex packages of care for both Children and adults, ASD and other areas and is therefore at risk from achieving its financial planning control total.	4	4	16	Common risk re financial plan and financial control target
Wakefield (2397)	There is a risk that the WDHCP part of the WYICS will not as a system develop a financial strategy to deliver a break-even position in future years. This is due in part to the fact that the WYICB - Wakefield Place delegated budget has an underlying deficit going into 2024/25. In addition MYTT has a significant underlying deficit however this may be mitigated by NHSE non-recurrent funding that has been delegated WYICB to be split between Acute	4	4	16	

	Trusts to reduce borrowing requirements. Awaiting WYICB decision re split between WY Acute trusts,. The scale of these pressures will require a financial recovery plan to deliver a break-even position in future years. The result of failure to deliver longer term financial balance will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHSE and a requirement to make good deficits in future years.				
Leeds (2413)	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2024 – 25. This could result in the system as a whole not meeting the statutory duties.	4	5	20	
Kirklees (2393)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position and deliver against the financial plan to break even in 2024/25, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in not delivering the 2024/25 plan, regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	4	5	20	
BDC (2337)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	5	4	20	
BDC (2433)	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	5	4	20	

BDC (2173)	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures.	5	4	20	

Place	Risk	I	L	Score	Common Risk
BDC (2386)	There is a strong and increasing risk to the sustainability of the VCSE sector. This includes the risk of VCSE organisations and services across Bradford District and Craven closing or reducing their delivery or activities. The risks centre around financial sustainability, ability to recruit and retain staff (especially due to employment uncertainty and cost of living) and the decision to withdraw the VCSE infrastructure contract due to local authority budget pressures. All these issues ultimately decrease the sector's resilience and sustainability and would decrease its capacity to engage with the system. This in turn has a knock-on effect on the wider health and care system, both in terms of increase usage of statutory services and a reduction in proactive preventative work to tackle inequalities.	4	4	16	VCSE sustainability risk
Leeds (2415)	There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of VCSE services and closure of VCSE organisations in the current economic and financial context. Loss of VCSE services will result in increased demand on already overstretched mainstream and community NHS services.	4	4	16	

Appendix 1 – Board Assurance Framework Summary and Heat Map

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 1.4	Date: March 2024
Mission		**Strategic risk**	**Risk appetite**	**Target WY score**	**Current WY score**	**Lead director(s) / board lead**	**Lead committee / board**
(1) Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	Ian Holmes	ICB Board
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	8	8	Ian Holmes / Jonathan Webb	ICB Board
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	Ian Holmes	ICB Board *(linked to place committees)*
(2) Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	Kate Sims	Transformation Committee
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	James Thomas	Quality Committee
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	Anthony Kealy	Finance, Investment and Performance Committee
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	Jonathan Webb / James Thomas	Finance, Investment and Performance Committee.Transformation Committee for Digital
(3) Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	Jonathan Webb	Finance, Investment and Performance Committee
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	Rob Webster	ICB Board
(4) Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	Quality Committee
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Anthony Kealy / James Thomas	Transformation Committee
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.	Open	12	16	Ian Holmes	Transformation Committee

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 1.4														Date: March 2024	
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield			
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)		
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20		
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	9	12	9	9	12	16	12	16	9	12		
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	6	8	8	8	8	12	8	8	8	8	8	8		
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12		
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	6	12	8	12	8	8	9	12	8	12		
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	4	6	4	6	4	12	4	12	4	12		
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	2	4	6	6	8	8	6	9	3	6		
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	12	9	16	6	9	9	12	9	12		
Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	4	9	4	12	8	12	4	9	4	9		
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	6	20	6	20	8	20	6	20	6	20		
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	4	12	4	16	2	12	4	16	4	12		
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	8	12	8	12	8	12	8	12	8	12		
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	4	9	8	12		
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required		
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required		

West Yorkshire Health and Care Partnership

Board Assurance Framework – Action Plan for Bradford District and Craven

NHS West Yorkshire Integrated Care Board

Action Required	Lead	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Comments
Strategic Risk 1.1 - There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic, social, and political factors.														
Promoting strategic vision to reduce inequalities via our published Call to Action on inequalities for Bradford District and Craven (covers health, lifestyle, wider determinants and community roles).	Duncan Cooper	X	X	X	X	X	X	X	X	X	X	X	X	Ongoing Promotions
The anti-poverty strategy, addressing economic inequality, has a range of initiatives that both prevent and mitigate the impact of poverty on health inequalities. This is led by Bradford Council with a multiagency group overseeing implementation.	Duncan Cooper	X	X	X	X	X	X	X	X	X	X	X	X	Ongoing initiatives with strategy in place
Strategic Risk 1.2 - There is a risk that operational pressures and priorities impact our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.														
The Closing the gap programme has been set up by the ICB so that we work in a collaborative way to respond to the extreme financial challenges that face all of us. As part of this we have a prioritisation framework for financial decisions that includes inequalities as a highly weighted factor.	Mike Woodhead	X												Closing the Gap Programme Established and ongoing
During Autumn 2023 we brought together our enabling functions (the Reducing Inequalities Alliance, Living Well, EDI programme and HDRC (Health Determinants Research Collaborative)) to work more closely to embed and coordinate the work on inequalities into strategy and investment decisions sitting under the District Plan (wellbeing board) and Bradford District and Craven Health and Care Partnership forward view. This programme contains a plan to strengthen governance, workforce and best practice via the combined efforts of the 4 enablers (e.g training, intelligence, learning networks, board assurance tools).	ICB Leadership Team	X	X	X	X	X	X	X	X	X	X	X	X	Action initiated since Autumn 2023

Action Required	Lead	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Comments
We continue to work in partnership via our Access to Care Programme (ATC) in developing waiting well initiatives and in the next 3 months we will be focusing our attention on improving our referrals using our Assist pathways to ensure we maximise the potential to support people both before they are referred but also to ensure they are treated as close of home as possible. Teams have committed resource (staff) to do this. Assurance will be via the ATC Programme Board.	Helen Farmer	X	X	X										Delivery by May
Strategic Risk 1.3 - There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbate) health inequalities.														
Undertake EQIAs, inclusive of Health Inequality assessments for all disinvestment cases.	Mike Woodhead		x	x	x	x	x	x	x	x	x	x	x	
Develop population health segmentation and population health need analysis to inform decisions	Mike Woodhead		x	x	x	x	x	x	x	x	x	x	x	We are ensuring that evaluation of our Reducing Inequalities in Communities programme RIC (20 separate evaluated projects) is informing our local Closing the Gap programme (to meet efficiencies)
Wherever appropriate, commit to service user engagement or consultation (minimum), and preferably co-production in significant rationing decisions.	Mike Woodhead		x	x	x	x	x	x	x	x	x	x	x	
Strategic Risk 1.4 - There is a risk that we fail to join up services in our communities, which means that we will not improve outcomes and reduce health inequalities.														

Action Required	Lead	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Comments
Supporting best practice in reducing inequalities in communities via our core20PLUS5 programme. This has a programme of hyper local commissioning and participatory budgeting (covering VCSE and 13 x community partnerships), developing a Community Health Check model to support NHS models. Place based evaluation plan for Core20PLUS5 approved. This is also supported by ABCD grants process and strengthening a Locality based working model (with NHS and LA posts, and Community Anchor network)	Duncan Cooper		x	x	x	x	x	x	x	x	x	x	x	core20PLUS5 programme ongoing
Deep dive session on inequalities in Tobacco Harm and Serious Mental Illness to bring partners together around strategy to reduce inequalities (to foster collaborative working, reduce duplication, shared resources)	Duncan Cooper	X												Via Reducing inequalities Alliance
Strategic Risk 2.1 - There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.														
Refresh place-based workforce programme to improve recruitment pathways into health and care organisations across BdC, including: • Launch of place based 'pathways into health and care' programme, focussed on engaging young people and groups currently excluded from the workforce in health and care careers. • Consolidation of entry level recruitment across BdC utilising BMDC 'Skills House' service which will reduce entry level vacancies and improve retention. • Launch of programme focussed on increasing clinical placements across BDC with a view to improve pipeline for registered health and care professionals.	Andrew Milner			X										March - Launch of initial pilot for entry level recruitment pilot The ability to recruit and retain sufficient staff across the Health and Care Partnership remains an issue rather than a risk, with the availability of workforce impacting upon health and care organisations ability to deliver.

Action Required	Lead	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Comments
														Timelines for pathways into health and care and clinical placements programme TBC
Refresh place-based workforce programme to improve retention within health and care organisations across BdC, building upon multiple initiatives already in place within organisations. These include a series of staff health and wellbeing initiatives as well as programmes related to leadership inclusion and belonging.	Andrew Milner													Details of timelines and programmes to be confirmed following Workforce Programme Board in Feb 2024.
Strategic Risk 2.2 - There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.														
Newly established governance and assurance arrangements which will take time to embed. Including establishment of sub-groups and oversight and assurance group (SQIAIG) operational by April 2024.	Amanda Stanford / John Hartley	X	X	X	X									
Development of the dashboard to include patient outcomes to be used as a source of assurance operational in first draft by May 2024	Amanda Stanford / John Hartley / Kerry Weir	X	X	X	X	X								
Strategic Risk 2.3 - There is a risk that we cannot measure and assess performance across the system in a timely and meaningful way, which impacts our ability to respond quickly as issues arise.														
Ongoing development of performance reporting structures/processes across place-based committees and transformation programmes	Kerry Weir									X				

Action Required	Lead	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Comments
Strategic Risk 2.4 - There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high-quality care.														
All relevant identified digital work programmes / workstreams must report to the Digital Programme Board to provide assurance that any planned activity will not hinder our ability to provide consistently high-quality care.	Paul Rice			X		X		X		X		X		
Create a Digital Stakeholder Assurance Group that will provide guidance and oversight to the relevant identified programmes/ workstreams to ensure that all stakeholders have received the right level of engagement and will not hinder our ability to provide consistently high-quality care.	Paul Rice				X									Group to be established in April
Continue to develop the Place Based Capital Infrastructure Strategy to ensure that our estate planning across health and care reflects changing service delivery models and supports safe and innovate service provision that is targeted at the areas of highest population need. Implementation will be overseen by the Strategic Estates Group.	Robert Maden						X							Draft strategy produced in June
Strategic Risk 3.1 - There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.														
Review BCF and other pooled budgets	Planning and Commissioning Forum		x	x										
Establish system-wide “financial task force” to work together on closing the gap	Mike Woodhead		x											

Action Required	Lead	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Comments
Strategic Risk 3.2 - There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.														
Agree credible system wide plans	Mike Woodhead		x	x										
Effective monitoring through Local DoFs and System F&P with recovery plans where needed.	Mike Woodhead		x	x	x	x	x	x	x	x	x	x	x	
Strategic Risk 3.3 - There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.														
HCP Governance review plan has been developed and a steering groups has been established to oversee this work.	Sue Baxter	X	X	X	X	X	X							Full review to have concluded by June
Committee Effectiveness Review to commence in March which will be used to evaluate 2023 – 2024 and inform partnership development	Carrie Haywood			X	X	X								Priority programmes will be able to participate in this informally to review effectiveness
Strategic Risk 4.1 - There is a risk that partnership working on wider societal issues is deprioritised to meet current operational pressures.														
Executive Leadership to be agreed from April 2024	Nancy O'Neill				X									
Allocative efficiency whole system planning processes are underway, designed to ensure use of resources better reflects strategic intent	ICB Leadership Team	X	X	X	X	X	X							
Strategic Risk 4.2 - There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.														
We are actively scaling up good practice across BDC such as the Bradford Council RESPECT Allyship programme to build on cultural competency, social connections and trust and reciprocal mentoring schemes to manage emerging and existing talent as well as building on movements into action such as the WY Root out Racism.	Zahra Niazi and Kez Hayat		X											EDI work to form part of workforce priority programme – first board in February

Action Required	Lead	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Comments
Our Diversity Exchange website is already collecting a bank of good practice. We now need to start evidencing progression and impact across our priority actions, but this will require commitment to additional measuring.	Zahra Niazi and Kez Hayat			X										workforce programme board to support impact assessment in March
Strategic Risk 4.3 - There is a risk that threats to our people and physical and digital infrastructure, e.g., cyber-attacks, terrorism, and other major incidents, prevent us from delivering our key functions and responsibilities.														
Strategic Risk 4.3 – Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.														

Key

	Complete
	On Track
	Not on track
	Overdue

Meeting name:	System Finance & Performance Committee
Agenda item no:	9
Meeting date:	29th August
Report title:	System Finance Report for July 2024
Report presented by:	Mike Woodhead
Report approved by:	Mike Woodhead, BDC Place Finance Lead
Report prepared by:	Karen Parkin Operational Finance Director / Amy Paffett, Deputy Finance Director BDC Place

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations:			
Finance and Performance Committee 29 August 2024			
Executive summary and points for discussion:			

This report provides information on the financial position of the Bradford District and Craven Health & Care Partnership as at the 31st July 2024 and the forecast financial position for the year.

Key Points:

- At Month 4, the BDC Place position for Health shows an adverse variance to plan of £3.2m (year-to-date). Full year forecast outturn is in-line with plan with a forecast deficit of £39.6m, although there is significant risk to be managed to achieve this position.
- Key risks continue to be the delivery of required savings targets that have been built into the plan across the ICB and Providers. At Month 4, Airedale FT and Bradford District Care Trust are forecasting under-delivery of their efficiency plans by £1.1m and £7m respectively and BTHT are keen to note that their efficiency challenge of £38.9m is unprecedented.
- All organisations are flagging under-delivery of Cost Improvement/efficiency schemes as part the worst-case scenario reported to the total of £20.7m. This is £1.8m for the ICB, £2.5m for AFT, £1.4m for BDCT and £15m for BTHT.
- Additional risks have been recognised in relation to ERF funding. The ICB has received an ERF allocation as part of the planning process however an element of this requires the delivery of a 14% increase on the 19/20 baseline for Independent Sector elective activity. In 23/24, the Bradford Place delivered a 9% increase on the baseline and so the achievement of 14% is considered a significant stretch. If this is not achieved, it is

possible that part of the ERF allocation will be reclaimed (up to £1.1m) and this is reflected in the ICB worst case position. AFT and BTHT have also flagged risks on their ERF income to the tune of £6.8m within their assessment of their worst-case scenarios

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

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

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

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

Recommendation(s)

The BDC Partnership Board is asked to:

1. Note the year-to-date financial position as at the 31st July 2024 and the full year forecast financial position;
2. Highlight any key messages for the Partnership Leadership Executive / Health and Care Partnership Board.

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. System Finance Report for July 2024.

Acronyms and Abbreviations explained

1. BDC: Bradford District and Craven

What are the implications for?

Residents and Communities	Efficient and effective use of resource to maximise potential investment and improve population health.
Quality and Safety	Deploying our resources in a way that manages quality and safety risks and supports improvement.
Equality, Diversity and Inclusion	Resource utilisation in a way that addresses equality, diversity and inclusion issues.
Finances and Use of Resources	Forecast spend within budgets demonstrates effective use of resources for our population.
Regulation and Legal Requirements	Organisations expected to operate within financial envelope with no over-spend.

Conflicts of Interest	-
Data Protection	-
Transformation and Innovation	Capital and revenue allocations assume spend to drive service improvement, transformation and innovation. Allocations include Service Development Funding.
Environmental and Climate Change	Ensure that resources deployed in a way that promotes environmental sustainability. Capital spend subject to strict carbon footprint regulations.
Future Decisions and Policy Making	Allocation methodologies to support delivery of the Bradford District and Craven Health & Care Partnership strategic objectives.
Citizen and Stakeholder Engagement	-

Bradford District and Craven Health and Care Partnership

System Finance Report for July 2024

Bradford District and Craven
Health and Care Partnership

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Summary Place Financial Position

Jul-24

Organisation	I&E reported Month 04 24/25			I&E forecast			Scenarios - Org assessment		
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m	Best Case Variance £m	Likely Case Variance £m	Worse Case Variance £m
Airedale NHS Foundation Trust	(8.7)	(11.2)	(2.5)	(17.8)	(17.8)	0.0	0.0	0.0	(13.5)
Bradford District Care NHS Foundation Trust	(1.0)	(1.2)	(0.2)	0.0	0.0	0.0	0.0	0.0	(2.8)
Bradford Teaching Hospitals NHS Foundation Trust	(9.5)	(10.0)	(0.5)	(14.0)	(14.0)	0.0	0.0	0.0	(24.2)
Bradford ICB	(2.6)	(2.6)	0.0	(7.8)	(7.8)	0.0	0.0	0.0	(11.0)
Total Position for Health	**(21.8)**	**(25.0)**	**(3.2)**	**(39.6)**	**(39.6)**	**0.0**	**0.0**	**0.0**	**(51.5)**

Key Headlines:

- At Month 4, the BDC Place position for Health shows an adverse variance to plan of £3.2m (year-to-date). Full year forecast outturn is in-line with plan with a forecast deficit of £39.6m, although there is significant risk to be managed to achieve this position.

- Key risks continue to be the delivery of required savings targets that have been built into the plan across the ICB and Providers. At Month 4, Airedale FT and Bradford District Care Trust are reporting underdelivery of their efficiency plans by £1.1m and £6m respectively and BTHT are keen to note that there efficiency challenge of £38.9m is unprecendented.

- All organisations are flagging underdelivery of Cost Improvement/efficiency schemes as part the worst case position reported to the total of £20.7m. This is £1.8m for the ICB, £2.5m for AFT, £1.4m for BDCT and £15m for BTHT.

- Additional risks have been recognised in relation to ERF funding. The ICB has received an ERF allocation as part of the planning process however an element of this requires the delivery of a 14% increase on the 19/20 baseline for Independent Sector elective activity. In 23/24, the Bradford Place delivered a 9% increase on the baseline and so the achievement of 14% is considered a significant stretch. If this is not achieved, it is possible that part of the ERF allocation will be reclaimed (up to £1.1m) and this is reflected in the ICB worst case position. AFT and BTHT have also flagged risks on their ERF income to the tune of £6.8m within their assessment of their worst case positions.

- The 'Worse Case' forecast outturn positions also include other items such as pressures relating to pay award funding, increasing costs of high cost drugs which is not reflected in increases to block contract funding.

- This report only contains the financial position for health partners across Bradford District and Craven. The Qtr 1 financial position for Local Authority is being presented to their Board on 2nd September and so will be available for inclusion in the next period report.

West Yorkshire ICB	Bradford
Finance Report 2024/25	
Month 04	

Bradford District and Craven Health and Care Partnership

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	YTD Plan	YTD Spend	YTD variance (Over)/Under	Annual Plan	Forecast Spend	Annual variance (Over)/Under	Change in variance (Adverse)/Favourable
	£000	£000	£000	£000	£000	£000	£000
ALLOCATIONS	**442,285**			**1,310,966**			
EXPENDITURE							
ACUTE	225,545	225,552	-7	670,428	670,428	0	0
MENTAL HEALTH	51,475	51,432	43	154,426	154,398	28	28
COMMUNITY	42,744	42,769	-24	128,232	128,257	-25	-25
CONTINUING HEALTH CARE	31,297	32,297	-1,000	93,890	94,107	-217	-217
PRESCRIBING	40,180	40,668	-488	120,541	122,064	-1,523	-1,523
PRIMARY CARE	2,528	2,516	11	7,582	7,562	20	20
DELEGATED PRIMARY CARE	47,620	47,687	-67	137,626	137,826	-200	-200
OTHER COMMISSIONED SERVICES	1,069	1,050	19	3,206	3,177	29	29
PROGRAMME ESTATES AND ADMINISTRATIVE COSTS	1,127	1,096	31	3,340	3,340	0	0
PROGRAMME STAFFING	957	922	35	2,870	2,904	-34	-34
RESERVES	-31	-31	-0	-92	-92	0	0
ANTICIPATED ALLOCATIONS - ERF	0	-170	170	-4,949	-4,949	0	0
UNIDENTIFIED QIPP	-782	0	-782	-1,806	-1,806	0	0
RUNNING COSTS	1,146	1,125	21	3,439	3,490	-51	-51
TOTAL EXPENDITURE	**444,874**	**446,912**	**-2,038**	**1,318,732**	**1,320,705**	**-1,973**	**-1,973**
DEFICIT PLAN	**-2,589**	**0**	**-2,589**	**-7,767**	**0**	**-7,767**	
IN YEAR POSITION	**0**	**-4,627**	**-4,627**	**-0**	**-9,739**	**-9,739**	
RISK RESERVE	0	-2,032	2,032	0	-1,973	1,973	1,973
REPORTED IN YEAR POSITION	**-2,589**	**-2,595**	**6**	**-7,767**	**-7,766**	**-0**	

- Overall, the year-to-date position shows a deficit of £2.6m and the full year forecast outturn position shows a deficit of £7.8m, both in-line with plan and as reported as part of the overall West Yorkshire position at Month 4

- To achieve this position, BD&C ICB has had to recognise a risk reserve of £1.97m. This is offset forecast pressures in the following areas:

1) Prescribing – prescribing information received to date (April and May only) is indicating that there will be a £1.5m forecast outturn variance to budget. Analysis of the information is ongoing however it is worth noting that the budget set included an assumption of £1m in cost savings relating to DOACs. Based on our usage of these drugs, it is anticipated that the majority of these savings will materialise in the 2nd half of the year and so are not currently factored into the forecast.

2) Primary Care – a £0.2m cost pressure has been recognised in relation to Shared Care. This is a tariff based contract and initial information received has evidence a significant increase in activity.

3) CHC – as reported last month, there is an ongoing pressure in relation to CHC staffing. This relates to the increased costs of using agency staff to fill vacancies. Recruitment is ongoing in order to fill this posts on a substantive basis to mitigate this overtrade as far as possible.

- The savings plan includes unidentified savings of £1.8m. At this stage in the year, we have identified opportunities to address this which total £1.1m however only £0.6m can be confidently delivered in year.

Savings Plan Performance

Organisation	YTD			FOT		
	Plan £m	Outturn £m	Variance £m	Plan £m	Outturn £m	Variance £m
West Yorkshire ICB Total	**29.3**	**23.9**	**(5.4)**	**98.5**	**96.7**	**(1.8)**
Recurrent	14.4	14.2	(0.2)	42.5	43.0	0.5
Non-Recurrent	14.9	9.7	(5.2)	56.0	53.7	(2.3)
Bradford District and Craven ICB Total	**4.3**	**4.3**	**0.0**	**12.9**	**12.9**	**0.0**
Recurrent	3.0	3.0	0.0	8.9	8.9	0.0
Non-Recurrent	1.3	1.3	0.0	4.0	4.0	0.0
Bradford Provider Total	**14.6**	**12.8**	**-1.8**	**67.9**	**59.8**	**-8.1**
Airedale NHS Foundation Trust	3.0	2.7	(0.3)	14.8	13.7	(1.1)
Bradford District Care NHS Foundation Trust	3.8	2.3	(1.5)	14.2	7.2	(7.0)
Bradford Teaching Hospitals NHS Foundation Trust	7.8	7.8	0.0	38.9	38.9	0.0

Comments on variances:

Airedale NHS FT - The Trust are still working through identifying schemes to deliver the efficiency target. External capacity has been sourced to assist with this, supported by NHSE.

Bradford District Care Trust : Higher than planned Out of Area placements - largely driven by secure patients in the PICU bed base. Escalations have been made through the Adult Secure Provider Collaborative and to the National team. Also, temporary staffing spend is higher than plan due to acuity on the wards.
Additional management controls have been introduced in July to provide headroom to mitigate against the CIP delivery risks.

ICB(BDC) : The savings plan includes £1.8m of unidentified savings. Since Month 3 reporting**,** further savings of £1.1m have been identified with at least £0.6m deliverable in year. Further savings oportunities area are expected to arise from the service review work being carried out by local Trusts. While it is still reported that the ICB in place will deliver the full efficiency plan, there is a high level of risk surrounding the remaining unidentified value of £1.2m in year.

Agency

Organisation	YTD			FOT		
	Plan £m	Outturn £m	Variance £m	Plan £m	Outturn £m	Variance £m
Airedale NHS Foundation Trust	2.6	3.6	(1.0)	7.7	9.6	(1.9)
Bradford District Care NHS Foundation Trust	1.7	1.7	0.0	5.4	4.3	1.1
Bradford Teaching Hospitals NHS Foundation Trust	3.1	2.7	0.4	7.5	7.5	0.0
West Yorkshire Provider Total	**29.2**	**27.0**	**2.2**	**88.1**	**68.4**	**19.7**
System level agency ceiling				**97.6**		
Agency spend as % of agency ceiling	**29.9%**	**27.6%**		**90.3%**	**70.1%**	

Comments on variances:

- Airedale NHS FT: Deficit in July was reduced from June (excluding industrial action impact), with 13% improvements in bank and agency spend, however agency still remains above the cap and further work underway through rapid improvement work on temporary staffing.

- BTHFT: greater expenditure is forecast in the 2nd half of the year due to winter pressures

Bradford District and Craven Health and Care Partnership

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NHS West Yorkshire Integrated Care Board

Meeting name:	System Finance & Performance Committee
Agenda item no:	9
Meeting date:	29th August
Report title:	Closing the Gap Update
Report presented by:	Mike Woodhead, BDC Place Finance Lead
Report approved by:	Mike Woodhead, BDC Place Finance Lead
Report prepared by:	Clare Smart Associate Director of Strategy / Mike Woodhead, BDC Place Finance Lead

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

Previous considerations:

Finance and Performance Committee 29 August 2024

Executive summary and points for discussion:

This report provides an update on progress regarding the Closing the Gap (CtG) programme.

Key Points:

- CtG Objective 1:
    - Q1 peer to peer review session held on 1 August, in line with action plans.
    - WYAAT commissioned PWC to conduct an externa review of leadership, culture and improving productivity and strengthening management grip and control – final reports to be shared in coming weeks.
    - That work to be extended in scope and also to cover ICB, Mental health and Community health in September.
    - WY ICS and five of the six WYATT Trusts now in segment 3 of the NHS Oversight Framework, increasing likelihood of regulatory intervention and direction.
- CtG Objective 2:
    - Detailed review of current services at each trust completed and shared.
    - System wide workshop to take place in September, facilitated by external consultant, to agree priority opportunities from greater collaboration.

- CtG Objective 3
    - Population health business intelligence well developed and shared with each programme board to inform the prioritisation of their programmes.
- CtG Obective 4
    - Review of Intermediate Care services and pathways well progressed, with a number of actions already implemented to reduce bed base and financial envelope.
    - Other workstreams (strategic estates, housing for health and complex children) less progressed.

The paper also summarises the governance and oversight arrangements for the CtG programme and gives and update on our approach to communications and involvement.

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

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

Recommendation(s)

The BDC Partnership Board is asked to:

1. Note the progress against various elements of the CtG programme.
2. Highlight any key messages for the Partnership Leadership Executive / Health and Care Partnership Board.

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

CtG: Closing the Gap

BDC: Bradford District and Craven

What are the implications for?

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Future Decisions and Policy Making	Allocation methodologies to support delivery of the Bradford District and Craven Health & Care Partnership strategic objectives.
Citizen and Stakeholder Engagement	-

Closing the Gap update

1. Purpose and Background

The purpose of this paper is to offer an update to the Committee on the collaborative programme of work known locally as 'Closing the Gap' in response to the extreme financial challenges that face the health and care system in Bradford District and Craven. The programme was established in April 2024.

The programme of work will mean short and long-term impacts to the delivery of our services, although we aim to:

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

The approach taken is a collaborative one. We know that by approaching this challenge as a Partnership, we will get greater value through the best use of our collective resources, minimising duplication, and waste.

2. Update position

2.1 Closing the Gap objectives

Closing the Gap has four objectives set out in the programme mandate. This section sets out a brief update on each of the 4 agreed objectives.

1. **Agree the top opportunities for improving productivity and tackling waste and strengthen mutual accountability**.

   The three Foundation Trusts have used benchmarking and key data sources (such as Model Health System, GIRFT, NHS Benchmarking etc) to identify the main opportunities for each organisation to reduce waste. This includes stopping procedures that are on the Evidence-Based Interventions list, reducing unwarranted variation in quality, cost, referrals, and demand, improving productivity and strengthening management grip and control. On 1st August, a "check and challenge" peer-to-peer review took place for Quarter 1, in line with our agreed action plan.

   In addition, the West Yorkshire Association of Acute Trusts (WYAAT) commissioned PWC to conduct an external review of the leadership, culture and financial accountability frameworks in each trust, in relation to their in-year financial improvement. Those reviews have now been completed and will be shared with

system partners in the coming weeks. West Yorkshire ICS is in the process of commissioning a wider piece of work to include ICB, mental health, community and ambulance services (scheduled to start in September).

This piece of work is a pro-active approach to undertake the kind of assessment, on our own terms, that we would expect to be mandated in the event of us coming under greater regulatory scrutiny. That likelihood of that event is increasingly high, and the Committee should note that:

- West Yorkshire ICS (i.e. the entire health part of the system) has been placed in segment 3 of the NHS Oversight Framework (we were previously segment 2, attracting lighter-touch regulation). This is defined by NHSE as "ICB or provider and/or wider system are significantly off-track in a range of areas. We lack confidence in the capability to respond to challenges without support". NHSE takes the view that "Support needs are diagnosed together and delivered through local support offers, defined national support programmes and bespoke regional interventions." They say they will drive improvements through "enhanced scrutiny targeted at delivering improvement in the most challenged performance areas. Recovery KPIs and trajectories are agreed upon and proactively monitored". And NHSE "may apply interventions and/or direct an organisation to take specific actions related to diagnosed issues. Enforcement action may be taken where required".

- All West Yorkshire acute trusts, barring Leeds Teaching, have now also been individually placed in segment 3.

2. Identify ways in which system partners could collaborate further on service delivery and prioritise services that could be rationalised, transformed, stopped, slowed, scaled down, or delivered in some other more efficient way.

Each organisation and the ICB at Place have completed a service line review of all provided and commissioned services. This is being used to agree opportunities for greater collaboration, the approach to the stabilisation of 'fragile' services, and areas for further rationalisation across organisations.

The next step is to identify the key opportunities from greater system-wide collaboration and agree what the "to be" map of services (and service delivery) should look like. We have commissioned an independent consultant, Mike Farrar, to facilitate the planned system-wide workshop in September and he is in the process of interviewing system leaders in preparation for that.

3. Progress our system population health approach

   ICB Business Intelligence work on population health and population health management is progressing well. This focuses on allocating our system resource based on population segmentation, a type of analysis that allows us to separate populations into subgroups so that we can better assess each groups wants, needs, and health priorities. This type of analysis supports the Partnership to develop effective and efficient interventions, identify variation in health outcomes, take a staged approach to implementing integrated care, and allocate resource based on healthcare usage.

   This approach to understanding our population will support our transformation work, with priority programme boards being introduced to the approach. The next phase will be to agree how to take this forward through service-based, segmentation-based, or a mixed model approach to resource allocation.

4. Progress immediate system priorities with Bradford Council

   This programme of work includes plans to tackle:

   - Complex children's packages of care and out of area placements
   - Intermediate care reform and the review of the Better Care Fund spend
   - Housing for health
   - Strategic estates work

   The main area of progress here is around the system-wide review of intermediate care which is well developed. This has been ongoing for well over a year and has already resulted in significant changes in the bed base and financial envelopes.

2.2 Governance and oversight

Closing the Gap Programme Board

The Programme Board is the assurance mechanism to demonstrate that every opportunity and action to move to a balanced financial position has been taken. It provides insight and support in relation to the Health and Care Partnership's approach to our financial challenge. The effective application and implementation of the objectives of the Closing the Gap programme mandate are overseen by a Programme Board. The Programme Board is chaired by the Partnership's lead for system finance.

Closing the Gap Business Case Appraisal Panel

The Business Case Appraisal Panel (BCAP) was established to maintain a robust and transparent process for the consideration of Health and Care Partnership business cases. It

takes an evidence-informed and data-driven approach in its deliberation using appropriate tools and frameworks. The BCAP makes recommendations to the Partnership Leadership Executive (PLE) on commissioning decisions in relation to business cases considered by the Panel. This includes advising the PLE should the recommendations indicate the need for engagement, involvement, or consultation. The work of the BCAP is shared with the system committees for finance and quality on request. The BCAP has submitted three tranches of recommendation to the PLE to date. The BCAP is chaired by the ICB's Associate Director of Strategy. The appraisal criteria used by BCAP is contained in Appendix A. The membership of the panel is wide and includes:

- Director of Strategy and Panel Chair
- Director of Population Health and Inequalities
- Programme Director Healthy Minds
- Associate Director of Reducing Inequalities
- Consultant in Public Health
- Programme Director Access to Care
- Assistant Director of Quality
- Place Director of Quality and Nursing
- Programme Director Healthy Children and Families
- CEO of the VCS Alliance
- Assistant Director of Workforce
- Associate Director of Finance (BDC ICB)
- Associate Director of Communications and Involvement
- Associate Director of Strategy
- Deputy Chief Operating Officer (provider)
- Place Director of Finance

2.3 Communications and involvement approach

Our communications and involvement approach is in line with our wider principles when sharing information with our stakeholders – we aim to be open, transparent, clear, and timely. Since the Closing the Gap programme was established we have set up a dedicated webpage, updating it with new information on a regular basis. We have now issued three briefings to system partners; this number would have been higher however we paused any proactive communications activity during the two pre-election periods we have had in 2024.

Our most recent reporting period for our website analytics (May – July 2024) showed that the Closing the Gap page was the most visited one on our place-based partnership site. However, we recognise that we must do more to ensure that the message permeates through to all members of our workforce and that it reflects the scale of challenge we are facing. In November, we will be sharing an update with members of Bradford District Health and Social Care Overview and Scrutiny Committee, this will allow us to start an open dialogue with

elected members. The outcome of this meeting, including the involvement and ideas of elected members will help shape our future strategy alongside wider system partner feedback.

Our 'Listen In' programme as well as broader insight from other involvement activity from across our partnership has helped us develop personas. These personas will be used for our involvement events but will also support our thinking when considering business cases and proposals. This alone though cannot form our only way to listen to the views and experiences of our citizens and colleagues. We are clear that we need to have a conversation with our population that sits outside of the statutory duty to involve people when making service change proposals. We want to be proactive in this space, using existing insight and intelligence as well as looking to have a deeper level of engagement with people – citizens and our workforce.

To do this we will be holding a deliberative event in October, the date is being finalised. We have rescheduled this from September as we have given ourselves more time to ensure our planning and our ask of citizens and colleagues is clear, allowing us to generate evidence to support our approach to future decision making. It will also give us the opportunity to test out whether local people align with national insights on public views. Prior to the event in October, we will test our thinking out with a prototype version of the deliberative event with ICB at place colleagues, taking any learning into our planning for the October public-facing event.

Appendix A: Business Case Appraisal Criteria

Closing the gap: prioritisation criteria

Bradford District and Craven Health and Care Partnership

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Our population

Improved health and equity for all local people

- **Effectiveness**
  The impact of the proposal on behavioural or health outcomes per recipient
- **Impact on health inequalities**
  To what extent the proposal reduces or prevents widening of health inequalities
- **Local need**
  The number or proportion of individuals in the community who could potentially be impacted by the proposal
- **Prevention**
  To what extent is the proposal area focused on prevention

Our partnership

Enable people to take more responsibility for health and self-care

- **Acceptability**
  Whether there are political, cultural, or moral objections to the interventions
- **Connectedness**
  The effect on other parts of the health system, but could also include wider impacts across our partnership
- **Building community strengths**
  To what extent the proposal builds assets in communities that will support them to maintain their own health and wellbeing
- **Local growth**
  To what extent the proposal contributes to developing the local economy

Our leadership

The sustainability of our health and care system is assured

- **Cost-effectiveness**
  To what extent a proposal has achieved (is expected to achieve) its results at a lower cost compared with alternatives or reduces costs within the system
- **Mandation**
  The proposal is partially or wholly mandated
- **Innovation**
  Whether the proposal area pioneers new approaches

All proposals must include a quality and equality impact assessment (QEIA)

Proceed or not questions

Regulatory requirement: Is the programme, intervention, or service provided mandated (this refers specifically to the service or intervention rather than the expected outcome)?

Partnership priority: Does the programme, intervention or service focus on a Bradford District and Craven Health and Care Partnership priority area?

	System strategy purpose and commitments	Criteria	Description	Evidence
1	Purpose, place	Effectiveness (health outcomes)	The impact of the proposal on specified behavioural or health outcomes on the targeted population.	The narrative clearly states which outcomes are addressed for the targeted population, what can be achieved and by when. It will also reference how outcomes will be measured and reported.
2	Purpose, people, place	Impact on health inequalities	To what extent the proposal will have a positive impact on health inequalities (see the Reducing Inequalities Toolkit). To what extent the proposal enables us to maintain the mental health investment standard, where relevant.	The narrative has a clear description of the target cohort, the health inequalities this group faces, the consequences of tthese inequalities, and the maintainance of the mental health investment standard, where relevant.
3	Purpose, people, place	Prevention	To what extent the proposal is focused on, and will impact on, prevention (reduce the incidence of disease and health problems within the population) and support healthy lifestyles.	The narrative identifies areas of delivery that will have a positive impact on the prevention of illness in the cohort identified and/or the improvement in management of existing conditions.
4	People, partnership	Acceptability	To what extent the programme / intervention is acceptable to the target population and is therefore likely to be successful. This includes both the outputs and the outcomes. Has the population been involved and engaged in design? Does a formal involvement exercise need to be carried out?	The narrative has clear evidence that the programme / intervention is feasible and will be utilised (it has been appropriately tailored for the target population).
5	Purpose, people, place	Evaluation	To what extent the programme / intervention has been evaluated and how positive the measured outcomes are.	The narrative shows a clear view of the evidence base of the proposal, how the proposal has been or will be evaluated, and/or the outcomes from the evaluation that has been undertaken.

	System strategy purpose and commitments	Criteria	Description	Evidence
6	**Partnership**	**Connectedness**	Potential effects on other parts of the system - including unintended consequences on other services. To what extent the proposal aligns with existing activities., including positive impacts on the wider determinants of health.	The narrative clearly describes how the programme / intervention will 'fit' with the wider system and how it will integrate with / complement existing pathways or support similar workstreams, programmes, or projects.
7	**Purpose, people, place, partnership**	**Meeting local needs** **Building community strengths**	To what extent the programme or intervention builds assets in the community that will support people to maintain and improve their own health and wellbeing. The proportion of the population who might potentially be positively impacted by the programme or intervention.	The narrative clearly states the need of the population being targeted, and the size of that population that will be impacted by the proposal.
8	**Place, partnership**	**Local economic growth**	To what extent the proposal contributes to developing the local economy.	The narrative makes reference to how the proposal will contribute to developing the local economy. This may be through using local suppliers, venues, focusing recruitment drives within the local community.
9	**Purpose**	**Cost-effectiveness**	To what extent the proposal will provide good value for money. To what extent a programme has achieved (or is expected to achieve) its results at a comparatively lower cost compared to the alternatives being considered.	The narrative has clear details of the cost of the proposal and evidence of cost-effectiveness. There are no other similar interventions with better value for money; and resources have been allocated in a way that reduces costs, maximises value and that the efficiencies associated with the proposal are sustainable.
10	**Purpose, partnership**	**Innovation**	To what extent does the proposal display innovation in testing, piloting, implementing, sustaining, pioneering new approaches to the provision of care.	The narrative highlights evidence of innovation in the design and planning of the proposal, including understanding of new ways of working to deliver solutions and / or the use of existing transformational and innovative approaches

Appendix B: Communications update from 15 July 2024

Closing the gap: meeting our financial challenge
Update 3: 15 July 2024

This is the third update from our Bradford District and Craven Health and Care Partnership's closing the gap programme. Closing the gap is our system-wide programme, to help us meet the significant financial challenges we face. We remain determined to use our Act as One ethos to involve all sectors in our health and care partnership as this is the only way we can make sound decisions, while acknowledging that there will be undoubted impacts that affect all of us.

In this update, we want to share details of the progress we're making and to share our prioritisation checklist we are using when assessing business cases.

Our current position
At the time of writing (July 2024) we have a planned deficit of around £40m across NHS partners in Bradford District and Craven, with a real risk that that could significantly grow. This deficit describes the difference between the money we receive (our revenue) and the money we spend. If we perform worse that planned, the ***entire*** deficit must be paid back, meaning that we would need to close an even bigger gap in future financial years. This is why we must work together to close this gap now.

We have made good progress since setting up the closing the gap programme as we have reduced our forecasted underlying deficit from £80-90m in December 2023 to £72m in March 2024 and our current position of £40m. While the progress has been noteworthy, we are clear that we have a long way to go, and we have some difficult decisions still to come.

Each of our place-based NHS Providers – Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust – are working alongside our place-based NHS West Yorkshire Integrated Care Board (ICB) and VCSE and local authority partners to thoroughly review all the services each of us provides or funds. This review is designed to look at current and anticipated future needs, supported by an understanding of our communities and using data that focuses on population health groups. You may be asked to contribute to your organisation's review process as well as taking part in work we do together across our partnership. It's important that we involve as many of you as possible, as you'll have ideas and solutions that can help us meet this financial challenge including through waste reduction.

System wide review
Our most recent financial figures show that we have fallen around £3m behind our expected target at this point within the financial year. Therefore, we are now focusing our efforts on reviewing our services to look at how we can do things differently as well as identifying where unnecessary duplication occurs.

This review will look at identifying any gaps, highlight any services that are at risk, reducing activity in some areas where there is limited value (patient and non-patient facing) and moving work to other providers where it is safe to do so. We have held an initial workshop, with more planned, that also involved wider regional partners, to challenge ourselves and to use the data available to us to consider any immediate actions we can take. This includes looking at our medium and longer-term opportunities where we can plan for greater collaboration and integration. This could mean more

teams working closer together to provide support across different organisations and sectors.

If you are employed by an NHS organisation, you will have noticed new systems and processes being put in place to further manage how we use our resources. This includes freezing or slowing down recruitment, reduction on non-essential travel and stricter approval processes in place for any non-healthcare spend. By doing all we can to reduce our spending and close the gap, we reduce the risk of financial controls being placed on us. We want to avoid this and continue to make our own decisions as we have the best understanding of the needs and challenges of our communities. Thanks to all that you have been doing to help us already make good progress in closing the gap.

Transparency in decision making: business case appraisal panel
Over the coming months we expect to be making decisions that result in services changing. To help us ensure we make our decisions well, we have a business case appraisal panel that assesses stopping, pausing or continuing any new business plans as well as assessing the value of any non-recurrent projects. The business panel reflects the different sectors that make up our place-based partnership and considers the quality and equality impact of our plans.

The business case appraisal panel is an advisory group that makes recommendations to our partnership leadership executive. To help us ensure we have a fair and consistent process to making recommendations, the panel uses a prioritisation tool. This tool has a number of strict criteria that panel members have to assess each business case against. We are sharing our prioritisation criteria with you, as part of our ongoing efforts to be as open and transparent as possible on the work we are doing through the closing the gap programme.

Undoubted impacts on all of us
While every effort will be made to reduce the impact of our decisions, we recognise that undoubtedly there will be short and long-term impacts when we must change the way we fund work or where we can no longer fund work. Our challenge is to limit the number of irreversible outcomes when we implement any decisions. Sitting alongside this is the duty to deliver financial balance, while ensuring we meet core health and care standards and maintaining a focus on doing all we can to tackle inequalities.

To help safeguard us from making decisions that could have unintended consequences our decision making groups have all sectors represented from the NHS, local authorities, independent care and voluntary, community and social enterprise sector. This is done through our existing governance and assurance groups, that include representatives from all sectors.

We remain committed to our vision
Using our Act as One ethos, underpinned with a commitment to tackle inequalities, we remain determined in working towards our vision of people living 'happy, healthy at home'.

In the next update on our closing the gap programme we will share details of our planned deliberative event to bring our colleagues and our communities together to work through our challenges.

In the meantime, if you have any ideas that could help us meet this challenge, please do get in touch by emailing actasone@nhs.net

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	BDC Partnership Board
Agenda item no:	10
Meeting date:	6th September 2024
Report title:	Better Care Fund 24-25 Plan update for North Yorkshire HWB
Report presented by:	Vicki Ackerley, Senior Service Manager, Integration
Report approved by:	Saskia Calton
Report prepared by:	Saskia Calton

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

Previous considerations and any resulting action:

N/A

Executive summary and points for discussion:

A two-year Better Care Fund (BCF) plan was submitted to the BCF national team on 19th July 2023. This included a jointly agreed plan with an accompanying narrative which was signed off by the chair of the North Yorkshire Health and Wellbeing Board on 15th March 2024 (Appendix 1).

In April 2024, the BCF national team released the reporting guidelines for 2024/25. This includes a requirement for local areas to agree a revised spend for 2024/25 if applicable and establish the use of the additional Adult Social Care Discharge Funds.

The NY BCF 24/25 funding contributions include:

- Minimum NHS Contributions (£51.5m) – increase of 5.66% from previous year towards uplifts to services. WY ICB share in the BCF NY Plan is £4.3m of which 1.6m is passported to North Yorkshire Council for the protection of social care element.
- Improved BCF (£17.3m) – same as previous year, ringfenced to social care.
- Adult Social Care Discharge Fund (£9.1m) – Increased by £3.1m to support pressures on hospital discharge. WY ICB has allocated 0.2m of their ASCDF to North Yorkshire Council for Reablement services in the area.
  Discharge costs are one of the main drivers of financial pressures in Adult Social Care and continue to increase.
- Disabled Facilities Grant (£5.6m) – reference to housing adaptations.

The BCF national team set a deadline of 10th June 2024, for the submission of the planning template and the NY BCF 2024/25 was submitted to the Assurance Panel on 3rd July.

The BCF 24/25 plans is continuing to commit to maintaining or improving current delivery.

An updated capacity and demand plan is required for 2024/25. Where appropriate, the C&D plan will align to the NHS operational plan. Further work is underway to understand the full extent of demand & capacity across all services (Appendix 2)
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 NY HWB BCF Plan 23-25; and 2. To note the NY HWB BCF updated plan 24/25.
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. NY HWB BCF Plan 23-25 Plan and Narrative 2. NY HWB BCF Plan 24/25 updated Plan
Acronyms and Abbreviations explained
1. BCF – Better Care Fund 2. NY North 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	-

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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	-

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North Yorkshire (NY)

Better Care Fund (BCF) Narrative

2023-25

Final Version – 28 June 2023

EXECUTIVE SUMMARY

The NY BCF continues to constitute a major programme of joint investment and commissioning between North Yorkshire Council and the NHS via North Yorkshire Place, within the Humber and North Yorkshire Integrated Care Board. The integrated delivery of the Better Care Fund remains a key driver for the establishment and improvement of integrated services across North Yorkshire.

Fund value

The total BCF value in 2023/24 is £77.2 million, comprising:

- Disabled Facilities Grant - £5,114,924
- Minimum NHS contribution - £48,759,576
- iBCF - £17,328,446
- Local Authority Discharge Funding - £2,429,421
- ICB discharge fund - £3,348,000

The current projected value of the fund in 2024/25 is £81.3 million, incorporating a rise in the NHS minimum contribution and increase in the NHS discharge fund (increasing from £3.3m in 23/24 to £4.7m in 24/25 – planned spend still to be determined for the increase).

Priorities for 2023-25

The head-line priorities for NY are included in a Place Board Plan as follows:

- Priority 1 – A comprehensive and integrated health and social care model
- Priority 2 – A high quality care sector, with sufficient capacity to meet demand
- Priority 3 – A strong workforce
- Priority 4 – Prevention and Public Health

In respect of BCF specifically, the following areas represent priority areas for development over the next 2 years:

- Development of Local Care Partnerships supported by locality-based plans
- Strengthened multi-disciplinary working and the development of neighbourhood teams
- Development of a population health management approach to address health inequalities
- Development of a new integrated model of intermediate care that will support both admission avoidance and expedite discharge from hospital
- Strategic review of integrated VSCE commissioning as true system partners
- Strengthened approach to collaborative commissioning, including comprehensive review of all existing partnership agreements given that both North Yorkshire Council and Humber and North Yorkshire ICB are new organisations

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- Strengthened care market with closer collaborative commissioning for packages of care between the Local Authority and Continuing Healthcare
- Improved systems and processes for prescribing community equipment
- Continued support for unpaid carers, including recommissioning of Carers Break Sitting Services
- Review of delivery of the Disabled Facilities Grant and wider services

Key changes since previous BCF plan

- The BCF Plan has been revised to include additional expenditure and reflect up-dated spend, including inflation uplift where appropriate.
- New aspirations have been included for the revised BCF metrics
- Development priorities and actions have been revised to reflect the current work programme, particularly to reflect the new Place Board priorities and plan
- North Yorkshire County Council has merged with its District and Borough Councils to create a single unitary authority.
- The Disabled Facilities Grant is therefore no longer passed through and is managed by the new authority.

1. Engagement

Bodies involved strategically and operationally in developing the plan

Editorial production of the plan has been led by a joint commissioning team between North Yorkshire Council (now a unified Authority from April 2023 bringing together all District Councils with the former County Council and now includes Housing and DFGs) and North Yorkshire Place within Humber and North Yorkshire ICB. This has drawn together planning, finance and business intelligence colleagues.

Additional content has been provided by: NHS West Yorkshire ICB (for Craven District of North Yorkshire), and NHS Lancashire and South Cumbria ICB (one GP practice in the Craven District of North Yorkshire is part of this ICB and hence an allocation is included within the NY BCF).

The content of the plan is built on broader engagement on priorities and developments with a wide range of provider organisations, including:

- York & Scarborough Hospitals NHS Foundation Trust (Y&SHFT)
- Harrogate and District Foundation Trust (HDFT)
- South Tees Hospitals NHS Foundation Trust (STHFT)
- Humber Foundation Trust (HFT)
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- Community First Yorkshire (CFY) – representative organisation for the VSCE sector

How have you gone about involving these stakeholders?

The development of the BCF plan is supported and informed by ongoing partnership work through a number of key Place-based forums. These include:

The **North Yorkshire Place Board** is now well established as a partnership vehicle for bringing the system together to agree priorities and plans:

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- Leads the delivery of a North Yorkshire plan within the Humber and North Yorkshire Health and Care Partnership
- 4 main strategic priorities:
    - Priority 1 – A comprehensive and integrated health and social care model
    - Priority 2 – A high quality care sector, with sufficient capacity to meet demand
    - Priority 3 – A strong workforce
    - Priority 4 – Prevention and Public Health
- Chaired by the Chief Executive of North Yorkshire County Council
- Executive level representatives from partner organisations

North Yorkshire and York Strategic Partnership – Silver:

- Over-arching system group with twin roles to identify operational issues and drive improvements to integration, health inequalities and discharge arrangements
- Comprises attendance from: H&NY ICB, NYC, City of York Council (CYC), Primary Care, Care Sector, VCSE Sector and NHS community and mental health provider organisations
- Chaired jointly by the North Yorkshire ICB Place Director and by the Head of Social Care for NYC
- Supported by a 'Tactical Group' that meets weekly to address operational performance, and develop plans to meet strategic priorities, including senior managers from NYCC, and H&NY ICB

Local Care Partnerships

Much of the work of the ICS is undertaken in the six Places across Humber and North Yorkshire, and North Yorkshire is the largest Place in terms of geography and population. Therefore, the ICB has worked with health and care providers and the VCSE to establish four 'localities' that can better reflect the diversity of needs and priorities across the North Yorkshire Place. Within each locality, health and care services have come together as ‘locality care partnerships’ (LCPs) and the ICB is working with the LCPs to understand how local priorities and actions align with the Place priorities and with the ICP priorities. The four North Yorkshire LCPs are as follows:

- Harrogate: LCP established chaired by PCN Clinical Director (CD)
- Hambleton and Richmondshire: Development conversations and working group established led by PCN CD / LMC Chair
- East Coast and Ryedale - Existing Partnership Board is being developed into LCP
- South Hambleton and Selby - Well established Vale System Partners Group will form the basis of the LCP

There is also a fifth locality, Craven, which is part of the West Yorkshire ICB. Close working relationships are maintained across the two ICBs and the Director of Integrated Health & Care, Bradford District and Craven Health & Care Partnership is a member of the North Yorkshire Place Board.

ICB Collaboratives

- H&NY ICB has established a Community Collaborative bringing together Local Authorities and community provider organisations to share good practice and take forward initiatives on a wider footprint where appropriate

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- Current priorities include: supporting Places with the implementation of intermediate care and discharge solutions, as part of the Discharge Frontrunner national programme, and developing crisis response services and virtual wards
- The collaborative approach has also been extended to include specific collaboratives for: VSCE, mental health, primary care, and acute care

Market Development Board

NYC has established a multi-partner MDB which brings together commissioning across the broader care sector, including domiciliary care providers, care homes, and VSCE. Membership includes NYC, H&NY ICB, including Continuing Health Care.

2. Governance

The strategic content for the BCF is generated through the broader programme of work and engagement described above This is supported by specific governance arrangements for administering the BCF Plan.

Health and Wellbeing Board – This is the body responsible for overseeing submission and delivery of the BCF Plan. The Board has given dedicated authority to the Director of Public Health to sign off the plan. A slide-deck summary of the plan is presented to the Board for information and endorsement.

Health and Care Management Group – This group provides strategic oversight to joint and collaborative commissioning for North Yorkshire Place. This consists of Director-level membership between North Yorkshire Place (for the H&NY ICB) and North Yorkshire Council, with attendance by key officers as appropriate. The content of the BCF and the associated plan are reviewed through this Group.

Financial management – There are specific arrangements to support the financial management of the BCF:

- **iBCF** – This is paid directly to the County Council and forms part of the Better Care Fund section 75; this is used each year to fund schemes identified by the Council to support local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
- **Section 75 agreements** – The remaining schemes and services included with the BCF are plan are covered by a section 75 agreement.
- **Section 256 (S256) agreements** – These comprise the mechanism for the transfer of funds for services commissioned by NYCC to which health contribute (not including BCF schemes via S75).
- **Discharge grant agreement between LA and ICBs** – both the LA and ICB have agreed each organisation's respective plans through the ICB. The schemes in the discharge fund for 2023/24 are generally listed as existing schemes. This is because they represent a continuation or modification of schemes commenced in 2022/23 under the original discharge fund, which launched in autumn 2022. The schemes are therefore best described as recent.

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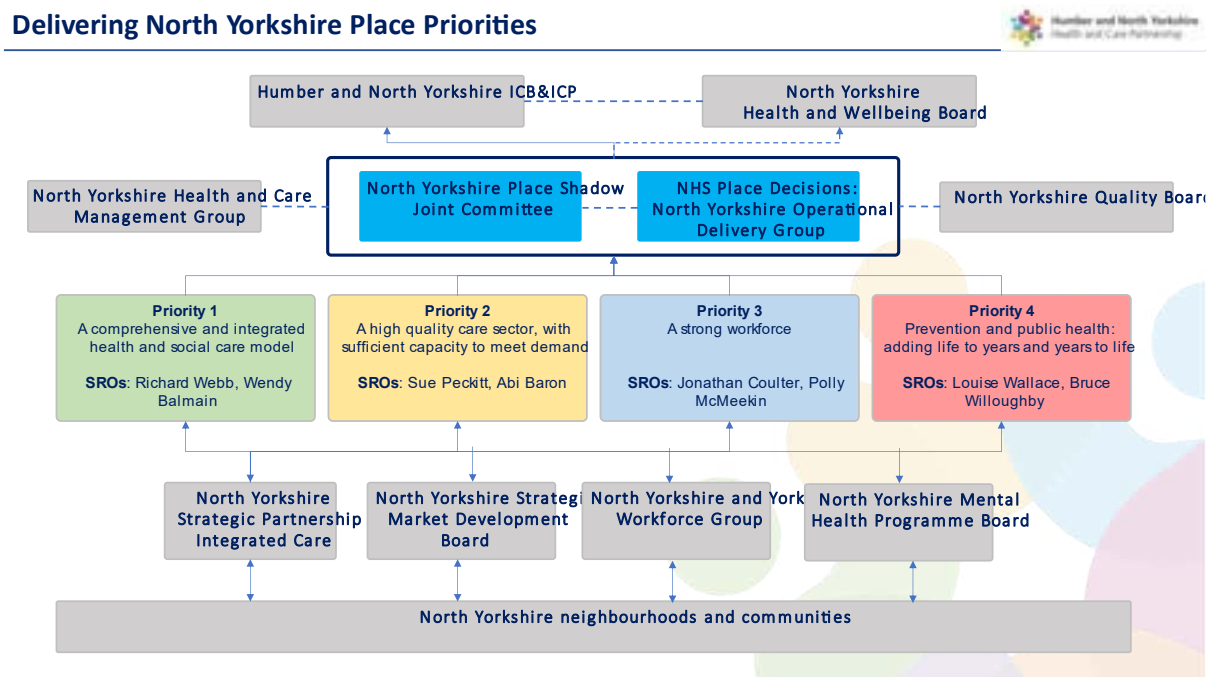
Summary diagram to illustrate governance processes:



3. National condition 1 – Overall BCF Plan and approach to integration

The North Yorkshire Place Board has identified four key priorities for embedding integrated, person-centred care within North Yorkshire. These priorities consider integrated approaches in a wide range of settings and to achieve a wide range of priorities. They are jointly agreed and progressed by partners.

The 4 high-level joint priorities within this plan are as follows:

Priority 1 - a comprehensive and integrated health and social care model

WHAT DOES GOOD LOOK LIKE:

- Increase in people living independently or managing safely at home/care setting.
- Increased care provided closer to home, with a sufficiency of supply of community health and social care services.
- Reduced need for acute beds for urgent care and for 24/7 residential and nursing beds.
- Significantly reduced delayed discharges into community care (whether nursing, residential or domiciliary care).
- Acute delivery operating much more in the community, coexisting with primary and social care.
- Partnerships that understand and respond jointly to the needs of their communities.
- People are supported to live in a broad range of housing that meets their circumstances.

KEY ACTIONS:

- Ensure a greater emphasis on self help, prevention and population health management (PHM).
- Develop a model for community health and social care which addresses sufficiency, comprehensiveness and skill mix, as well as integration.

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- Develop a consistent model for intermediate care.
- NHS, local authority and other partners to develop integrated models of care, e.g. strong multi disciplinary teams and consistent ‘any door’ access.
- Develop alternative services in or near Emergency Depts urgent community response, virtual wards
- Strengthened role for the VCSE.
- Supporting Enhanced Health in care homes and joint work through the
- Quality Improvement Team to improve responsiveness and quality.

Priority 2 - A high quality care sector, with sufficient capacity to meet demand

WHAT DOES GOOD LOOK LIKE:

- Increase in people living independently.
- Higher recruitment and retention levels across health and social care.
- A care market sustainable for providers and affordable for commissioners and service users.
- Reduced reliance on acute beds and 24 hour nursing/residential care Home First approach.
- Enhanced community capacity that can flex to prevent avoidable hospital admissions and facilitate timely hospital discharge.

KEY ACTIONS:

- Shaping the care market through the transformation of Approved Provider Lists consider impact of social care funding levy and cap.
- Recruitment and retention of care staff through attractive pay, training and career development.
- Develop innovative models for domiciliary care
- Undertake fair cost of care exercises for domiciliary care and implement actual cost of care for residential /nursing care to deliver a sustainable care market.
- Work with care providers to implement the national charging reforms for adult social care and the next phase of the NHS discharge pathway.

Priority 3 – A strong workforce

WHAT DOES GOOD LOOK LIKE:

- Sufficient trained and motivated staff to meet demand through:
- Positive narratives about the various different roles and professions.
- Increasing numbers of people being recruited.
- Range of innovative, possibly even joint funded, posts to help bridge gaps and/or break down silos (e.g. part primary care / community, or part health / social care).
- High recruitment and retention levels of all care staff.

KEY ACTIONS:

- Develop more balanced/varied roles and better work/life balance, wellbeing support, appropriate rewards.
- Develop innovative approaches to recruitment.
- Develop innovative workforce models.
- Innovative use of technology to support staff.

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- Identify opportunities for cross sector working and roles.
- Support international recruitment across sectors.

Priority 4 - Prevention and public health: adding life to years and years to life.

WHAT DOES GOOD LOOK LIKE:

- Narrowing of the gap in health inequalities between the least deprived areas compared with the most deprived areas across North Yorkshire.
- Increase in overall healthy life expectancy across the County.
- Narrowing of the gap in healthy life expectancy between the people in the least deprived areas compared with those in the most deprived areas across North Yorkshire.
- Having a clear, resourced strategic plan with dedicated staff to implement.

KEY ACTIONS:

- Commission and provide high quality, accessible prevention and primary care services.
- Support people to maintain good mental health with timely access to effective primary, secondary and specialist services when needed.
- Support people to be physically active across all ages and stages of the life course.
- Influence through the strength of the partnership the wider determinants of health with a particular focus on coastal communities.
- Promote and invest in stronger communities and strategic commissioning of the VCSE.
- Engage with people in a dialogue about self care, early help, loneliness and using digital tools.

Approaches to joint collaborative commissioning and key changes during 2023-25

Delivery of our shared priorities will be driven and supported by a strengthened approach to collaborative commissioning.

The earlier sections on engagement and governance explained the groups and processes that are being used to develop a collaborative commissioning approach. Collaborative commissioning arrangements are being reviewed through a comprehensive stocktake of all such arrangements through the Health and Care Management Group, including BCF and other supporting agreements.

Arrangements will be particularly strengthened over the next 2 years in the following areas:

- Development of joint plans to deploy the NHS bed capacity fund and the Adult Social Care Discharge Fund (both ICB and direct to LA tranches)
- Joint review of existing VSCE commissioned services and development of new strategic priorities
- Reprocurement of certain VSCE-delivered services, including carers break sitting services and dementia support
- Joined-up commissioning in relation to the care market and high cost packages of care through both NYC and CHC

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- Development of an integrated model for intermediate care (see later sections for detail), bringing together a range of services through BCF to achieve improvements to both flow and discharge outcomes

4. National condition 2 – Enabling people to stay safe, well and independent at home for longer

The delivery of this objective is closely linked to the delivery of national condition 3 (below), with many services and schemes impacting on both of these national conditions. Information has therefore been presented in the most appropriate section, rather than duplicated where possible.

Key areas of work under BCF during 2023-25 which enable people to stay safe, well and independent at home include the following:

Personalised care and asset-based approaches

Personalised care is at the heart of all that we do. Ensuring that our staff teams across health and social care understand and embrace the values of putting the person at the centre, understanding how they can keep themselves safe and well for longer and give them the tools to meet their needs is integral to our approach in North Yorkshire. This is combined with 'strengths-based practice' where health and social care professionals take a solution-focussed approach to supporting individual people and their families, moving away from traditional models of care that focus on "deficits" to supporting people to identify their own strengths and solutions.

There is a strong approach to prevention across North Yorkshire, supporting people before they hit a crisis, providing a wide range of information, advice and guidance. Investing in services for unpaid carers, social prescribing and into the VCSE is a key priority. When people do require professional support, promoting the use of PHBs and direct payments to enable individuals and families to design their own support is key. We are committed to developing an integrated intermediate care offer, with rehabilitation and reablement key to supporting people to recover well and improve both their physical health and wellbeing.

Population health management and proactive approaches

North Yorkshire is taking a Population Health Management (PHM) approach to a number of different projects by encouraging providers and localities to develop PHM skills and capacity. Examples of the different types of initiatives are shown below.

- PCNs are engaging with the ICB funded North East Commissioning Support (NECs) PHM programme. NECs are working with PCNs to identify their strengths and weaknesses around PHM and take them through a flexible cycle of PHM and/or training using local data to identify cohorts of patients to work with, so that PCNs can work with their partners to improve their populations' health. Examples include proactive working with families in deprived neighbourhoods in Selby, and identification of
- Another initiative in North Yorkshire is the Harrogate Proactive Care Team (PACT) which uses PHM methods to identify people who may benefit from Occupational Therapy interventions, working closely with primary care, to empower patients to live better for longer and increase access to healthcare. The team ensures seamless

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coordination of care, facilitates access to appropriate services, and promotes self-management strategies.

- Also North Yorkshire has developed its own cardiovascular disease (CVD) dashboard, extracting information from GP clinical systems to highlight where e.g. GP hypertension registers are low (compared to expected numbers); what proportion of the people have their treatment maximised; and, importantly, to celebrate success where practices have made improvements. The dashboard highlights opportunities for improvements with the associated searches identifying individuals within practices clinical systems who may benefit from different interventions.

These PHM approaches in North Yorkshire aim to enhance population health outcomes by targeting high-risk individuals, promoting care coordination, and utilizing data-driven strategies. By adopting a proactive and holistic approach, the aim is to improve health equity, reduce healthcare costs, and enhance the overall well-being of its population

Multi-disciplinary teams at place or neighbourhood level (building on Fuller recommendations)

All practices and PCNs across North Yorkshire Place (including Vale practices) are actively engaged in taking forward the primary care recommendations within the Fuller Report. This includes developing new ways of working towards more integrated multi-disciplinary teams. This will be a mix of both formal organisational arrangements and informal processes for closer collaboration and joint working.

Multi-disciplinary teams (MDTs) are in place across NY in formats to suit the locality and local partners. Many focus on the frail elderly to prevent admission and maintain patients in their own homes. This is additional to a local Frailty LES in the Hambleton, Richmondshire and Whitby area that brings a funded focus to reducing the health and social care impact of frailty. MDTs are based on joint working with key partners including community nursing services. Other MDTs will focus on end-of-life care or complex community patients.

The concept of joint working with all health and social care partners including the voluntary sector is now embedded as BAU (business as usual). The roll out of MDTs and integrated working continues across NY where gaps exist, building on experience from others and as capacity allows. The intention for the future is to broaden inclusion in MDT and neighbourhood teams with a wider range of partners and develop a more consistent approach across the county.

Work will progress over the next two years during the full period of the BCF plan (2023-25). This recognises that a significant priority in 2023/24 for primary care will be the delivery of Capacity and Access improvement plans and post-pandemic recovery planning.

Development of Urgent Crisis Response Services

A key challenge for 2023-25 will be to embed and promote activity through Urgent Crisis Response (UCR) services, delivered through community providers. These services have been commissioned and established over the past 2 years and are now delivering services 8 to 8 across North Yorkshire for 9 clinical specifications.

The next objective will be to promote and increase activity through these services, working to trajectories set as part of the NHS planning process and agreed through the H&NY ICB Community Collaborative.

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An external review of UCR services has been commissioned by the Community Collaborative, to provide a clear understanding of the system benefit and impact of the services. NHS Arden and Greater East Midlands Commissioning Support Unit (CSU) have been successful in the bid and will work with Place and provider colleagues to understand the services that are being delivered further. This will include assessing the views of a range of partners, including primary care, social care, and VSCE, regarding access to the services and the impact on primary care. The review will also need to consider the overall impact on hospital admissions, particularly for falls and ambulatory care sensitive conditions.

Falls prevention and management

Falls has been identified as a county-wide system priority. A multi-partner North Yorkshire and York Falls Summit was held in April 2023 to review current progress against falls initiatives and identify where partners could successfully work together to achieve improvements for the future. A range of emerging themes were identified to help both prevent and address the consequences of falls, including:

- Collaborative working – follow-up events, regular updates / meetings to develop services, locality discussions
- Consistency of prevention and responder services
- Standardised tools, e.g. assessment,
- Training, awareness raising and sharing resources
- Co-ordination of pendent alarm provision and monitoring
- Mapping falls offer and joint commissioning to address gaps
- Opportunistic case finding
- Links to Leisure Services review

A key part of the planning was the inter-relationship between ambulance services, UCR services, pendant alarm and other technology providers, and community-based first responder services. Monitoring will be undertaken to assess the volumes of fallers who will now be supported by UCR services and to determine capacity requirements and pathways related to non-clinical community responder services. The over-arching aim will be to reduce ambulance call-outs for category 1 and 2 fallers.

North Yorkshire Sport are offering a substantial programme of home-based exercise and support for deconditioned frail elderly patients. This programme is delivered by trained facilitators and is intended to impact on general mobility, with an associated impact on falls prevention. This service is being promoted across the county as a major opportunity to support vulnerable elderly people.

Community equipment prescribing and provision

Targeted provision of community equipment is a key factor in keeping people at home safely, both to prevent admissions to hospital or care homes, and to facilitate earlier discharge. H&NY ICB and NYC jointly commission Medequip as the North Yorkshire community equipment provider. This contract is a significant area of BCF spend.

During 2023-25, we want to achieve several improvements to support how equipment is prescribed:

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- Data-base management changes to how prescribers are registered on the ordering system to ensure that they have the correct authorisations and permissions to order equipment quickly and appropriately. This will involve working with Medequip to agree new systems and processes.
- Greater clinical support for the ordering, review and authorisation of special non-catalogue items. These currently go through an external approval process, creating both delays and inefficiencies. The intention will be to facilitate dedicated OT support to work with both prescribers to improve the process.
- Catalogue review for high-cost items and identify suitable Close Technical Equivalents
- Collection strategy to encourage equipment recycling

Expected impacts on key BCF indicators:

Unplanned hospital admissions for chronic ambulatory care sensitive conditions:

- The latest data in 2022/23 shows 4629 admissions (745.9 per 100,000 population) compared to 4834 in the previous year.
- This is a significant improvement from our expected number of avoidable admissions in 21/22, which was 6,543 according to the 21/22 national avoidable admissions indicator tool for unplanned hospitalisation for chronic ambulatory care sensitive conditions
- The proposed trajectory for 2023/24 is for an average rate of 135.8 admissions per 100,000 population over the year – this would be achieved through continued and increased impact of Urgent Crisis Response services in the community and the impact of Frailty SDCE services
- Urgent crisis response (UCR) services (as described above) have a collective capacity of 6,156 patients per year for 2023-25 across the services provided by STHFT, HARA and Humber FT as community providers (Craven and Selby areas are excluded from these figures).
- While not all of this activity will directly stop a hospital admission, we will be looking for a further step-change in performance against this metric over the next 2 years as UCR services become better established.

Emergency admissions following a fall for people aged over 65:

- Currently we only have data for three quarters of 2022/23, which suggests a count of 2,542 falls, including Craven. This is significantly below the last reported actual count for 2021/22 of 2,840.
- Target - If we assume that we can maintain the estimated level for 2022/23, this would set the 2023/24 target to a count of 2,542 across North Yorkshire (including an estimate for Craven) for an over 65s population of 155,016 – representing a sustained improvement compared to the full 2021/22 base-line
- Much of the focus of work on falls will be to prevent unnecessary ambulance call-outs and ED attendances due to having alternative options in place, like UCR services, community first responders, and support from Immedicare (a telemedicine support to care homes) – this may have a small impact on emergency admissions too, as some people who attend ED inappropriately may subsequently also be admitted
- However, reducing admissions for the majority of people will depend on successful falls prevention programmes, for example the North Yorkshire Sport reconditioning programme for frail elderly people

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- Investment in core health and social care community services through those schemes listed in BCF directly will help achieve this target as it will be the community staff delivering these services are those who will address both falls and subsequent prevention

Number of people aged over 65 whose long-term support needs are met through admission to residential or nursing care homes per 100,000 population:

- In 2021/22 we have seen a rise in the number of people admitted into residential and nursing care homes across North Yorkshire. Some trends link this to an increase in short-term bed usage.
- A priority in 2023/25 is to embed the Home First principles and reduce the use of short-term beds for hospital discharge, investing into the community and increase reablement capacity. It is expected that reduced hospital lengths of stay, reduced deconditioning, and greater rehabilitation and reablement will allow more people to return home rather going into a permanent residential or nursing home placement.
- This will draw on the multiple BCF-funded schemes that contribute to the intermediate care model
- While the need for specialist and nursing care is rising, demand for traditional long term residential care is falling and this is reflected in our 2023/25 plans.
- The proposed plan is for 616.9 long term support needs (aged 65 and over) met to nursing or residential care homes per 100,000 population

5. National condition 3 – Provide the right care in the right place at the right time

This section builds on the range of schemes and services described in the previous section, and particularly focuses on the following 2 priority areas:

- The development of a new intermediate care model - as a vehicle to embed a Home First approach and deliver the ministerial requirement to address delayed transfers of care
- Responsibilities under the Care Act

New North Yorkshire intermediate care model

The development of a new intermediate care model by utilising BCF funding combined with NHS capacity fund / adult social care discharge fund is a major priority for the next 2 years.

The following **case for change** has been identified:

Intermediate care BCF review revealed insufficient intermediate care capacity in place to meet demand:

- Significant system capacity gaps, particularly intermediate care across pathways 1 and 2
- Range of non intermediate care bed provision is not achieving desired outcomes and not used to capacity
- Shortfall in intermediate care impacts on NHS acute care

Currently up to 145 people not meeting criteria to reside across STHFT, HDFT and Scarborough Hospitals:

- Discharge hubs focused on exit from hospital rather than the most appropriate long-term placements

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- Adverse impact on ambulance turn-around times, long-term discharge outcomes due to deconditioning while in hospital, and acute elective programme
- National drive to release more acute capacity through national Urgent Care Delivery Plan – H&NY ICB is a discharge frontrunner

Significant pressures similarly created across Adult Social Care:

- Waiting list for new referrals into community teams - waiting for assessment and support impacts long term independence
- Market pressures, over reliance on bed-based support

Reduced intermediate care capacity impacts outcomes for people across the system:

- Long term impact on health, wellbeing and independence – creating pressures in acute health care and long-term social care.
- Waiting more than 2 days for intermediate care significantly reduces positive impact (NICE)
- Excessive short term bed placements creates dependency and increases long-term residential placements
- We need to 'build back' Prevent, Reduce and Delay into the adult social care pathway

A **new model of care** is being developed based on the following principles:

1. Person centred and strength based
2. 'Home First' approach
3. Therapy/Social work led and MDT delivered
4. Free, responsive, 7-day delivery, single point of access.
5. Aligned with supporting services
6. Inclusive
7. High quality, outcomes driven, short term
8. Locality based
9. Single intermediate care hub for entry and exit

Project governance:

An NY Project Group has been created to deliver this key piece of work, with over-arching leadership from the Head of Community Services (H&NY ICB) and Head of Prevention and Integration (NYC), reporting upwards to the Place Board.

A key project deliverable will be a Business Case for a remodelled service from 24/25 onwards.

The **diagrammatic model below** explains how the new model is being developed, based on 4 key components:

- Crisis Response
- Home-based intermediate care
- Integrated rehabilitation and reablement
- Bed-based intermediate care

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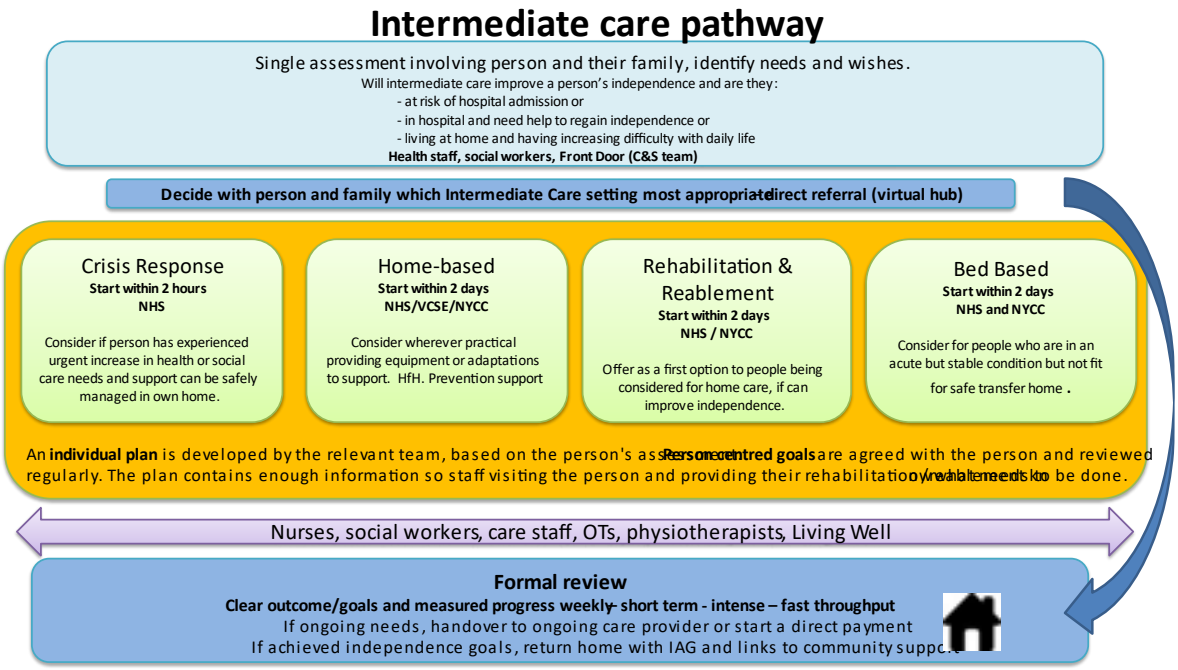

Capacity and Demand modelling

The BCF C&D modelling this year has been a collaborative effort between the ICB colleagues working at Place, North Yorkshire Council and community health and care providers.

How we completed the capacity modelling:

- Initially developed a list of services that we knew to be providing intermediate care across the HWB footprint, using the BCF C&D modelling work from the previous year as a starting point.
- Wrote to all our community providers to ask them to validate the list and to provide capacity data, supplying providers with the BCF definition of intermediate care to support this.
- Asked providers to indicate which 'service type' each of the services fell into, and asked them to estimate the split between categories where a service provided more than one type of care and data wasn't available by category (e.g. a service that supported both discharge and admission avoidance).
- Capacity was mainly based on activity data from the previous year, accounting for anomalies and in a minority of cases, estimating a capacity of slightly higher than the reported activity where services were known to not be operating at full capacity (however the vast majority of our services are at full capacity and therefore capacity is equal to the activity data)
- In some cases, capacity was estimated by local authority or ICB colleagues where we have access to this data (e.g. VCS to support discharge and some commissioned bedded capacity).
- A few services were providing intermediate care that did not fit into one of the 14 categories. These were mainly bedded facilities that were not providing true rehabilitation or reablement, but were supporting a discharge or helping to avoid an

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admission (e.g. enabling people to be discharged whilst awaiting a package of care to be arranged, supporting carer breakdown). To enable these services to still be captured, we created an additional category called "short-term bedded care (not true rehab/reablement)", which was equal to 10 new patients per month for discharge capacity, and 6 new patients per month for community capacity – these have been included in the "short-term residential/nursing care for someone likely to require a longer-term care home placement" discharge category, and "other short-term social care" category for community capacity.

- We have not included spot-purchased capacity from private providers

How we completed the demand modelling:

- We used NHS planning return figures for estimating discharge demand by pathway.
- Our providers do not collect pathway 1 data split by rehabilitation and reablement, and so we have there split the pathway 1 data between the two categories as 22% reablement, and 78% rehab, as this is the capacity data split.
- We were unable to provide discharge demand estimates for South Tees Hospitals NHS Foundation Trust.
- We did not use local authority discharge hub figures as these do not represent the full number of discharges.
- Estimating demand for admission avoidance was challenging as we do not collect this data, however it is anticipated that demand is much higher than capacity. To estimate community demand, we have used the avoidable admissions estimate (which is based on Q1-Q3 SUS admission data and the national indicator tool (Indicator 2) for estimating unplanned hospitalisation for chronic ambulatory care sensitive condition) and split this into the different pathways as per the below percentages and added this to expected capacity.
- The percentages are the same as the capacity split.

Social support (including VCS)	0%
Urgent Community Response	41%
Reablement at home	1%
Rehabilitation at home	51%
Reablement in a bedded setting	5%
Rehabilitation in a bedded setting	1%
Short term bedded care (not true rehab/reablement)	1%
Other short-term social care	0%

Geographical coverage:

- The area that surrounds the City of York (the "Vale of York") is part of the North Yorkshire HWB footprint however it has only recently become a part of the North

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Yorkshire Place geography within the ICB. As such, we do not yet have optimum data flows for NHS-provided services in this area at Place.

- The demand data includes the Vale of York, and the capacity data includes services delivered in the Vale of York that are provided by local authority and VCS. However, we have not included capacity data for the services delivered in the Vale of York that are provided by York & Scarborough Hospitals NHS Foundation Trust at this stage.

Results of the C&D modelling:

The results can be viewed in full in the BCF return excel spreadsheet, however in general, demand outweighs capacity for every pathway.

Variation in capacity and demand through the year:

The BCF Plan includes additional capacity to support intermediate care and meet demand throughout the year, principally through the Adult Social Care Discharge, but also through the NHS bed / capacity fund. At this stage, the additional capacity has been planned equally throughout the year. This is because over the past few years, pressures on the health and social care system in the summer months have been sometimes as great as those over the in winter period. However, contracts for key elements of capacity such as additional community intermediate care beds are placed on a 3 month by 3 month basis. This provides the opportunity to reduce capacity in summer in line with any fall in demand and provide additional capacity over the winter period if necessary.

The impact on new capacity of through services will also be tracked through the year, linked to the development of the new intermediate care model. The final capacity in new services is heavily dependant on recruitment, with the final capacity profile for the year depending on how successful providers are in bringing in additional staff.

BCF funded delivery 2023-25:

The absolute emphasis of the new model is 'Home First' to a person's own place of residence, although we recognise for some people returning home may require step down through an intermediate care bed as part of the journey. We also do not want to preclude people from returning home with more complex care needs, hence maintaining a discharge to assess approach for pathway 3 discharges.

Core services funded through BCF are being brought into the developing intermediate care model. These will be augmented by additional capacity through new national funding.

For 23/24, a range of interim capacity measures are being commissioned through the Capacity Fund / Social Care Discharge Fund that will contribute to our new intermediate care model, including:

- Established strengthened intermediate care bed provision at key NYC facilities supported by in-reach therapy - 27 beds across the following locations: Silver Birches, Filey (7), Benkhill, Hambleton (6), Station View, Harrogate (14)
- Providing additional block-booked / complex nursing care capacity – 15 beds
- Growing community-based rehabilitation and therapy capacity to provide Home First support (pathway 1) and in-reach to intermediate care beds (pathway 2)
- Improving the quality and speed of community equipment prescribing
- Strengthening home-based support for pathway 1 discharges through additional Home from Hospital capacity through VSCE providers

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- Supporting complex discharges and admission avoidance for pathway 3 'time to think' discharge to assess and end-of-life
- Strengthening support for people with learning disabilities in relation to hospital discharge
- Continuing use of personal health budgets via discharge enabling grants
- Additional ASC assessment capacity in the discharge hubs
- Additional commissioned domiciliary care provision to support winter pressures and ensure reablement capacity is not diverted to support domiciliary care
- Extend brokerage capacity in the discharge hubs

Development and delivery of the new intermediate care model is being informed and influenced by **the High Impact Change Model**.

There are 5 Discharge Hubs across North Yorkshire, all linked to an Acute Trust and ASC Locality team. All are working towards the High Impact Change model, with an improvement action plan linked to each.

- Early identification of more complex cases is improving with a more structured response through Hub MDT calls. Where ASC staff are based at acute sites this works more effectively and this will be rolled out to all sites. The use of the Yorkshire Humber Care record also supports this, long term development of implementing Optica will bring greater benefits
- The North Yorkshire system is undertaking a comprehensive capacity and demand modelling exercise. Real time data availability need to be improved and aligned to formal systems. The demand and capacity modelling is integral to the development of an integrated IC model and is supporting our commissioning plans. Commissioning plans are built on data, with bed-based care reduced to support increase in Home First. Home First Perfect week actions have been progressed, supporting demand and capacity modelling.
- Multi-disciplinary working is embedded into processes and practice, works well when teams are co-located – some areas for improvement identified through perfect week and ASC diagnostic. Using technology for integrated working works well – across NHS and ASC.
- There is still some reliance on short-term beds – future modelling supporting a move to decommission some block booked beds. Some good areas of improvement through Home First improvement plans – blended roles across ASC to support. Pressures in the market for domiciliary care and reablement – used Block Booked dom care over winter with some improvement identified, this to be explored further. VCSE used to support pathway 0 via HfH – increased capacity over the winter period and volunteer transport for pathway 0 and 1.
- Flexible working – 7-day working not working across the whole system, for example there are gaps within pharmacy. Using demand and capacity modelling to identify where staff should be redeployed for maximum impact. Reablement 7-day offer and direct referrals into provider services.
- Improvement plans for the Trusted Assessment are in place – digital TAF to be trialled. Quality of the TAFs varies which can create delays and duplication of work – this is a priority area for 2023/25

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- Choice issues are a concern – involving families during times of pressure; bed-based focus for D2A. Leaflets are being issued and reviewed. Humber and NY Choice policy has been re-written. Escalation processes in place, including at individual level. Engagement with people supported through the discharge process to inform future development. Quality audits are used and seek feedback from people and families
- Direct referrals to the some provider services is working well for our IC. Where there is a named worker linked to the short-term IC beds, this creates positive working relationships between providers and acute trusts and ASC homes. Investment in this area has been made through the ASCDF in 2023/25
- Housing and related services are not embedded into the hub meetings at present, this is a priority area for 2023/25. Good links to extra care facilities including SUSD beds, adaptations and equipment

Care act delivery

Additional investment through the BCF, iBCF and ASCDF has been put into ASC assessment and prevention activity, meeting statutory Care Act requirements and the of prevent, reduce, delay requirements. This includes:

- Investing significant resource into Transfer of Care Hubs to meet the statutory Care Act requirements for people requiring long term care and support following a hospital stay. This includes additional social workers, assessment worker and enhanced brokers.
- Increasing resource with the Living Well service – a front line social prescribing service for ASC
- Working with and developing the VCSE offer for prevention and early intervention – supporting people to stay well and prevent, reduce and delay their need for ongoing adult social care.
- Investing additionality in front line social workers to meet all statutory Care Act responsibilities including safeguarding
- Investing in the care market to meet people's assessed unmet needs – including complex care provision and domiciliary care

Expected impacts on key BCF indicators:

Discharge to usual place of residence:

- The latest data in 2022/23 shows that this is achieved on average for 91.3% of people. The plan for 2023/24 is to improve this level of performance to 91.5% or above.
- The new intermediate care model prioritises 'Home First' and additional capacity is being invested in therapy and reablement services to help achieve this – this should maintain and improve the current level of performance

Proportion of people who are still at home 91 days after discharge from hospital into reablement / rehabilitation services:

- The target for 2023/24 is 78.1% - to be achieved through continued development of integrated rehabilitation and reablement services, as part of the new integrated intermediate care model

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- Again, the assumption is that greater proactive preventative care in the first 6 weeks post discharge through strengthened rehabilitation and reablement services will enable more people to remain at home after 91 days – this draws on multiple BCF-funded schemes that contribute to the intermediate care model

6. Supporting unpaid carers

BCF funded services include carers support services and carers break services delivered under contract jointly with the local authority by VCSE providers across North Yorkshire. Carers Support Services: The aim of the service is to promote, support and improve the mental, physical, emotional and economic wellbeing of carers, so that they can continue in their caring role, look after their own mental health and wellbeing and have a life of their own in terms of opportunities for work, training, education, leisure and social interaction. Delivered by two community based organisations. Contract runs from 1 July 2023 for maximum of eight years.

Services offered by the local carers' support services include:

- confidential information, advice, emotional support and representation
- benefits advice
- regular information by way of circulars, bulletins or newsletters
- referrals to other specialist support organisations
- information sessions, courses and other related activities
- help for carers who need support to continue working and caring

The local carers' support services also work in partnership with carers, carer groups and other organisations to improve services for carers and promote their interests.

Carers Sitting/Short Breaks Service: the aim is to support and sustain carers in their caring role and promote their health and wellbeing by providing a break from caring. Contract runs to 30 September 2023 and procurement process is underway to deliver services from 1 October 2023.

7. Disabled facilities grant and wider services

Disabled facilities grant:

Following Local government reorganisation, the delivery of disabled facilities grants is due to be transformed. A new policy is due to be implemented which utilises the Regulatory Reform (Housing Assistance) Order 2002 and its discretionary flexibilities relating to the use of DFG. This will ensure that mandatory grants are available to applicants, but also that residents have access to discretionary assistance where applicable, this includes financial "top-up" over and above DFG ceiling where additional funding requirements are evident and valid to support outcomes and give clear benefit to residents and the health and social care economy and a range of discretionary support to enable residents to remain independent in their own homes.

A review of the current delivery will be undertaken to look at DFG performance and additional development needs, demand, workflow and systems, and delivery staffing resources. This will result in changes to the delivery team structure and resourcing to promote efficiency, the aim is to establish a countywide home improvement agency service, integrating with health and social care to deliver a fair and equitable service across the

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authority supporting a joined-up approach to improving outcomes across health, social care and housing through the Disabled Facilities Grant and Better Care Fund programme. This will also include reviewing agreements with social landlords to build effective partnerships and maximise resources in the delivery of adaptations for tenants.

The countywide Home Improvement Agency, will provide a wide range of advice and support for people seeking assistance with adaptations. This includes providing information and advice on home improvements and other housing related support such as fire and crime prevention and energy efficiency. The delivery of minor adaptations will also be transformed to give consistent and timely provision and joined up approach regardless of the level of adaptation.

The Agency will support closer working between health and social care, for example by using systems to enable health to make direct referrals for less complex adaptations. This is supported by a jointly designed web based referral system which includes screening tools to assist the referrer which is being rolled out across the service.

A new multiagency group is to be established to provide oversight of the adaptations where additional planning and resources may be required to ensure that all parties are involved and the best outcomes are provided, with the needs of the customer at the centre of service design.

Discretionary services

Yes - NY does make use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 RRO to fund a portion of discretionary services.

The discretionary support will be countywide. No overall limit is currently set, through careful monitoring, we will ensure that mandatory grants are available to applicants, but also that residents have access to discretionary assistance where applicable, this includes financial "top-up" over and above DFG ceiling where additional funding requirements are evident and valid to support outcomes and give clear benefit to residents and the health and social care economy and a range of discretionary support to enable residents to remain independent in their own homes. Our policy allows us the ability to stop the flow of discretionary support should demand for mandatory grants not permit discretionary uses.

Broader housing strategy and issues:

In respect of wider housing strategy and its role within integrated services, there is a general recognition that addressing housing issues is hugely important to the achievement of improved health and social care outcomes. The new integrated Council will bring a new and closer relationship between housing and other services.

The Housing function within NYC is still forming following the move to a unitary authority from April 2023. Existing close working relationships across teams and services are being formalised and work is ongoing to bring Housing, Social Care and Mental Health teams together to ensure that the Council can effectively meet people's needs and minimise gaps and duplication in services. NYC Supported Housing teams meet regularly with TCP leads to review need and make placements where properties are available and to progress new developments / opportunities where there are gaps in need.

A new Housing Strategy has been developed through the reorganisation process, this will be consulted on and adopted through the Autumn of 2023. A cross directorate Housing group

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has formed with a view to creating structures which will ensure we maximise the impact of housing related services including DFG in supporting the BCF priorities. Housing, including DFG forms a key cross cutting theme of the Strategic Market Development Board which has attendees from across Health, Social Care, Housing and the community sector.

Incorporating consideration of housing issues linked to improved intermediate care will be another area of development, linked to the High Impact Change Model. Intermediate care hubs will need facilitate greater focus on addressing housing problems as part of a person's rehabilitation and reablement. North Yorkshire has always been a pioneer of the implementation of Extra Care Housing, and this approach continues. However, we will explore opportunities to develop intermediate care options linked to Extra Care Housing as part of the new intermediate care model.

8. Equality and health inequalities

Addressing equality and health inequalities is a crucial part of our strategies within North Yorkshire. Improving health and reducing health inequalities 'adding years to life and life to years' is one of our four place priorities.

Background:

North Yorkshire is a great place to live in lots of ways, with beautiful countryside, vibrant market towns and active communities. Most people in North Yorkshire live relatively healthy lives, and average life expectancy for both men and women is higher than the England average. However, it's not the same for all - some groups of people are less healthy and die sooner, from illnesses that are preventable.

- Healthy life expectancy (number of years lived without serious illness) for women is below the England average, and over the past 9 years, has not increased.
- North Yorkshire is the largest county in England by area, and we see geographical variation in life expectancy. At the ward level, people who live in the wards with the highest life expectancy live 12.6 years (women) and 15.4 years (men) longer than those in the wards with the lowest life expectancy.
- The proportion of children achieving a good level of development at the end of reception is generally good for North Yorkshire, but lower for those pupils with free school meal status.
- Employment rates in North Yorkshire population are better than the national average; however, we see a larger gap between employment rates in those with a long-term disability when compared to the general population.

Age profile:

North Yorkshire has an increasingly aging population with rural deprivation, and the majority of BCF investment is therefore aligned with the challenges associated with this.

- The population tree shows that North Yorkshire has a higher proportion of people aged over 50 and a lower proportion of children and adults aged under 50, compared with England and the Yorkshire and Humber region overall
- Most districts show a similar pattern to the County, apart from Richmondshire and Scarborough. Richmondshire has a high proportion of males in their 20s, due to people living in Catterick Garrison

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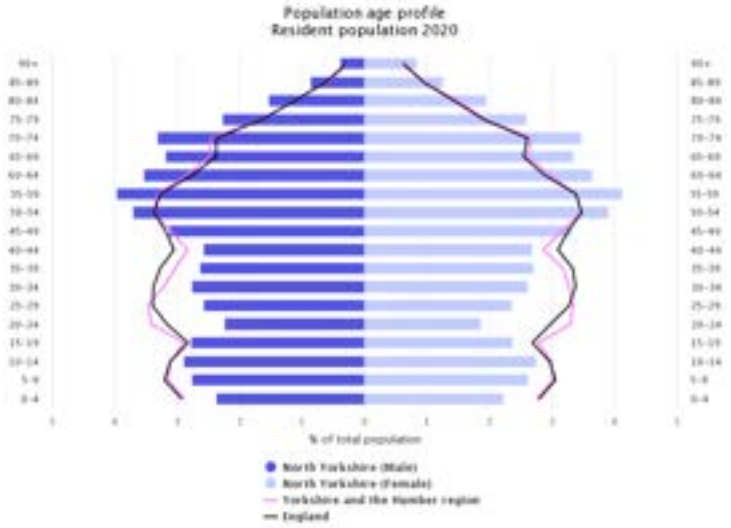
- Scarborough has a more even distribution through ages 20-44, perhaps suggesting that fewer young people leave the area for study and careers



- Cardiovascular, cancer and respiratory causes are the greatest contributors to inequalities in life expectancy across North Yorkshire
- Frailty and care and support for older people is recognised as a core priority for BCF partner organisations. NHS Rightcare state that nationally people living with frailty are experiencing unwarranted variation in their care
- Due to the population being older, North Yorkshire has high rates of people living with frailty. There are approximately 17,000 people living with frailty (as indicated by eFI) which equates to 4% of the total population
- Older people have been disproportionally affected by covid-19, with risk of death involving covid-19 in people aged 80 years over 30 times greater than those aged 50 years. The risk of hospitalisation through covid-19 is also age-related.
- Typically, people with frailty are living at home (there are only 4,475 Care Home places in North Yorkshire)
- The North Yorkshire loneliness strategy identifies that around 1 in 3 are living alone
- The rate of dementia diagnosis (QoF 19/20) is 1% (6,081) which is the second highest compared to our statistical neighbours for local authorities and is set to rise. By 2025, 13,573 people are expected to be living with dementia, in North Yorkshire. The proportion of people who have been diagnosed with dementia compared to the estimated prevalence is around 59%

Rurality and isolation:

- There are 8490 people aged 60+ in North Yorkshire (excluding Craven) living in the most deprived 20% lower super output areas in England when looking at IMD scores. The vast majority (7574) are in the Scarborough District
- However, North Yorkshire is a significantly rural area
- 16.35% of the Lower Super Output Areas in North Yorkshire are in the most deprived 10% nationally when looking at the Barriers to Housing and Services sub section of the Index of Multiple Deprivation.
- The sub-section measures two sub-domains: 'geographical barriers', which relate to the physical proximity of local services; and 'wider barriers' which includes issues

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relating to access to housing such as affordability and homelessness. This rate is the second highest for English County Councils

- In the recent North Yorkshire Rural Commission report: 'Rural North Yorkshire: The way forward' (July 2021) seven key themes were examined: rural economy; energy transition; digital connectivity; farming and land management; rural schools, education and training; rural housing; rural transport
- Challenges include:
    - People who live in super sparse and rural areas need to travel for school, employment, shopping, and health facilities. This raises issues that include accessibility, affordability, and environmental impact.
    - Deprived populations living in rural areas may face isolation, fuel poverty, winter deaths, falls and a high level of social care needs.
    - Despite the significant investment, digital connectivity remains a significant challenge, especially in rural areas.

Military health:

Catterick Garrison is the largest military base in the UK. It is situated within Richmondshire District. The uniqueness of the population, including veterans and forces families and 'camp followers', leads to a range of health inequalities:

- health needs characterised by obesity, drug and alcohol abuse, smoking, risky behaviour, chaotic lifestyles, poor lifestyle choices, homelessness
- a young population which has significant deprivation and a high level of dependency, and which therefore places a high level of demand on services for children. This is driven in part by an MOD policy to base families with special needs in Catterick rather than any other army base in the UK
- care which is both fragmented and reactive
- Veterans have specific additional health needs (e.g. mental health, trauma, prosthetics), access to services to meet those needs which form part of the Armed Forces Covenant.

Revised and updated plans for 2023-25:

Addressing prevention and public health is one of the 4 key priorities in the North Yorkshire Place Plan (see section 3, which details the headline objectives). This includes plans for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. It is also heavily linked to the development of a population health management approach (see also section 4).

We are working jointly on our refreshed Health and Wellbeing Strategy. It will ask everyone - in particular the wider health and care system - to think about PEOPLE, PLACE, POPULATION HEALTH AND PREVENTION. It is still being developed but it is being themed around our 'P's':

- Think 'People': In North Yorkshire, we will work with our communities who experience the poorest health outcomes to make sure that they can access and benefit from the services and opportunities they need.
- Think 'Place': In North Yorkshire, where you live should help you stay well and happy. We want to make sure that where you live does not unfairly reduce the quality of your health or length of your life.

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- Think ‘Population Health and Prevention’: In North Yorkshire, we will improve the health of all our residents by prioritising interventions that will make the most difference and that make sense to do at scale.
- We also want to think about Putting it all together – the links between our Ps. We will use the NHS CORE20PLUS5 approach to help us to do this

Examples of continued areas of focus and development include:

- **Frailty** – continuing to promote and utilise the Rockwood Clinical Frailty Scale as the universal language across health, social care and the voluntary sector to recognise the degree to which people are vulnerable and at-risk, backed up by an comprehensive offer of supportive services for different Rockwood levels through NHS, social care and VSCE partners in the community
- **Catterick Integrated Care Campus** - is progressing well to bring together traditional NHS GP practice, military health, and mental health, outpatient and VSCE services in a new integrated facility to address the needs of military families and veterans using a holistic preventative approach – currently the project is proceeding through the final stages of business case approval
- **Transport** – reviewing community transport voluntary sector services, using the learning from the IVAR Connecting Health Communities project in North Yorkshire and a pilot project in 2022/23 to explore how community transport organisations might help to support patient discharges
- **Coastal communities** – recognising the particular challenges relating to Scarborough and the East Coast, linked to deprivation and poorer health outcomes – driven by the recommendations in the CMO Report 2021 into health in coastal communities and a new NHS East Coast locality director posts to drive integration and develop plans through the emerging Local Care Partnership
- **Prevention grants** – implementation of a new approach to grants to support prevention through multiple VSCE organisations in neighbourhoods and communities across North Yorkshire
- **NHS Healthchecks, Living Well Smokefree and YorSexual Health and Adult Weight Management services** – maintaining service offer across North Yorkshire
- **Community Anchor Organisations** – organisational development of Community Support Organisations into a new model led by NYC Stronger Communities Team
- **Partnership with Public Health and NY Sport** – focused on promoting physical activity across all ages including innovative approaches such as ‘Discovery on your Doorstep’.
- Considering opportunities for health through ‘Levelling Up’ and Prosperity Funding. Promoting Health in All Policies.

The BCF plans for 2023-25 maintain the wide range of investments that impact on protected characteristics, particularly those relating to both age (frailty) and disability. These include:

- Core budgets for community-based services delivered by health and social care which significantly (but not exclusively) impact on older people, including the delivery of proactive geriatric assessment and support in the remodelled Humber FT frailty service (for people in Scarborough and Ryedale).

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- The full budgets for community equipment, wheelchairs and assistive technologies, which are delivered through an integrated approach on behalf of both health and social care
- A range of voluntary sector commissioned, particularly including services through Age Concern and Carers organisations, Dementia navigators, and support to veterans (though the First Light Trust)

9. Conclusion

This document shows a substantial body of integrated development work is underway across North Yorkshire. This is supported by an engaged and supportive collective culture amongst both commissioner and provider organisations. The intention is to make a measurable difference to outcomes. This will include addressing the national expectation of expediting hospital discharges and reducing people not meeting criteria to reside. However, we also intend to improve our capacity and capability to undertake community-based admission avoidance and encourage a greater focus on prevention.

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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:	North Yorkshire
Completed by:	Anton Hodge
E-mail:	Anton.Hodge@northyorks.gov.uk
Contact number:	01609 532141
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	Councillor	Michael	Harrison	Redacted
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Stephen	Eames	Redacted
	Additional ICB(s) contacts if relevant		Wendy	Balmain	Redacted
	Local Authority Chief Executive		Richard	Flinton	Redacted
	Local Authority Director of Adult Social Services (or equivalent)		Richard	Webb	Redacted
	Better Care Fund Lead Official		Louise	Wallace	Redacted
	LA Section 151 Officer		Gary	Fielding	Redacted
*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.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Partnership Board
Agenda item no:	10
Meeting date:	06 September 2024
Report title:	North Yorkshire Joint Local Health and Wellbeing Strategy 2023–2030
Report presented by:	Victoria Turner, Public Health Consultant, North Yorkshire Council
Report approved by:	North Yorkshire Health & Wellbeing Board
Report prepared by:	North Yorkshire Health & Wellbeing Board

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

Previous considerations and any resulting action:

The draft version of the Strategy was presented and discussed at the Partnership Board Development Session on Friday 16th February 2024. Feedback from members of the Board was shared with the team developing the final version of the Strategy on behalf of the North Yorkshire Health & Wellbeing Board.

Executive summary and points for discussion:

The North Yorkshire Joint Local Health and Wellbeing Strategy 2023-2030 was formally approved by the North Yorkshire Health and Wellbeing Board at its meeting on 22nd May 2024.

Summary

Each local area must have a Joint Local Health and Wellbeing Strategy which sets out the priorities identified within its Joint Strategic Needs Assessment (JSNA) that local government, the NHS and other partners will deliver through its Health and Wellbeing Board.

The overall ambition of the North Yorkshire Health and Wellbeing Board is to reduce the gap in life expectancy, increase years of healthy life expectancy and reduce differences between health outcomes in our population. We want to add years to life, and life to years.

This is the third Strategy for North Yorkshire, and sets out priorities for action over the next 7 years (to 2030). The priorities focus on areas where there are opportunities for partners to work together to have real impact on health and wellbeing outcomes for people of all ages, to provide children with the best start in life, and to reduce health inequalities.

The three key priorities are:

1. **Prevention** - we will improve the health and wellbeing of all our residents by concentrating on the big actions that will make the most difference to our population
2. **Place** - where you live should help you stay well and happy. We want to make sure that where you live does not unfairly reduce the quality of your health or length of your life.
3. **People** - we will work with our communities who experience the poorest health outcomes to make sure that they make the most difference to our population.

In addition to the three key priority areas, there are several identified cross-cutting themes:

- Workforce, employment and volunteering opportunities
- Accessibility of services and information
- Making best use of our resources
- Digital inclusion and innovation
- Joining up our coproduction and engagement

Keeping track of progress

Change can take a generation for some of these issues. We recognise that, so we also want to identify other ways we will monitor achievements and progress. One important measure of our success will be reducing the number of years that people spend in ill-health and reducing unfair variation in this.

Another important measure will be what people say – the feedback that our communities give us about their experiences, their health and their wellbeing, and how involved they are in making the changes. We will continue to develop the ways that people can get involved in the work of the Board.

External scrutiny will provide additional rigour in the monitoring of our work together, including the new Care Quality Commission (CQC) Inspection of Adult Social Care and Integrated Care Systems, as well as existing inspection frameworks for health and care providers (CQC) and children's social care and education (OFSTED).

We will develop a delivery plan with ways to measure the difference we are making, and progress reports will be presented at the quarterly Health and Wellbeing Board Meetings, with information available to the public. In addition to this, the Health and Wellbeing Board will hold a spotlight session on each priority to examine progress in more detail through the year.

Outline how this supports our partnership vision and strategy

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

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

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

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

Recommendation(s)

The Partnership Board is asked to:

1. **Receive and note** the new North Yorkshire Joint Local Health & Wellbeing Strategy 2023-2030

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2.	**Consider** the strategic direction and applicable content of the strategy when making decisions regarding the health and wellbeing of North Yorkshire residents

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.	Joint Local Health and Wellbeing Strategy 2023-2030 (northyorks.gov.uk)

Acronyms and Abbreviations explained
CQC = Care Quality Commission JSNA = Joint Strategic Needs Assessment

What are the implications for?

Residents and Communities	There is a strategic vision to improve health and wellbeing for residents and communities across North Yorkshire, including Craven
Quality and Safety	**n/a**
Equality, Diversity and Inclusion	**n/a**
Finances and Use of Resources	**n/a**
Regulation and Legal Requirements	Health & Wellbeing Boards have a duty to prepare Joint Local Health and Wellbeing Strategies – this fulfils that requirement for the North Yorkshire Health & Wellbeing Board
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	Future decisions and policies that impact on health and wellbeing in North Yorkshire should align with the Strategy
Citizen and Stakeholder Engagement	Citizen and stakeholder engagement occurred as part of the consultation process during development of the Strategy

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Health and Wellbeing Board
North Yorkshire

North Yorkshire Joint Local Health and Wellbeing Strategy 2023–2030

For all residents of North Yorkshire to have a fair chance of living a fulfilling life, free from preventable ill health, 'adding years to life and life to years'.

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Foreword

In developing our strategy, we have reviewed data, evidence and research and listened to what local people have told us matters to them. The impacts of the global COVID-19 pandemic as well as climate change and the cost of living are affecting the health and wellbeing of people in North Yorkshire. We know that different communities face different challenges, for example in our rural and coastal areas, and that working together with other organisations locally plays an important role in responding effectively to these. We also know that there are differences in health outcomes for different groups in our population.

In response to this, we have identified three priorities of:

- **Prevention** - we will improve the health and wellbeing of all our residents by concentrating on the big actions that will make the most difference to our population
- **Place** - where you live should help you stay well and happy. We want to make sure that where you live does not unfairly reduce the quality of your health or length of your life.
- **People** - we will work with our communities who experience the poorest health outcomes to make sure that they make the most difference to our population.

Our priorities focus on issues where there are opportunities for partners to work together to have a real impact on health and wellbeing outcomes for people of all ages, to provide children with the best start in life and to reduce health inequalities. We know that this strategy will also influence the priorities and actions of individual organisations in North Yorkshire.

As a Health and Wellbeing Board, we will build on our history of working together as partners with local communities to respond to the current and future challenges facing our population. Together we will improve people's health from childhood to later-in-life across North Yorkshire.

Amanda Bloor
Chief Operating Officer, Humber and North Yorkshire Health and Care Partnership
Vice Chair of North Yorkshire Health and Wellbeing Board

County Councillor Michael Harrison
Executive Member Public Health and Adult Social Care
Chair of North Yorkshire Health and Wellbeing Board

What we want to achieve through our Joint Local Health & Wellbeing Strategy?

For all residents of North Yorkshire to have a fair chance of living a fulfilling life, free from preventable ill health, 'adding years to life and life to years'.

To achieve this ambition, the Health and Wellbeing Board wants everyone - and in particular the **wider health and care system** - to:

Think Prevention

In North Yorkshire, we will improve the health and wellbeing of all our residents by concentrating on the big actions that will make the most difference to our population

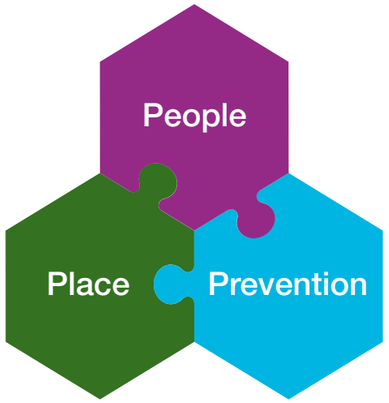
Think Place

In North Yorkshire, where you live should help you stay well and happy. We want to make sure that where you live does not unfairly reduce the quality of your health or length of your life

Think People

In North Yorkshire, we will work with our communities who experience the poorest health outcomes to make sure that they can access and benefit from the services and opportunities they need

There are lots of links between Prevention, Place and People; we will work together to connect our actions so that we can tackle health inequalities as effectively as possible.



Our cross-cutting themes act as a focus for the Health and Wellbeing Board to develop our role as leaders in the wider health and care system, and collectively make a difference:

- **Workforce, employment & volunteering opportunities**
- **Digital inclusion and innovation**
- **Making best use of our resources**
- **Accessibility of services and communication**
- **Joining up our coproduction and engagement**

Introduction

What is the Joint Local Health and Wellbeing Strategy?

Each local area must have a Joint Local Health and Wellbeing Strategy which sets out the priorities identified within its Joint Strategic Needs Assessment (JSNA) that local government, the NHS and other partners will deliver through its Health and Wellbeing Board.

The overall ambition of the **North Yorkshire Health and Wellbeing Board** is to reduce the gap in life expectancy, increase years of healthy life expectancy and reduce differences between health outcomes in our population. **We want to add years to life, and life to years.**

This is our third Joint Local Health and Wellbeing Strategy. It builds on our previous strategies and sets out priorities for action over the next 7 years.

Our priorities focus on areas where there are opportunities for partners to work together to have a real impact on **health and wellbeing outcomes** for people of all ages, to provide children with the best start in life and to reduce **health inequalities**.

We will work collaboratively as a partnership and with our communities to deliver these priorities.

You can find a short explanation of the words in orange at the end of this strategy.

What do we mean by health inequalities?

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They are created by the conditions in which we are born, grow, live, work and age. We all have some influence over our own health through the lifestyle choices that we make, but the conditions we live in and whether we have fair access to services will have a much greater impact. These factors are often referred to as the **building blocks of health**, or **wider determinants of health**:

- Where we are born
- The amount of money we have
- The quality of our education
- Where and what we do for work
- Connections such as digital and social networks
- Where we live
- The food we eat
- Healthcare
- Where and how we play and exercise

People's views of health inequalities

Members of the public from different walks of life spoke to researchers about what health inequalities mean to them. Watch the video here

"The health difference across the country matters. What's on the map is unfair."

"You shouldn't have to learn a system in order to know best how to use it."

"Respect, accept and value all people, regardless of how we look or where we live".

"Decision makers should involve communities in the beginning, middle and end of decision making, recognising their strength."

What does health and wellbeing look like in North Yorkshire?

North Yorkshire is a great place to live in lots of ways, with beautiful countryside, vibrant market towns and active communities. Most people in North Yorkshire live relatively healthy lives, and average life expectancy for both men and women is higher than the England average.

However, it's not the same for all - some groups of people are less healthy and die sooner, from illnesses which we can prevent.

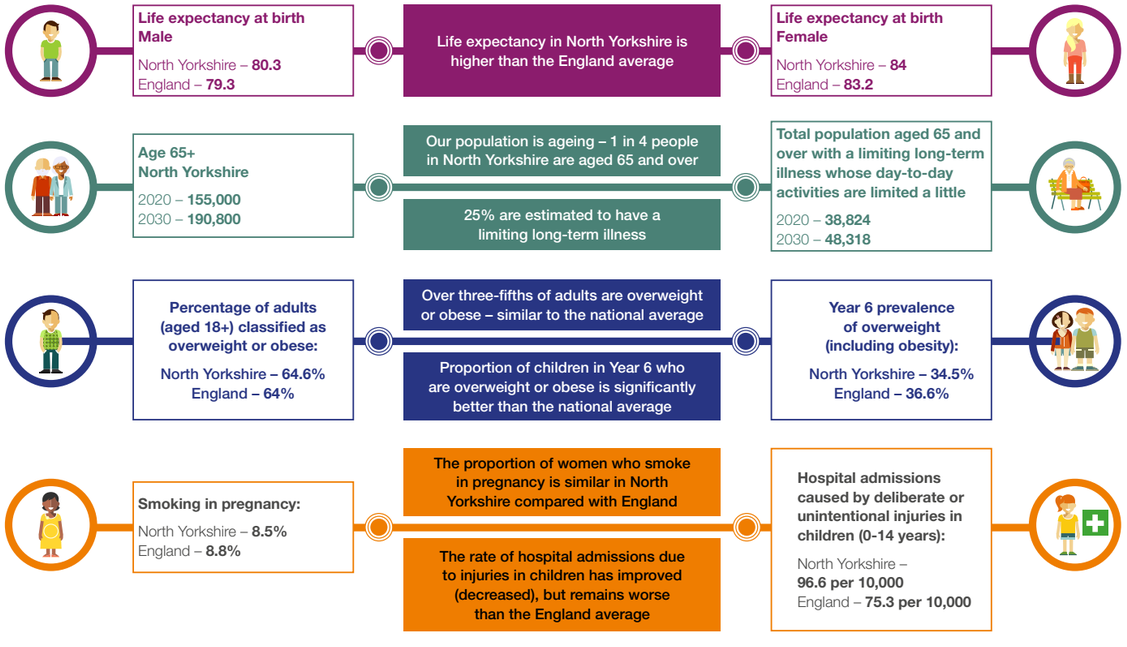
There are also areas where life expectancy is worse, particularly in Scarborough, but also in parts of Selby, Harrogate and Richmondshire. The gap in life expectancy between our most deprived and least deprived wards can be as much as 11 years for men and 10 years for women.

We also know that there are inequalities within wards, and even within streets, including in areas that are not considered 'deprived'. The action we take through this strategy is about reducing these differences.

We serve a total population of 615,400 people with 153,800 people (25%) over the age of 65 years. With projected trends and inward migration of older people to the area, we expect this figure to increase to almost a third by 2035; this is higher than the national average. We will also see an increase in the prevalence of conditions often associated with older age such as falls and dementia.

The actions in this strategy will help us to focus on preventing and delaying the impacts of some of these conditions, improving quality of life and maintaining people's independence for as long as possible.

You can find more facts and figures about health in North Yorkshire here: datanorthyorkshire.org



How we have developed this strategy

To develop this strategy, we looked at what the data was telling us about health in North Yorkshire. We reviewed the progress that had been made under our previous strategy, and we worked with partners to understand what was most important for them. You can find out more about our partners and priorities in the appendix.

We considered the impact of the COVID-19 pandemic on people's health and what we know about this so far, and we also looked at the cost of living crisis and what this meant for people's ability to live healthily.

We looked at what people had told us through engagement during and since the pandemic, to understand their experiences and views of health and social care, and wider health and wellbeing. Although this brought in a wide range of voices and communities across North Yorkshire, some were less well represented – in particular, those groups who experience the poorest health outcomes, including Gypsy, Roma, Traveller and Show communities, refugees, asylum seekers and homeless people. Reaching these groups is a priority for this strategy.

In North Yorkshire, our engagement review showed that the cost of living is a concern for all ages, with people sharing worries about money, the impact on mental health, and on physical health if not able to afford to keep homes adequately heated, the choice for some of 'heat or eat', affordability of travel, and young people worried about their parents struggling. This was reinforced in the feedback from our consultation on the draft strategy. People also told us what was important to them to be able to stay healthy and well, including access to healthcare, physical activity, green spaces and social connection.

The impact of the COVID-19 pandemic on people's health and wellbeing has been immense, and it will take many years for the full scale of this to be realised. You can find out more about the impacts of the pandemic in the **North Yorkshire Director of Public Health Annual Report 2021-22** To view click here

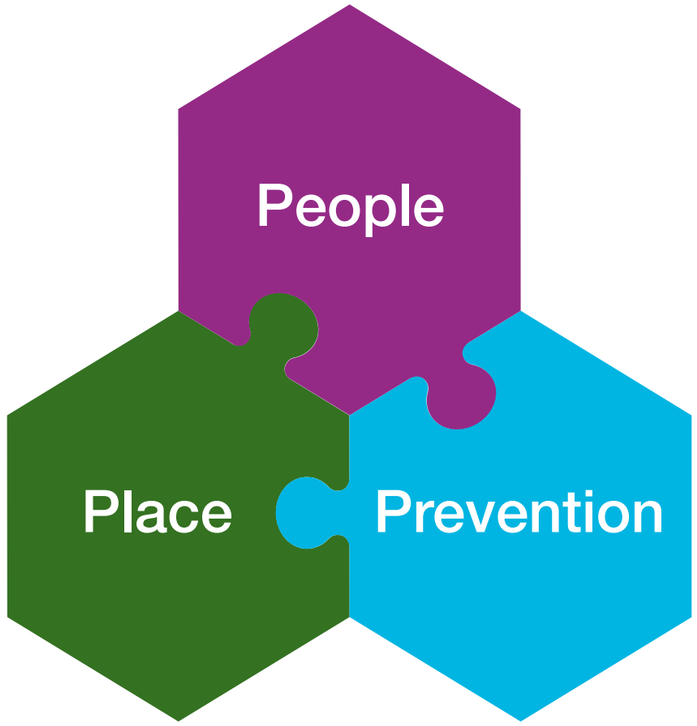
Introducing our strategic priorities

The links between Prevention, Place and People

If the **place** we live in has good housing, access to green spaces, transport, education and employment opportunities, this helps **people** to live well and **prevent** ill health.

However, some **people** who experience the poorest health outcomes live in our most deprived places and are more likely to experience some of the population health major conditions that we want to **prevent** – for example, chronic respiratory disease. They will take these skills with them through to the next generation.

Although we have separate sections in this strategy for **Prevention**, **Place** and **People**, we know that there are lots of links between them. By making sure that we connect up our work across the system, it will be more effective and result in better outcomes for people in North Yorkshire.



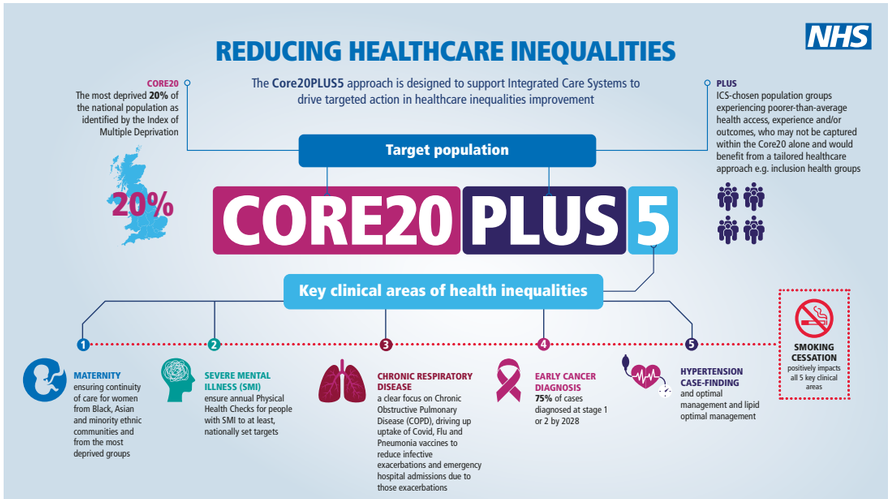
Think people | **Think place** | **Think prevention**

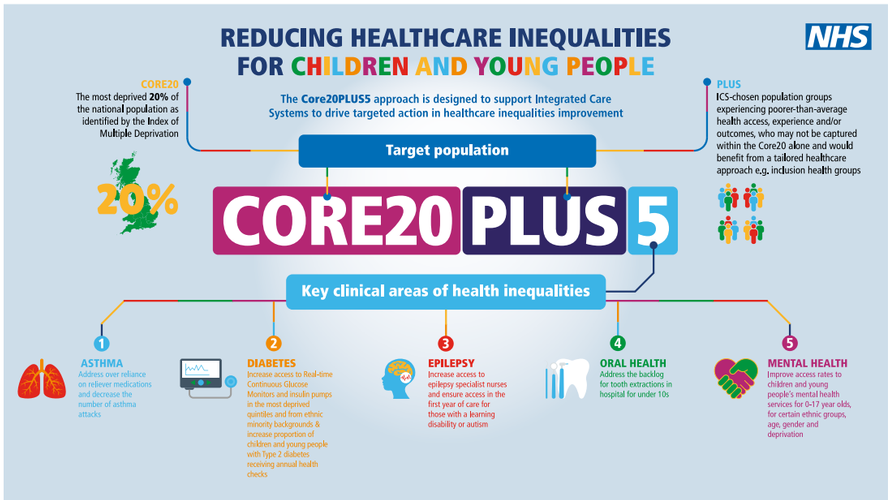
Core20PLUS5

The NHS Core20PLUS5 is a national approach aimed at reducing healthcare inequalities at both national and local level via targeted action.

It concentrates on the most deprived 20% of the national population (Core), the groups that experience poorer than average health outcomes (PLUS), and 5 specific clinical areas (5).

The Core20PLUS5 approach underpins our strategy, and is in turn strengthened by the strategy's focus on the building blocks of health; putting both together, we can ensure a more robust and joined-up response to health inequalities.





For more information about Core20Plus5, please see the following links for children and young people: NHS England Core20PLUS5 – An approach to reducing health inequalities for children and young people and for adults: NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

Think Prevention

In North Yorkshire, we will improve the health and wellbeing of all our residents by concentrating on the big actions that will make the most difference to our population.

What does this mean?

North Yorkshire people are healthier, and live longer, than the average for England. But there is still work to do to reduce the number of people affected by conditions that, by everyone working together, can be prevented or delayed. **The national 'Major Conditions Strategy: case for change'** shows that in most instances, poor health arises from living with at least one of 6 major health conditions: cancer, heart disease, musculoskeletal disorders, mental ill-health, dementia and respiratory diseases. Together, these conditions account for over 60% of ill health and early death in England. **One in 4 adults has at least 2 health conditions**.

Many of these illnesses can be prevented where people are able to live healthy lives, underpinned by effective prevention services/ interventions that start in pregnancy and childhood, for example the Healthy Schools Award Programme, and various other initiatives within schools and Early Years settings.

Investing in prevention can protect individuals and their health by improving their quality of life and extending healthy life expectancy.

Activities focussed on prevention are also beneficial to wider parts of the economy such as helping to increase productivity through reduction in sickness absence and lowering costs by reducing the need for hospital care and medical treatment.

We want the **healthy choice to be the first choice** for people. For this to happen people need the skills, opportunities and motivation to take action, supported by a healthy environment and with access to good services.

Skills should first be taught to our youngest residents in schools, promoting good nutrition, active lifestyles, and resilience and wellbeing. They will take these skills with them through to the next generation

Why does it matter?

Many health conditions affect a wide proportion of the population; heart disease, stroke and cancer account for the greatest proportion of deaths within North Yorkshire. 61% of adults are classified as overweight or obese, and in year 6 aged children, the proportion that are overweight or obese is 34%.

More worrying, Reception Year children have higher levels of excess weight than the national average. Although smoking prevalence in North Yorkshire is lower compared to England, in some areas it is higher than the England average.

The rate of hospital admission for alcohol related conditions is worse than the England average. We also need to consider the number of young people starting vaping and then work with partners to reverse this trend.

As we see an increase in the numbers of older people we will also see an increase in falls, frailty and other conditions often associated with old age. Organisations will need to work together to plan services to meet this future demand whilst at the same time focusing on prevention.

What people have told us

Concern about timely access to GP and other health appointments came through as a particularly strong theme in our review of engagement, and people said that it affected their health and their ability to manage long-term conditions. Another strong theme was about both children's and adults' experiences of mental ill-health and problems getting support. We know there are significant concerns around access to autism assessment and support for both children and adults, but with children, this has impacts on education that may be lifelong. Many of the issues mentioned in People and Place are also relevant here, including availability of accessible public transport and what people need for their area to be a healthy place to live. By addressing these barriers, prevention interventions are more likely to succeed.

Access to health care was also a key theme from the consultation on the draft strategy, alongside feedback on what people need to stay healthy, including affordable physical activities, access to green spaces, social connection and support for families.

East Barnby Healthy Schools. Jemison Photographer Ltd.

What we are going to do

- Develop our local response to the national **Major Conditions Strategy** (2023) including:
  - **Supporting the mental health and emotional wellbeing of children** and families, with a focus on those in our communities who have been hit the hardest by the pandemic as evidence on this emerges;
  - Tackling issues which cause health inequalities and make it harder for **people with poor mental health to stay well.** These include employment, loneliness, discrimination, debt and housing;
  - **Preventing the onset and reduce the impact of cardiovascular disease** (CVD) by identifying those at risk earlier, focusing on prevention and improving the management of CVD health conditions.
- Focus on **prevention** to reduce the risk of people developing long-term conditions by:
  - Continuing to **reduce smoking levels** in North Yorkshire, working towards our aim of achieving 'smoke-free 2030';
  - Continuing the successful partnership approach of the **Healthy Weight Healthy Lives** strategy, developing our whole system transformational approaches to physical activity and access to healthy food.
- Implement the new national **Modern General Practice** model to support recovery of access to primary care in communities. This will support the continuing growth in the number of appointments available in GP Practices.
- Improve **quality and efficiency of patient pathways** across health and social care to free up bed capacity in hospitals, by:
  - Providing **good access to primary care and urgent care** to reduce the need for admission into a hospital bed and reducing the average length of stay in a hospital bed through timely and safe discharge back home or to suitable community-based care;
  - Delivering **quality healthcare through innovative models** eg virtual wards and a new intermediate care model including improvements in triage, assessment, discharge, reablement and community-based care and support;
  - Developing a multi-agency programme of work around **falls and frailty**;
  - Reducing long waits for care and treatment in line with the NHS long term plan and joint forward plans of the ICBs, with a focus on prioritising clinical need.
- Improve uptake of **NHS health checks**, screening and immunisation programmes.
- Implement the **North Yorkshire Sexual, Reproductive Health and HIV strategic framework**, working across the system to deliver the associated action plan.

- In line with our transformation plan, continue the ICB programme of investment in access to NHS dentistry, and use population health data to direct dental funding to the areas of most need to help reduce inequalities.
- Develop robust, flexible commissioning strategies to enable a wider range of dental services including community dental services, intermediate minor oral surgery, referral management service, urgent dental care and dental checks in special educational need schools.
- Implement the Age Friendly Communities framework, co-producing actions with the North Yorkshire Age Friendly Network
- Continue to develop a network of **Community Anchor Organisations** to support individuals, groups and agencies in around 30 local geographies to contribute to prevention goals and reduce health inequalities - making local voices easier to hear, improving social connection, growing volunteering, running community activities or services and developing local solutions to local needs.
- Strengthen the health and wellbeing offer in local libraries including social connection, volunteering opportunities, activities, information & signposting, literacy and digital connection.
- Further develop our partnership approach to the **prevention of seasonal health issues**, including adverse weather planning, heatwaves and climate change, fuel poverty, and prevention of excess winter deaths.
- Improve our approach to **Community Infection Prevention & Control** to support health protection in frontline services across the system.
- Develop a local response to the national **Suicide Prevention Strategy**. Ensure that **parents have the pre and post-natal support they need**:
  - Continue to ensure our Health Visitors
  - provide appropriate support to every family, stepping up care where appropriate and ensuring that women have the right help in the first few years of their child's life;
  - Continue to promote breastfeeding friendly venues and expand breastfeeding peer supporters;
  - Continue to work together on perinatal mental health services;
  - Support local communities to provide parent and baby groups for peer support;
  - Close strategic working between children's services and the Integrated Care Boards.
- Continue to explore funding initiatives to provide **affordable activities** for children, young people and their families.
- Continue to focus on improving children and young people's **mental wellbeing and resilience** via:
  - the Healthy Schools Award Programme and other school initiatives;
  - work with school safeguarding leads around **online safety, peer relationships and mental health and wellbeing**.
- Continue our **health surveillance** to act on those health issues we have identified as being of concern **for children and young people**, including:
  - Childhood admissions from unintentional injuries;
  - Childhood unhealthy weight;
  - Drug and alcohol admissions.
- Maintain the **downward trajectory of unplanned pregnancies in under-18's**, with a sustained focus on Scarborough with higher than England rates.

Think Place

In North Yorkshire, where you live should help you stay well and happy. We want to make sure that where you live does not unfairly reduce the quality of your health or length of your life.

What does this mean?

We know that where we live is important: our access to services, education, homes, supportive networks, employment, green spaces, activities and leisure opportunities affects how healthy and happy we are. We also know that connected and empowered communities will contribute to healthier, happier and flourishing societies, and we want the people of North Yorkshire to be able to actively participate in their locality and feel a strong sense of belonging.

Social, economic and environmental factors interlink to create communities in which we should all be able to thrive. Tackling these building blocks of health can help make significant improvements to the quality of life of all our communities, at both a county level and a neighbourhood level.

Why does this matter?

North Yorkshire is the largest county in England by land area, and its geography ranges from rural to urban and coastal. Eighty-five percent of the county is classed as very rural or super- sparse. This diversity brings many opportunities for quality of life for our communities and for visitors, but also challenges, particularly around delivering consistent and accessible services, affordable homes and access to high-quality education and employment across the area.

The county is relatively prosperous but there are pockets of very high levels of deprivation, particularly in Scarborough town and Whitby.

Life expectancy at birth for men and women in North Yorkshire is generally significantly higher than the England averages. However, as we describe in the introduction to this strategy, at the local level life expectancy across the county varies widely.

As highlighted in the Chief Medical Officer for England's Annual Report 2021, coastal communities include many of the most beautiful, vibrant and historically important places in the country. They also have some of the worst health outcomes in England, with low life expectancy and high rates of many major diseases. There is a 15 year difference in life expectancy for males between the ward with the lowest overall life expectancy (Castle ward, Scarborough district) and that with the highest overall life expectancy (Ripon Minster ward, Harrogate district).

The Index of Multiple Deprivation (IMD) 2019 highlighted 24 neighbourhoods in North Yorkshire that fall within the most deprived quintile in England, 20 of which are concentrated in Scarborough town and Whitby.

The final report of the independent North Yorkshire Rural Commission (2021) noted the beauty of spacious countryside and opportunities for thriving rural communities, but highlighted problems including a lack of affordable housing, poor public transport links and a huge issue with digital connectivity for both mobile and internet coverage.

What people have told us

In our engagement review, we heard about the importance of place for good health and wellbeing. People said that for good health, they needed affordable public transport; accessible, inclusive and affordable opportunities for exercise, including being in nature; supportive communities and networks. Public transport came through as a key enabler for many of the building blocks of health, and a big concern for people. The geography of North Yorkshire was also highlighted, and in particular the reduction of specialist health care in local areas due to the concentration of specialisms in larger urban areas. For children and young people, what matters to them at all ages is their family, friends, environment and having something to do - this is shown in our Director of Public Health Annual Report 2023 focussing on children & young people.

These themes also came through strongly in our consultation on the draft strategy.

What we are going to do?

To build our stronger, fairer and greener places, we will focus on five key actions for Healthy Places: community, homes, food, spaces and movement – and no-one left behind:

Community: we will -

- Ensure that local areas are designed to enhance people's mental and physical health, and involve local people via **neighbourhood planning**.
- Develop approx. **30 informal local Community Partnerships**, predominantly around our market town footprints, and support their focus on prevention and reducing inequalities, in particular offering help to progress any local action plans which have identified health and wellbeing as a local priority.
- Support **voluntary, community and social enterprise (VCSE) sector** organisations to sustain and grow opportunities to reduce inequalities, and improve the wellbeing and social connectedness of people of all ages.
- Develop opportunities for **communities** across North Yorkshire to have **greater control in leading change** that positively impacts health and wellbeing, and builds resilient, connected communities.

Homes: we will -

- Influence healthy design in the **Housing Strategy** – including work to improve quality of housing, increase energy efficiency of homes, increase adaptable and affordable homes and homes which are flexible for the needs of specific groups.

Food: we will -

- Focus on improving **food infrastructure and the local food environment**, taking a whole system approach that looks to provide accessible, sustainable and nutrient dense food, from food production to distribution, nutrition, consumption and food waste disposal:
  - Develop the first **North Yorkshire Food Strategy** by end of 2024;
  - Focus on developing an Eatwell culture starting with access to good food and education in schools through to affordable and diverse access in communities, and acting on recommendations from food insecurity research and insight project;
  - Work with **farmers and producers** to support access to nutrient-dense food.
- Influence healthy design in the **Economic Growth Strategy** - enhance the growth of local economies by using the approach as set out by the PHE 2021 Inclusive and Sustainable Economies: no-one left behind.

Spaces: we will -

- Influence healthy design in the North Yorkshire Local Plan - we will prioritise the design of places to improve health and wellbeing; ensure developments do not adversely affect health; and use planning to promote creation of healthy places which make healthier choices easier.
- Enable our **Local Care Partnerships** to lead the design of local integrated health and care services across the county.
- In addition to the above actions, take opportunities to **design environments that include:**
  - **High-quality, climate-resilient natural environment and streetscape**, for example increasing street tree planting and urban greening;
  - **Improving indoor and outdoor air quality** to reduce air pollution-related impacts;
  - **Neighbourhoods that are complete and compact**, with enhanced connectivity through walkability and accessibility.
- Influence healthy design in the Community Safety Strategy (due for refresh in 2024) – look for opportunities for the design of places to enhance safety and support community safety priorities.
- Reduce health inequalities in **rural and coastal communities** with an initial focus on:
  - Improving **data and research** into those communities;
  - Increasing health and care workforce in coastal communities working with partners in the academic sector;
  - Building on the work of the **North Yorkshire Rural Commission** to address access issues for health and care;
  - Developing innovative models for **domiciliary care in rural areas**, including care built on community strengths.

Movement: we will -

- Influence healthy design in the **Local Transport Plan** - we will ensure links to Local and Strategic Transport Plans where possible with the aim of providing Active Travel infrastructure; prioritising active travel and safe road use; enhanced accessibility for all ages; improving and creating rural solutions for public transport.
- Physical activity – **develop the new sport and active well-being approach** following the Council's strategic leisure review including:
  - services that complement wider community activity, and create opportunities for **active well-being for all** across our diverse geography;
  - make best use of **open spaces & natural environments**;
  - create evidence based approaches to **tackle major health conditions** (such as weight management, falls prevention, cancer prehab);
  - support **inclusive & accessible activity** for those who find it hardest to participate.

In addition: we will -

- Make sure that all partners have a **shared understanding** of what is meant by a **place-based** approach, by agreeing together our vision and principles for healthy, happy places, and change the way that we **communicate about the building blocks of health** to increase public and partner understanding.
- Maximise the opportunities to improve the health and wellbeing of our population through the **devolution deal** for North Yorkshire and York which will support economic growth and strategic infrastructure.

Think 'People'

In North Yorkshire, we will work with our communities who experience the poorest health outcomes to make sure that they can access and benefit from the services and opportunities they need.

What does this mean?

For many people North Yorkshire is a great place to live a healthy life, and the joint action we take under this strategy will help to sustain this, building on community strengths. Our aims and actions for Think Prevention and Think Place will benefit all our communities.

However we know that there are people within our communities for whom it is much harder to live a healthy lifestyle and to access the right services to prevent ill health. We also know that some people will experience additional barriers – for example, ethnic minority people, disabled people, women and LGBTQ+ people.

By concentrating on areas and population groups where the inequalities are greatest, we will start to close the gap on inequalities and have the biggest impact

Why does it matter?

Some groups of people across North Yorkshire can experience multiple overlapping risk factors for poorer health, such as trauma, poverty, violence and discrimination. This leads to extremely poor health outcomes - often much worse than the general population, lower average age of death, and greater health inequalities. We want to work together to address this.

We will focus on people who are in at least one of these groups:

- **experience poor mental health and/or mental illness;**
- **have learning disabilities;**
- **are autistic;**
- **are older people living on low income and/ or with multiple health conditions;**
- **experience homelessness;**
- **experience drug and alcohol dependence;**
- **have experienced adversity or difficulty in their childhood;**
- **are vulnerable migrants, refugees and asylum seekers;**
- **live in Gypsy, Roma, Traveller and Show communities;**
- **are sex workers;**
- **experience the justice system;**
- **are victims of modern slavery;**
- **military community or veterans.**
- **Carers both paid and unpaid**

Individuals in these groups tend to die younger than the rest of the population and in some of the groups, much younger. For example, the average mortality rate for homeless individuals, prisoners, sex workers and people with substance misuse disorders is between 9 and 15 times higher than the wider population for women and between 5 and 11 times higher than the general population for men. Source: OHID Spotlight. Women spend a significantly greater proportion of their lives in ill health and disability when compared with men. While women make up 51% of the population, historically the health and care system has been designed by men for men. *Source: Women's Health Strategy, 2022*. There will also be differences in needs within these groups (for example between men and women, through age or culture), so we must understand these differences.

What people have told us

In our engagement review, we heard that for some people there are more barriers to access health care because of who they are.

This included concerns that services lacked awareness of how to support LGBTQ+ people, unreliable access to interpreters for refugees and migrant families, poor availability of accessible information and communication particularly for disabled people and worries about being stigmatised or viewed negatively because of their identity or conditions. Older people have reported feeling excluded from health and other services due to the focus on digital technology. In our consultation on the draft strategy, people said that they needed accessible health and care services, community facilities and information. We heard about the importance of good support for families, and improved access to mental health support. We also heard about the impact of financial exclusion on physical and mental health.

What we are going to do

- Work together to understand more about who and where our **priority groups** are in North Yorkshire, and their barriers to living healthy lives. Use this to develop a framework to support services to **address these barriers in design and delivery.**
- Identify specific actions to support **improved health outcomes for key groups** of people through refreshing our joint strategies for autism, carers, dementia, substance use, mental health, Special Education Needs & Disabilities (SEND).
- Strengthen how we work with **particular communities** to support improving their health outcomes, for example refugee, asylum seeker and migrant communities and Gypsy, Roma, Traveller and Show communities.
- Review and improve how we work together to support people with **complex life circumstances**.
- Work together more closely across partners to better **coordinate our responses to financial inclusion for those most in need,** including our work on:
  - affordable, good quality and well-insulated housing;
  - access to affordable food;
  - cash and non-cash based benefits;
  - transport;
  - sports, leisure and wellbeing activities.
- In response to the national 10-year Women's Health Strategy, continue to develop a North Yorkshire approach to **improve the health of women and girls** to reduce the disparities that currently exist.
- Implement a programme of work around **healthy ageing** which includes a focus on reducing inequalities and improving outcomes, particularly in areas where there is a higher proportion of older people.

- Work together across the health and care system to improve **waiting times** for assessment and access to services.
- **Transform the care market** with a focus on rural and coastal areas, dementia and working age people with complex life circumstances. Work across the health and care system to support providers with workforce development initiatives.
- Develop our **specialist housing offer** including Extra Care, Supported Housing and Supported Living to address shortages, particularly for working age people with care and support needs, guided by a new housing framework and in partnership with Housing and Care Providers
- Develop an innovative and improved offer across North Yorkshire to **improve the health and wellbeing both paid and unpaid carers**.
- Strive to enact the recommendations set out in The Best Start for Life Programme.
- Promote and support **mental and physical health in pregnancy** to ensure that our children have the best start in life, including support for parents who may need extra help with their mental and physical health, parenting and the rising cost of living.
- **Support the most vulnerable families** with the **cost of living**, ensuring they are enrolled in schemes for which they are eligible, eg:
  - Free school meals;
  - Healthy Start Scheme;
  - Government-funded childcare;
  - Work with schools to poverty-proof the school environment.
- Initiate a programme of **children and young people's mental health transformation** to ensure that all organisations involved are connected and communicating as an effective system, so that young people receive the right support in the right place at the right time.
- Promote this system of **mental health and wellbeing** around a flexible, asset-focused, needs-based programme of support, in the knowledge that appropriate input will be advised no matter the organisation where concerns are first raised.
- Support children and young people to be **school ready** and continue to maximise their life chances through continuing to **access education and training**.
- For those young people most at risk, in the care system, ensure that the Council's responsibilities as **corporate parent** provide holistic support for the building blocks of health.
- Collectively examine, with our partners, the **children & young people's priorities** for North Yorkshire and determine which are best tackled more locally and which are best tackled at a regional level to make the best use of all our resources.
- Continue working together to **safeguard people of all ages** across the health and care system.

Cross-cutting themes

From our discussions with partners and our engagement work, we have identified some cross-cutting themes. These themes are important to our work under our priorities of Prevention, Place and People. For each of the themes, we also want to make sure that we share knowledge and learning to enhance our effectiveness. As a Health and Wellbeing Board, we will have a programme to develop our role as leaders in the **wider health and care system ("system")** on the following issues:

Workforce, employment and volunteering opportunities

As a **system**, show leadership in providing employment and volunteering opportunities for people who experience barriers to employment, including those who live in areas of deprivation, disabled people, young people with Special Educational Needs and people from our priority groups. We also acknowledge the important contribution the workforce makes to delivering the improvements in this strategy and will equip them with the skills and knowledge they need for their roles and to work with others across the system.

Accessibility of services and communication

As a **system**, ensure that our services and communication channels are accessible to everyone, and in particular make improvements for disabled people and others who may experience barriers to access, making reasonable adjustments to support this. Work with representative groups and communities to identify barriers to access and practical solutions.

Making best use of our resources

As a **system**, we acknowledge the pressures facing each organisation so we will work together to make best use of our collective resources (our people, our finance, our buildings, our research, data and intelligence) to deliver the strategy together. Efficient use of these resources will avoid duplication, maximise impact at a community level and enable delivery at scale where appropriate.

Digital inclusion and innovation

As a **system**, act to reduce digital exclusion and enhance the opportunities provided by digital innovation. We also recognise that some people will not want to access digital solutions, therefore we will engage to understand the reasons, provider alternatives solutions and ensure that people who cannot or do not want to access digital options do not receive a lesser service. In our health and social care services, we will embed digital innovations to support admission avoidance, improve discharge, support digital pathways of care and support people to stay as independent as possible in their own homes and communities.

Joining up our coproduction and engagement

As a **system**, collaborate on our coproduction and engagement work to ensure that we listen to and involve our communities as we implement this strategy, in particular by embedding excellent coproduction practice. Create a better experience for our communities in the way we do this, with the aim of strengthening community relationships, reaching those who are under-represented and managing the demand on community groups (particularly socially excluded groups).

Delivering our Strategy

In North Yorkshire we have a strong working partnership across the health, social care and voluntary organisations who work with local people to prevent ill-health and deliver care. As a Health and Wellbeing Board, we are stronger together and recognise the commitment across the whole system to enable North Yorkshire to be a good place to live a healthier longer life.

The implementation of this strategy presents a powerful opportunity for North Yorkshire to create a partnership system for the future,

building on previous success and momentum of the last strategy and the new developments of the health and care system and unitary council for North Yorkshire. This includes working at the local community level with Local Care Partnerships and Community Partnerships.

The Health and Wellbeing Board will provide leadership and direction to the system and hold organisations, including Integrated Care Systems, to account on how they are delivering the priorities of the North Yorkshire Joint Local Health and Wellbeing Strategy through annual action plans. The Health and Wellbeing Board will also advocate at both regional and national levels for improvements which will benefit the health of North Yorkshire residents.

Our principles for how we will work collectively to deliver the ambitions of our new strategy?

- **We will focus on early intervention and prevention in everything we do starting with our youngest children;**
- **We will work with our local communities using an asset based community development approach to identify and support local solutions to improve health and wellbeing**
- **We will work to address the building blocks of health that drive poorer health outcomes, for example transport, housing, and access to services;**
- **We will promote inclusion, recognising diversity and reducing inequalities;**
- **We will work with communities to develop a collective understanding of and responsibility for actively managing our health and wellbeing.**

This short film from our neighbours in Leeds explains asset based community development. To view click here

How we will keep track of our progress

Change can take a generation for some of these issues. We recognise that, so we also want to identify other ways we will monitor achievements and progress.

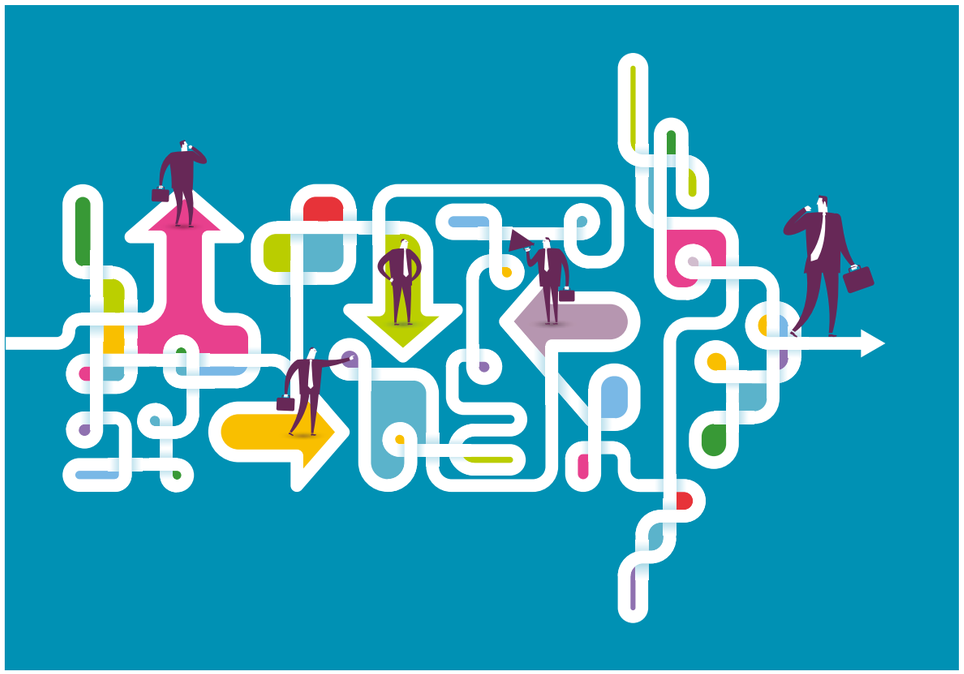
One important measure of our success will be reducing the number of years that people spend in ill-health and reducing unfair variation in this. Achieving this will require action over the long term. Our collective work on our priorities will contribute to this and we will track progress on each of them. We will ensure that our work is evidence-based and informed by research. This will be supported by Public Health intelligence and Population Health Management approaches, and by the new North Yorkshire Health Determinants Research Collaboration (HDRC). The HDRC will better identify the local social, economic and environmental factors that influence the health and wellbeing of our residents, and help partners to shape policies and interventions that promote health equity and reduce health inequalities.

Another important measure will be what people say – the feedback that our communities give us about their experiences, their health and their wellbeing, and how involved they are in making the changes. We will continue to develop the ways that people can get involved in the work of the Board.

External scrutiny will provide additional rigour in the monitoring of our work together, including the new Care Quality Commission (CQC) Inspection of Adult Social Care and Integrated Care Systems, as well as existing inspection frameworks for health and care providers (CQC) and children's social care and education (OFSTED).

We will develop a delivery plan with ways to measure the difference we are making, and progress reports will be presented at the quarterly Health and Wellbeing Board

Meetings, with information available to the public. In addition to this, the Health and Wellbeing Board will hold a spotlight session on each priority to examine progress in more detail through the year.



Appendix 1

Strategic landscape

In April 2023, the county council and seven district and borough councils in North Yorkshire became one council, making North Yorkshire Council one of the largest councils. The new unitary council delivers a wide range

of local services which contribute to the health and wellbeing of people and places across the county, including housing, social care, leisure, community safety, economic development and planning. In addition, the new York and North Yorkshire Combined Authority launched on 1 February 2024: this new devolution deal for North Yorkshire and York will support economic growth and strategic infrastructure, benefiting the health and wellbeing of our population.

The planning of our local NHS services is now overseen by **Integrated Care Boards** (ICBs). The ICBs work together with all parts of the NHS, local councils and other partners to deliver joined-up care for people, in Integrated Care Systems.

Integrated Care Systems (ICSs) are partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

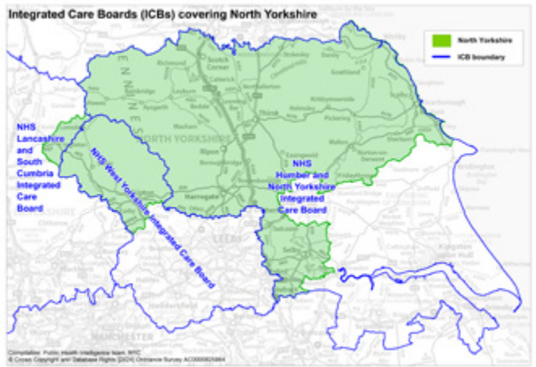
The two main Integrated Care Systems in North Yorkshire are Humber & North Yorkshire Health and Care Partnership and Bradford District & Craven Health Care Partnership. They include NHS organisations, local councils, health and care providers and voluntary, community and social enterprise (VCSE) organisations.

We all play an important role in reducing health inequalities and improving population health and wellbeing in North Yorkshire.

The establishment of North Yorkshire Council alongside the Integrated Care Boards provides new opportunities to work together with partners to transform local services to improve the health and wellbeing of people and communities.

Our Joint Local Health and Wellbeing Strategy has been developed in this context. It is both an expression of our shared commitment to delivering actions which add value through working together, and a clear set of priorities to influence the core work and focus of all partners.

The diagrams on the following pages describe how each major sector in our partnership contributes to the Joint Local Health and Wellbeing Strategy through both their individual priorities and collective action.



The contribution of local health services to our joint health & wellbeing strategy

North Yorkshire Joint Health and Wellbeing Strategy

Prevention | **Place** | **People**

Putting it all together

Shared action to deliver our priorities

Humber & North Yorkshire Integrated Care Systems Integrated Strategy

Narrowing the gap in healthy life expectancy between the highest and lowest levels in our communities by 2030 and increasing healthy life expectancy by five years by 2035:

- Start well
- Live well
- Age well
- Die well

Humber & North Yorkshire Integrated Care Systems North Yorkshire Place Plan Priorities 2023-2028

- Comprehensive and integrated health & social care model
- A high quality care sector, with sufficient capacity to meet demand
- A strong workforce
- Prevention and public health: adding life to years and years to life

West Yorkshire Integrated Care System Bradford & Craven Place Plan

Priorities

- Access to care
- Children & young people
- Healthy communities
- Healthy minds
- People development

Enablers

- Living well
- Reducing inequalities
- Digital data intelligence & insight
- Research & innovation
- Estates

NHS National Annual Operational Plan delivered by ICSs

Priority areas

- Urgent & Emergency Care
- Community Health Services
- Primary Care
- Elective Care
- Cancer
- Diagnostics
- Maternity
- Use of Resources
- Workforce
- Mental Health
- People with a learning disability & autistic people
- Prevention & health inequalities

Key joint partnership strategies: Mental Health, Carers, Healthy Ageing, Autism, Substance Use, SEND, Learning Disability, Tobacco Control, Suicide Prevention, Community Safety, Economic Development, Local Plan, Housing, Transport, Leisure, Food, Community Partnership Plans

The contribution of North Yorkshire Council to our joint health & wellbeing strategy

North Yorkshire Joint Health and Wellbeing Strategy

Prevention | **Place** | **People**

Putting it all together

Shared action to deliver our priorities

Council Plan 2023-2027

Health & Wellbeing Priorities

- People are supported to have a good quality of life and enjoy active and healthy lifestyles
- Reduced variations in health through tackling the root causes of inequality
- People can access good public health services and social care across our different communities
- People have control and choice in relation to their independence and social care support

Connected Priorities

- Place and environment; economy; people; organisation

Underpinned by Locality working

- Local services and access; local accountability, action & empowerment

Children and Young People's Services (CYPS) Priorities

- Transformation of the Mental Health system with shared vision with partners around I Thrive model
- Auto enrolment in free school meals
- Continued surveillance to address emerging issues and trends for CYP
- Working with wider partners for the safeguarding of every child in North Yorkshire
- Ensuring high quality provision of services for Early Help, Safeguarding, SEND, Education and Transitions to Adulthood
- Delivery of 0 – 19 Healthy Child Programme through partnership
- Striving to enact the recommendations set out in the Best Start for Life Programme

Health & Adult Services Plan

- Opportunities for everyone everywhere
- My time and experiences are valued
- My home, my community, my choice

Public Health Priorities

- Best start in life – for babies, children and young people
- People moving more – improving health and wellbeing through physical activity
- Healthy aging – ensuring that older people are able to age well
- Reducing health inequalities through health place shaping and targeted work with vulnerable groups/ communities
- Ensure measures are in place to protect the population's health
- Improve the mental health of our population
- Ensure the working age population have opportunities to live well
- Work with our NHS partners to maximise our joint effectiveness and impact on health outcomes
- Developing a centre for public health excellence including in research, training and behavioural science

Adult Social Care Improvement Priorities

- Waiting Well
- Reviews
- Direct Payments
- Carers
- Reablement
- Home First
- Complex Care

Key joint partnership strategies: Mental Health, Carers, Healthy Ageing, Autism, Substance Use, SEND, Learning Disability, Tobacco Control, Suicide Prevention, Community Safety, Economic Development, Local Plan, Housing, Transport, Leisure, Food, Community Partnership Plans

The contribution of other key partners to our joint health & wellbeing strategy

North Yorkshire Joint Health and Wellbeing Strategy

Prevention | **Place** | **People**

Putting it all together

Shared action to deliver our priorities

Local independent consumer champion for health and social care

Healthwatch North Yorkshire: 2023-2024 priorities

- Continue to build on the work that we have already championed such as GP access, dentistry, social care and mental health
- Expand our reach and engagement with those communities who aren't always listened to or involved in their health & social care
- Establish a people's voice network for North Yorkshire to ensure people are at the heart of decision making

Voluntary and community sector

Community First Yorkshire

- Having a strong collective voice to help raise the profile of voluntary organisations & community groups
- Helping communities & organisations to thrive
- Supporting individuals to help their communities and volunteer

Key joint partnership strategies: Mental Health, Carers, Healthy Ageing, Autism, Substance Use, SEND, Learning Disability, Tobacco Control, Suicide Prevention, Community Safety, Economic Development, Local Plan, Housing, Transport, Leisure, Food, Community Partnership Plans

Glossary

North Yorkshire Health and Wellbeing Board	The North Yorkshire Health and Wellbeing Board is a statutory committee of North Yorkshire Council and provides a forum where political, clinical, professional and community leaders from across our health and care system come together to improve the health and wellbeing of our local population and reduce health inequalities.
Health and wellbeing outcomes	The difference made by actions to improve health and wellbeing. For example, more people take up regular exercise (action) which results in fewer people being overweight and reducing their risk of heart disease (outcome)
Health inequalities	Unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.
Wider determinants of health	The wide range of factors that affect our health – the places we live, our education, the jobs we have, how much money we have, how connected or how isolated we feel
Wider health and care system	All the organisations, community groups and so on that are involved in organising and delivering health and social care – broader than the NHS or the local council
Integrated Care Board	A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a specific area.
Integrated Care System	Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.
Socially excluded	Groups that: • Are not consistently recorded in electronic systems (dropping through the system) • Experience stigma and discrimination • Have insecure housing, overcrowding or communal accommodation • Experience barriers in access to health care and other services • Have multiple poor health risk factors (poverty, violence, complex trauma) Such factors lead to extremely poor health outcomes across physical and mental health.
Inclusion health	Making sure that people who experience social exclusion have their health and wellbeing needs met, by targeted activity where required.
Devolution deal	In England, devolution is the transfer of powers and funding from national to local government. It is important because it ensures that decisions are made closer to the local people, communities and businesses they affect. Each devolution deal is negotiated separately between ministers and local council leaders, but most deals devolve a core set of powers relating to transport, skills and economic development.
Local Care Partnerships	Local Care Partnerships help to deliver the aims of the Integrated Care System at a more local level, working in and with communities.
Community Partnerships	North Yorkshire Council is developing Community Partnerships to work in and with communities within North Yorkshire. Community Partnerships will connect with Local Care Partnerships.
Asset-based community development (ABCD)	ABCD focuses on a community's assets, capacities and abilities, rather than on needs, deficits and problems. In this way, communities work together to share skills, strengthen relationships and build on what is strong, not what is wrong.

Contact us

Online: **northyorks.gov.uk/contact-us**
By telephone: **0300 131 2 131**

North Yorkshire Council, County Hall, Northallerton, North Yorkshire, DL7 8AD

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Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	BDC Partnership Board
Agenda item no:	11
Meeting date:	6 September 2024
Report title:	Bradford District and Craven Joint Forward Plan – Refresh 2024/25
Report presented by:	Kerry Weir, Associate Director of Strategy
Report approved by:	Nancy O'Neill, Director of Partnerships and Place
Report prepared by:	Kerry Weir, Associate Director of Strategy

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

Previous considerations

This is a refresh of the Joint Forward Plan developed in 2023/24. It has been approved by the Partnership Leadership Executive.

Executive summary and points for discussion

The Joint Forward Plan (JFP) is a statutory document owned by NHS West Yorkshire Integrated Care Board (WYICB). The JFP should demonstrate how the ICB will operationalise its strategy and WYICB published its first plan in 2023/24, with each of the five Places invited to develop a local JFP to form part of the overall West Yorkshire plan.

Our first Bradford District and Craven Health and Care Partnership JFP set out, within the context of our 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 planning commitments.

There is an expectation that Joint Forward Plans will be refreshed annually. The annual review is an opportunity to update plans based on updated assumptions or priorities, including those set out in the 2024/25 priorities and operational planning guidance, and address the last year of the five-year look ahead.

Rather than re-write what is a five-year plan, our JFP refresh is an addendum to the original JFP, which set out any changes to our priorities, what we have delivered in 2023/24 and specific areas of focus for 2024/25.

Recommendation(s)
The Committee is invited: To note and comment on the update to our 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 – Refresh 2023/25.
Acronyms and abbreviations explained
JFP – Joint Forward Plan BDC – Bradford District and Craven NHSE – NHS England WYICB – West Yorkshire Integrated Care Board

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

Refresh 2024

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Overview

Bradford District and Craven Health and Care Partnership developed its Joint Forward Plan (JFP) in 2024:

- 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.

Our first Joint Forward Plan set 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 1).

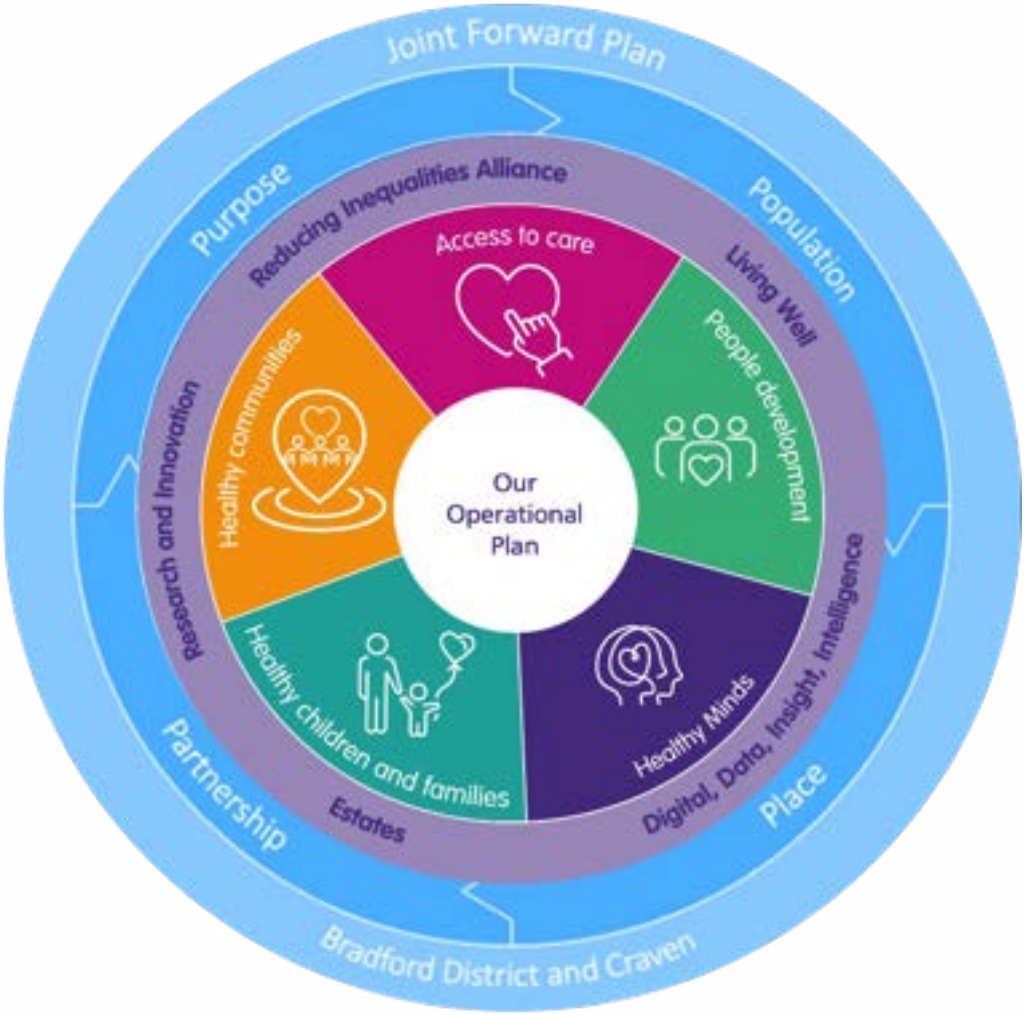

Figure 1: Our Joint Forward Plan

This document provides an overview of progress against our JFP and sets out the priorities for 2024/25. It should be read in conjunction with the original plan. Our work also closely aligns with that of the wider West Yorkshire Integrated Care Board (ICB), and we work collaboratively, where there is benefit in doing so on a wider footprint than just Bradford District & Craven. This plan should also therefore be considered in the context of the West Yorkshire JFP.

Engagement

We continue to be committed to ensuring that the work of our partnership is influenced by our population through conversations and engagement. During our first year of 'Listen In' in 2023-2024, we have seen consistent themes emerge from our conversations with our communities. These cover the following:

- Being able to book appointments with GP practices;
- The impact of the increased cost of living, including accessing travel and transport to attend appointments;
- Waiting to be seen for mental health support; and
- Children and young people needing more option to access mental health support.

This feedback will continue to influence how we design and deliver services for our population.

We are also working with voluntary, community and social enterprise (VCSE) sector partners to look at a new citizen activation model that ensures we continue to listen, learn and understand from the unique community connections and insights our VCSE partners bring.

Over 2024-2025 we will co-design a future model of delivery. This will be focused on our shared ambition of citizen voice and activation contributing to our shared vision of people living 'happy, healthy at home'. We want to ensure that alongside citizen voice, we continue to bring sector voice to key decision making bodies and strategic meetings.

In addition, our interim arrangements continue to have a focus on some limited capacity building, especially where we work with organisations that help divert pressure on statutory services. We will value and will actively encourage your involvement throughout this co-design process. This gives us a chance to refocus our energies with a system-wide reset of expectations and what we will deliver for our communities. This will allow us the opportunity to give greater opportunities for grassroot organisations.

Challenges

Increasing demand, our workforce capacity, and our current estate continue to pose challenges. Industrial action during 2023/24 impacted our ability to deliver our elective recovery plans. As yet unclear on what impact the new GP collective action will have across the health and care system and the current cost-of-living crisis is impacting on population health. We also now have a new Government and are yet to see what changes may be proposed in terms of how the NHS and Social Care operate moving forwards; with an independent investigation currently underway into the state of the NHS by Professor Lord Darzi.

However, our greatest challenge remains the financial pressures we face as a system.

Closing the gap: meeting our financial challenge

Our Bradford District and Craven Health and Care Partnership is committed to working in a collaborative way to respond to the extreme financial challenges that face all of us. To meet these challenges head on we have set up a project group and programme. This programme of work is called 'Closing the Gap'.

At the time of writing (August 2024) we have a planned deficit of around £40m across NHS partners in Bradford District and Craven, with a real risk that that could significantly grow. This deficit describes the difference between the money we receive (our revenue) and the money we spend. If we perform worse than planned, the entire deficit must be paid back, meaning that we would need to close an even bigger gap in future financial years. This is why we must work together to close this gap now.

We have made good progress since setting up the closing the gap programme as we have reduced our forecasted underlying deficit from £80-90m in December 2023 to £72m in March 2024 and our current position of £40m. While the progress has been noteworthy, we are clear that we have a long way to go, and we have some difficult decisions still to come.

Our first steps have been to identify how and where we spend the overall system resource (£1.7 billion net across the NHS and council). Our next steps are to set out our population health needs and assess this against our activity, outcomes, and expenditure. We are clear that we will not be focusing on a solely cost cutting exercise and instead will carefully consider the wider impacts any decisions could have – both in terms of the health and wellbeing of the people we serve and our future budgets. By taking a more needs-based approach to the way we use the resources available to us, we can ensure that resources are directed to where they are most needed and that patients receive the care they require. We do however recognise that there will be undoubted impacts as we work through our programme as we will have to make difficult decisions.

Our Closing the Gap priorities in 2024/25 are to:

- Agree the top opportunities for improving productivity and tackling waste using benchmarking and key data-sources;
- Identify and prioritise services and activities that could be stopped / slowed, paused, and scaled down, or delivered in more effective and efficient ways across our partner organisations;
- Complete population segmentation work and health needs assessment and analysis to inform in-year allocative efficiency opportunities and future planning rounds; and
- Progress immediate system priorities with City of Bradford Metropolitan District Council.

Our Purpose

Reducing Inequalities Alliance (RIA)

The Alliance aims to support and coordinate collective action to reduce inequalities in Bradford district and Craven and is made up of allies across our partner organisations.

In 2023/24:

- A Call to Action was published and launched at our second annual conference in November 2023 (which included workshops from City of Culture, NHS, community teams, research partners and the Local Authority);
- In May 2023, we launched our RIA website (and inequalities animation), which aims to be the central point of key inequalities information in our place (RIA homepage is the fourth most visited page on the partnership website with 4,000+ page views) and there has been a monthly RIA newsletter since March 2023, which shares best practice, updates on data & research and a library of blogs from the local workforce;
- We have continued to support all staff in reducing inequalities. Our "My role in Tackling Inequalities" work is aimed to help staff understand their own role in reducing inequalities and the 'inequalities badge' scheme (over 200 badges have been shared), uses the badge as a prompt to ask the question 'what can I do to tackle inequalities?'. Bradford also has a high proportion of West Yorkshire Health Equity fellows (supported via mentoring and RIA publications) and we are conducting a survey to see how we can embed them further into local work;
- Within the Reducing Inequalities in Communities (RIC) programme we have introduced human stories, a powerful tool to help illustrate the impact of interventions and enhance traditional data collection and following the final evaluation phase a number of RIC services have successfully moved to business as usual within Priority Programme work;
- To support our workforce and community teams to better understand inequalities in their areas, we have undertaken a 'major health conditions' needs assessment and produced data packs and distributed to each of the 13 Community Partnerships;
- We have conducted an inclusion health needs assessment and have worked with system partners, and West Yorkshire ICB colleagues, to enhance our local approach to inclusion health groups (with a framework for action). Inclusion health is a term used to describe people who are socially excluded and experience multiple risk factors for poor health such as poverty, violence and complex trauma.

This can include people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers, victims of modern slavery, refugees, asylum-seekers and undocumented migrants.

- Using Core20PLUS5 funding we have worked with priority programmes and Community Partnerships to develop 46 separate community interventions to reduce inequalities (as of May 2024), contributed to the Bradford VCS Alliance small grants scheme and supported the participatory budgeting process. To support the programme, the Core20PLUS5 sub team has developed and distributed Community Partnership guidance, Reducing Inequalities Toolkit, Core20PLUS5 evaluation plan, 'What works' evidence packs for Core20PLUS5 (repository of tools and resources) and in support of the Children Young People & Families programme, we have commissioned the adversity, trauma and resilience projects 'Sleep Tight' and 'My Healthy Mind';
- We have facilitated five deep dive sessions into inequalities in Children & Young People, digital inclusion, anti-poverty strategy and severe mental illness and developed a COVID-19 and flu inequalities plan (we are working with the Healthy Communities programme to coordinate delivery;
- Our communications and engagement lead has led on the development of an Inclusive Language Guide, which summarises best practice in developing communications;
- We have supported the development of the Wellbeing Collaborative, which coordinates activities between key enabler programmes (the Equity, Diversity and Belonging; Living Well; the Health Determinants Research Collaboration & RIA) and support for other partnerships under the Wellbeing Board, including co-leading the Wellbeing board annual partnership event in Autumn 2023; and
- We are working with colleagues in the Healthy Communities team to develop a best practice approach for carrying out community health checks.

In 2024/25 our plans include:

- Continuing to support our Health & Care Partnership to address health inequalities and deliver on the Core20PLUS5 approach.
- Supporting partnership boards and priority programmes with tangible short-term plans to reduce inequalities.
- The place-based implementation of the NHS England Digital Inclusion Framework by supporting priority programme leads to complete baseline assessments against the framework's domains and analysis and our digital inclusion leads in the delivery of the Digital Champions pilot with 5 VCSE organisations.

- Support the development of a place-based plan for major health conditions and multi-morbidity.
- Provide evidence-based recommendations for reducing inequalities and horizon scan for threats to population health could increase inequalities.
- Maintain/update specific inequalities profiles and contribute expertise to support ongoing community partnership planning and share interim learning from Core20 prevention interventions to inform district wide commissioning and decision making.

Our Population

The following three areas remain our priorities for the next five years: Access to Services; Healthy Minds; and Healthy Children and Families.

Access to Care

Our focus continues to be on elective recovery while addressing inequality, collaboration on outpatient improvement and digital resources and development of preventative approaches to long term conditions, with the work delivered through four workstreams (Figure *2*).

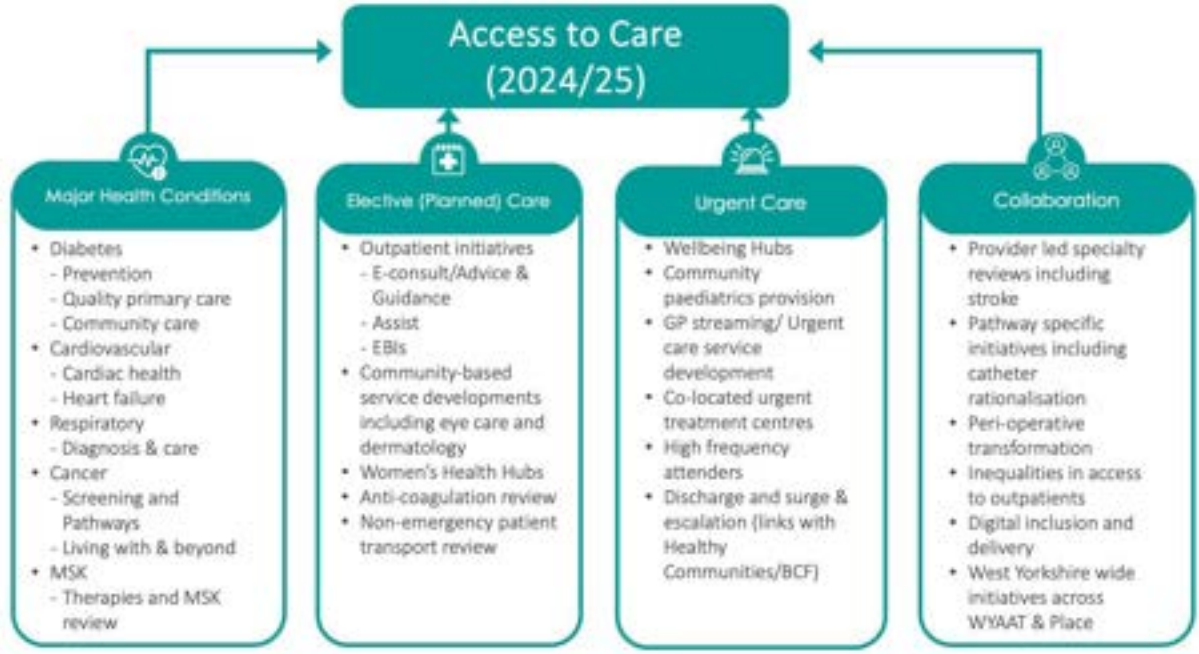

Figure 2: Access to Care workstreams

In 2023/24 we have:

- Improved performance against the 4-hour A&E target between March 2023 and March 2024 from 72% to 83% at Bradford Royal Infirmary and 57% to 64% at Airedale Hospital;
- Implemented an Urgent Treatment Centre at Bradford Royal Infirmary;
- Piloted paediatric and respiratory hubs through our winter resilience offer which has reduced our A&E demand and supported primary care with patients who they have needed some additional support;
- Continued to strengthen our wellbeing hubs, supporting people where they live to access services which address their wider health and care needs;

- Despite periods of industrial action, reduced 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, by 2,200 since March 2023, with no patients now waiting more than 2 years, a 65% reduction in those waiting over 65 weeks and a 40% reduction in those waiting over 52 weeks;

- Delivered an increase of 22,000 diagnostic tests in 2023/24, reducing the percentage of patients waiting more than 6 weeks from 31% in March 2023 to 18% by March 2024;

- Implemented our Community Diagnostic Centre at Eccleshill, and delivered almost 9,000 additional tests as a result;

- Doubled the number of patient-initiated outpatient follow-up appointments, empowering patients to take control of their care, and ensuring they can see a specialist sooner than planned if they need to, as well as avoid an unnecessary trip to hospital if they have no need to be seen;

- To support our GPs in referring appropriately, we have expanded the use of the Assist Pathway and Protocol Management tool with the addition of 20 new pathways. On average GPs use the tool 27,000 times a month reducing referrals to our acute and community providers. This includes our award-winning Assist BCD which provides evidence-based clinical decision trees to support best-practice in diabetes care;

- Evaluated our Rethinking Pain community chronic pain service. Those using the service reported improvement in mental and physical health, reduction in pain medication, reduction in GP appointments, and significant social improvements such as returning to exercise and to work;

- Developed new services in the community in dermatology and ophthalmology, reducing pressure on busy hospital services and ensuring people can be seen closer to home;

- As a result of the multi-disciplinary team support provided by our long covid service, we have supported more people to return to work, reduced their anxiety levels and improved their overall health issues;

- Used local data to identify cardio-vascular and respiratory conditions based on population need, to support people with their self-care to help them improve their long-term condition;

- Worked across the system to improve outcomes and quality of life for people living with or at risk of developing diabetes, including: Partnership working with Diabetes UK and VCS organisations to run diabetes awareness events for communities that reached 3,700 people;

- Doubled the number of people accessing the NHS Diabetes Prevention Programme; Improved access to diabetes foot checks by reducing appointment non-attendance from 27% to 17%; and trained 500 primary care staff covering diabetes prevention, diabetes education, new medications and Assist BCD. In addition, 94% of GP practices are participating in an NHS England programme to improve care for people aged 18-39 living with type 2 diabetes (T2Day programme);

- Introduced a digital Cancer Decision Support Tool in Primary Care, to help with early cancer diagnosis and implemented Targeted Lung Health Checks (covering 38 GP Practices in Phase 1). As of June 2024, there have been over 4,000 low dose CT scans reported, 32 Lung cancers diagnosed alongside over 1,900 incidental findings diagnosed such as emphysema, COPD etc. supporting earlier diagnosis, treatment, and management of conditions;

- Applied Behavioural Science and Nudge Theory Techniques in patient correspondence to cervical cancer screening invitations. The techniques deployed, were successful, with one practice having an increase of 123.6% uptake in a 3-month period. We have also worked closely with Learning Disability communities with engagement and education events, resulting in small increase in uptake; and

- Introduced a comprehensive personalised care support package to ensure that people diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.

In 2024/25 our plans include:

- Ensuring that we deliver as a minimum the national 78% improvement target for people waiting less than 4-hour in A&E across both hospital sites alongside reducing waits over 12-hours and admitted/non-admitted time in A&E and that services are in place to address the needs of high intensity users of emergency care.
- Working with Yorkshire Ambulance Service to further reduce hospital handover delays and continuing to engage in conversations across West Yorkshire to implement the new national guidance around non-emergency patient transport services eligibility criteria and wherever possible mitigate any negative impact.
- Further increasing productivity of bedded/ non-bedded capacity, improving flow, length of stay and clinical outcomes and improving day case and theatre utilisation to increase activity by 6%, reduce the number of people waiting more than 18 weeks and support the elimination of anyone waiting over 65 weeks by September 2024.

- Improving access to diagnostics to ensure 95% of people receive their diagnostic test within 6 weeks by March 2025 and expanding GP direct access to services, developing a plan for one stop diagnostic testing ahead of a 1st outpatient appointment.
- Continuing to transform how outpatient appointments are delivered including increasing patient-initiated follow-up appointments and the use of remote monitoring and further expanding the use of advice and guidance to ensure appropriate hospital referrals and the use of the Assist Pathway and Protocol Management tool.
- Map all provision across health, social care and VCSE services that delivers hospital avoidance and/or provides discharge support, to support the streamlining of service provision and to ensure we are maximising all available resource.
- Developing a new weight management pathway to include a redesigned Tier 3 service and the prescribing of GLP-1 medication, whilst ensuring increased capacity to meet the growing demand.
- Fully implement our women's health hub improving access to services in our communities for conditions such as the menopause.
- By March 2024, ensure consistent delivery of the national cancer standards of: 77% of people find out within 28 days of referral whether they have cancer or not and 70% treatment within 62 days.
- Expansion of Targeted Lung Health Checks across all GP Practices in Bradford District and Craven. This includes the implementation of a Clinical Trial YorQuit for smoking cessation.
- A further focus on improving cancer screening uptake including: Implementation of a Learning Disability & Autism cancer screening programme which involves the education and upskilling of primary care staff and raising awareness in the respective communities; Expanding Behavioural Science and Nudge Theory Techniques to all cancer screen correspondence from GP Practices to help to encourage uptake (this includes Lung); Introducing a Digital Marketing Project to promote and encourage uptake; and Implementing a cervical self-sample pilot beginning November 2024.
- Development of an Inclusion and cancer pathway programme, from screening through to diagnosis, treatment and Living with and Beyond with a phased approach beginning with the homelessness community.
- Continue to develop a cancer prehabilitation programme to support people to be as healthy as possible from receiving a cancer diagnosis and before secondary care treatment starts and following treatments and to help to increase patient physical and lifestyle outcomes.

- Continuing to take a whole system approach to the management of people with long term conditions including: Treating 80% of people with hypertension to NICE Guidance by March 2025; Provide a single pulmonary rehabilitation service from March 2025, offering a choice of face to face and digital options to improve uptake and completion of pulmonary rehabilitation; and Broadening access to the NHS Diabetes Prevention Programme by enabling more people with a history of gestational diabetes to access it and roll out the T2Day programme to support more people aged 18-39 who are living with type 2 diabetes to enable more people to achieve type 2 diabetes remission.

Healthy Minds

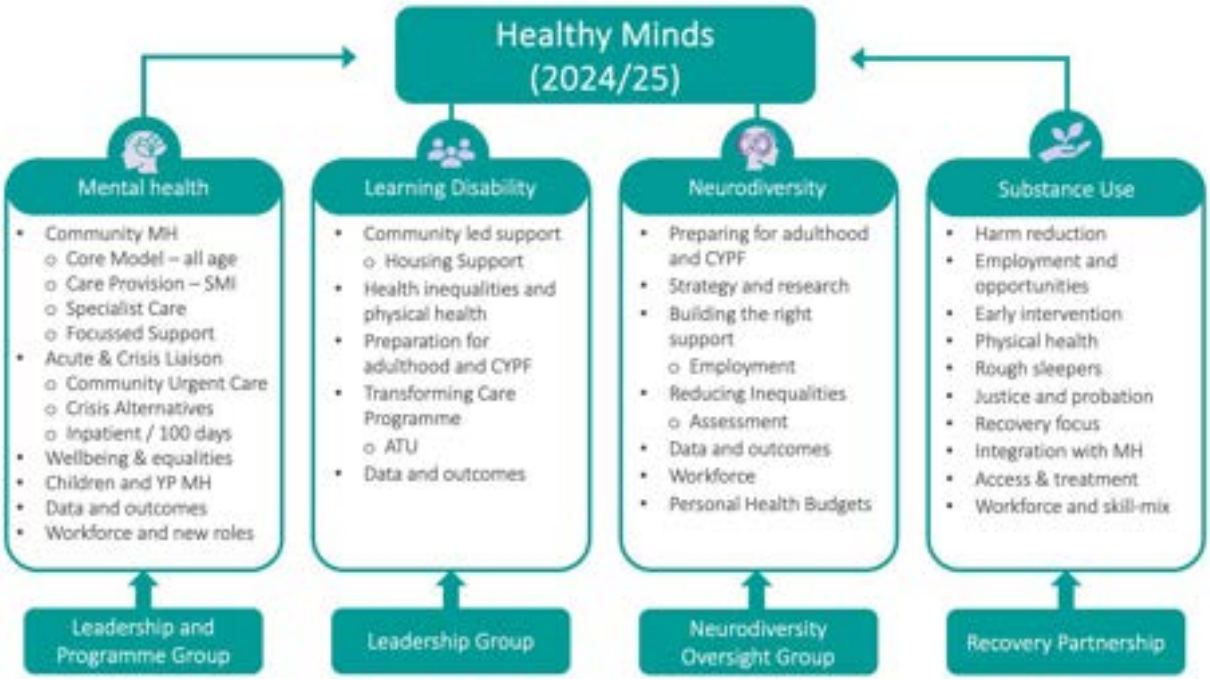

Figure 3: Health Minds Workstreams

Through our Healthy Minds priority programme of work (Figure *3*) in 2023/24 we have:

- Redesigned and invested in staff to deliver co-occurring substance use and mental health support within our community mental health transformation;
- Following a deep dive into the inequalities faced by people who have mental health, learning disabilities or neurodiversity needs, we have developed training to raise awareness of cardiovascular health needs and worked with the Cancer Alliance to improve the identification and support of people accessing early diagnostics;

- Developed our Core Model and established 14 whole time equivalent (WTE) mental health workers across 11 primary Care Networks and we have 3 WTE community pharmacists and 3 VCSE anchor organisations delivering a transformed model of multidisciplinary team support in localities;
- Established our severe mental illness action plan;
- Introduced the culturally adapted therapies to our Talking Therapies services and improved access, recovery rates, reduced missed appointments and improved completion rates;
- Established the first Crisis House in Bradford. This opened in May and in the first 12 months 98 people have accessed support with an average length of stay of 5 days, 96 people were not admitted and only 2 people went on to receive a planned admission;
- Rolled out our Crisis Safe Spaces and Crisis Cafe's across the district which employs 20 WTE people and 14 volunteers who have delivered 13,167 interventions to 3,750 people (2224 were new people accessing for the first time);
- Established the personal health budgets scheme for people who are inpatients, and in the first quarter of the project we had 53 inpatient PHB's costing around £8,000, which helped to support early discharge and reduced bed days by 85 days which equates to a saving of circa £61,000;
- Developed a whole system directory with all services mapped to the Thrive framework;
- Rolled out universal children and young people's services via Kooth digital access and the Healthy Minds charter and champion for schools and continued our roll out of Mental Health Support Teams into schools and established an educational therapeutic offer;
- Redesigned our Youth in Mind service into a lead provider model with over 10 providers working in partnership, reaching 3,492 children and young people receiving 13,977 interventions and with a 89% paired Goal Based Outcome recovery rate. The number of children and young people accessing this service has increased by 14% from 2022/23 and the waiting list has reduced from 15 weeks to 6 weeks maximum;
- In response to the high rates of respiratory issues for people with learning disabilities highlighted by Learning Disability Mortality Review (LeDeR), Bradford District Care NHS Foundation Trust (BDCFT) clinicians, supported by the Working Academy at the University of Bradford, worked in partnership with people with learning disabilities, their families and carers to co-produce a digital resource. The respiratory pathway and website will support people to manage their respiratory health at home by providing of suite of accessible videos and text guidance available in multiple languages.

The site is enabled for use on both tablets and phones and can be accessed by scanning the QR code that is embedded in an individual's Keeping My Chest Healthy care plan. The Keeping My Chest Healthy digital hub launched in September 2023. The development of the digital hub has followed on from the respiratory pathway and screening work that has been done by BDCFT's learning disability health support team;

- Launched 2 autism hubs in the district and established the Neurodiverse City ambition, which launched in partnership with businesses across the district and opened the sensory rooms at Lynfield Mount, The Broadway and Life Centre; and
- Launched the Housing and Health network.

In 2024/25 our plans include:

- Further work on improving flow and reducing length of stay for mental health inpatients to ensure that there is adequate capacity so that no-one needs to receive in-appropriate care outside of Bradford District and Craven.
- Continue to improve access to community mental health services through further roll out of PCN aligned models of care.
- Increase access to perinatal mental health services.
- A further 4% growth in the number of children and young people aged 0-17, supported through NHS-funded mental health services, receiving at least one contact and maintain responsive access to eating disorder services.
- An increased focus on completed treatments and improved outcomes for Talking Therapies support with 67% of patients seeing improvement and 48% recovery.
- Ensure 60% of those with a severe mental illness receive a full annual health and continue to support them into employment.
- Continue to ensure that 69% (above the national recovery target of 66.7%) of our estimated population with dementia receive a formal diagnosis.
- Ensure 75% of people with a learning disability receive a full annual health.
- Continue to develop services to support people experiencing a mental health crisis.
- Improve autism diagnostic assessment pathways.
- Leverage opportunities such as digital therapy to provide more high-quality care.

Healthy Children and Families

The work of our Healthy Children and Families programme has been re-focussed to work towards a set of principles and ambitions (Figure *4*).

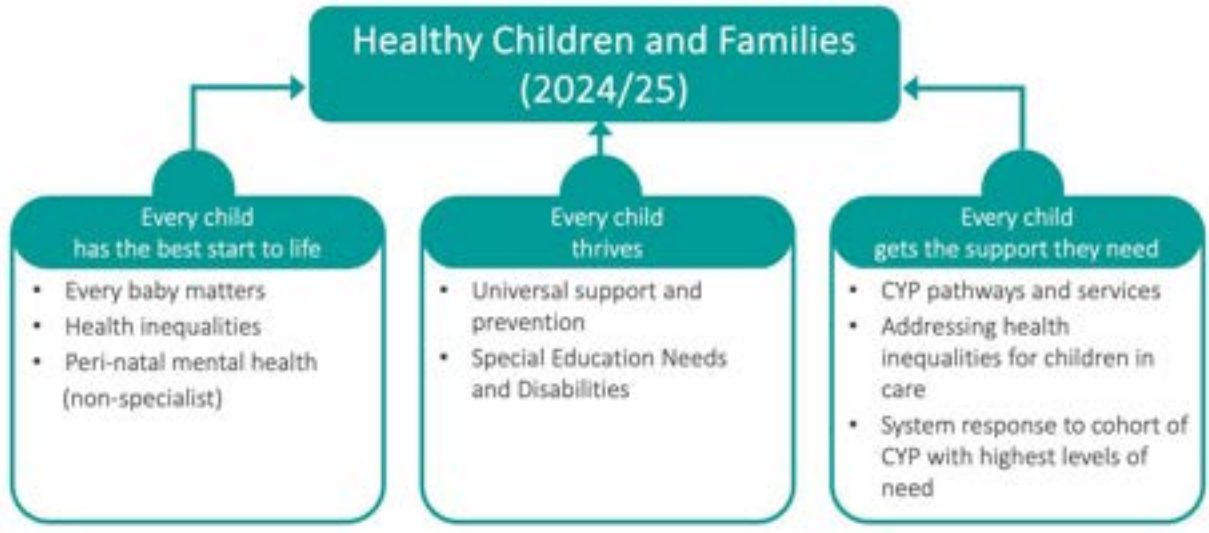

Figure 4: Healthy Children and Families

In 2023/24 we have:

- Continued to work collaboratively with Local Authority colleagues to implement the recommendations of the 2022 inspection of Bradford's special educational needs and/or disabilities (SEND) provision with robust governance and assurance arrangements in place, including the SEND Quality Assurance Framework and a focus on using data and analysis to drive improvement;
- Improved communications with Children, Parents & Carers Partners;
- Developed and rolled out a Dynamic Support Register to inform health and care staff about the type of support a person with a learning disability or an autistic person needs to stay well at home. We now have evidence, including case studies, of where care has improved as a result and West Yorkshire has recognised the great work taking place in Bradford and awarded us £30,000 to trial out a psychologist pilot. Children and young people with autism and learning disabilities who are at high risk a mental health admission, specialist placements and 52-week residential schools, will receive a keyworker and the system will have oversight to their care;
- Made improvements to Speech and Language Services including the Talking Bradford programme and developed services especially around Autism and Learning Disabilities, supported waiting and preparation for adulthood and transitions;

- Continued discussions regarding how joint commissioning & joint funding can be utilised to optimise service delivery;
- Successfully recruited 20 maternity volunteers through our Volunteer to Career Initiative. This initiative has been a proven method to nurture a home-grown workforce, reflective of the community we serve; and
- Successfully bid for Bradford District to be one of 9 national Pathfinders for Early Language Support for Every Child (ELSEC). We have secured £500,000 per annum over 2 school years to fund the ELSEC Programme, which will launch in September 2024. A team has been recruited, 10 schools have been selected and this will be an evaluated learning programme that will enhance provision across Bradford. The aims include: improving early identification and support for children & young people speech, language and communication needs (SLCN); reducing the rate of specialist referrals; increasing workforce capacity; improving quality of data and evidence; and Improving joint working between health and education;

At the end of 2023/24, the Department for Education and NHS England agreed to release Bradford from formal monitoring under the Written Statement of Action due to the progress made towards the actions.

In 2024/25 our plans include:

- Delivering the Every Baby Matters and Health Inequalities strand of the Best 1001 days programme, ensuring that every woman is 'fit for pregnancy' and every baby has the best start to life with a focus on reducing health inequalities. This includes work on smoking in pregnancy, genetics, drug and alcohol, infant feeding, maternal and infant nutrition and supporting peri-natal mental health.
- Using data and intelligence, set out what we have, what we know, and identify gaps in universal support and prevention. Focus on school readiness, school attendance, 0-19 services, with a view to exploring greater collaboration on the delivery of services.
- Aim to meet our objectives on the Special Education Needs and Disabilities change programme through collaborative commissioning and delivery.
- Improve pathways and services for children and young people, with a focus on addressing health inequalities for children in care, working to meet our statutory duties. This will be achieved through work on: Initial Health Assessments, Review Health Assessments, Adoption Medicals, and Fostering Medicals.

- Adopt a system response to designing and delivering services for children and young people with the highest levels of need, from early help to high costs placements including transition to adulthood; and a crisis pathway protocol.
- Increase vaccination uptake and reduce long waits in community service.

Our Place

Living Well

Living Well is our whole system approach to obesity and improving wellbeing. The work continues to be delivered under four workstreams (Figure 5).

Figure 5: Living Well workstreams

In 2023/24:

- We launched a new Living Well Health and Care delivery project to integrate prevention and embed Living Well into health settings, with a focus on patient communications, staff wellbeing, pathways and roles as anchor organisations in the community;
- We have worked with Bradford teaching Hospital Foundation Trust (BTHFT) to integrate Living Well services and offers across 13 specialties on the patient portal, to enable patients to access information about healthy lifestyles when they receive correspondence about their appointments and are waiting for treatment;
- We have Embedded the BEEP exercise referral service into cancer pre-habilitation, multiple sclerosis and musculoskeletal pathways and increased self-referral routes to improve access;
- The Living Well Children and Families Service received 293 (an increase of 23%) due to delivering targeted engagement sessions to community groups, schools and a range of health care professionals;

- We collaborated with Living Well Schools to support district-wide delivery, while promoting awareness of the Children & Families service, self-referrals (from secondary schools) and consistency of a compassionate, health focused messaging;

- We developed a new Weight Management Steering group to oversee the transformation of weight management services across Public Health and the NHS in preparation for the emerging guidance from West Yorkshire ICS. We had to cease referrals into the Tier 3 Weight Management Service due to demand, so this pathway re-design work will be a priority in 2024/25;

- We developed a Living Well Community Health Development programme including a new team of seven staff to deliver a grassroots community-centred approaches to reducing health inequalities and strengthening community participation for health and wellbeing. The team supported 34 events and engaged with 4,175 residents throughout this period;

- We launched a new Community Health Development grants scheme and invested £137,000 to build capacity within communities to support activities that address inequalities and improve the wellbeing of underserved populations. We have funded 14 defined community of interest organisations will continue this into 2024/24;

- We have improved health literacy by expanding our Living Well Training Academy offer to deliver a new Living Well Champions programme and Making Every Contact Count training to frontline staff;

- The 'Every Move Counts' physical activity strategy was launched in January 2024, alongside a new physical activity search portal to promote opportunities across the District. We also delivered the '20 Minute Movement' campaign and started work on the 'Active Travel Social Prescribing' project with a £1.4 million investment from Active Travel England;

- We held the first 'Bradford Food Symposium' event to launch the 'Good Food Strategy' in November 2023 and created a food advocacy toolkit to enable partners to support the delivery of the whole systems approach to food. We also started a new Living Well Takeaways delivery project, delivered the 'Grow Well to Eat Well' campaign and were accepted into the EU Food Trails Cascade Cities Programme;

- We agreed board representatives for each of the five 'Act As One' priority programmes and identified key focus areas to embed Living Well across programmes. We also supported the development of the new 'Wellbeing Collaborative' group which aims to bring together enabler programmes to integrate Living Well across the system; and

- We co-ordinated the Living Well Collaborative Network by holding monthly meetings to build capacity, disseminate key messages and share good practice. We also engaged with stakeholders through our governance arrangements, delivery projects and the interconnectivity between Living Well and the Sustainable Food Partnership and Bradfords Whole Systems Approach to Physical Activity.

You can read our 2023 progress report, presented to the Health Overview and Scrutiny here.

In 2024/25 our plans include:

- Transforming weight management services across Public Health and the NHS to develop a clear pathway of support to include new weight management medications alongside local and national guidance.
- Developing a programme of work to help more residents to stop smoking following significant national investment. This will include additional resource into the Living Well smoking cessation service, enhanced campaigns and more local support to help people change behaviour. Work will also include ways to reduce vaping in children.
- Building on the Living Well Health and Care delivery project by expanding reach into more targeted pathways and creating toolkits to enable more settings to embed prevention and healthy lifestyles into clinical services.
- Transforming the Living Well service offer for individuals and families by streamlining referral routes and increasing self-referrals to improve access for communities and health and care professionals.
- Improving health literacy levels by continuing to deliver our Living Well Community Health Development programme, expand on our Living Well Community Champions model and commissioning a new project to better understand the levels of health literacy and community readiness of our most underserved communities to better inform services, project, strategies and campaigns.
- Developing a new 'Creative Health' programme of work to build relationships across the culture, arts and health sectors and create more opportunities for collaboration in Bradford's 'City of Culture 2025' year to recognise the significant impact that culture and arts can have on improving health and wellbeing.
- Expanding on the Health In All Policies work with the 'Wellbeing Collaborative' enablers group to integrate health and wellbeing into contracts, partnerships and programme boards across the sector.
- Formally launch the Living Well schools offer to primary schools across the district.

- Strengthening our healthy places plans to influence the physical infrastructure of the district include focussing on opportunities to create a healthier place to live through the development of the Local Plan and Active Travel agenda.
- Embedding School Streets and rolling out Play Streets with our communities across the district.
- Continuing to implement the action plans within both the 'Good Food Strategy' and 'Every Move Counts' physical activity strategy and roll out the advocacy programmes across health and care organisations.

Research and Innovation

Through our 'Research as One' work, in 2023/24:

- We have promoted a collaborative approach across organisations such as the Primrose programme, a collaboration between a PCN and BDCFT to encourage better uptake of physical health checks in those with an SMI and the Patient Recruitment Centre which, although based at BTHFT, is working across place to enable more commercial research in line with the O'Shaughnessy review;
- As part of the NHS England Research Engagement Network we have worked closely with the Race Equality Network to fund community volunteers to become research champions, fostering conversations about research, this has already enabled several funded focus groups and community meetings. This has been a concerted endeavour to demystifying research: understanding what research is and isn't with our underserved populations;
- We have worked closely with our NHS partners Health Determinants Research Collaborative (HDRC) based in the local authority to ensure research opportunities exist in all of our statutory agencies in health and care;
- We have engaged with the university so that they are considered a partner in the health and care partnership, this has resulted in several collaborations on new research projects;
- The Bradford Institute for Health Research (BIHR) has been awarded several research grants, notably Join Us Move Play (JUMP), and within the ICB we are also hosting several research grants, bringing further resource and projects to the area;
- Along with our REN we have been working with the communications team and University to have a coordinated research engagement approach;

- We are engaged with members of the VCSE and community groups to ensure that research opportunities are spread across the place;

In 2024/25 our plans include:

- Further engagement with our local library services and the University to promote improved knowledge mobilisation. This will also mean opening up training opportunities for staff in knowledge mobilisation and evaluation.
- Further roll out of the Research Engagement Network project.
- Audit and feedback programmes with all of our general practices on the Lowering Antimicrobial Prescribing (LAMP) initiative to promote better antibiotic stewardship.
- Ongoing implementation of an audit and feedback approach with all of our practices to promoting better quality and greener asthma care through the Campaign to Help Improve Respiratory Prescribing (CHIRP);

Our Partnership

Healthy Communities

We continue to deliver our healthy communities work across three footprints: Community Partnerships (CPs); Locality collaboration, through integrated neighbourhood teams; and Place-based, community health and care integration (Figure *6*):

Figure 6: Healthy Communities Workstreams

Some of our key achievements against last year's JFP include:

- Exceeding our planned urgent community response (UCR) growth, with 4,435 referrals to our UCR teams and 92% seen within 2 hours, avoiding attendance at A&E;
- We now have 149 Virtual Ward beds across Bradford District and Craven, despite challenges faced around ongoing funding, offering ongoing care in a patient's home to either avoid a hospital admission or allow earlier discharge;
- We have developed a Blueprint to transform how we deliver Intermediate Care services to improve outcomes, discharge, and flow;
- Exceeded our target of reducing falls related hospital admissions for over 65's;

- Using data provided by the Reducing Inequalities team, our 13 Community Partnerships have each identified 3 key priorities and have each co-produced an action plan for delivery for their hyper-local population;
- Supporting the development in leadership, partnership and harnessing the power of community. 11 of our 13 Community Partnerships have been assessed against the framework and all have a development plan. Self-assessment showed improvements in ways of working and the ability to get things done, with improved relationships between members and monitoring of projects.
- 200 asset-based community development grants have been made to VSCE organisations to address health inequalities according to CP priorities. £473,698 distributed, via nominated 'fundholding' organisations, to grass roots organisations that keep people happy, healthy and at home;
- We have successfully mobilised CORE 20 plus 5 implementation across CPs, with 46 projects targeting the most deprived communities and health inclusion groups;
- There has been the development and implementation of a locality operating model that integrates health and local authority teams working within neighbourhoods to meet our population's needs; and
- Partners across health and care have co-designed 'we statements'. These have allowed us to benchmark and will enable assessment of progress towards a 'one team culture'; and
- A 6% growth in GP appointments (an additional 290,000 appointments in 2023/24).

In 2024/25 our plans include:

- A further 2% reduction in emergency hospital admissions due to falls in people aged 65 and over.
- 79.5% of older people (65 and over) will still be at home 91 days after discharge from hospital into reablement/rehabilitation services.
- 87% bed occupancy across the health and social care intermediate care bed base.
- Achieve an average 28-day length of stay across our health and social care intermediate care beds.
- 75% of people will be discharged home following a stay in a health and social care intermediate care bed.

- Increase the number of people who will be supported through our health and social care Urgent Community Response and Virtual Ward services.
- Improve system and processes and discharge pathways to support people to spend less time in a hospital bed when they no longer meet the criteria to reside and will be supported to leave hospital with the right care and support to meet their individual needs.
- Reduce the number of people residing in general and acute beds who have no Criteria to Reside.
- Co-creation of integrated neighbourhood teams building on existing MDT, primary care network, locality and community partnership approaches, with demonstrable improvements in workforce collaboration across all partners.
- Planning and implementation of proactive care models to support people with complex health needs to remain supported at home through multi-disciplinary care teams.
- Reducing long waits in (adult) community services.

To support this, we will build on existing work bringing primary care and community organisations together to shape integrated neighbourhood teams (INTs), ensure wider public sector and non-statutory partners are included in these arrangements, with an explicit development plan to work with the VCSE sector. We will also further improve the alignment of community services to the primary care network footprint through evolution of locality working into INTs and link Community Partnerships with Pharmacy and Modern General Practice Access, through a shared work plan to support primary care to achieve access targets inclusively.

General Practice (Primary Medical Care)

A key priority for 2024/25 will be to continue to work with and support general medical practices (and the wider primary care networks of which they are part) to improve access to, and the quality of, services provided to local populations. We know that access to appointments remains an area of very high interest for patients and the public across Bradford District and Craven. This year represents the second year of the national Delivery Plan for Recovering Access to Primary Medical Care, which is focussed on tackling the '8am rush' and making it easier and quicker for patients to get the help they need from primary care. We are progressing implementation of the Modern General Practice Access model, which includes improving patient experience of access through introducing digital cloud-based telephony and better online access.

Whilst the national programme is concerned with increasing the quantity of appointments in General Practice, locally we also want to work on quality of interaction, better integration of primary care and community services, and other measures that will eventually lead to a more integrated and holistic offer for our local communities – so that patients can see the most appropriate health and care professional for their needs.

We will continue to hold local quality visits to general practices, where we work with local practice teams to review together the data on the services they provide and identify potential areas for improvement. We will also continue to work with primary medical care and secondary care providers to improve pathways and communication to improve patient care.

We currently also have challenges in recruitment and retention of GPs and the wider primary care workforce, especially in deprived areas, and the workload of GPs has increased. The West Yorkshire Primary Care Workforce and Training Hub (which is based in Bradford but covers the whole of West Yorkshire) will continue to have an important role in working with individual practices, providing support, workforce planning advice and signposting to available training and education opportunities.

In 2024/25 our plans include:

- Implementing the improvements associated with the national Delivery Plan for Recovering Access to Primary Care.
- Continuing our programme of quality visits to general practices, and also creating opportunities for practices and primary care networks to come together for shared learning - such as through our district-wide engagement events.
- Working with the Healthy Communities programme and the stakeholders on the Healthy Communities Board to further evolve approaches to integrated-team based working in local communities - which will also help meet the national planning priority on supporting the development of integrated neighbourhood teams.

Workforce

Following the publication of NHS England's Long Term Workforce Plan, our people development programme has re-aligned its priorities under the following 3 areas (Figure 7).

Figure 7: Workforce workstreams

Several Programmes will sit across multiple workstreams, e.g. student led clinics and services sits under developing a pipeline for the registered workforce as well as reforming our services. Several areas are included as 'placeholders', with further thinking required on the specific programmes that will be progressed under the People Priority. It is proposed that a data/ intelligence driven approach is taken to the identification of these programmes. These include: Placements; Apprenticeships; Enabling greater staff movement; and Collaborating on identification of new roles.

In 2023/24 we have:

- Grown our workforce by 6% as we focus on reducing our vacancies with 263 more whole time equivalent (WTE) nursing staff, 72 WTE more medical and dental and 51 WTE more scientific and allied healthcare professionals.
- Used a mix between domestic recruitment/newly qualified and the use of apprenticeships along-side international recruitment. This includes successful international recruitment campaigns across the system welcoming over 40 additional registered nurses;
- Worked collectively to look at joint recruitment to entry level roles through Skillshouse;

- Grown 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 and Ockenden roles;
- Piloted student led clinics to increase training placement capacity and continually improve student experience;
- Reduced sickness and staff turnover with providers achieving levels set out in workforce plans and a shift from using agency to local bank staffing; and
- Increased our primary care workforce with 62 WTE additional GPs and 13 WTE more in training, 76 WTE more nurses and 125 WTE other direct patient care roles. This includes recruiting to the Additional Roles Reimbursement Scheme (funding for a range of new primary care roles) with additional advanced Nurse Practitioners, Care Co-ordinators, Health & Wellbeing Coaches, Pharmacists, Physiotherapists and Social Prescribing Link Workers now providing care in general practices.

In 2024/25 our plans include:

- Prioritising the experience of people who work in Bradford District and Craven, ensuring that staff survey feedback is acted upon and all providers are committed to the principles within the sexual safety charter.
- Systematic implementation of the People Promise retention interventions: Undertake retention self-assessment tool; Implement local High Impact Actions; Engage in National People Promise Communities of Practice. Airedale hospital will recruit a dedicated People Promise Manager and learn from previous exemplar role at Bradford hospital.
- Embedding the 6 high impact actions in the NHS equality, diversity and inclusion (EDI) improvement plan with a focus on creating a sense of belonging across Bradford District and Craven.
- Increasing choice and flexibility for Doctors in Training, through delivering the commitments as part of the national improving the working lives of Doctors in Training initiative.
- Ensuring sufficient local placements and apprenticeships to meet the NHS Long Term Workforce Plan, continuing the work around joint entry level recruitment and student led clinics.
- A continued focus on reviewing the mandatory training undertaking, aligning with the latest Core Skills Training Framework, and contributing to the national review of required subjects including to continue to roll out staff training in learning disabilities & autism, in line with the Oliver McGowan Code of Practice.

- Strengthening the provision of wellbeing services through implementing the growing occupational health and wellbeing strategy and consider learning from the improving attendance toolkit to support wellbeing strategies and sickness absence support.
- Implementing strategies to continue to reduce the reliance on temporary staffing across Bradford District and Craven in line with the workforce plans.

Digital, Data, Intelligence, Insight

In 2023/24 we have:

- Completed 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, and are awaiting the outcome from NHS England;
- Started to adopt a population health management approach to better understand the needs of our population and support the design and delivery of services, through the linking of primary care data with other health datasets;
- Established an existing community of IT/Cyber professionals working and communicating across provider services, demonstrating a collaborative and cohesive ambition;
- Implemented plans to allow staff from across partner organisations to work effectively at our Scorex House offices, with a view to extending this across other key locations;
- Progressed our Digital Inclusion work to ensure the population of Bradford District & Craven has access to the necessary technology and skills to navigate and use services, and the general resources needed to lead a healthy life including: The development of 30 Digital Champions Family Hubs; £6,000 funding secured for 5 libraries; and Work underway with community partnerships to agree a process for device and internet connection offer to community groups; and
- A Digital Inclusion Officer in post, who is working with PCNs and wider health colleagues to develop a digital friends network and encouraging organisations to join the Good Things Foundation for access to grant funding, devices, free sim cards and a basic digital skills learning platform and providing access to over 400 technology user guides via the Digital Unite site.

In 2024/25 our plans include:

- Implementing a new electronic patient record at Airedale Hospital.
- Continuing to implement the framework for NHS action on digital inclusion including: The development of an NHS toolkit and standardised approach to digital inclusion; Continued work on developing the brand and the creation of a website as a source for all digital inclusion information; Continued work with the local education sector/universities to maximise on digital inclusion education opportunities; and Aligning digital inclusion work to digital workforce needs in the NHS and Council.
- Developing a system wide robust cyber security plan.
- Developing plans for the implementation of the NHS Federated Data Platform (FDP). The FDP is software that will enable NHS organisations to bring together operational data, currently stored in separate systems; to support staff to access the information they need in one safe and secure environment. Clinicians will easily have access to the information they need to do their job, in one place, freeing up time spent on administrative tasks and enabling them to deliver the most appropriate care for patients, ensuring more joined up care, greater choice and improved health outcomes.
- Supporting the national initiative to increase the use of the NHS App, allowing patients to better manage their own care with access to their GP healthcare records, symptom checkers, NHS 111 and online consultations and the ability to book appointments and order repeat prescriptions.

Our Estate

Progress with our estates plans over the last year include:

- Completion of a Community Diagnostic Centre at Eccleshill which became fully operational in February 2024;
- Completion of a new surgical day-case facility on the St Lukes Hospital site to provide additional capacity for people waiting for elective procedures;
- Approval to proceed with a GP Surgery extension in Burley-in-Wharfedale to provide additional capacity for significant local population growth due to housing developments; and
- Engagement with Primary Care Network leads to begin to develop a Primary Care Network Estates Strategy for Bradford District and Craven.

In 2024/25 our plans include:

- Continued development of the clinical services strategy and outline business case for the new Airedale Hospital.
- Looking forward, as part of the requirement for a West Yorkshire ICS Infrastructure Strategy, we are developing a Bradford District and Craven Infrastructure Strategy that will form the basis of our system estates strategy. This will set out our estates infrastructure priorities, reflecting our emerging clinical strategy and changing needs of our population over the next 5 to 10 years, along with the associated capital investment required. The Infrastructure strategy is in its early stages of development and will continue to evolve in line with our Joint Forward Plan.