Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Bradford District and Craven Partnership Board

23 May 2025
10:00 – 13:00
G7/G8, Scorex House, Bolton Road, Bradford, BD1 4AS

AGENDA

Item	Lead	Purpose	Time	Mins	Links to Board Assurance Framework strategic risks
1. Welcome, introductions, apologies and quoracy	Chair	Information	10:00	10	
2. Declarations of interest – a register of Board members can be found at (mydeclarations.co.uk)	Chair	Assurance	10:10	0	
3. a. Minutes of the meeting held on 14 February 2025 b. Action log / matters arising c. Previous BD&C Partnership Board Triple A report	Chair	Approve and to note	10:10	10	
4. Public questions	Chair	Information	10:20	5	
5. Listen in	Victoria Simmons	Discussion	10:25	20	Topics link to multiple BAF strategic risks
6. Place Lead's update	Matt Sandford	Information	10:45	20	Topics link to multiple BAF strategic risks
7. Reports from committees and fora	Committee and Forum Chairs	Information / Approval	11:05	15	1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 2.4, 3.1, 3.2, 3.3, 4.1
8. Partnership high level risk report	Asma Sacha	Assurance	11:20	10	Includes oversight of all BAF strategic risks
Break 11:30-11:40					
9. Our plans for Health, Care, and Wellbeing	Matt Sandford	Information / Discussion	11:40	15	1.1, 1.2, 1.3, 3.1, 4.1

Item	Lead	Purpose	Time	Mins	Alignment with Board Assurance Framework risks
10. Financial and Operational Planning Update	Mike Woodhead/Kerry Weir	Information	11:55	20	1.2, 2.1, 2.3, 3.1, 3.2, 3.3
11. Better Care Fund 2025/26	Iain MacBeath	Information / Assurance	12:15	10	1.1, 1.2, 1.3, 3.1, 3.2, 3.3
12. Governance - End of year review - Partnership governance arrangements 2025/26 including Strategic Partnering Agreement and Governance handbook	Sue Baxter	Approval	12:25	30	Underpins all BAF strategic risks
13. Any other business	All	Information	12:55	3	
14. Reports/escalations to WY ICB and review of meeting	Chair	Information	12:58	2	

Date and time of next meeting –
10:00 – 13:00
Friday 5 September 2025
Belle Vue Suite, Belle Vue Square, Broughton Road, Skipton, BD23 1FJ

For any queries regarding this agenda, please contact: westyorkshireics.committees@nhs.net

Board Assurance Framework Summary, Cycle 1 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 9	Date: March 2025
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	16	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	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
(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.	Open	8	16	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	6	8	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	9	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 / Shaukat Ali Khan	Finance, Investment and Performance Committee.Transformation Committee for Digital
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Anthony Kealy	ICB Board
(3) Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	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	9	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	8	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 / Shaukat Ali Khan	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

Board Assurance Framework Summary, Cycle 1 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 9													
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	16	9	12	9	9	6	12	12	16	9	16
	1.3	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.	Open	8	16	6	12	8	12	8	12	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	6	8	4	6	4	6	4	8	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	9	2	4	2	6	2	8	2	6	2	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	16	9	16	9	16	9	12	9	12
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	4	12	4	12	8	12	4	9	4	9
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	20	6	20	6	20	6	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	9	12	4	12	4	16	4	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	8	8	8	8	12	8	12	8	12	8	8
	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

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	3
Meeting date:	23 May 2025
Report title:	Bradford District and Craven (BD&C) Partnership Board Meeting Business Items
Report presented by:	Elaine Appelbee, Independent Chair of the BD&C Partnership Board
Report approved by:	Elaine Appelbee, Independent Chair of the BD&C Partnership Board
Report prepared by:	Catherine Smith, Governance Manager, NHS WY ICB

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

Previous considerations and any resulting action:

WY ICB Board: 18 March 2025 – BD&C (Bradford District and Craven) Partnership Board Triple A Report

Executive summary and points for discussion:

This report contains BD&C Partnership Board business items for information and approval:

- Minutes of the BD&C Partnership Board formal public meeting held on 14 February 2025
- BD&C Partnership Board action log
- BD&C Partnership Board Triple A report submitted to the WY ICB Board meeting on 18 March 2025

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. **APPROVE** the draft minutes from the meeting held on 14 February 2025
2. **DISCUSS** any open actions on the action log
3. **RECEIVE** the previous Triple A report 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 BD&C Partnership Board meeting held in public on 14 February 2025 2. BD&C Partnership Board action log 3. BD&C Partnership Board Triple A report submitted for the WY ICB Board meeting on 18 March 2025
Acronyms and Abbreviations explained
• BD&C: Bradford District and Craven • WY ICB: West Yorkshire Integrated Care Board

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	n/a
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	n/a
Citizen and Stakeholder Engagement	n/a

Attendees of the Bradford District and Craven Health and Care Partnership Board
Friday 14 February 2025
Held at Belle Vue Suite, Belle Vue Square, Broughton Street, Skipton, BD23 1FJ

Members	Initials	Role
Elaine Appelbee (chair)	**EA**	Independent Chair of Bradford District and Craven Health and Care Partnership (BD&C H&CP)
Andy Withers	**AW**	Interim Chair, Airedale NHS Foundation Trust and Non-Executive Chair of the Quality Committee of the BD&C H&CP (until 12:30pm)
Ashley Green	**AG**	Chief Executive, Healthwatch North Yorkshire
Foluke Ajayi	**FA**	Chief Executive, Airedale NHS Foundation Trust
John Pattinson	**JP**	Chief Executive, Independent Care Group
Linda Patterson	**LP**	Chair of Bradford District Care NHS Foundation Trust
Louise Bestwick	**LB**	Chief Executive, Bradford Care Association
Marina Bloj	**MB**	Professor of Health Research/Associate Dean (Research and Innovation) Faculty of Health Studies University of Bradford
Grainne Eloi	**GE**	Associate Director of Nursing and Quality, BD&C H&CP (deputising for Philippa Hubbard)
Richard Haddad	**RH**	Chair of the Clinical Advisory Board (CAB)
Charlotte McKeown	**CM**	VCS Craven
Sam Keighley	**SK**	VCSE System Lead
Sarah Jones	**SJ**	Chair, Bradford Teaching Hospitals NHS FT
Therese Patten	**TP**	Chief Executive, Bradford District Care NHS Foundation Trust/ BD&C Partnership Place Lead
Danielle Hann	**DH**	Deputy Chair, Bradford and Airedale Branch of YORLMC
Jane Wood	**JW**	Assistant Director – People Commissioning & Business Support, City of Bradford MDC (deputising for Iain MacBeath)
Helen Rushworth	**HR**	Chief Executive, Healthwatch Bradford District
Louise Wallace	**LW**	Director of Public Health, North Yorkshire Council
In attendance		

Alison Horsfield	**AH**	Governance Manager, NHS West Yorkshire Integrated Care Board (NHS WY ICB)
Elaine Hewitt	**EH**	Head of Mental Health, Emergency duty team, Transforming Care and s. 117 team, North Yorkshire Council
Matt Sandford	**MS**	Director of Partnership and Place, BD&C H&CP
Mike Woodhead	**MW**	Director of Finance, Contracting and Estates, Bradford District Care NHS Foundation Trust / Lead Finance Director, BD&C H&CP
Shak Rafiq	**SR**	Associate Director Communications and Involvement, BD&C H&CP
Sue Baxter	**SB**	Head of Partnership Governance, NHS WY ICB
Victoria Simmons	**VS**	Senior Head of Communications and Involvement, BD&C H&CP
Victoria Turner	**VT**	Public Health Consultant, North Yorkshire Council
James Garratt	**JG**	Interim Locality Head of Care and Support (Craven) North Yorkshire Council
Asma Sacha	**AS**	Risk Manager, NHS West Yorkshire Integrated Care Board (NHS WY ICB) (11:00am to 11:10am)
Sharon Hudson	**SH**	Communications Customer Services and Partnerships Manager, North Yorkshire Council
Kerry Weir	**KW**	Associate Director Planning, Performance & Business Intelligence, BD&C H&CP
Apologies		
Karen Dawber	**KD**	Chief Nurse, Bradford Teaching Hospitals NHS FT
Karen Siennicki	**KS**	Assistant Director of Adult Social Care, North Yorkshire Council
Lorraine O'Donnell	**LoD**	Chief Executive, City of Bradford MDC
Julie Lawreniuk	**JL**	Non-executive chair of the Finance and Performance Committee of the BD&C H&CP
Jonathan Kerr	**JK**	Chief Officer, Age UK North Craven
Marium Haque	**MH**	Strategic Director – Children, City of Bradford MDC
Phillipa Hubbard	**PH**	Director of Nursing, Professions and Care Standards, DIPC, Deputy Chief Executive, Director of Nursing and Quality for BD&C H&CP
Iain MacBeath	**IM**	Strategic Director – Health and Wellbeing, City of Bradford MDC
Mel Pickup	**MP**	Chief Executive, Bradford Teaching Hospitals NHS FT
Richard Webb	**RW**	Corporate Director, Health and Adult Services, North Yorkshire Council

Helen Farmer	**HF**	Director of System Transformation, BD&C H&CP

Observers – 3

01 WELCOME, INTRODUCTIONS AND APOLOGIES

Elaine Appelbee (EA), as the Chair of the meeting, welcomed everyone to the Bradford District and Craven (BD&C) Health and Care Partnership Board meeting held in public. Apologies were noted as above.

02 DECLARATIONS OF INTEREST

Sue Baxter (SB) advised that all Board members had a direct interest the Section 75 agreement at item 6 on the agenda. The Board members agreed they had mutual accountability in respect of this item and agreed unanimously that all members would take part in the decision.

03 MEETING BUSINESS

a) Minutes of the meeting held on 15 November 2024

The Board received the minutes of the meeting held in public on 15 November 2024.

RESOLVED: The BD&C Partnership Board **APPROVED** the minutes of the Partnership Board meeting held in public on 15 November 2024 and **CONFIRMED** these were an accurate record of the meeting.

b) Action log

The Chair noted that there was one open action and three marked for closure. It was agreed that the three actions marked for closure would be closed and the due date for outstanding action (2024/05) would be amended to September 2025.

c) Previous BD&C Partnership Board Triple A report

The BD&C Partnership Board received the previous Triple A report for information.

d) Matters arising

Members did not raise any matters that were not already on the agenda.

04 PUBLIC QUESTIONS

No questions had been received from the public in relation to the agenda.

05 PLACE LEADS UPDATE

Therese Patten (TP) 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 Partnership as well as the national context. The report informed the Partnership Board of progress made by the Executive and the whole Partnership in response to key issues and in pursuit of strategic goals.

Nationally TP highlighted the publication of the NHS Confederation blog: Prevention needs brave leadership and a thriving VCSE written by Sam Keighley the place-based partnership's VCSE sector lead and Chief Executive of the VCS Alliance. TP advised it was an important piece of work that highlighted the challenges faced locally in ensuring that the VCSE sector continues to be seen as an equal partner and the recommendations made to national policy makers. TP acknowledged the risk faced by the VCSE sector in relation to funding issues and increase to NI rates.

TP highlighted the evaluation of the review carried out by Dame Donna Kinnair in October 2024 on behalf of West Yorkshire Health and Care Partnership. In addition to the original four themes identified in the October 2020 review the impact of the riots during the summer of 2024 and racism on children and young people was examined. A paper providing an update was shared with the West Yorkshire Health and Care Partnership 21 January 2025.

TP advised that the new tool kit and the reasonable adjustments resources to support neurodivergent staff and recruits are free and available to download and share.

TP advised that West Yorkshire had been selected as part of the Get Britain Working inactivity trailblazer and that work carried out in relation to this would be brought before the Board at a future meeting.

TP advised the first ever Women's health conference which will be held on Thursday 27 February 2025 is fully booked.

The Mayor of the City of Bradford opened the new NHS surgical day case unit at St Luke's Hospital and despite technical difficulties, which have been resolved, the £19m building is due to start seeing patients in February 2025.

RESOLVED: The Partnership Board **RECEIVED** and **NOTED** the Place lead's update.

5b Shipley Hospital: confirmation of closure of site

Shak Rafiq (SR) presented a report which confirmed that Shipley Hospital is now vacant and the site has been handed back to NHS Property Services. No interest was received for the property to remain in the public sector due to significant refurbishment costs and will therefore placed on the open market for sale in February 2025. It is intended that the

proceeds of sale will be invested in the Shipley Health and Wellbeing Campus. SR noted that the Hospital was a well loved facility by staff and patients alike and a call out to current and former staff to share memories has been made with the intention of these being shared late spring.

The Chair expressed thanks to the team involved and that of the local elected members for their careful and respectful work in respect of this matter.

RESOLVED: The Partnership Board **RECEIVED** and **NOTED** the update and **AGREED** for the formal record of this decision to be included in the AAA Report to the WY ICB.

06 SECTION 75 AGREEMENT VARIATION

Jane Wood (JW) presented a report which set out the collaborative work overseen by the Planning and Commissioning Forum to refresh and update the Framework Partnership Agreement relating to the commissioning of Health and Social Care Services (s 75 Agreement). To ensure legal compliance Browne Jacobson provided legal advice and assistance during the process. The s 75 Agreement which, has remained unchanged since 2017, required several amendments to align with the current partnership arrangements and ensure legal compliance. The s 75 Agreement had previously 13 Schedules in total and for this variation the number of schedules had increased to 30 schedules with a total value of £111million (£89m for the Better Care Fund (BCF) and £22m for all other schedules).

Sue Baxter advised that on 17 December 2024 the WY ICB agreed amendments to its Constitution which granted further delegation of power to Places in respect of s 75 Agreements which will take effect once agreed by NHS England. Therefore, the s 75 Agreement will be signed by Iain McBeath on behalf of BDC and Rob Webster on behalf of WY ICB.

JW advised that the Planning and Commissioning Form at BDC will review the schedules of the Variation Agreement prior to the end of the next contract date review.

Mike Woodhead (MW) confirmed that the s 75 Agreement had been considered by the System Finance and Performance Committee and more accurately reflects the current partnership arrangements and how the £111m funding is accessed. MW questioned how best value is assessed and highlighted a separate piece of work into access to care and best value carried out by Ian Holmes.

Foluke Ajayi (FA) noted it was an excellent piece of work and highlighted the need to keep the s 75 Agreement up to date and in line with existing planning guidance.

Therese Patten (TP) noted the NHS Financial Planning Guidance was received 3 weeks ago and questioned whether the NHS Neighbourhood Health Guidelines and Better Care Fund (BCF) piece of work was going ahead.

JW confirmed the BCF has reached the end of a 2 year cycle and the draft plan needs to be completed by 31 March 2025. Karen Parkin and Helen Farmer have carried out work in relation to how this will look which will be considered by the Health and Wellbeing Board at the next meeting. The governance structure of this also needs to be considered and a report will be brought by Mike Farrar, Independent Consultant, to the PB in May 2025.

Action: Bradford District and Craven Health and Care Partnership leadership and governance review undertaken by Mike Farrar to be considered and brought to the next PB meeting in May 2025.

MW advised that a review of value for money is not possible within the operational and financial planning timescales and that consideration needs to be given to a more detailed piece of work. FA stated that time scales needed to be pragmatic to permit provided involvement with the review of VFM piece of work. JW stated that BCF work sits with intermediate care work and related to value for money target work that needs to be carried out collectively. Sohail Abbas (AH) advised that discussions had taken place by the Clinical and Professional Forum in relation to how value for money is defined and highlighted that this needs to be considered alongside the safety of services provided.

Louise Wallace (LW) advised that the s 75 Agreement for North Yorkshire Council and Craven will would be brought to the Board in due course.

Action: the NYC s 75 to be added to the Partnership Board workplan.

The Chair acknowledged the work that had gone into the amendment to the s 75 Agreement and thanked Iain McBeath, Helen Farmer, Jane Wood, Karen Parkin, Walter O'Neill, Sue Baxter and Javeid Karim for their contributions.

RESOLVED: The Partnership **NOTED** the work undertaken by the Planning Commissioning Forum in respect of the updating and reviewing of the s 75 Agreement; and **APPROVED** the variation of the s 75 Agreement to accurately reflect the current partnership arrangements.

07 PARTNERSHIP HIGH LEVEL RISK UPDATE

Asma Sacha (AS) 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 four of 2024/25. The report included the NHS West Yorkshire ICB corporate risk register and Board Assurance Framework for information and detail on the common risks across the West Yorkshire Places.

AS noted three new risks:

- Risk 2486: a risk of physical and psychological harm and longer waiting times for

patients due to capacity issues;
- Risk 2482: an increase in clinical risk and workload across system partners due to the failure to transition to electronic patient records; and
- Risk 2477: the significant risk of the statutory adult social care market failure due to insufficient funding.

Two risks that had decreased in score:

- Risk 2314: RAAC at Airedale Hospital, likelihood had reduced from 4 to 3 with impact remaining at 5; and
- Risk 2421: Insufficient capacity to host clinical placements across all professions has reduced from 12 to 9.

One risk that had closed:

- Risk 2357: the risk that people with diabetes will be unable to access and receive renal screening.

Sam Keighley (SK) agreed with the scoring for risk 2477 relating to the independent care sector and noted that this had been reported via the triple A from the November PB to WY ICB.

TP noted that risk 2266 in relation to ADHD remained static and duplication and rating of risks were discussed at the Executive Management Team meeting.

FA noted risk around weight management will need to change as currently this states Bradford and should be for Bradford district and Craven.

Louise Wallace (LW) queried risk 2448 vaccinations and noted it should include Craven taking into account the difference in the population and vaccine uptake and health protection.

Ashley Green (AG) noted the importance of the visibility of the VCSE and the impact it has on our population. SK highlighted the work carried out in relation to contracts not being uplifted or reduced. JW advised that fee setting had concluded and an uplift had been allocated to VCSE to mitigate the rise in NI contributions however, it is difficult to ascertain the impact of the uplift on the VCSE community.

Louise Beswick (LB) advised that there was no news in respect of funded nursing care.

AS highlighted key changes made to the Board Assurance Framework (BAF) following review during Cycle 4 2024/25 set out at paragraph 3.4 of her report.

TP advised that in relation to BAF Risk 3.1 as a new planning round is underway the proportion of money allocated to different sectors needs to be kept under consideration. Andy Withers (AW) advised the risk was discussed at the Quality Committee and noted it

was Bradford focused and would need to be broadened to include Craven and needed to address other sectors in addition to the NHS, including VCSE and independent sector.

RESOLVED: The Partnership Board **RECEIVED** the BDC HCP cycle four risk report and confirmed assurance on the critical and serious risks scoring above 15. The Partnership Board **RECEIVED** the ICB risk register and BAF for consideration and confirmed assurance on the BD&C H&CP risks captured in the ICB Risk Register.

08 REPORTS FROM COMMITTEES AND FORA

The Chair explained that each subcommittee and fora completed a Triple A Report from each of the meetings to provide assurance to the Partnership Board and allow Committee Chairs to alert the Board to any significant risks or asks.

AW, as Chair of the System Quality Committee advised of the new Sentinel Stroke National Audit Programme (SSNAP) methodology which will likely result in lower scores notwithstanding there has been no change to the quality of care. AW noted that digital change is not easy and noted the major impact caused the by the introduction of the Laboratory Information System (LIMS) at Leeds Teaching Hospital Trust in December 2024. The impact on GP's had been significant and by example it had taken one GP an extra hour each day to process 3,500 patients. There had been significant progress in relation to the delays in the issuing of death certificates due to weekend working. FA noted that the SSNAP methodology is ambitious with ANHSFT needing an additional £1m to meet new standards. This needs to be considered in context of the current financial situation and the expectation in the NHS Financial Planning Guidance 2025/26 to "live within our means".

MB highlighted that as a member of the Partnership Board the University's Digital Centre could be accessed for help in relation to testing viability and whether things are fit for purpose.

Sohail Abbas (SA) as Chair of the Clinical and Professionals Forum (C&PF) noted that a development session is being planned for February 2025 with a focus on developing the Bradford District & Craven Health and Care Strategy. Terms of Reference will be updated to reflect the new arrangements and the proposal for new C&PF lead will be presented to the Partnership Board for ratification and approval.

Victoria Simmons (VS) noted that the two Listen in reports under the Partnership Board's Listen in programme would be taken into the March Development session to afford time for due consideration, as todays focus has been on Craven and North Yorkshire. Linda Patterson as Chair of the BDCFT noted that these Listen in reports are taken into our organisations too as we all Partnership Board members having a commitment in relation to Listen In.

Matt Sandford (MS) questioned why there is a need to go out and ask the same questions and noted a lot of the work can be done across the groups that are already in place. MS also questioned how knowledge and understanding about the position we are in is built and how communities are engaged. MS also highlighted the work carried out by Leeds Healthwatch as a good model and the connections across West Yorkshire regarding the engagement with the NHS Ten Year Plan change consultation.

RESOLVED: The Partnership Board **RECEIVED** THE Bradford District and Craven subcommittee and Fora Triple A Reports.

The BD&C Partnership Board took a comfort break from 11:25-11:35am

09 Understanding Ourselves in Craven

VS provided a summary overview of the craven Listen in programme undertaken in October 2022, including transport, digital access, the importance of community groups, access to domiciliary care, and children and young people's access to CAMHS services.

The Chair noted the work carried out by partners across health, care and the VCSE sectors delivering services in Craven and the working taking place across boundary lines of Local Authorities and Integrated Care Boards to deliver that work. This agenda item is in response to the challenge from representatives from North Yorkshire of the importance of recognising Craven's distinct characteristics and needs. It is aimed at building our understanding in terms of population needs and the work that is happening to address them with the intention of broadening our understanding so that the Board can better identify issues that the system might be missing or may need strengthening.

Louise Wallace (LW) and Sharon Hudson (SH) and Victoria Turner (VT) delivered a presentation which highlighted what is being heard from the people in Craven.

It was noted by LW that Craven matters deeply to North Yorkshire Council (NYC) which became a unitary authority in 2023 with 8 Councils merging to form NYC which covers a large area including Scarborough and Skipton. The area differs greatly in respect of geography (both rural and urban) and population (both elderly and young) and stretches across two Integrated Care Systems.

Victoria Turner (VT) highlighted the data sets in relation to health in Craven and noted the key demographics in relation the population pyramid taken from the 2021 census and noted that one quarter of the population is over 65 years old and questioned where the population of North Yorkshire (NY) will be in a decade. The increase in adult obesity and reduction in green spaces was highlighted as were the number of people seriously injured or killed on roads. It was noted that although inequalities in Craven were less pronounced, the area of Skipton with the greatest deprivation is in Skipton South Ward.

LW highlighted the work that is ongoing in relation to giving the best start in life, increasing physical activity and healthy ageing and the key transformation work in relation to

substance use service and redesign, infection prevention and control and Moving North Yorkshire (stronger for longer). The largest budget is around children's services and a CQC inspection is anticipated in the near future.

The work taking place around wider system transformation was highlighted in particular the "team around the person". SH advised that this would be a two to three year programme with a concentration on preventative work and how anchor services can be put in the best position.

Charlotte McKeown (CM) highlighted work that has taken place in Knaresborough in relation to flash flooding.

VS highlighted the work taking place around the Craven Listen in Programme and the 25 Community Anchors in North Yorkshire with four located in the Craven area. A volunteer led transport programme is in place to assist with issues caused by limited transport availability for frail and disabled people. VS highlighted that community groups play a vital role and are strongly valued. VS advised that waiting lists in relation to ADHD are long, as are the distances those waiting are prepared to travel to obtain a diagnosis. LP questioned the thoughts around the challenges to transport and travel. SA noted the item was timely given the work that is being carried out on the Place Health, Care and Wellbeing strategy and this can be given consideration as to what that looked like, through the lens of Bradford District & Craven.

TP highlighted the voluntary organisations in Skipton and Settle and in particular what had been done in respect of social isolation in a school in Settle. TP also noted the job opportunities for young adults in these areas are limited with boys opting for farming and girls opting for administrative roles. LW highlighted the work in Scarborough college around a plan to stay and work in the area rather than plan to leave.

Ashley Green (AG) noted that bringing services to communities is a challenge given the diverse population of Bradford district and Craven and the ageing population of Craven and highlighted the reluctance of farming communities to access services with most preferring to discuss their health issues with the vet than medical professionals. The high suicide rate amongst famers was highlighted as well as the need for them to access services around the variation in work caused by the seasons.

SK noted that physical inactivity is the 5th largest cause of death and questioned what physically active meant and noted it was more than just moving more. SK highlighted the partnership's strategic intent with community anchors and noted that funding for these come to an end by the end of March 2025.

FA noted that linking work around home first and a proper discharge from hospital was important and the benefit of the generations of families that have worked in the hospital and highlighted the importance of placements in respect of recruiting and retaining the workforce.

Richard Haddad (RH) noted obesity and inactivity is an issue with the younger population and the national children measurement programme that is ongoing.

CM highlighted how the setting up of Skipton Step into Action at the start of the COVID pandemic and the volunteers provided a lifeline to the community during such a difficult and unprecedented period and noted the befriending service that was set up to help isolated and lonely people. SK highlighted a small amount of investment as little as £15k helps organisations grow. SR highlighted the City of Culture team programme aimed at social isolation.

RESOLVED: The Partnership Board **NOTED** the content of the presentation.

10 Year-end position moving into next year

Finance update

MW advised for the 2024/25 financial position at month 9 BDC are £8.6m off plan. It was expected that the position could change by month 10 to around £20m off plan excluding any Elective Recovery Fund risk. NHS West Yorkshire ICB had agreed with NHS England to reforecast at month 11 rather than month 9, when the outturn position for 2024/25 will be clearer. An overall deficit position for West Yorkshire impacts on £50m additional NHS England funding allocated at the outset of 2024/25 as well as having a potential impact on capital allocations for 2025/26.

Annual Planning Guidance

Kerry Weir (KW) advised that NHS operational and financial planning 2025/26 guidance was published on the 30 January 2025. A first high level draft was due for submission on 20 February which covered finance, total workforce numbers, high-level metrics and narrative on the delivery of the plan with a final submission due on 20 March covering more of the detailed requirements set out in the guidance. Bradford District and Craven's contribution is being submitted to NHS West Yorkshire ICB colleagues as one of the five places in West Yorkshire. KW noted that due to short timescales, it will be challenging for plans to be sighted at the various governance meetings prior to submission.

RESOLVED: The BD&C Partnership Board **NOTED** the update on the 2025/26 Operational and Financial Planning Guidance and process; and **DELEGATED** authority to the PB chair, Place Lead, SFPC Chair, System Lead for Finance and the Director of Operational Finance to approve the final submission on behalf of BDC HCP

11 ANY OTHER BUSINESS

The Chair noted her and the Board's thanks to Jonathan Kerr for his service to the Board as an active participant and contributor and wished him well in his future endeavours. The chair formerly noted the arrival of Carrie's baby on the 2 January 2025.

12 REPORTS/ESCALATION TO WY ICB AND REVIEW OF THE MEETING

The Chair advised that NHS West Yorkshire ICB Board would be alerted to discussions related to the impact of the budget on the VCSE, care providers and primary care in the BD&C Partnership Board's Triple A report.

DATE AND TIME OF NEXT MEETING

Friday 23 May 2025
10:00 – 13:00
G7/G8, Scorex House, Bolton Road, Bradford, BD5 7JR

Ref No	Meeting date	Agenda item	Action Required	Lead	Due Date	Status	Notes
2024/05	21-Jun-24	Development Session	The Communication and Engagement Team to explore a kindness campaign, in reference to ANHSFT campaign to develop something place-wide	Shak Rafiq	05-Sep-25	Open	The kindness campaign has not been revisited yet due to other system-wide priority campaigns however there is consideration to progress it, most likely over summer 2025
2024/07	14-Feb-25	6 - Section 65 agreement variation	B&DC H&CP leadership and governance review undertaken by Mike Farrar to be considered and brought to the next PB meeting in May 2025.	Therese Patten/Matt Sandford	23-May-25	Open	
2024/08	14-Feb-25	6 - Section 65 agreement variation	NYC Section 75 to be added to the Partnership Board workplan.	Louise Wallace/Catherine Smith	tbc	Open	

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven Health and Care Partnership Board (BDC HCPB)

Date of meeting: 14 February 2025

Report to: WY ICB Board

Report completed by: Sue Baxter for Elaine Appelbee (chair) & Therese Patten (place lead)

Date: 17 February 2025

Key escalation and discussion points from the meeting
Alert:
• **s75 agreement variation (recommendation)**: the City of Bradford Metropolitan District Council and NHS West Yorkshire ICB in Bradford district and Craven had not been reviewed since 2017 and had now been updated to accurately reflect the current partnership arrangements. This review was overseen by the Planning and Commissioning Forum with legal advice provided by Browne Jacobson. The section 75 agreement had previously 13 schedules in total and for this variation the number of schedules had increased to 30 schedules with a total value of £111million (£89m for the Better Care Fund and £22m for all other schedules). In addition, it was noted that the section 75 agreement for North Yorkshire Council and Craven would be brough to the Partnership Board in due course. (BAF 1.3 and RR 2419) **Decision: members of the Bradford District and Craven Health and Care Partnership Board recommended the variation of the section 75 agreement to the NHS West Yorkshire Integrated Care Board for approval on the 17 March 2025.**
Advise:
• **2024/25 financial position at month 9**: the reported forecast at month 9 is that BD&C Place is £8.6m off plan. All that variance currently sits with the ICB. The three provider trusts were still reporting a breakeven forecast at month 9. However, we expect that the position could change by year end to around £20m off plan, mainly as a result of likely changes in the acute trusts' forecasts. NHS West Yorkshire ICB have agreed with NHS England to reforecast at month 11 rather than month 9, when the outturn position for 2024/25 will be clearer. An overall deficit position for West Yorkshire impacts on £50m additional NHS England funding at the outset of 2024/25 as well as having a potential impact on capital allocations for 2025/26. (BAF 3.1, RR 2433 & RR 2337) • NHS operational planning 2025/26 guidance was published on the 30 January 2025. A first high level draft is due for submission on 20 February which covers finance, total workforce numbers, the high-level metrics and narrative on the delivery of the plan. A final submission is due on 20 March covering more of the detailed requirements set out in the guidance. The Bradford district and Craven contribution is being submitted to NHS West Yorkshire ICB colleagues as one of the five places in West Yorkshire. Due to short timescales, it will be

challenging for plans to be sighted at our various governance meetings prior to submission. (BAF 3.1 & 3.2, RR 2168)

Decision: the Partnership Board delegated authority to the PB Chair, Place Lead, Chair of the Finance and Performance Committee, BD&C H&CP Finance Director, Director of Operational Finance and the Associate Director Planning, Performance & Business Intelligence to approve the final submission of the operational and financial plan 2025/26. Note: the final operational and financial plan submission will be added to the Partnership Board workplan

- **Shipley Hospital (decision)**: the decision to close Shipley Hospital and hand the site to NHS Property Services was confirmed and formally noted by members of the Partnership Board. (BAF 2.4)
- Leeds Teaching Hospitals Trust introduced a new **Laboratory Information System (LIMS)** on 3 December 2024. Mobilisation has created delays and duplicate results and regular communication had been sent to GP practices regarding vigilance of results and delay of routine results in first instance. A specific service desk line for primary care colleagues has been set up to respond to existing or new issues, and any concerns or questions. Clinical risks are escalated to West Yorkshire Association of Acute Trusts (WYAAT) and via ICB routes to Dr James Thomas, West Yorkshire ICB medical director, and Shaukat Ali Khan, WY ICB Chief Digital and Information Officer. It was highlighted that learning should be shared before implementing the roll-out in other areas.
  Partnership Board agreed an action to add to the BD&C H&CP risk register.

Assure:

- **BTHFT Day Case Unit** opening of the new £19m NHS surgical day case unit at St Luke's Hospital is progressing and is set to open April 2025; with the operational go live date not yet confirmed.(BAF 2.4)
- North Yorkshire Council, which formed on 1 April 2023 from eight councils to one County Council, focus on communities from Scarborough to Craven. Twice a year we hold the Partnership Board meeting in the Craven area and for 2025 we will be focusing on what matters for the communities and population of Craven with an **understanding ourselves in Craven** item. At this meeting the item covered tailoring services for and with communities informed by the public health needs for the Craven population, and outlined the transformation priorities of substance use service redesign, Infection Prevention and Control service and moving North Yorkshire – Stronger for Longer. Stay Healthy and connected funding from NYC supported Charlotte McKnown's community anchor organisation to mobilise during the recent flooding event, this community anchor began at the start of the communities response to the COVID-19 pandemic and now provides befriending, signposting, walk and talk and ground yourself in green – including yoga and tai chi in the park. (BAF 1.3)
- **Listen in** reports on Disabled people and their carers, and LGBTQ+ people will be taken at the May 2025 Partnership Board meeting. In addition the upcoming Listen In activity in the

next cycle will focus on racial minority communities, with a particular focus on African and Syrian communities.

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:	23 May 2025
Report title:	Listen in – how what we are hearing is shaping our strategy
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:

- Listen in, how we act on what we hear. Presented at Partnership Board meeting September 2024
- Listen in, deep dive on Craven. Presented at Partnership Board meeting January 2025
- What are we hearing from LGBTQ+ people? Presented at Partnership Board development session February 2025
- What are we hearing from disabled people and their carers? Presented at Partnership Board development session February 2025

Executive summary and points for discussion:

Over the past two years, our team has developed systematic approach to meaningfully involving people and communities that goes beyond formal consultation and means working with people across Bradford District and Craven as partners.

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

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

Together, these involvement activities have built a deep and dynamic understanding of our local population needs and wants. When considering how to develop our refreshed strategy, rather than go back out and ask communities questions which may feel abstract or disconnected from their lives, we wanted to start by making better use of everything people had already told us.

Qa Research, an independent market research agency, carried out secondary analysis of the outputs and reports we had already produced. Their work helped us look across all that insight with a clear question in mind: what can we learn that will help us respond to national policy direction and shape our strategy in a way that is rooted in people's real experiences?

We also sought specific insights on how citizens and communities across Bradford District and Craven can take an active role — both in shaping and delivering a shared vision for the future of health and wellbeing, and in taking ownership of their own health. This included exploring how people can be supported and empowered to act individually and collectively to improve health outcomes, shifting the relationship from passive recipient to active shaper of health and care.

The appended report provides detailed insights into the three 'Darzi shifts' and people's needs and expectations of health and care services. A summary of the high-level insights is included in the supporting slide deck. This evidence has been shared through development sessions and has directly shaped and informed the draft strategy.

When considering the draft strategy, and in future assurance that we are delivering on our bold ambitions, the Board may wish to consider the following lines of enquiry to ensure we stay grounded in what we hear:

1. Are we delivering actions and making decisions that directly reflect what people have told us matters most?

2. How are we ensuring that the voices of marginalised communities continue to shape delivery and that they see the benefit from change?

3. How are we supporting citizens and communities to take greater ownership of their own health and wellbeing, and play an active role in shaping services?

4. Are we making it easier for people to find, access and use services in ways that make sense to them?

5. As we innovate (e.g. through digital and neighbourhood models), how are we making sure no one is left behind?

Outline how this supports our partnership vision and strategy

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

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

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

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

Recommendation(s)

The Partnership Board is asked to:

1. Consider the suggested lines of enquiry to help guide assurance and decision-making, ensuring our strategy stays rooted in what we have heard.

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. Slide deck - What are we hearing from communities to inform our strategy?
2. Listen in – secondary engagement analysis

Acronyms and Abbreviations explained

LGBTQ+ is an inclusive acronym that stands for Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), with the '+' representing other diverse sexual orientations, gender identities, and expressions.

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

What are we hearing from communities to inform our strategy?

May 2025

Victoria Simmons, Senior head of communications and involvement

Secondary analysis – what have people already told us?

Over the past two years, through our Listen in programme and the Closing the Gap deliberative dialogue, we have developed a rich and dynamic understanding of what matters most to our communities.

Insights from these engagement activities have been analysed by an independent market research agency and have informed our strategy chapter on citizens as active partners in health, care and wellbeing.

Lines of enquiry:

Darzi shifts – How do our communities view the shift from hospital to community care, from analogue to digital services, and from treatment to prevention?

Developing the place-based health, care and wellbeing strategy – What opportunities and challenges do communities see?

Enablers and community activation – What needs to be in place to support these changes? How can we systematically involve citizens as co-producers and partners in shaping local health and care?

Our personas: bringing insights to life

Bradford District and Craven
Health and Care Partnership

ACTasONE

The three shifts

Shift from hospital to community

- Positive: Reducing travel barriers, VCSE-led community health hubs, mobile clinics, better home-based care.
- Concerns: Risk of postcode lottery, variation in quality, accessibility concerns for some groups.

Shift from analogue to digital

- Positive: Digital access for younger residents, smoother communication between services, potential efficiency gains.
- Concerns: Digital exclusion (older, non-English speakers, low-income groups), digital literacy and the need for non-digital access options.

Shift from treatment to prevention

- Positive: Strong support for early intervention but trade-off needs to be clear, prevention linked to broader social determinants (housing, diet, education).
- Concerns: Preventative approach must complement acute care, barriers to accessing screening/vaccinations, support needed for mental health prevention.

I avoid going to the hospital because transport is too expensive and unreliable. If care was closer to home, I'd actually use it.
Online booking sounds great, but what if you don't have a smartphone or know how to use it?
I've had to explain my medical history to five different people—why don't systems talk to each other?
We need more mental health support before things spiral – not just when it's already a crisis.

What communities want from acute care:

- timely, **free at the point of use** access to care
- improvement in **waiting times** and overall hospital communication
- more **joined-up care pathways** to prevent patients falling through the cracks
- **mobile & satellite clinics** to improve local access and reduce travel difficulties
- ensuring hospitals remain inclusive spaces, particularly for **neurodivergent or disabled people, and inclusion health groups**
- better **hospital-to-home discharge support** to ensure people leave safely with the right follow-up care
- delays in **follow-up care** after hospital treatment, leaving some patients without necessary rehabilitation or support
- variation in **quality of care** across different hospital departments – some report excellent experiences, while others feel dismissed or rushed
- mental health **crisis support in hospitals** is not working – people feel "bounced around" between services

What communities want from integrated neighbourhood health and care services:

- better use of **VCSE and community hubs** to deliver healthcare in trusted, accessible spaces
- clearer **pathways for accessing services** – people need to know where to go for different types of care
- improved **coordination between NHS, social care, and community services** for continuity of care
- focus on **preventative care & early intervention** to reduce reliance on hospital services
- **seamless transition from hospital to home** – follow-up care after hospital stays must be timely, well-communicated, and accessible to avoid delays in recovery
- a **clear desire for inclusivity and accessibility** across health services for patients of different backgrounds, specifically regarding language barriers, learning difficulties, disability and LGBTQ+.
- risk of **postcode lottery** – variation in quality and availability of community-based services

Hospital care needs to be quicker, more joined-up, and easier to navigate - too many people fall through the cracks because communication isn't working

People want to take charge of their own health, but too many things get in the way - cost, transport, knowing where to go…

We trust people in our communities more than big organisations - work with not around them.

If you put services in places we already trust, like our community centre, more people would use them

Citizen activation

- **harnessing peer support** – enabling volunteers and community champions to share health advice and signpost services.
- **building health confidence** – improving understanding of when and how to access care, reducing unnecessary healthcare visits.
- **strengthening self-care** – providing simple, practical tools for managing long-term conditions at home.
- **mobilising community assets** – supporting local groups to deliver low-cost health initiatives, such as walking groups and food clubs.
- **partnering with trusted leaders** – working with community figures to reach underrepresented groups without adding pressure on services.
- **supporting unpaid carers** – equipping family carers with skills and resources to reduce reliance on overstretched services.
- **culturally appropriate and adapted** - information and support that is tailored to reflect the readiness, needs and lifestyles of our diverse communities
- **embedding prevention in everyday life** – making healthy choices easier through better community design and local initiatives

Bradford District and Craven
Health and Care Partnership

ACTasONE

“We have so many strengths in our communities - if we work together, we can create a health service that truly works for everyone."

How might we challenge ourselves to ensure our strategy is grounded in our listening?

1. Are we delivering actions and making decisions that directly reflect what people have told us matters most?
2. How are we ensuring that the voices of marginalised communities continue to shape delivery and that they see the benefit from change?
3. How are we supporting citizens and communities to take greater ownership of their own health and wellbeing, and play an active role in shaping services?
4. Are we making it easier for people to find, access and use services in ways that make sense to them?
5. As we innovate (e.g. through digital and neighbourhood models), how are we making sure no one is left behind?

Secondary Engagement Analysis for Bradford District and Craven Health and Care Partnership

Summary Report | March 2025

Georgina Culliford

QaResearch

Contents

1. Introduction 3

2. Aims & Objectives 3

3. Methodology 3

4. Findings: the three 'Darzi Shifts' 4

4.1 Shift 1: Hospitals to communities 4

4.2 Shift 2: Better use of technology 7

4.3 Shift 3: Treatment to prevention 10

5. Findings: Development of the Place commissioning strategy 15

5.1 Hospital for the future 15

5.2 Out-of-hospital for the future 18

5.3 Enablers 21

5.4 Citizen and community assets 23

6. Conclusions 26

7. Appendix 27

1. Introduction

This report presents the findings from a meta-analysis of various reports and secondary data from Bradford District and Craven Health and Care Partnership (BDCHCP).

In order to provide insights in light of some strategic research questions, Qa Research were commissioned by BDCHCP to undertake re-analysis of data sources. The research aimed to review the community Listen In reports, which were not written by Qa, and gain deeper analysis of the raw data from Closing the Gap events. Listen In locality reports were also reviewed for any pertinent findings.

2. Aims & Objectives

The aim of the re-analysis was to address the following research questions:

- What have communities already told us that links to the three Darzi shifts?
- What are the things which matter most to communities that we need to focus on in developing our Place commissioning strategy?
- Are there any gaps in our knowledge where focused engagement with key communities might be needed in the future to ensure our strategy is informed by what matters to our population?

3. Methodology

The secondary research undertook re-analysis of various reports and secondary data. Overall, 4 different data sources were re-analysed, with a total of 16 documents.

The sources of data for re-analysis were:

- 6x locality cycles of Listen in
- 5x communities of interest cycles of Listen in
- 2x wider Closing the Gap deliberative events
- 6x locality Closing the Gap deliberative events

Each piece of engagement was read through and key findings under each topic were inputted into an excel analysis matrix. From this, findings were synthesised into a list of key points, organised into a structure and written up into the report.

4. Findings: the three 'Darzi Shifts'

Following Lord Darzi's review into the health service and subsequent NHS 10-year long term plan, there has been a recent commitment from the government to three strategic shifts for the NHS, which are:

- hospital to primary care and community services
- analogue to digital
- treatment to prevention

This section outlines existing knowledge from past engagement (since 2022) regarding what communities think of the three shifts, what they would view as a successful shift in this direction, and what considerations the NHS should take into account when planning these shifts.

4.1 Shift 1: Hospitals to communities

The first shift relates to boosting 'out-of-hospital' care and delivering more services within communities. The following evidence was gathered through different cycles of engagement on the topic:

Positive reaction and vision for the shift:

- Generally speaking, feedback from various engagement activities suggests the hospital to communities shift is seen as a positive development.
- A major reason for preferring care delivered within communities is due to issues travelling to hospital. This affects various communities or personal situations in different ways, including rural transport, challenges travelling early or far with conditions like dementia, travel meeting accessibility needs or being challenging with disabilities, affordability of transport, finding or paying for parking, taking time off work/school, accessing learning disability transport, impact on or need for carers, and reliability of public transport.
- Existing community infrastructure run by the voluntary and community sector (VCS) could be a major asset in realising the hospital to community shift, utilising the infrastructure that exists rather than starting from scratch. It is important to note that this was a view shared mainly by VCS stakeholders rather than users. People using community-based organisations often talk about the value of the community group or centre and the service it provides rather than referring to the VCS as a sector. Positive feedback was shared in all engagement cycles about how the VCS have already started to support with delivering health information sessions, suggesting this could extend to practical health delivery such as health checks, vaccinations, screening, clinics, and drop-in sessions.

- Community groups and centres are highly valued for the general wellbeing support they provide to residents, especially for marginalised groups such as inclusion groups, LGBTQ+, disabilities and communities whose first language isn't English. Having the VCS Wellbeing Hub model with lots of services in one place appears to be proving successful in some places, particularly for supporting inclusion groups through a 'no wrong door' approach. Some people fed back that it makes sense to extend this 'hub' model to include more health services.
- Potential models for community-based services beyond the VCS were suggested by stakeholders and citizens alike, particularly in the Closing the Gap work. These include – mobile and satellite clinics, home visits, prescription deliveries, at-home monitoring, virtual wards. All of these have their pros and cons based on who is using them, so feedback suggests each service needs to consider their target group and their specific needs e.g. digital skills, home set-up, rurality, transport, informal carers, language and comprehension. If implemented correctly and appropriately, these models could be very empowering to get people taking a more active role in their own care.
- There was a positive reaction if things like in-home virtual appointments could speed up waiting times and it could make the patient experience smoother and more efficient, taking appointments from their own home and not having to travel.
- There was evidence across all cycles of patients misusing A&E as a last resort after struggling to access primary care, and often the reasons for attending were not 'accident and emergency' reasons. People shared that they were aware they are misusing A&E but have no other ideas of where to go. There were several mentions across all cycles about the lack of a walk-in centre or urgent care centre in the Bradford District. There was a clear feeling that this could ease pressure on both GP and A&E which are seen as the bottlenecks and hardest place to access care, but currently the only 'front door' that many people know about.
- Access to dentistry is seen as very poor, and communities are in need of local access to NHS dental care. Residents are keen for community health services to bring dental care under the same umbrella as it feels like a key gap. Some people shared stories of having to travel a long way for NHS dentists due to their rarity.
- There was some mistrust in formal NHS support, particularly from marginalised communities, which came through particularly in the Listen In cycles. A shift away from hospitals and into the community could therefore have a positive impact in this regard, especially if community services are able to link in with existing trusted institutions.
- There were some positive experiences shared in some cycles about hospital-to-home discharge support. Patients felt very empowered and supported by

the step-by-step personalised approach that helped them leave hospital and be more comfortable at home, without feeling unsafe. There may be space for the hospitals to communities shift to involve more of this 'Home First' approach, getting people out of hospital in a safe and managed way.
- There were one or two comments from or about NHS workforce, suggesting the shift to communities could be a positive thing for staff to work within their local communities or not have to travel to a hospital every day.

Possible concerns or considerations for the shift:

- One possible downside or risk of the hospital to community shift could be a possible increase or development of inequalities. Already there were various comments about services being a 'postcode lottery' or variable between different providers or locations. If services become more localised then the variation in patient experience might increase, with some getting a better service depending on where they live. Wealthier areas may end up having better or quicker service as the demand is lower, widening inequality.
- In the Closing the Gap engagement, there were a few concerns that a shift to communities needs to complement, not completely replace, acute care. Some were worried that they would only be offered one or the other, and missing out on hospital based care where it was needed.
- Using pharmacies better came up fairly regularly in the Listen In cycles as a positive development, but there was a clear need to educate communities on what can be done in pharmacies. One particular challenge with pharmacies involves consistency, as people raised the issue that there is so much variation between them, and also the question of privacy, as many pharmacies do not have space for a private consultation which can be off-putting.
- Health literacy was a key theme to enable this shift to work properly. Already there is evidence that people are struggling to navigate various 'doors' to the health service and methods of accessing care. If there are further changes, then this will need further explaining through clear communication. Comms should be mindful of jargon, languages and other communication needs to ensure the most marginalised communities have equal knowledge and access.
- Specialist services (inpatient and outpatient) have been repeatedly praised throughout different cycles of engagement, and a possible concern would be whether the quality or specialist expertise found in these services may be diluted if spread throughout communities rather than centralised in a hospital setting.
- Already the engagement has revealed some existing concerns over communication, particularly with different languages and additional needs

such as neurodiversity and disabilities, trans individuals plus inclusion groups like homelessness, refugees or those recently released from prison. There may be scope for increasing community care to be a positive development in this respect, particularly if services are located within communities with high levels of particular languages or cultures, as the staff may be more likely to be able to speak the language and be sensitive to their needs. However, there may be risk of some communication needs being less well catered for in a community setting, particularly if specialist training is needed, as this might be more likely to be met in a centralised hospital setting e.g. not every community setting would have a BSL interpreter but a hospital might.

- Important that community spaces (including any specific NHS programmes operating in community spaces) are free of judgement and are welcoming; to language, culture, social background, age, homelessness, addiction, children, employment status. When people attend and feel welcomed, this support can be impactful.
- There was considerable feedback in all cycles of engagement on the struggle to access primary care. While not entirely related to the hospital to community shift, it is important to consider how the shift will fit in with existing primary care networks and access points – even if there is a shift to community services, where will the 'front door' to access them be? In primary care or somewhere else? If in primary care, will the same bottlenecks to access be experienced and how are these being mitigated?

Key gaps in knowledge:

- There was widespread support for the principle of shifting care from hospitals to communities, in particular for routine appointments, tests, check-ups and things that currently require regular travel to hospitals.
- A possible gap in knowledge is around how the different existing infrastructure could best form a single, comprehensive community offer – primary care, VCS and pharmacies in particular. This may be achieved through stakeholder engagement, as well as exploring with local residents how they currently access care and what would be their 'ideal' model of community-based services.
- When the model of community-based services is more developed, it's likely to need some engagement on health literacy, specifically around what the routes into care are for different health needs, and how these routes/access points are different to what people are used to.

4.2 Shift 2: Better use of technology

Positive reaction and vision for the shift:

- Across various cycles of engagement, there was a theme that younger residents had positive experiences with digital technologies, preferring to use an app or online services over other methods of access.
- Across different phases of engagement, but particularly the Closing the Gap events, there was consistent feedback on communication between different health services, departments and parts of the system. Residents recounted experiences of poor communication, with different partners unable to access information easily, leading to delays, repeated tests, frustrations or difficult encounters when health professionals did not know their history or key details about them.
- Therefore, there is an opportunity for better use of technology to result in a more joined-up health service, benefitting patients. Technology could be used to make it easier for different services to interact and access the information they need in order to provide better care. This could also help tackle issues with patients having to recount their history to each professional they interact with. It can also be used to streamline services, overcoming administrative bottlenecks to ensure shorter waiting times for care.
- There were also comments around using technology to make the health service more efficient through virtual appointments, which could save money. While many patients still prefer face-to-face, there was also feedback accepting virtual appointments where appropriate, as they recognised it could make efficiencies and save the NHS money. This feedback was particularly noted in the Closing the Gap events which centred on budget and efficiency.
- There is an opportunity to introduce a smoother digital system which is designed around patients' needs. For example, offering a space in health records to record the story and needs of those with mental health difficulties or who are neurodivergent, or collecting pronouns for non-binary or transgender individuals. This would help avoid some situations that were shared in the Listen In communities engagement, where patients recalled negative interactions with health services as a result of not feeling their patient history or communication needs were either known or respected. It can also be tiring or traumatising having to repeatedly explain pronouns, mental health challenges or communication needs, so a dedicated space to say this once would be appreciated.

Possible concerns or considerations for the shift:

- Across almost all engagement activities there was some level of fear and anxiety about using digital technologies, particularly amongst older age

groups, those with limited English skills, and digitally excluded groups. This also covered 'inclusion groups' such as those recently released from prison or refugees who may struggle to access the equipment to get online. There was a sense that while the direction of travel is more digital, there will always be people who struggle to use digital booking systems and access digital results online.

- Residents from these backgrounds shared their experiences of struggling with digital systems, such as online booking systems, due to a lack of digital skills, understanding, and confidence. Older age groups particularly felt the anxiety of not being able to access the care they need as they get older, and the feeling that 'everything is going digital'. Therefore, it's important to provide choice of access method to prevent digital exclusion.
- Another consideration is ensuring there is support or training provided to help patients use new technology, particularly if it relates to managing their own health. For example, in the Closing the Gap events, residents discussed the possibility of patients using an app to monitor their INR levels. While the opportunity was positively received as it could be convenient and empowering, there would definitely be a need for training on how to do this correctly and someone to contact if they need any help.

Key gaps in knowledge:

- There was not much evidence around views towards specific technology beyond online booking systems. Most comments centred around older residents or those with additional needs struggling to use online booking systems and occasionally accessing online results. This came across as a general reluctance and a plea for a range of access methods, so that those who are digitally excluded do not miss out on access to care.
- There was a sense particularly in the Closing the Gap engagement that anything that can be done 'behind the scenes' to improve communication and efficiency within and between health services was supported, so this is less likely to need engagement as it is widely seen as a positive development. However, there may need to be some more understanding of how patients feel about the data sharing side of this, as the 'ideal' scenario many describe would involve sharing full patient records with a wide range of partners in different parts of the health system. The implications of this may not be well understood by patients who suggest this.
- Future engagement could explore views towards different uses of technology that could benefit patients beyond booking and test results. For example, innovations that relate to self-management of conditions like app-based or online interfaces to manage things like diabetes, medications, INR

testing, COPD etc. While these were seen as good opportunities, there was hesitation about how these would work in reality.

- Further engagement could also explore the specific support that marginalised groups need in order to overcome some of the barriers to engaging with digital technology. It would be interesting to understand how far communities can (and want to) be upskilled and what they need to do so, and what uses of technology is simply too much to ask and would lead to disengagement. This is likely to be an important line to walk as innovation and use of technology increases, but inequality remains prominent in Bradford District and Craven.

4.3 Shift 3: Treatment to prevention

Positive reaction and vision for the shift:

- In the more recent Closing the Gap events, the consensus was 'the more you can do in prevention, the better' as it is more cost-effective in the long-run and reduces need for hospital care 'downstream'. Participants clearly got behind the 'left-shift' towards services that catch and manage health conditions earlier on and prevent reliance on acute services. This was both from the point of view of a patient (e.g. I would rather stay healthy) and the system (e.g. it costs less to fund prevention and early intervention).
- Prevention extended to tackling societal issues that contribute to poor health outcomes, such as homelessness, alongside health conditions that can be prevented or managed with early intervention such as diabetes and mental health. There was clear acknowledgement that healthy communities don't just rely on health services, and there needs to be a strong partnership approach with housing, education and other sectors. There was also recognition that national and local legislation needs to support healthy lifestyles, for example the number of takeaways or unhealthy food advertising within communities.
- Healthy lifestyles are a major factor in preventative healthcare and were by far the easiest thing to think about when it comes to prevention, particularly relating to education on what makes a healthy lifestyle. Residents did see a role for the NHS to provide support and information on what makes a healthy lifestyle, especially ensuring there is information available that is culturally sensitive and inclusive e.g. different cultural diets, different ways of exercising. However, there was also recognition that people need to overcome other barriers to healthy lifestyles that the NHS has less control over – lots of people know what is good for them but there are challenges that make it harder to do, such as finances, disabilities, transport and

community opportunities. A partnership approach may help overcome some of these barriers.

- Some residents shared positive views on having yearly health checks as a way of picking up any possible conditions or risk factors. Some even requested a detailed bodily 'MOT' as people get older. These general health checks could be provided in communities, which is already happening in some instances, and may be a good opportunity especially where there is low trust of formal NHS services within some communities.
- In some engagement feedback, access to preventative services like screenings and health education was seen as variable. While some participants valued local efforts, others found these services difficult to navigate. Participants shared frustrations about limited awareness and difficulty accessing screenings, vaccinations, and health education. A concerted focus on preventative health could see access to these improve, and there does appear to be an appetite for this.
- Preventative mental health support was seen as a major priority and a theme across all engagement cycles. There was increasing awareness and open discussion of mental wellbeing as a concept, and people appeared to feel confident speaking the 'language' of mental health. Community groups and VCS organisation were seen by citizens as vital in providing preventative mental health support, in particular relating to loneliness and isolation. These groups provided not just companionship but also practical resources, such as subsidised meals and accessible venues, and in some cases support with physical health (e.g. help using new walking aids, support with dementia, transport to appointments).
- Across all cycles there were comments suggesting an opportunity to utilise community groups and centres – which those working within the health care system would commonly refer to as the VCS – to administer prevention programmes. Stakeholders feel there is a strong existing infrastructure already working in the VCS sector with trusted community venues or leaders, which may be available to support multiple types of prevention. Some community centres and groups have formed extremely supportive and close support networks, and are the first port of call for lots of residents rather than primary care. This suggests that at least some prevention work could sit comfortably within the VCS network already in place.
- There is an opportunity within the preventative umbrella to improve health literacy and empowerment on topics like - how to manage health conditions, when to see health professional and what type of health professional to see. An example given in one of the Listen In cycles noted there was a reduction in health visiting post-Covid, and new parents felt unconfident or didn't know where to take their concerns. A positive engagement with health visiting service could pick up a number of concerns for parent and child under the umbrella of prevention or early intervention,

educate them with how to handle different health needs as well as preventing 'wrong door' access going to A&E out of desperation.

- However, it is very important to take these views in the context that citizens and stakeholders found it very hard to prioritise prevention over treatment. They struggled to trade one off for the other, instead most had the view that 'everything needs funding more'. This clearly does not quite reflect the 'treatment to prevention' shift, but rather calls to add more resources to preventative programmes in addition to funding treatment and acute care. When confronted with the possibility of an actual shift, citizens were more uncomfortable supporting the shift away from treatment as they were concerned about the impact on acute care, particularly in the short term before preventative work could have an impact.

Possible concerns or considerations for the shift:

- When the preventative shift was discussed in recent Closing the Gap events, some noted that this would require a mental shift towards prevention for the NHS, as some evidence that patients feel that health services are not currently treating causes of illness but being more reactive. It would also require a mental shift to prevention for the population, who would need to take greater responsibility over their own health and wellbeing to make this work.
- There was some discussion at the Closing the Gap events about increasing cancer screening by reducing age brackets and looking to overcome barriers why people don't take up the offer. Certainly the second point around overcoming barriers may be possible to address within a local strategy.
- There were mixed views on vaccination programmes as preventative healthcare within the Closing the Gap events, suggesting some ongoing community work is needed, as vaccination can be a controversial or misunderstood topic in some communities.
- Some comments suggested there needs to be consideration about access routes into prevention programmes and whether there are likely to be bottlenecks in getting to the prevention e.g. needing a GP referral to access social prescribing or courses such as diabetes management. There were examples of these bottlenecks already in existence, so a further shift to prevention may need to address this.
- Youth work was seen as somewhat of a gap in activities for young people and getting young people early support. In terms of mental health prevention and general wellbeing, there was clear feedback that young people need 'places to go and people to see', so there was a feeling it is important to invest in youth groups as well as quality youth workers who

can help guide young people to early support. Some participants felt that youth services are 'firefighting' and only providing support when it is too late and the family may have been struggling for years.

- Accessing support in schools was noted as difficult, particularly if there are additional needs. There may be opportunities to link with schools within the preventative umbrella, ultimately to promote a better environment for young people and support preventative mental wellbeing, which is important given the lengthy waiting time for CAMHS. Young people described how access to resources such as mental health support services, nutritious meals, and opportunities for physical activity can significantly contribute to wellbeing, as well as relaxed rules on uniform and other inclusivity measures.
- Preventative support and 'waiting well' while trying to get support for mental health or neurodiversity was seen as crucial, particularly for young people where the waiting lists are very long. Although the treatment is still needed, making this not entirely 'preventative', the reality of a very long waiting list suggests that additional support preventing exacerbation is likely to benefit those on the waiting list.
- Mental health was a key issue raised among inclusion groups, but often the experiences shared in these events were far more complex and beyond 'prevention' due to the interaction with addiction and being in prison. This point really illustrates that while prevention was broadly supported, it must go hand in hand with treatment. In addition, for these inclusion groups, the treatment provided must see their interacting challenges (e.g. addiction, mental health) as a whole rather than separate conditions.
- Linked to this, there was some concern across the Closing the Gap events that a preventative shift could be used to mask the phasing out of acute services, particularly for mental health. They noted that anxiety prevention is not always possible, and there is still need for support services to pick up the acute needs of mental health patients.

Key gaps in knowledge:

- There was broad support for the principle of preventative healthcare, although residents were less able to make tough decisions on the trade offs of preventative care. For example, when faced with questions around funding acute services less in order to fund preventative services, this became an impossible choice for residents. Therefore, there isn't a lot of evidence on the acceptability of this reality when it comes to reducing 'treatment' in favour of increasing 'prevention'.
- There is a lot of evidence to suggest a partnership, multi-agency approach is supported by communities, and that the VCS is likely to play a key role in

delivering prevention in this way. This particularly was suggested by VCS stakeholders, but also citizens – with citizens referring directly to the support offered by community groups or centres. There is less evidence on the specific models of this prevention and how it would work, i.e. would NHS prevention services 'pop up' in VCS venues or would preventative programmes be delivered directly by VCS colleagues? This may be something to explore with communities and stakeholders over what they would prefer and what is likely to make the most impact.

- There is an existing body of evidence on barriers to take-up of screening programmes and vaccinations, some of which came through this secondary analysis as well as other pieces of work going on locally and nationally. This is likely to fill most gaps in knowledge, although programmes aiming to increase uptake of these preventative offers may want to do some targeted work with communities who have lowest uptake.

5. Findings: Development of the Place commissioning strategy

The government has also committed to the development of a Neighbourhood Health Service, with more care delivered in local communities, supported by a shift in resources. Bradford District and Craven will be creating their Place commissioning strategy, and want to understand what their citizens think should be part of it. In particular:

- What care needs to happen in hospital?
- What should the 'out of hospital' neighbourhood offer look like?
- What enablers does the NHS need to make this vision a reality?
- What do people and communities need in order to be active partners?

5.1 Hospital for the future

There will always be a need for high quality acute care delivered in hospitals. This section presents views from the various cycles of engagement around what they would like to see from hospital care in the future.

Access to hospital care:

- A clear point that came through all cycles, but particularly the Closing the Gap work, is that the NHS must be free at the point of use and hospital care should be delivered within a reasonable time frame. These are the fundamental expectations for NHS provision. Some residents were worried about the prospect of paying for healthcare and concerned about a gradual erosion of NHS services. There was also evidence coming through in the Listen In cycles of residents paying for private healthcare purely because of waiting lists. There is a risk here of widening inequalities as those who can afford private health insurance or paid-for treatment are accessing quicker care, therefore timely access is a priority for the future.
- There were some stories shared about appointments at hospitals being missed for unnecessary reasons, often due to communication or transport. This suggested that hospitals may need to have transport support available where patients have to attend hospital.
- Carers often shared that they play a crucial role in facilitating hospital visits, managing transport, communication and emotional support. However some carers noted that their contributions were sometimes overlooked by healthcare providers or hospital settings weren't set up to support them, leading to additional stress.

Experiences of hospital care:

- Accident & Emergency (A&E) was a frequent point of concern when it comes to the lengthy waiting times. Many patients reported feeling frustrated and anxious due to the long delays in receiving care. A hospital of the future would have a smoother, quicker A&E experience.
- Adapting the inpatient environment to be more inclusive would be ideal for patients who are neurodiverse, have learning difficulties or dementia. Some Listen In cycles revealed how distressing the hospital environment can be. Could the hospital of the future have a better approach for different needs, or could these needs be met better in the community?
- Over different engagement cycles, participants observed differences in the quality or experience of care between departments and facilities. This variability created inequalities, particularly for patients requiring specialised support or accommodations. Positive experiences often involved attentive clinicians who took the time to explain procedures and involve patients in their care plans. Negative experiences involved feeling rushed, ignored, unable to communicate or patronised.
- Feedback was shared on how the hospital of the future could be made a more inclusive place. Training staff in neurodiverse-friendly communication and interaction was seen as a key step towards more inclusive care. Another example is language inclusivity, with patients who do not speak English being supported by bi-lingual healthcare staff or interpreters being available. LGBTQ+ individuals, particularly those who are asylum seekers, refugees, or from ethnic minorities, reported instances of discrimination, bias, or misunderstanding in hospital settings. Simple training for NHS staff and markers like pride flags, pronouns etc may help overcome this.
- Inclusion groups shared many good experiences when in hospital, especially with the in-reach from drug and alcohol services. But there were also instances where individuals felt dismissed or not adequately supported by hospital staff, such as being told to "just go away and sleep it off". This highlighted the importance of improving healthcare provider understanding of addiction and mental health issues to enhance the quality of care received in hospital. It was noted that some felt this had already improved in recent years, when the engagement was done in April 2024.
- There was widespread feedback suggesting mental health crisis support is seen as particularly difficult to access. People appeared unclear on pathways for crisis support, and there is evidence of being turned away or ‘bounced’ between First Response and A&E over a number of hours, which can be highly distressing and does not give the patient the support they need in that moment. There may be a role for high-quality hospital-based mental health crisis support.

Discharging and linking to out-of-hospital care:

- Shortening post-op stays was looked at in one of the Closing the Gap events, but was not seen to be simple as the idea of sending people home 'before they are ready' was panic inducing. Home-based rehab seen as positive, but it's important that there is still adequate inpatient bed provision and patients don't feel forced home. When they do go home, people suggested it's important that support is there to keep patients safe and reassured. The 'in-hospital' offer needs a joined-up pathway to discharge which relates to the situations of families, as not everyone can provide this care or has the home set-up for it.
- After an acute episode, such as an inpatient stay or operation, people described a long waiting period before follow-up care was offered, such as outpatient clinics and physical therapies. The impact of this was some patients not recovering as quickly as they should, and feeling worried that they have been left alone to deal with their condition and recovery. Examples included gastro clinics, memory clinics for dementia and physio following an operation
- There was evidence across all engagement cycles that residents would like to see an improvement in communication between GPs, Hospitals and patients. People shared stories of either no communication, doubling up on communication, or communication delivered too late. Patients value transparency of information for why things or happening and what is happening, particularly those who are anxious about their health. Another example is poor communication between different parts of the system e.g. GP and pharmacy or blood tests, leaving patients confused and worried their care is going to be interrupted.

Key gaps in knowledge:

- Most feedback under this heading relates to improvements in the quality of care provided in-hospital, and less to do with the actual services that need to be located in a hospital setting. Naturally, A&E and major surgery are obvious services that are likely to remain hospital-based, but beyond this there is limited engagement on services that residents feel should stay in the hospital setting. This suggests a gap in knowledge that could be explored.
- This is likely to be best explored through engagement that provides specific, real examples of services that could go into the community and explains what the implications would be, both for the patient and for the quality of service, as well as other factors like finance, staffing, and impact on how inclusive the service is able to be.

5.2 Out-of-hospital for the future

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.

The evidence presented here from past engagement activities show how residents feel about neighbourhood / community-based healthcare, what they feel would make a successful 'out of hospital' offer and what considerations need taking into account.

Out-of-hospital care models:

- Mobile or satellite clinics were seen as a positive method of providing services in the community and would help with the widespread travel issues reported throughout all engagement (affordability and availability).
- For some health conditions, at-home management and virtual wards were raised as possible ideas, but there was more scepticism about this due to the reliance on technology. Developments of this kind would need to go hand in hand with designated support and take into account the most vulnerable, but overall there was positive feedback from Closing the Gap engagement that it could help people who have to visit hospital a lot avoid unnecessary hassle and trauma.
- There was a call for better integration between community support and formal health and social care services, which speaks to a broader point around the out-of-hospital offer being joined-up and consistent.
- With regard to the geographical placing of services, there is a risk that some communities are better served by the placing of out-of-hospital services and this may impact inequalities. Closing the Gap engagement openly addressed the geography of health inequalities, and though most people recognised that targeted support is needed, the idea of giving more to some communities was not wholly comfortable or accepted. A compromise on some tables was made in that support should be concentrated in more deprived areas but still available to all residents of Bradford District and Craven, because inequality isn't just about postcode.

Utilising Community Hubs:

- Feedback from all cycles of engagement claimed that community organisations have great potential in the delivery of out-of-hospital

healthcare. Some noted that the physical buildings were often underutilised, and could host standard health checks and triaging on basic health issues. Libraries, churches, food banks, community cafes - all have the available space and community standing to offer more than just social groups and activities.

- People are already using community hubs to access direct support for their health through specific groups (e.g. health talks, testing and mental health signposting), as well as indirect support (e.g. socialising, wellbeing support, activities). For some, community groups are an alternative way of accessing health advice to the GP, when they are struggling to get appointments. Health speakers and testing services had received positive reception in some community organisation, with a clear appetite to absorb health information in these trusted environments, rather than formalised healthcare which felt uncomfortable or inaccessible.
- VCS colleagues highlighted that it usually costs less for VCS to deliver services in the community, and that more community services would be a good opportunity to strengthen partnerships between VCS and NHS. These stakeholders suggested that utilising VCS, especially in places that have a particular cultural focus, would support with language barriers and trust.

Community leaders and referral routes:

- Community group leaders may play a role in the out-of-hospital care model, as there were reports of leaders supporting residents in a much more holistic and involved way than expected – offering advice, mental health support, signposting or referrals, completing applications or phoning GPs and much more. It was clear that in some places, leaders are highly trusted and create a safe environment.
- Some Listen In engagement noted that the support of a social prescriber can be instrumental in taking the plunge to access local wellbeing resources and preventative care like community groups. However, there are limits to social prescribing as often they need a referral from the GP.

Support for young people:

- Several engagement cycles suggested that community groups have a positive effect on young people's mental health. Youth groups appeared to help keep young people safe and supported, but generally report having limited resources and are already going along their remit. There may be role for youth work in an out-of-hospital care model, but resources are already stretched.
- Across all engagement, there were stories from children and young people about long waits for diagnosis or support for a range of services but particularly in relation to mental health or neurodivergence. Within these

long waits, they emphasised the importance of 'waiting well' with clear communication and good support making a huge difference to how people felt while waiting for diagnosis or treatment.

- The school environment was often mentioned as a significant factor affecting mental health and the role of schools in supporting children's health was discussed in most engagement cycles. While there is an opportunity to integrate out-of-hospital services into schools, there was also evidence of school staff feeling insufficiently supported to handle mental health needs and a lack of clear responsibility for health services within the educational environment.

Inclusive support for marginalised communities:

- There was widespread feedback on how health services situated in communities (and indeed in hospitals) can be supportive and inclusive of different marginalised communities and access needs.
- Residents from South Asian backgrounds talked about specific challenges in their communities around understanding and acceptance of mental health and neurodiversity, and how this adds an additional layer of difficulty for families. Further comments related to being inclusive of the South Asian diet when recommending lifestyle changes, and having interpreters or bi-lingual staff if English is not their first language.
- Services that adapted to the specific requirements of disabled individuals were celebrated. At a local group, one facilitator ensured participants could access activities like fitness classes, gardening, and peer-led workshops. These programs not only fostered skills but also demonstrated the valuable contributions of disabled people to their communities. Community-based services may have more opportunities to link up with disability-friendly groups to offer inclusive or adapted health services.
- As with hospitals, community settings also need to have trained staff who are respectful and educated on LGBTQ+ health needs.
- Some people requested consistent and wraparound support for families of people in prison or leaving prison, as well as those leaving prison themselves. Similarly, some people experiencing homelessness were frustrated with the lack of specialist support they could access for issues such as addiction and alcoholism. Inclusion groups are likely to need multiple support services at once due to their complex needs, not just health support, so any community health services are likely to benefit from linking into a hub model if looking to support inclusion groups.
- Individuals with ADHD and autism often struggled to find support tailored to their needs. The lack of localised support left many feeling isolated and unsupported, particularly when services failed to account for neurodiverse communication styles and sensory needs.

Key gaps in knowledge:

- There was a lot of evidence around how different marginalised communities would like to be supported, so this is not necessarily a knowledge gap, although there may need to be a mapping and stakeholder exercise to understand whether it is feasible to offer health services that are flexible to all marginalised communities, or if it is better to utilise VCS organisations that support specific marginalised communities, or perhaps a combination of the two.
- Similarly, there may need to be an exercise to understand what is possible to deliver in terms of using youth services and school as a vehicle for out-of-hospital health services.
- The main evidence gap with patients and citizens, as with the in-hospital services, is around what specific services could be provided in the community. On principle it appears that anything that requires regular or ad-hoc appointments or tests is acceptable to be based in the community, in order to minimise travel and disruption. However, when it comes to actually changing service provision, this principle will need testing in greater detail to ensure residents agree.

5.3 Enablers

This section explores any evidence relating to things that will enable the health services to meet the three Darzi shifts and provide a high quality partnership of in-hospital and out-of-hospital healthcare.

Workforce:

- There were persistent comments around staffing and retention challenges in the NHS, noting that it is difficult to provide care and fulfil patient needs without enough qualified staff, which extends to the care sector. A fully staffed workforce would be a major enabler to delivering the vision outlined by health planners and the government.
- In terms of how to meet workforce needs, some engagement activity felt that healthcare career paths could be more straightforward and easy to access, for those who are interested in working or volunteering in the health sector. In particular, some Listen In cycles highlighted interest from young people or refugees and asylum seekers, who aren't typically aware of the career opportunities.
- An additional key enabler, although not one within local control, is improved working conditions and pay for healthcare workers. Listen In

cycles noted a range of current and ex-healthcare workers reporting issues with burnout, poor mental health, low wages, and poor working culture.
- Some cycles noted it would be a positive step to being inclusive of different communities and cultures if health services recruited staff from diverse backgrounds and trained staff on how to be mindful of cultural sensitivities.

Services to support access:

- Support schemes available for marginalised communities who struggle to access care for practical reasons, for example travel costs or specialist transport, equipment or digital exclusion, respite carers or childcare.
- Support schemes for unpaid carers who are helping the people they care for access health services and take on responsibilities that free up health workers. Support could involve financial support, respite care, wellbeing and mental health support, or simply practical things that give recognition to the carer's contribution and role.
- Investment in initiatives and training on how to provide inclusive care to patients from a range of backgrounds, and provide services that support inclusivity, for example easy access to interpretation for languages and BSL.

Infrastructure and facilities:

- There may be an opportunity to provide smoother administrative processes through improved technology and digital infrastructure. It was reported that care can be slowed down by inefficient areas of the system, such as ordering equipment or having to make a request in writing, as well as systems not 'talking to each other'.
- Use of technology could also be used to offer smoother transfer of patient data between services so that they can all access the information they need, with the hope that this will ultimately provide a better patient experience.
- With procurement and estates, some workforce in the Closing the Gap events felt there must be efficiencies to be made in the procurement process and ways to ensure the NHS is getting the best deal on equipment and building contracts.

Partnerships:

- Especially when it comes to prevention work, a clear enabler would be a multi-agency approach, as the NHS alone cannot drive prevention. For example, schools and local authorities have a role to play in education and support to prevent health issues arising.
- VCS stakeholders supported the increased use of community hubs, which can provide accessible care in the community, such as health checks or counselling. The financial challenges facing VCS organisations were raised

by stakeholders, as they would likely need funding to offer these services. Some of these stakeholders noted that it would be a positive step to have more long-term commissioning for the VCS to allow more sustainable investment and employment.

Key gaps in knowledge:

- While some enablers could be found throughout the existing engagement activity, there was not a comprehensive list or full exploration, as this wasn't the major focus of any of the events.
- Future engagement may benefit from a workforce event or programme of engagement with stakeholders to understand what they need to make the Place vision a reality. While the broader points (i.e. staffing, training, technology, partnerships) are clear, there may be value in exploring this in a more specific, meaningful way and how this could practically move forward in the place-based strategy.

5.4 Citizen and community assets

This final section looks at what citizens and communities of Bradford District and Craven need to be active partners in the health service, drawing on any evidence from past engagement activity.

Practical barriers and inequalities:

- The ongoing struggle that many residents face with the cost of living could prevent them from actively participating in the health service and playing their part in creating healthy communities. For example, the cost of nutritious food and exercise activities was repeatedly mentioned, as well as inability to pay for transport. On top of this was lack of access to safe housing, or the cost of care and equipment for individuals, or taking time off work to be an unpaid carer. Financial issues means that health and community engagement become less possible and sometimes less of a priority.
- Access to transport is a barrier. There are issues with transport infrastructure in general (particularly in rural communities) and the affordability of transport. This means people can often struggle to engage with health services and their community. Offering free or affordable transport is likely to be effective, although a more practical option may be to provide services directly in communities.
- More could be done to meet additional communications or support needs (e.g. for those with learning disabilities or limited English skills), which can otherwise be a barrier to engagement.

Community resources:

- Community organisations work hard to tackle social isolation, as engagement activity highlighted the impact on individuals when feeling lonely or unable to connect with their community, which has negative mental and physical health impacts. This was particularly prevalent in older age groups, but not exclusively.
- Community assets, such as community hubs, centres and groups would benefit from any available funding in order to be sustainable and continue to provide the breadth of support currently on offer. Engagement activities in these venues showed they have a strong positive impact on people's physical and mental health. Community assets are in a precarious position due to issues with funding, meaning they are understaffed or only able to offer less than is required, and they felt that relying on volunteers is risky.
- The locality cycles and Listen In activity revealed there are disparities in community assets. Some areas lack community hubs, staff or support groups, which then impacts on residents and these gaps may contribute to inequalities.

Positive relationships:

- For some citizens, there is a need to build trust in the NHS, particularly in marginalised communities as it may prevent individuals from engaging with services. This lack of trust is down to a variety of factors: poor access to care, long wait times, inadequate communications, and a sense of not being listened to.
- Some unpaid carers felt they need more support; they shared that they are not experts on care, mental health, systems or finances so do not feel confident on their own, therefore would benefit from support in navigating this.

Knowledge and education:

- Fostering health literacy came through strongly as very important, which includes how to communicate health needs and also how to use and access health services. It needs to be explained to citizens how and when to use different health services, and how to manage their own health. This is particularly important for those who are unfamiliar with the health service e.g. children, young people, or those who have been in prison or are new to the country.
- There was recognition from some citizens that they have a part to play in managing their health and using services responsibly e.g. turning up to

scheduled appointments, using the right access method. However, this is not widespread and a broader understanding of this may support citizens to play a more active role in the health system of the future.
- Awareness of healthy lifestyles and how this can play a role in prevention and promote overall wellbeing. While there is a base understanding in many communities over what healthy looks like, there is less awareness of how to make this a reality in daily life, particularly when there are competing priorities or practical barriers like cost, culture, disability.

Key gaps in knowledge:

- The evidence from engagement so far suggests that citizens need to know more about how to look after their own health, where to access health services when they need them, and the financial and practical support to make this a reality.
- The gap in knowledge really comes down to specifics (i.e. What do you need to know? What type of transport or communication do you specifically want to see?).
- However, it also depends on how the Darzi shifts manifest as this could help overcome several of these barriers e.g. transport and access to affordable healthy lifestyles. Any future engagement would benefit from waiting until the Place 'vision' is established, and then filling in specific gaps on what citizens need in order to be part of that vision.

6. Conclusions

All three Darzi shifts generally received a positive reception and in principle align with residents' expectations for the future of the health service, as they are ultimately hoping for a smoother, quicker, more accessible experience going forward. There were some overarching themes coming out of all the engagement activity analysed that should be considered when planning the next phase of health and care services in Bradford District and Craven.

There was a clear desire for inclusivity and accessibility across health services for patients of different backgrounds, specifically regarding language barriers, learning difficulties, disability and LGBTQ+. There were examples of excellent inclusive service and examples where patients shared negative feedback. This suggests there may be opportunities to improve inclusivity as services move into communities, as community organisations were often praised for their inclusive approaches.

Further to this, rather than a one-size-fits-all approach, consideration of inclusivity is needed to ensure no-one is left behind in terms of access. This relates to the Hospital to Communities shift and the Better Technology shift, for example, ensuring technology improves efficiency of the NHS without blocking the digitally excluded from access. It also relates to the Prevention shift as some prevention and wellbeing activities are not accessible to all communities due to practical or financial barriers. Once again, service design must consider the needs of the most vulnerable and offer choice where possible.

There are already strong partners and community assets that provide some local infrastructure that could be built upon to realise the Darzi shifts, e.g. community organisations, primary care, pharmacies. However, one of the chief challenges will be communication and cohesion between all parts, as patients already report an inconsistent experience and this is when services are relatively centralised, so moving to a neighbourhood model carries the risk of increasing inconsistency and complicating communication.

The strong established links between the VCS and local communities present many opportunities to use these assets to host health services. However, there are challenges to overcome in terms of patients in different localities getting a variable experience, and how this might impact health inequalities. It is also important to be mindful of those who are not engaged with community organisations, to ensure they are not excluded if health services are provided in this way.

7. Appendix

The documents analysed included:

Engagement cycle	Community / locality	Date	Data
Locality Listen In	Craven	Oct-22	22 slide report
Locality Listen In	Bradford South	Dec-22	25 slide report
Locality Listen In	Keighley	Mar-23	29 page report
Locality Listen In	Bradford West	Apr-23	24 page report
Locality Listen In	Bradford East	Jun-23	23 page report
Locality Listen In	Shipley	Jul-23	19 page report
Community Listen In	Summary report	Aug-24	30 page report
Community Listen In	Inclusion health groups	Apr-24	19 page report
Community Listen In	Children & young people	Feb-24	20 page report
Community Listen In	LGBTQIA+	Nov-24	13 page report
Community Listen In	Disability	Nov-24	13 page report
Closing the Gap	Staff and community	Nov-24	26 page report
Closing the Gap	Locality events	Feb-25	34 page report

Project details

Project number
HEALT01-9666

Location https://qaresearch.sharepoint.com/sites/QaData_S-ProjectFiles/Shared Documents/ProjectFiles/B/Bradford_Health_and_Care_Partnership/HEALT01-9666_Bradford_Secondary_Analysis/Reports/Secondary_analysis_report_v3.docx

Date 27th March 2025

Report status Final

Approved by Georgina Culliford

Authors Georgina Culliford and Ellie Craven

Comments georgina.culliford@qaresearch.co.uk

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

Address
Qa Research,
Merchant House,
11a Piccadilly,
York, YO1 9WB
01904 632039

www.qaresearch.co.uk
Company registration: 3186539

MARKET RESEARCH SERVICES ISO 20252 Cert No. 0475 UKAS PRODUCT CERTIFICATION 036

MRS Evidence Matters™ Company Partner

QaResearch

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:	23 May 2025
Report title:	Place Lead's Update
Report presented by:	Matt Sandford
Report approved by:	Therese Patten
Report prepared by:	Shak Rafiq and Lesley Tillotson

Purpose and Action

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

Previous considerations:

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

Executive summary and points for discussion:

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

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

Outline how this supports our partnership vision and strategy

Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives.
Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.
Our Place - Making our district a great place to live, work and thrive.
Our Partnership – Greater value through the best use of our collective resources, minimising duplication and waste.

Recommendation(s)

The BD&C Partnership Board is asked to

1) receive and note the Place Lead's update

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

This report provides an overview of the partnership context, recent highlights, and forthcoming activities. As such it touches on several areas of the BAF but does not seek to provide assurance on any specific risks.

Appendices

n/a

Acronyms and Abbreviations explained

1. ICB integrated care board
2. HCP health and care partnership
3. BD&C Bradford District and Craven
4. MP member of parliament
5. DHSC Department for Health and Social Care
6. WY West Yorkshire
7. NHSE NHS England
8. ICP integrated care partnership
9. IDVA Independent Domestic Violence Adviser
10. WYPP West Yorkshire Pathfinder Partnership
11. AGH Airedale General Hospital
12. RCN Royal College of Nursing
13. IOF International Osteoporosis Foundation
14. HSJ Health Service Journal
15. GSK GlaxoSmithKline
16. SFPC system finance and performance committee

Supreme Court ruling

On Wednesday 16 April 2025, the UK Supreme Court ruled that the legal definition of a woman is based on biological sex. We know that this ruling has received widespread coverage and has also caused anxiety and concern among our colleagues as well as our wider communities. On behalf of the partnership, Therese wrote a statement confirming the importance of all of us showing allyship with people from the trans community, reminding ourselves of our responsibilities under the Equality Act 2010 and demonstrating the values of inclusion that define the way we work as a partnership. This statement is available on our partnership website. At the time of writing this update (7 May 2025), we were still waiting for further national guidance and how this will impact on us locally.

National context and policy development

Merger of NHS England and Department for Health and Social Care

In March, Wes Streeting MP – Secretary of State for Health, announced that NHS England would be merged with the Department for Health and Social Care. This forms part of the government's stated aims of reducing running costs in the NHS, including reducing head counts across both bodies. At this stage, I want to ensure that place-based colleagues are aware that this work is ongoing and that we await further information on timelines and how a future merged organisation will operate. I will cover the national announcements on ICBs later in this update.

Change of leadership at NHS England

Amanda Pritchard, the previous Chief Executive of NHS England stood down from her role at the end of March 2025. From 1 April 2025, Sir James Mackey took on the role of Chief Executive for NHS England. Since taking on the role, Sir James has announced changes to the leadership team at NHS England that will support the work that happens as part of the transition to a merged organisation. Fiona Edwards has been appointed as the new Regional Director at NHS England for the North East, Yorkshire and Humber. We will keep the board updated on any further changes.

10 year health plan

The government's 10 year plan for health is expected to be published in the coming weeks. The focus will be on three key shifts – from hospital to community; from sickness to prevention and from analogue to digital. The plan has been shaped by a significant national engagement exercise. This has been the biggest ever conversation about the future of the NHS, with over 220,000 contributions from the public and health and care staff. Locally our Bradford District and Craven Health and Care Partnership's Health, Care and Wellbeing Strategy is also being developed based on these three shifts.

New permanent secretary appointed to Department for Health and Social Care

Samantha Jones has been appointed as the new Permanent Secretary at the Department of Health and Social Care. Sam is currently a non-executive director at DHSC, and the Chief Operating Officer for Xlinks, a renewable energy company.

Sam began her career as a nurse in the NHS, and was a hospital Chief Executive before moving to NHS England to lead the New Models of Care programme.

Government launches call for evidence on men's health

The 12-week call for evidence will gather vital insights from the public, health and social care professionals, academics and employers so the government can properly consider how to prevent and tackle the biggest issues facing men from all backgrounds. This will inform a Men's Health Strategy for England. This call for evidence closes at 11:59pm on 17 July 2025.

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

National direction for ICBs to reduce their running costs

NHS England has mandated that all Integrated Care Boards (ICBs) reduce their running costs by 50 per cent by the end of Quarter 3 of 25/26, as part of a broader financial and operational reset. This directive follows previous cost-cutting measures and will require significant changes across the entire health, care and NHS system, including our organisation. In all of this, a focus on quality, productivity and effective working remains. On Friday 2 May 2025, NHS England published the Model ICB Blueprint. The Blueprint has been developed jointly by NHS England and a group of ICB leaders from across the country, representing all regions and from systems of varying size, demographics, maturity and performance.

To deliver their purpose, the blueprint sets out that ICBs will focus on the following core functions:

- **Understanding local context:** assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision
- **Developing long term population health strategy:** Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence
- **Delivering the strategy through payer functions and resource allocation:** oversight and assurance of what is purchased and whether it delivers outcomes required
- **Evaluating impact:** day-to-day oversight of healthcare utilisation, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes

ICBs will also have governance and core statutory functions to ensure they are compliant, accountable, and safe.

As a reminder, the draft high-level timeline our ICB is working towards is as follows:

- our draft future structure and functions should be set out and shared with NHSE by the end of May 2025; and
- the new structure will need to be implemented during quarter 3 (October-December) of 2025-26.

At the time of writing, work on the draft future structure and functions is continuing and colleagues are working through the blueprint to understand what this means for our ICB. We will keep board members updated on progress.

Cathy Elliot appointed Chief Executive of NHS Cheshire and Merseyside ICB
Congratulations to ICB Chair, Cathy Elliott, who will be stepping down from her role at the end of May 2025 following her successful appointment to a new role as Chief Executive of NHS Cheshire and Merseyside ICB. Cathy has been Chair of the ICB since late 2021. Alongside her ICB Chair role, she is also Deputy Chair of the West Yorkshire Integrated Care Partnership (ICP). We also know Cathy from her time as Chair for Bradford District Care NHS Foundation Trust. We wish her well in her new role.

Bradford District & Craven Partnership progress and issues to note

Health, Care and Wellbeing Strategy
We are developing our Health, Care and Wellbeing Strategy – 2025-2035 – to maximise the impact of our partnership, across all aspects of health and care delivery, alongside strengthening and drawing on our citizen voice to shape, take control, support and co-produce the way that services are developed, designed and delivered. Our strategy underpins our Act as One place strategy and will become a core element within both the City of Bradford Council District and North Yorkshire Council Plans. Our strategy will support developments in Craven, such as the Airedale New Hospital Programme, ensuring it aligns with wider health and council plans and services, promoting the government's three shifts, alongside local priorities.

'Foluke Ajayi appointed vice-chair of the NHS Confederation
'Foluke, Chief Executive of Airedale NHS Foundation Trust started her role at the NHS Confederation in February 2025. The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland.

Bradford initiatives showcased to Children's Commissioner for England
Bradford played host to Dame Rachel de Souza, the Children's Commissioner for England, who found out how community insights, world-leading research and people's experiences are shaping services in Bradford District and Craven and across West Yorkshire. Rachel visited Miriam Lord Primary School and Farcliffe Family Hub in Manningham before meeting researchers from the Bradford Institute for Healthcare based at Bradford Royal Infirmary.

Movement launched aimed at making women's health a priority
A movement has been officially launched to tackle the inequalities and challenges faced by women in accessing care and finding trusted information about their health. Across Bradford District and Craven, women have shared the challenges they face in accessing care, finding trusted information, and being heard when they raise health concerns. The insight work presented a very clear message that 'women's

health has been overlooked for too long'. That's why Bradford District and Craven Health and Care Partnership launched the 'Taking Women's Health Seriously' movement at a landmark event with over 200 people at University of Bradford. Join the movement today, visit BetterHealthWomen.co.uk.

Women's Health Grants awarded to community-led projects in Bradford District and Craven

Nineteen local organisations have been awarded funding through the Women's Health Grants programme, a new initiative supporting grassroots projects that will help activate a movement for women's health across Bradford District and Craven. The grants form part of the recently launched 'Together, we can make women's health a priority' movement, designed to ensure that everyone impacted by women's health gets the information and support they need.

Prestigious £4.5m Wellcome Discovery Award boosts Bradford research to tackle childhood health inequalities

The internationally renowned Born in Bradford research programme has received a prestigious £4.5m Wellcome Discovery Award to fund an ambitious eight-year study aimed at addressing childhood health and wellbeing inequalities. The new research will be carried out in partnership with local schools, families, and health professionals, and will involve more than 8,000 children and their families living in some of the city's most disadvantaged areas.

Staying Put in successful West Yorkshire pathfinder bid

Staying Put is delighted to secure and lead on the new Family Court Independent Domestic Violence Adviser (IDVA) delivery model of the West Yorkshire Pathfinder Partnership (WYPP). Since March 2022, the Pathfinder Pilot Scheme has been trialled in the family courts in North Wales and Dorset. The scheme was implemented to trial a more problem-solving approach, which is aimed to improve the court experience and outcomes for survivors of domestic abuse and to ensure that the voice of the child is the focal point in proceedings.

Innovation challenge fund to help set up two health hubs in schools

Bradford District Care NHS Foundation Trust's Better Lives charity has been awarded £199,278 to improve access to health services for local children, young people and their families. This will bring together the Trust's community children's services, Dixons Academies Trust, Oastlers School, member of Exceed Academy Trust, Education Alliance for Life Chances and Citizens UK, The investment over two years will enable 'health hubs' to be set up at the two schools, so children and families can experience earlier and better co-ordinated support in a place near to where they live that they know and trust.

Spreading kindness: an anti-bullying Campaign transforming schools across Bradford

The kindness, compassion and understanding (KCU) anti-bullying campaign is inspiring students across Bradford to lead with kindness and stand up against bullying. Since its launch in February 2020, the KCU Anti-Bullying Campaign has been delivered to 66 schools, won two community awards, and positively impacted the lives of 19,039 pupils across the Bradford District.

Award winners
There have been some notable successes achieved by individuals, teams and organisations across our partnership which I have summarised below. Well done to everyone!

- AGH Solutions have won the award for Data, Security, Infrastructure at the 2024/25 HTN Now Awards for their RAAC management project at Airedale General Hospital.
- Airedale NHS Foundation Trust Neonatal Sister, Chloe Taylor, has received the RCN Foundation Leathersellers' Award for Outstanding Achievement in supporting children and young people's mental health.
- Airedale NHS Foundation Trust Fracture Prevention Service has achieved a Gold Star from the IOF (International Osteoporosis Foundation) Capture the Fracture programme.
- Bradford Teaching Hospitals NHS Foundation Trust picked up the 'best contribution to improving the efficiency of NHS services' gong at the HSJ Partnership Awards for its partnership work with DrDoctor on the Rheumatology Nurse Advice Line.
- A Bradford hospital porter has won an 'Outstanding Contribution to Patient Experience' prize at the prestigious national 'MyPorter' Awards. Laura Ward joined Bradford Royal Infirmary's portering team – part of Bradford Teaching Hospitals NHS Foundation Trust – in December 2023 and is currently working in the Emergency Department (ED).
- Healthwatch North Yorkshire has been recognised at the national Healthwatch Impact Awards. Healthwatch North Yorkshire set out to understand the experiences of adults accessing mental health services.
- Keighley Healthy living was awarded the GSK Impact Award for their efforts in reducing social isolation, addressing health inequalities, and improving physical and mental wellbeing in the community.

Partnership Leadership Executive Discussions – February to April 2025

The focus of our most recent PLE meetings has been on developing our Health, Care and Wellbeing Strategy.

Partnership Board Decision taken out of committee

Partnership Board members should note the following decision that was noted in the margins of a Partnership Board development session.

Annual Planning Guidance
In the Partnership Board meeting on 14 February 2025, it was noted that the first high-level draft of the NHS operational and financial planning submission for 2025/26 was due for submission on 20 February with a final submission due on 20 March. It was noted that due to short timescales it would be challenging for plans to be sighted at the various governance meetings prior to the final submission so the Partnership

Board delegated authority to the Chair of the Board, Place Lead, Chair of the System Finance and Performance Committee, System Lead for Finance and the Director of Operational Finance to approve the final submission on behalf of the Bradford District and Craven Health and Care Partnership. It was noted in the Partnership Board development session on 28 March that approval of the operational and financial plans was given, and the final submission was made by 20 March.

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	7
Meeting date:	23 May 2025
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:	Catherine Smith, Governance Manager, West Yorkshire ICB

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

Previous considerations:

N/A

Executive summary and points for discussion:

Each subcommittee 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 **BD&C Partnership Board** is asked to:
RECEIVE the Bradford District and Craven subcommittee 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:
N/A
Appendices
1. Clinical Forum Triple A Report 2. System Finance and Performance Committee Triple A Report 3. System Quality Committee Triple A Report
Acronyms and Abbreviations explained
1. BD&C: Bradford District and Craven

What are the implications for?

Residents and Communities	None identified
Quality and Safety	None identified
Equality, Diversity and Inclusion	None identified
Finances and Use of Resources	None identified
Regulation and Legal Requirements	None identified
Conflicts of Interest	None identified
Data Protection	None identified
Transformation and Innovation	None identified
Environmental and Climate Change	None identified
Future Decisions and Policy Making	None identified
Citizen and Stakeholder Engagement	None identified

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven Clinical Forum

Dates of meetings: 12th February 2025, 12th March 2025, 9th April 2025

Report to: Bradford district and Craven Partnership Board

Report completed by: Sohail Abbas / John Hartley / Iram Amin

Date of Partnership Board: 23rd May 2025

Key escalation and discussion points from the meeting
Alert:
None
Advise:
• A development session for the clinical forum was held on 9th April 2025, with a primary focus on developing the Bradford District & Craven Health, Care and Wellbeing Strategy. The session outcomes included: o Identification of clinical requirements to inform digital system development o Collaborative engagement in defining success metrics o Strengthen the Clinical Professional Forum's role in strategy development, guidance, and oversight. o Adoption of an outcome-based approach. • Terms of Reference have been updated to reflect the new arrangements and the proposal for new forum lead will be presented to Partnership board for ratification and approval. • ***The Partnership Board is requested to approve the reviewed Terms of Reference for 2025/2026.***
Assure:
• Clinical and Professional Forum will be meeting regularly, discussing and advising partnership on key issues.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: System Finance and Performance Committee

Date of meeting: 24 April 2025

Report to: Health and Care Partnership Board

Report completed by: Mike Woodhead

Key escalation and discussion points from the meeting
Alert:
Regarding System Performance: - *Routine* Children and Yong People Eating Disorder performance has dipped to 72.4% - Notes continued elevated levels of Mental Health OAPs/ private beds - Increased demand on local authority services is leading to increases in the use of independent reablement and other services
Advise:
Regarding System Performance: - A&E performance at AGH remains challenging **Regarding Month 12 finance**: - The committee heard an overview and had a discussion on the financial performance of each individual organisation - BDC Place report a £34m deficit (£11m worse than plan) for year – the adverse variance to plan sits in ICB & AGH - ICB deficit is mainly re CHC and also some overspends on community contracts (eg AQP). **Regarding Closing the Gap**: - The committee discussed the need to reboot and reframe the Closing the Gap Programme, with specific requirement re: o Work across 3 trusts around collaboration, rationalisation etc o Difficult decisions list o Grip and control at organisational level o Programme management resource (one person identified to help) o Revised governance – agreed a proposal to come to this committee **Regarding Committee Effectiveness**: - Agreed that the committee needs more purpose and focus - Proposal to move to quarterly SFPC meetings with monthly forums in between to get into the detail

Regarding AOB:

- Noted AGH capital bids re SDEC extension
- Ministerial letter received by AGH confirming the NHP envelope £1m-£1.5b
- WYAAT agreed standard bank approach - move to mid-point of scale across the board

Assure:

Regarding System Performance:

- Reported slow but steady improvement in overall elective performance
- Improvements (reductions) seen in numbers of patients not meeting the criteria to reside during March
- Perinatal MH performance is still better plan (but some risks on the horizon)
- AGH report a significant reduction in 52 week waits

Regarding Risk Register:

- Considered the risk report
- Consensus that 16 is too low a score for in-year financial risk. Agreed to review for next time.
- Agreed to amalgamate the CHC risk into the overall financial risk

Regarding Terms of Reference:

- Agree minor updates to the ToR.

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 February 2025, 13th March 2025, 9th April 2025

Report to: Bradford district and Craven Partnership Board

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

Date of Partnership Board: 23 May 2025

Key escalation and discussion points from the meeting
Alert:

Primary Care

- **National Screening Program -** 27 practices in Bradford District & Craven (BD&C) have been identified in a National Screening incident involving routine screening for cervical, breast, and bowel cancer, and abdominal aortic aneurysm. Due to a systems error from 2008, patients were not invited for routine screening. NHS England is ensuring patient registrations are completed and all eligible people invited for screening, including those above screening age, to support affected individuals.

Bradford Metropolitan District Council (BMDC)

- **Care Home in Keighley –**The former Registered Manager and a Care Assistant were recently given custodial sentences for the abuse of residents within the home. The offences took place five and a half years ago. The home closed in January 2020. A meeting of relevant managers in the Council will meet to begin to scope lessons learned.
- **Care Home in Bradford North –**concerns about the safety and care quality have arisen. The Council and the Care Quality Commission (CQC) had increased monitoring and conducted several site visits to the service. On 13/14 March 2025, the Council found the owner of the service couldn't make necessary improvements, deeming the care unsafe and ineffective. The Council made the decision to terminate the contract and support all ten residents to move to alternative care homes.
- Ongoing monitoring of one service following Whistleblowing. Improvement plan in place and being monitored. One young person currently places and search for an alternative suitable placement is ongoing.
- Inadequate Ofsted rating received by one provider in Jan 25. One young person in placement. Copy of Ofsted Action plan requested and quality assurance monitoring taking place.

- A 16+ Supported Living provider has been refused Ofsted registration. New requirement for these settings to be registered with Ofsted. Bradford young people are placed in the service and an appeal is expected. Contract and Quality Team are monitoring.

Bradford Teaching Hospitals NHS Trust (BTHFT)

- Increased levels of violence perpetrated against staff across the hospital with incidents requiring Police support. There is an increase of patients were detained under Section 136 that are being brought to Bradford Royal Infirmary Accident Emergency Department (AED) as a place of safety due to the Section 136 suite not being able to accommodate due to capacity and resource.
- Patients attending Emergency Department (ED) with Mental Health concerns remains an on-going challenge both in adult's and children's. Delays in assessments are impacting on timely transfer of care and appropriate placement when needed.

Airedale NHS Foundation Trust (ANHSFT)

- Infection Prevention & Control- Position remains an issue with mitigating actions ongoing, exacerbated by outbreaks of community norovirus.
- Levels of demand and acuity remain high with the organisation moving into OPEL 4 on occasions.
- Increased levels of patient violence remain an issue within ED and on wards.

Bradford District Care NHS Foundation Trust (BDCFT)

- Significant demand for acute inpatient services over late February and early March 2025.
- The Trust formally received the Regulation 28 regarding access for assessment. Response currently being formulated and will be shared once signed off.

Advise:

System Quality Insight, Assurance, Improvement Group update (SQIAIG)

- The planned transfer of the Individual Funding Requests (IFR) neuro rehab service to the Continuing Health Care (CHC) team has raised concerns. The service has traditionally been managed by WY, but approximately 12 Bradford people need case management. The CHC team will now handle the administration process, but there is no clear plan for quality assurance. The high-cost care packages are not currently funded, adding pressure to the service. Consideration of how this could be managed at West Yorkshire level needs to be considered as part of the 'rethink' as we progress with the efficiency savings.
- Martin's Law- Highlighting the need to understand responsibilities and actions required to ensure compliance.

Care Homes

- Regulation 28 issued for Harbour Healthcare Ltd. Two homes in West Yorkshire (Calderdale and Bradford) are currently under Organisational Safeguarding Enquiry (OSE) process and support is being provided by the quality teams and local authorities.

Primary Care

- **Laboratory Information System (LIMS)- LTHFT** & **ANHSFT**. Regular communication sent to GP practices regarding vigilance of results and delay of routine results in first instance. A specific service desk line for primary care colleagues has been set up to respond to existing or new issues, any concerns, or questions. Updates are shared from pathology task group.

Bradford Teaching Hospitals NHS Trust (BTHFT)

- Summary Hospital-level Mortality Indicator (SHMI) has increased slightly to 117.18 from 116.84 for November 2024 (Reported in February 2025). Continued efforts are being made to eliminate the coding backlog. The full effect of this will not be seen in the data for at least 6 months.
- The large increase in patient deaths for December 2024 can be attributed to a much older population of patients, who had an increased number of life-limiting co-morbidities, who were increasingly described as frail from old age, dying from respiratory infections (particularly Influenza) and serious cardiac causes (e.g. Myocardial Infarction, Congestive Cardiac Failure etc.). BTHFT Quality Committee was assured by the paper submitted.

Bradford District Care NHS Foundation Trust (BDCFT)

- Pressure Ulcer training within care homes highlighted. To be followed up via the Local Authority/Safeguarding and System route.
- The Involvement Partners process - The Committee recognised the important role and the further work that was being undertaken within this area was discussed.
- First Response Line – feedback from Involvement Partners was discussed. This would be taken forward.
- The Patient Safety Strategy review was underway.
- Patient and Carer Race Equality Framework (PCREF) have reviewed data on the use of restraint, formal detention and inpatients. The report highlighted differences in experience which need to be addressed by the Trust.

Bradford Metropolitan District Council (BMDC)

- Contract for Independent Visiting and Advocacy for Children in Care under performance improvement plan due to concerns over ability to meet need
- Two Quality Assurance visits taken place in March due to identified quality concerns

Assure:

Bradford Metropolitan District Council (BMDC)

- **Ofsted Inspection Outcomes - Residential Homes-** All homes are kept under monthly review by Contracts and Quality Team and responsive works undertaken following changes to rating. This includes Quality Assurance visits, desktop assurance works and regular reviews of action plans ensuring remedial actions are undertaken in a prompt manner.

Bradford District Care NHS Foundation Trust (BDCFT)

- Pressure Ulcers within the Trust were lower when benchmarked to other Trusts, there was stability of numbers, despite a rising number of service users with complex needs. The Team's dedication and innovative approach was noted. The high numbers occurring in people in care homes was highlighted as a concern.
- Care Trust Way had been utilised to align value streams linked to sustainability and quality within operations. A key focus had been on whether service users were socially/emotionally ready for discharge.
- CQC – there were 5 enquiries in quarter three, a decrease from quarter two and lower than other Trusts when benchmarked. The Trust continued to work transparently with the CQC to highlight enquiries/incidents.
- Complaints process continued to be improved; this was reflected in positive/reduced figures.

Bradford Teaching Hospitals NHS Trust (BTHFT)

- Positive assurance visit from Local Maternity and Neonatal Service (LMNS)
- CQC engagement meeting taken place, no further confirmation of Well Led report publication
- A deep dive into falls data was completed in January. Further discussion around the data has taken place in March to provide more analysis to the Quality Committee.
    - There has been an increase in falls with harm
    - An improved compliance with Multifactorial Assessment to optimise Safe Activity (MASA)
    - Improved completion of post falls documentation.
    - New recommendations from National Audit of Inpatient Falls widens scope of data collection, now includes falls with head injury and all fractures, analgesia administered within 30 mins of suspected bony injury.
    - Full improvement plan in place.
- Data shows an overall decrease in pressure ulcers. However, the trust did see an upward trend in AED. Deep dive to report back to BTHFT Quality Committee in March 2025. The number of pressure ulcers per 10,000 bed days decreased but is still within normal variation. Category 2 incidents are above the control limit but cat 3+ have decreased. During February there were 2 wards/ depts with 4 or more pressure ulcer incidents (Wards 1 and 23). Ward 26 is continuing work on quality improvement projects using the Model for Improvement relating to Pressure Ulcers.
    - ED has completed a staff survey on pressure ulcer care and is reviewing training (this includes 'sweeper' days and e-learning). The team are planning to

concentrate on risk assessment completion in the Amber Zone/HDU with provision of prompts to support staff.

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 Bradford districts & Craven Health & Care Partnership Workforce Programme and the Closing the Gap Programme.
- An update from the Local Authority on the Care Home and Staffing challenges.
- An update on Autism and Attention Deficit Hyperactivity Disorder (ADHD) waits
- Updates on the Quality, Equality and Impact Assessments and the Board Assurance Framework
- An update from BDCFT on the Assurance Statement following a Double Mental Health Homicide Independent Investigation (NHSE) for BDCFT
- An update on the proposed changes in frequency of the System Quality Committee at Place from monthly to quarterly
- Update on the Terms of Reference, Annual report and the Committee Effectiveness Review.

The Partnership Board is requested to approve the reviewed Terms of Reference for 2025/2026; subject to further review depending on the changes required through the changes to the frequency of meetings and the governance and assurance requirements.

Bradford District and Craven Health and Care Partnership ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven (BDC) Partnership Board
Agenda item number:	8
Meeting date:	23 May 2025
Report title:	High Level Risk Report: Cycle 1 2025/26 (March – June 2025)
Report presented by:	Asma Sacha, Risk Manager (WY ICB)
Report approved by:	Sue Baxter, Head of Partnership Governance (WY ICB)
Report prepared by:	Asma Sacha, Risk Manager (WY ICB)

Purpose and Action:			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/com-ment/discuss/escalate	Information ☐

Previous considerations:

Extended Leadership Team Meeting, 9 April 2025; Finance and Performance Sub-Committee, 24 April 2025, Quality Sub-Committee, 8 May 2025.

Executive summary and points for discussion:

This report presents the BDC Place High Level Risk Reports, Risk Log and Risk on a Page Report as at the end of the current risk review cycle (Cycle 1, 2025/26).

Following review of individual risks by the Risk Owner and the allocated Senior Manager, all risks on the BDC Place Risk Register were reviewed by the BDC senior leadership team and then by the Quality Sub-Committee and the Finance and Performance Sub-Committee.

The total number of risks during the current cycle and the numbers of Critical and Serious Risks are set out in the report.

The paper includes the summary of the Board Assurance Framework (BAF) at Appendix 2. The BAF will be reviewed by the Executive Directors of the West Yorkshire Integrated Care Board in the current cycle which will be presented to the ICB Board meeting on 24 June 2025. The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet 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.

With which purpose(s) of an Integrated Care System does this report align?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s):

The Bradford District and Craven ICB Committee is asked to **RECEIVE** and **NOTE** the High-Level Risk Report, Risk Log and Risk on a Page Report as an accurate representation of the BDC Place risk position, following any recommendations from the relevant sub-committees.

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 provides details of all risks on the BDC Place Risk Register. The various ICB Risk Registers support and underpin the BAF, and relevant links are drawn between risks on each.

Appendices:

Appendix 1: BDC Place risk register
Appendix 2: Summary of the Board Assurance Framework Cycle 1 2025/26
Appendix 3: Risk on a Page Report Cycle 1 2025/26

Acronyms and abbreviations explained:

In Appendix 1:

- Static – 'x' archives – risk score has been unchanged for 'x' risk cycles
- Static description – neither the risk score nor its description has changed since the previous cycle
- Reached tolerance – current risk score has reduced to target score so risk may be closed

What are the implications for:

Residents and Communities	Any implications relating to individual risks are outlined in the Risk Registers
Quality and Safety	Any implications relating to individual risks are outlined in the Risk Registers
Equality, Diversity and Inclusion	Any implications relating to individual risks are outlined in the Risk Registers
Finances and Use of Resources	Any implications relating to individual risks are outlined in the Risk Registers
Regulation and Legal Requirements	Any implications relating to individual risks are outlined in the Risk Registers
Conflicts of Interest	None identified.
Data Protection	Any implications relating to individual risks are outlined in the Risk Registers
Transformation and Innovation	Any implications relating to individual risks are outlined in the Risk Registers

Environmental and Climate Change	Any implications relating to individual risks are outlined in the Risk Registers
Future Decisions and Policy Making	Any implications relating to individual risks are outlined in the Risk Registers
Citizen and Stakeholder Engagement	Any implications relating to individual risks are outlined in the Risk Registers

1. **Introduction**

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

1.3 The report sets out the process for review of the BDC Place risks during the current review cycle (Cycle 1 of 2025/26) which commenced on 19 March 2025 and ends after the West Yorkshire ICB Board (WY ICB) meeting on 24 June 2025.

1.4 The report shows all high-scoring risks (scoring 15 and above) recorded on the BDC Place risk register. Details of all BDC Place risks are provided in **Appendix 1.**

1.5 The report includes a summary of the Board Assurance Framework (BAF) which is being reviewed by the West Yorkshire ICB during Cycle 1 2025/26, this is attached at **Appendix 2.**

1.6 The risk on a page/ heat map is attached at **Appendix 3.**

2. **BDC Place Risk Register**

2.1 The West Yorkshire Integrated Care Board (ICB) risk management arrangements categorise risks as follows:

- Place – a risk that affects and is managed at place.
- Common – common to more than one place but not a corporate risk.
- Corporate – a risk that cannot be managed at place and is managed centrally.

2.2 The West Yorkshire Risk Management Policy and Framework was approved at the West Yorkshire ICB Board on 21 March 2023 which details the risk management process including the risk scoring matrix.

2.3 All high scoring place risks and all risks common to more than one place are reported to the WY ICB Board.

2.4 The Place Risk Register will not capture risks which are owned by ICS System

Partners that they are accountable for via their individual statutory organisations.

2.5 This cycle work has been undertaken with risk owners to update their risks, review the risk score and ensure that additional information is complete. This more focused and supportive approach will continue.

2.6 There are currently 33 risks on the BDC Place Risk Register of which 31 are open risks. There are six new risks, no risks have increased in risk score, there are two risks which have decreased in risk score and two risks which have been closed.

3. **High scoring Risks**

3.1. There are 12 high scoring risks (15+) in Cycle 1 2025/26;

Risk ID	Risk Rating	Risk Description	Risk Status
2527	20 (I4xL5)	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 in 2025/26, 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. This may also lead to smaller independent sectors, VCSE organisations and hospices to be disproportionately affected by reduced investment.	New risk to reflect in-year financial position 2025/26. The risk score remains the same.
2447	20 (I4xL5)	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	Static – 3 cycles Work is ongoing on the acute dialysis unit, all resources have been reviewed including the move to additional wards at the St Lukes site. Further updates will be provided.

Risk ID	Risk Rating	Risk Description	Risk Status
		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.	
2173	20 (I5xL4	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures. There is also a risk that BMDC will not be able to set its budget if Exceptional Financial Support is not received from the government. If additional support is not received a section 114 notice will be issued.	Static – 4 cycles
2433	16 (I4xL4)	IN-YEAR FINANCIAL PERFORMANCE There is a risk that the Bradford & Craven Place will not deliver the 2025/26 financial plan of a £31.7m deficit and contribute to the requirement for the ICS to break even (as submitted to NHS England on 27 March 2025). This is due to the significant level of risk contained within organisational plans (including a share of the £33.2m 'system risk' value, currently held within the ICB), and the fact that delivery is predicated on delivering efficiencies of £84.5m. Failure to deliver a break even position will result in: - reputational damage to the BDC Place, BTHT, AFT, BDCT and the ICB; also the impact on the wider ICS. - additional scrutiny from NHS England, - a requirement to make good deficits incurred in future year - likely implications on future access to capital (i.e. would be reduced).	Decreasing. The risk score has decreased from 20 to 16 which is in line with the West Yorkshire ICB financial position.

Risk ID	Risk Rating	Risk Description	Risk Status
		- potential detrimental impact on some patient facing services - potential detrimental impact to staff in the top down approach to cost cutting	
2386	16 (I4xL4)	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. The focus of the Activation contract has created an additional risk of small grassroots VCSE organisations being unable to access support required to support our most marginalised communities. 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. Additionally the public sector's decisions to cut contracts and grants to VCSE organisations supporting the health and care sector are being made in isolation which has a disproportionate negative effect on the sustainability/survival of some critical VCSE organisations.	Static – 4 cycles
2266	16 (I4xL4)	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 £1,000,000 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.	Static – 10 cycles This has been recognised as a standing risk due to the Right to Choose requests. This risk is also on the ICB corporate risk register.

Risk ID	Risk Rating	Risk Description	Risk Status
		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.	
2227	16 (I4xL4)	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.	Static – 2 cycles Review of Adult ADHD service is taking place with the view to develop a business case by September 2025. Medium to long term mitigation of risk dependent on securing additional investment to manage growing demand.
2039	16 (I4xL4)	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.	Static – 14 cycles The business case and new model has been developed to closing the gap, to be delivered April 2026. All providers maintaining a waiting list and wellbeing check completed. ND care navigator to support with offering families support who are on the waiting list.

Risk ID	Risk Rating	Risk Description	Risk Status
			Supply issues with ADHD medication which has impacted on increasing ADHD medication backlogs - this continues in 2025/26.
2519	15 (I3xL5)	There is a risk of an inability to deliver all of the statutory functions of the ICB in regard to AACC due to challenging workforce pressures resulting in risk to organisational reputation, financial efficiency, complaints, challenges and appeals, and staff burnout.	New risk
2314	15 (I5xL3)	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).	Static – 1 cycle

Risk ID	Risk Rating	Risk Description	Risk Status
		This links to risk number 2312 (risk that AFT is unsuccessful in securing funding from the new hospitals programme).	
2312	15 (I5xL3)	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).	Static – 2 cycles
2168	15 (I3xL5)	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.	Static – 13 cycles There are ongoing improvements regarding elective recovery, but some challenges still remain e.g. ANHSFT 4-hour A&E performance. The 2025/26 operational plans have been developed and delivery performance improvements set out in the planning guidance. The risk score to remain the same.

4. **New Risks this Cycle**

4.1. There are six new risks added to the BDC place Risk Register in Cycle 1 2025/26, the new risks 2527 and 2519 are outlined above and;

Risk ID	Risk Rating	Risk Description	Risk Status
2520	10 (I2xL5)	There is a risk that individuals will not be reviewed in a timely manner due to challenging workforce issues resulting in increased cost to the ICB, the ICB not delivering against its statutory duties, or individuals presenting with unmet needs.	New
2518	9 (I3xL3)	There is a risk of the ICB not being able to source high quality and cost effective care for individuals eligible for NHS CHC due to gaps in cost for care and affordable budgets resulting in higher costs to the ICB or individuals presenting with unnecessary deterioration due to unmet needs.	New
2516	9 (I3xL3)	There is a risk of overspend against the AACC budget due to increasing service demand and rising care costs resulting in the Place financial targets not being met.	New
2528	6 (I3xL2)	There is an increased risk of data breach by some of our smaller VCSE providers (21Core20+5 project providers with funding of c£540K in 25/26) Due to the fact that they have not registered for and / or published a recent self-assessment against the NHS Data Security & Protection toolkit, which is a requirement of the NHS standard grant agreement Which could result in reputational damage for the ICB, as well as negative impact to relationships between the ICB and the local VCSE sector	New

5. **Emerging Risks this Cycle**

Risks will be developed with place leads as part of the West Yorkshire ICB organisational change programme in Q2, 2025/26. There is also a new risk in development in relation to shared care.

6. **Change to risk score**

6.1 There are two risks which have decreased in risk score during Cycle 1 2025/26.

Risk ID	Risk Rating	Risk Description	Reason for change
2433	16 (I4xL4)	IN-YEAR FINANCIAL PERFORMANCE There is a risk that the Bradford & Craven Place will not deliver the 2025/26 financial	Risk score has reduced from 20 to 16 to reflect the

Risk ID	Risk Rating	Risk Description	Reason for change
		plan of a £31.7m deficit and contribute to the requirement for the ICS to break even (as submitted to NHS England on 27 March 2025). This is due to the significant level of risk contained within organisational plans (including a share of the £33.2m 'system risk' value, currently held within the ICB), and the fact that delivery is predicated on delivering efficiencies of £84.5m. Failure to deliver a break even position will result in: - reputational damage to the BDC Place, BTHT, AFT, BDCT and the ICB; also the impact on the wider ICS. - additional scrutiny from NHS England, - a requirement to make good deficits incurred in future year - likely implications on future access to capital (i.e. would be reduced). - potential detrimental impact on some patient facing services - potential detrimental impact to staff in the top down approach to cost cutting	position on the corporate risk register of the WY ICB.
2477	9 (I3xL3)	There is a risk of significant adult social care (statutory care provision) market failure and disruption in Bradford place due to insufficient funding being available to fund the changes to the national insurance contributions employers have to make and the cost of pressures around the national living wage and inflation. This may lead to delayed discharge, displaced service users, reduced choice for service users, impact on quality of care and pressures on the wider health and social care system.	The risk score has reduced from 12 to 9. The funding uplift has now been agreed from Bradford Council and includes jointly funded arrangements with the ICB from 7 April 2025, this includes

Risk ID	Risk Rating	Risk Description	Reason for change
			contribution to NI and covers the living wage inflation although the full impact of this has not been realised therefore the cautious approach is to reduce the risk to 9 with a view to review in Cycle 2, 2025/26.

7. **Risks Marked for Closure**

7.1 There are two risks that are marked for closure during Cycle 1 2025/26.

Risk ID	Sub-Committee	Risk Description	Risk Status
2337	Finance Sub-Committee	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 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 regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes. This may also lead to smaller independent sectors, VCSE organisations and hospices to be disproportionately affected by reduced investment.	Closed. The underlying deficit risk for 2024/25 has closed and a new risk has been developed to reflect the new financial year 2025/26.
2417	Finance and Performance Sub-Committee and Quality	There is a risk that there will be further closures to care and nursing homes, and/or reduced capacity due to a lack of experienced registered managers (RMs) and registered nurses (RNs) impacting on quality and ability to support complex people in community potentially causing	Closed. The risk has been merged with Risk ID 2434.

Risk ID	Sub-Committee	Risk Description	Risk Status
	Sub-Committee	delays to patient flow from hospital to community settings.	

8. **Board Assurance Framework (BAF)**

8.1 The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet 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. These risks are owned by members of the Executive Management Team.

8.2 The BAF will be reviewed during risk cycles 2 and 4 by Place risk owners following which the assurance will be provided to Place Committees and the quarterly West Yorkshire Integrated Care Board meetings. The WY ICB Executive Management Team will review the BAF during risk cycles 1 and 3.

8.3 As at the date of this report, there were no changes that had been made to the BAF in places during Cycle 1, 2025/26.

9. **Next steps**

9.1 The risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 24 June 2025. The next risk cycle will be Cycle 2, 2025/26.

10. **Recommendations**

The Bradford District and Craven ICB Committee is asked to;

1. **RECEIVE** and **NOTE** the High-Level Risk Report, Risk Log and Risk on a Page Report as an accurate representation of the BDC Place risk position, following any recommendations from the relevant sub-committees.
2. **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.
3. **RECEIVE** and **NOTE** the Board Assurance Framework summary for Cycle 1 2025/26.

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
2527	10/04/2025	Finance	Enhance productivity and value for money	20	(4x5)	9	(3x3)	Karen Parkin	Mike Woodhead	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 in 2025/26, 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. This may also lead to smaller independant sectors, VCSE organisations and hospices to be disproportionately affected by reduced investment.	1. Joint planning process established across the Bradford District and Craven Place which is used to agree operational plan performance trajectories. 2. Closing the gap programme board and business case process to support shared decision making on the use of resources. 3. Established difficult decisions list containing short to long-term transformation programmes which will now become the focus of 'closing the gap'. 4. Planning principles and financial framework agreed at ICS finance forum which set-out the approach to managing within current resources. 5. Additional financial controls implemented across the NHS system in line with NHSE requirements. 6. Closing the Gap Programme Board established with clear mandate reporting into PLE and FPC. 7. Business Case Appraisal Panel established with a clear appraisal and scoring process for considering cases for investment/disinvestment.	Development of a medium to long term strategic financial plan to demonstrate the path to recurrent balance. Continued development of 3-5 year plan in line with national timelines - ? New governance and business structure at BDC Place to take forward the requirements of the difficult decisions and the longer term plan Control and monitoring structure to maintain pace and impact on implementing the difficult decisions list In connection with the point above, 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. Place based strategy	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.	System wide check and challenge in August and Nov 2024 system wide service review complete and externally facilitated workshop - 4th October 2024. partnership / PLE development sessions on understanding financial plans, difficult choices, transformational change with agreement to change the governance and meeting structure Shared future plans (difficult decisions list) with no surprises	No longer term plan to provide assurance on Need a robust framework for managing programmes. 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.			New - Open
2447	25/07/2024	Both FPC and QC	Improve healthcare outcomes for residents	20	(4x5)	12	(3x4)	Ray Smith	Phillipa Hubbard	Renal Services Capacity - Renal Services Capacity There is a risk that as the demand for hemodialysis (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 Friday) are now open. Plans to extend twilight shifts at Skipton to 6 days per week with funding agreed. Twilight sessions now open 6 days per week at Skipton dialysis unit (Mon-Sat). Sunday dialysis now commenced at SLH. The above will provide sufficient capacity for predicted increase in dialysis patients for 9-12 months. Work continues to increase use of home therapies. Update Q1 - 2025/26: Feasibility studies will be undertaken in Q1, 2025/26 to explore the potential to expand dialysis provision at SLH to provide resilience in the mid-term.	The additional capacity which has been created at Skipton by opening twilight sessions is predicted to be filled within 6 months.. Continue to build capacity in home therapies to decrease the rate of growth of the in-centre dialysis demand. Developing options to expand dialysis capacity including at St Lukes by introducing Sunday dialysis shifts and exploring an increase in the number of chairs. Skipton expansion plan also being worked up. Additional money (£250K) from Spec Comm to explore expansion of Skipton footprint and capacity.	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			Static - 3 Archive(s)
2337	28/06/2023	Finance	Enhance productivity and value for money	20	(4x5)	9	(3x3)	Karen Parkin	Mike Woodhead	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 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 regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes. This may also lead to smaller independant sectors, VCSE organisations and hospices to be disproportionately affected by reduced investment.	1. Joint planning process established across the Bradford District and Craven Place which is used to agree operational plan performance trajectories. 2. Business case process to support shared decision making on the use of resources. 3. Expenditure controls in place to limit new expenditure commitments. 4. System transformation programmes established to support demand management. 5. Planning principles agreed which set-out the approach to managing within current resources. 6. Additional financial controls implemented across the NHS system in line with NHSE requirements. 7. Closing the Gap Programme Board established with clear mandate reporting into PLE and FPC. 8. Business Case Appraisal Panel established with a clear appraisal and scoring process for considering cases for investment/disinvestment. 9. A medium term strategic financial plan is in development in line with national timelines to demonstrate the path to recurrent balance. 10. There is currently a gap of a collective strategy on how we support the VCSE / hospice sector to maintain sustainable services and funding. A proposal is being presented at WY EMT in January 2025 with recommendations to follow.	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. Clarity on the in-year CHC cost pressure will potentially impact the underlying position.	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 1st August 2024. Phase 1 of the system wide service review complete and externally facilitated workshop scheduled for 4th October 2024.	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.			Closed - 2024/25 financial risk closed. A new risk will open to capture the new financial year 2025/26.
2173	17/10/2022	Finance	Enhance productivity and value for money	20	(5x4)	12	(4x3)	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. There is also a risk that BMDC will not be able to set its budget if Exceptional Financial Support is not received from the government. If additional support is not received a section 114 notice will be issued.	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). Medium Term plan Oct / Nov 2024 completion.	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 - 4 Archive(s)
2433	29/04/2024	Finance	Enhance productivity and value for money	16	(4x4)	12	(4x3)	Karen Parkin	Mike Woodhead	IN-YEAR FINANCIAL PERFORMANCE There is a risk that the Bradford & Craven Place will not deliver the 2025/26 financial plan of a £31.7m deficit and contribute to the requirement for the ICS to break even (as submitted to NHS England on 27 March 2025). This is due to the significant level of risk contained within organisational plans (including a share of the £33.2m 'system risk' value, currently held within the ICB), and the fact that delivery is predicated on delivering efficiencies of £84.5m. Failure to deliver a break even position will result in: - reputational damage to the BDC Place, BTHT, AFT, BDCT and the ICB; also the impact on the wider ICS. - additional scrutiny from NHS England, - a requirement to make good deficits incurred in future year - likely implications on future access to capital (i.e. would be reduced). - potential detrimental impact on some patient facing services - potential detrimental impact to staff in the top down approach to cost cutting	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 from WY to BDC to enable more robust budget setting at place through the planning process. 3. Review of financial principles, horizon scanning and monitoring of financial position via the West Yorkshire ICS Finance Forum as well as monitoring within each organisation. Regular reporting to the BDC system finance and performance committee and key messages to BDC PLE. 4. Implemented additional controls to manage recruitment and non pay expenditure. Other 'grip and control' measures implemented at organisation level. 6. Use of Closing the Gap programme board and business case approvals panel to focus on key strategic and system efficiency opportunities. Clear appraisal and scoring process in place. (NB: governance is under review) 7. Monthly budgetary control procedures and reporting including close monitoring of efficiency saving plans	1. Saving schemes not fully identified to achieve efficiency target 2. Deficit plans in 2 providers with no longer term solution 3. Absence of a contingency in financial plans to mitigate against unplanned expenditure or efficiency delivery shortfall 4. No plan to deal with the BDC share of the stretch control targets - share of the system risk (total of £33.2m in 25/26) between the ICB and providers. 5. Difficult decisions lists established, some decisions/actions taken but a coordinated system approach is required. Need to identify a programme/project lead for every scheme and implement a process for monitoring, unblocking, holding to account, delivery etc 6. Governance and business framework required to manage the above. 7. Some gaps identified in the PWC review of controls - need re-visiting to ensure implemented and followed.	1. Overview of financial performance and risk in BDC SF&P committee with key messages to PLE. 3. Closing the gap board and business case approvals panel receives regular updates. 4. Organisational checkpoint and system oversight meetings. 5. Deep dives as part of financial planning process with further in-year ones when necessary 6. NHS England review of financial position on a monthly basis 7. NOF 3/4 framework and additional DoF led scrutiny of specific NOF3/4 provider organisations 8. Outputs of PwC assurance work and associated action plan	1. BDC Place plans approved by SF&P committee with a PLE development session to ensure knowledge and understanding by senior execs. 2. Financial planning assumptions were subject to peer review and challenge across the WY ICS, particularly for those organisations in deficit Quarter 1 system wide check and challenge session scheduled for 1st of August 2024. Phase 1 of the system wide service review complete and externally facilitated workshop scheduled for 4th October 2024.	1. Further review of risks and mitigations leading to additional unmitigated risk with no formal route to address 2. No formal requirement to achieve any further control total (linked to approach for distribution of £33.2m system risk) 3. Formal assurance structure surrounding the system difficult decisions and how this is managed N/A			Decreasing
2386	09/10/2023	Both FPC and QC	Improve healthcare outcomes for residents	16	(4x4)	12	(4x3)	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. The focus of the Activation contract has created an additional risk of small grassroots VCSE organisations being unable to access support required to support our most marginalised communities. 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. Additionally the public sector's decisions to cut contracts and grants to VCSE organisations supporting the health and care sector are being made in isolation which has a disproportionate negative effect on the sustainability/survival of some critical VCSE organisations.	• VCSE voices in key decision making arenas and partnerships. This is being strengthened through the Activation Contract. • VCSE system lead post holder involved in Wellbeing Board, priority boards, ICB, PLE, PLT and other key decision making bodies. • The VCSE and commissioner forum which has a remit to develop conversations in place about shared approaches to commissioning is currently on hold. • VCSE Representation on the 'Business Case Approval Panel' and 'Closing the Gap Programme', ensuring decisions consider the views and impact on all partners. • Through the Activation Contract MyCake diagnostic tool we are seeing potential weaknesses in VCSE organisations early and we are keeping a record of impact.	• An annual programme (4 – 6 days a year) of visits to VCSE organisations so public sector staff could better understand the value, pressures and circumstances of VCSE organisations across the BDC footprint (building on successful pilot) was established in 2024 but staff are struggling to find the time to attend. • System wide commissioning strategy (to be developed from or replacing adult social care one) is currently on hold. • System support to enable VCSE organisations delivering health and care services to ensure they have robust and effective IG systems is on hold. • There has been no active progress regarding 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 new Activation Contract will support VCSE organisations who are supporting our Health and Care Partnership, although the capacity to do this has significantly reduced. - Taking a system approach to the reduction of contracts output - there has been	• Activation 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. This is resourced by VCSE infrastructure • Appointment of Insight and Impact Manager will support the oversight of the sustainability of the sector risk.	• The Activation Contract is now being delivered. VCS ISOs, Council and health commissioners are working collaboratively to deliver the best support within reduced resources.	• MyCake diagnostic tool resourced through the Activation Contract is providing real-time information about the sustainability of VCSE organisations supporting the health and care system. • The reduction in the Bradford infrastructure contract has impacted on the assurance activities and active involvement of the VCSE in all strategic meetings due to reduced financial and human resource.			Static - 4 Archive(s)
2266	03/04/2023	Finance	Tackle inequalities in access, experience, outcome	16	(4x4)	4	(2x2)	Emma Hughes	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, the assessment request for right to choose would significantly increase. However, this is planned for April 2025 via the WY Neurodiversity Team. Business case approved at place for ND referral and assessment and support, which will reduce requests for right to choose assessments. April 2026. Likely increase use in right to choose. Procurement and contract to be issued to approved providers, increase quality but not reduce costs - May 2025 (WY work) 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 and Autism - Ongoing 2025/26. WY programme being developed, specifically around Right to Choose, AQP and shared care AQP and tariff work - ongoing	Furthering health inequalities by not being transparent to the population's constitutional Right to Choose and making sure this route is accessible to all. A letter has been developed and is awaiting system sign off but this is likely to increase right to choose referrals. 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.	Developed a letter for those accepted onto waiting list to provide transparency around waiting times and a letter to support reasonable adjustments in school. Work taken place on 2024/25 backlog - long waits in services, appear to correlate with an increase in this route. FAQs have been developed to support with shared care in collaboration with the LMC. Shared issue across West Yorkshire and work due to take place around a joint approach and tariffs which is due to conclude Dec 2024	Consolidated contracting team now checking robustly invoices and appropriate contracts are in place.	An uncontrolled cost - this is arranged via GP and provider with no ICB oversight until assessment is completed. This is a national issue.			Static - 10 Archive(s)
2227	02/02/2023	Quality	Tackle inequalities in access, experience, outcome	16	(4x4)	6	(3x2)	Emma Hughes	Sasha Bhat	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 Programme Board. BDCFT have allocated additional non-recurrent financial resource to increase BANDS ADHD capacity. Uncertainty as to whether the funding will continue. Further conversations will be taking place whether further funding is available for BDCFT (May 2025) Review of Adult ADHD service is taking place with the view to develop a business case (September 2025)	Healthy Minds PB to explore and determine key options to deliver a sustainable adult ADHD service. No agreed Adult ADHD strategy or plan to address growing demand/capacity gap and revise Adult ADHD Pathway. PLE aware of the wait in Adult ADHD (22 years).	Briefing on current state of BANDS adult ADHD to PLT. Business case being developed; work with other areas commenced, WY work on AQP and tariff commenced due to end in September 2025; pilot models of assessment on inpatient wards in progress and picked up in LD/ND delivery groups. There is an identified clinical lead for BDCFT - Adult ADHD pathway.	Briefing on current state of BANDS adult ADHD to PLT. Monthly data reporting to commissioners continues. 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. Focus piece of work commencing reporting to the healthy minds board.			Static - 2 Archive(s)
2039	11/07/2022	Quality	Improve healthcare outcomes for residents	16	(4x4)	6	(3x2)	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	The business case and new model has been developed to closing the gap, to be delivered April 2026. All provider maintaining a waiting list and wellbeing check completed. ND care navigator to support with offering families support who are on the waiting list. Ongoing support. Commissioned Bradford Early Advice Team (BEAT) via aware to provide support while waiting - in place and ongoing 2025/26. An electronic system was developed for use in April 2025 and timescales given to the provider to migrate all patients to this new system by July 2025.	See controls above	Minutes of PLT and PLE. Minutes of Systems Finance and Performance Committee. Minutes of System Quality Committee. Full engagement in the ICB led deep dive on autism and ADHD pathways. Removed requirement for diagnosis to access support.	The patient tracking list (PTL) gives us oversight of the Autism/ADHD waiting list. 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. Work with WY continues to take place to support regional working. Introduced clinical prioritisation criteria to ensure the most in need are prioritised.	Referral numbers continue to increase, impacting on our ability to deliver a reduction on the overall waiting list numbers. Supply issues with ADHD medication which has impacted on increasing ADHD medication backlogs - this continues in 2025/26.			Static - 14 Archive(s)

2519	08/04/2025	Quality	Improve healthcare outcomes for residents	15	(I3xL5)	9	(I3xL3)	Vickie Milner	Grainne Eloi	There is a risk of an inability to deliver all of the statutory functions of the ICB in regard to AACC due to challenging workforce pressures resulting in risk to organisational reputation, financial efficiency, complaints, challenges and appeals, and staff burnout.	- Completion of staffing compliment and structures work - Work to be undertaken to understand capacity and demand across Place - Regular staff supervision and 1-1s in place to address any wellness/wellbeing issues - support of organisation to recruit clinicians into post outside of workforce controls	- Sickness absence due to work-related conditions - inability nationally to recruit into clinical posts - inability to retain all staff due to high workload demands, nature of interactions with patients/representatives as part of CHC process, or other patient representatives (external companies/legal firms) Financial challenges of increasing the workforce in current operating model, even if the workforce is available."	- Capacity and Demand modelling will identify any potential areas of efficiency/inefficiency - Ability to consider economies of scale with development of WY wide functions	- Increased number of applicants for clinical posts due to reduction in use of agency staffing across the ICB - reduction in leavers over last 12 months - Staff have settled into the new structures and ways of working since the organisational change programme.	- Significant staffing gaps remain, particularly clinical - AACC activity continues to be a consistently challenging environment for all staff, clinical and non-clinical due to the nature of the work and implications of decision making - Relationships at Place with Local Council can be strained at an operational and strategic level			New - Open
2314	05/06/2023	Both FPC and QC	Improve healthcare outcomes for residents	15	(I5xL3)	6	(I3xL2)	Matt Sandford	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).	Overall Programme SRO is Chief Executive. 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 £18.6m 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 Inspections 8. Building Information System (BIS) collates RAAC data for more efficient reporting 9. Operations Director for RAAC (this role also interfaces with new hospital programme) and Director of Estates appointed.	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. Situation extends beyond RAAC panels as deterioration in structural frame, corbels. This is now a routine process. 6. 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 Securing the Future Programme meetings - Risk summit discussions - Meeting with NHS England national RAAC team - Ferro scanning of all building - emerging industry scanning available - 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.	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 - 1 Archive(s)
2312	05/06/2023	Finance	Improve healthcare outcomes for residents	15	(I5xL3)	10	(I5xL2)	Lesley Tillotson	Matt Sandford	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). In September 2024, Airedale NHS Foundation Trust received permission from the Government to proceed with the New Hospital project, despite an ongoing review into the wider New Hospital Programme - with confirmation that the project would proceed at pace due to the substantive safety risks associated with the RAAC issue. However the risk remains that the commitment to replace before 2030 overruns, or that a significant RAAC incident could occur ahead of this date.	1. Programme team has secured a place on the New Hospital Programme (NHP) with the NHP committing to prioritise RAAC Trusts in line with the Governments direction and so focus on completing the Airedale project by 2030. 2. Securing the Future Committee, Programme Board, Delivery Group and Workstreams in place to oversee New Hospital Programme and remedial RAAC works established from November 2023 3. Securing The Future Programme Director for new hospital has been appointed in April 2024 (umbrella title for both RAAC and NHP) 4. Securing The Future Programme developed 5. 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	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 4. Securing the Future board reports to programme board and committee 5. Execs RAAC reports 6. 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 Hospital Programme.	N/A		There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to delivery consistently high quality care.	Static - 2 Archive(s)
2168	17/10/2022	Finance	Improve healthcare outcomes for residents	15	(I3xL5)	4	(I2xL2)	Sohail Abbas	Kerry Weir	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	System F&P Committee meets bi-monthly and planning now undertaken on a system footprint. System performance and recovery dashboards in place Transformation programme's supported to monitor delivery and impact upon performance 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. Oct 2024 - H2 plans are being reviewed as part of winter planning. Apr 2025 - 2025/26 operational plans developed and deliver performance improvements set out in the planning guidance	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 at ANHSFT from the 25th July to support improvement in A&E waiting times. Oct 2024 - Improvements being seen in some areas (ANHSFT cancer targets, diagnostic performance) but in general performance remains below national standards. Apr 2025 - Ongoing improvement r.e. elective recovery, but some challenges still remain e.g. ANHSFT 4-hour A&E performance	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 - 13 Archive(s)
2486	24/01/2025	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I2xL3)	Collette Brauns	Helen Farmer	There is a risk of physical and psychological harm and longer waiting times for patients in Bradford and Craven place who require a Tier 3 weight management service due to the closure of the service at the previous provider due to capacity issues in March 2024. This may result in an increase in referrals though the Right to Choose patient choice pathways with an increase in expenditure, an increase in referrals to Tier 4 bariatric services therefore impacting on longer wait times and it could have a detrimental impact on the quality and suitability of services for our local population in Bradford and Craven.	1. Regular discussions at Executive level to ensure awareness of the risk and oversight of the development of a replacement service. 2. Regular communications with primary care to advise patients of the position if they raise concerns 3. Ongoing work to develop new model of delivery 4. Regular communications to the public so patients understand that access to the new medications will be prioritised to those who need it the most. 5. Right to Choose referral monitoring (monthly)	1. Current financial position will result in us being restricted in the service we can commission. 2. Not all practices will read the communications issued or share these updates with patients. 3. Awaiting guidance from NHSE 4. Wider media influence and public demand 5. Lack of ability to mitigate any referrals to Right To Choose providers. 6. Limited control over the quality of the service for our patients as our local WYICB does not hold a direct contract with the provider. 7. Additional private providers may become available for referrals. 8. Each place has different arrangements in place regarding pathways and providers.	1. Worked with Bradford Care Alliance to agree a process to communicate to the 1,130 patients who were on the previous waiting list for specialist weight management services and from mid-April, BCA and GP practices will be contacting patients. 2. Raised the issue at PLT in March 2024 and again in September 2024 and December 2024 to ensure that strategic leaders are sighted. 3. Fixed agenda item at the fortnightly Weight Management Steering Group. 4. Exploring new delivery models with the other places across the ICB.	See above	1. Now received signed data processing agreements from every GP practice to meet IG requirements. 2. Changes happening nationally with new medications means that it is a challenging time to design and implement new service models. New national NHS Commissioning Guidance due out week commencing the 24/3/25 3. The Closing the Gap programme is looking to make reductions rather than investments into new services. 4. No agreement yet of a consistent approach.			Static - 1 Archive(s)
2482	14/01/2025	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I3xL2)	Leanne Cooper	Justin Tuggey	EPR (Electronic Patient Record) There is a risk of an increase in clinical risk and workload and across system partners including primary care due to the transitioning of electronic patient records from SystmOne to Millenium use across the majority of acute services Airedale NHST Foundation Trust. This could lead to potential delays to referrals being actioned, a delay in the receipt and sharing of key discharge information from Airedale NHST Foundation Trust to external stakeholders including primary care colleagues which could impact patient outcome, experience and appropriate follow up intervention.	A clear programme plan that reflects the immediate and long-term strategic goals of EPR deployment. A robust governance and reporting architecture to support effective delivery, oversight, and assurance of the programme plan. Securing sufficient financial capital to enable programme delivery. Ensuring good data insight and intelligent practice exists across system partners. Oracle Health Gateway process. Strategic delivery partner.	Securing sufficient digital capital funding for 2025/26 by August 2025. Capacity of shared domain due other partners requirements (C&H and BTH). Confirmed in detail plan no later than June 2025. Ability to secure skills and expertise on site in the timescales available. Confirmed in detail plan no later than June 2025.	1st line : (Programme) Clinical Risk management process in place to identify and monitor mitigations impacting on clinical safety exists, and reports through existing programme 2nd line (Organisation Oversight) EPR Transformation Assurance Group Revised reporting line to FPDC 3rd line (external / regulator) Independent external review by PwC commissioned and completed External delivery partner External assurance to be provided by NHSE at appropriate time intervals Oracle Health Gateway process NHSE Digital assurance process	See above section	Provision of external capital funding yet to be confirmed – expected August 2025. Sufficient skills and expertise on site – expected as part of replanning with strategic partner by June 2025.			Static - 1 Archive(s)
2448	25/07/2024	Quality	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Jorge Zepeda	Rose Dunlop	There is a risk of major outbreaks of infectious diseases like measles, flu and COVID-19 requiring rapid escalation of a multiagency response beyond business as usual. The risk is due to low uptake of vaccines, in particular MMR, COVID-19 and flu alongside community circulation of pathogens including new variants of respiratory viruses and is aggravated by unclear responsibility for commissioning key health protection functions like surge vaccination, prescription of antivirals, community testing, and clinical assessment of exposed individuals. Major outbreaks in unvaccinated groups could result in high number of cases overwhelming capacity of the healthcare, social care and public health systems. Delayed and/or insufficient response to outbreaks because of unclear responsibilities could further increase spread, fatality rate and pressure on services. The risk is greater in areas where there are other vulnerabilities eg poor housing conditions.	Multiagency plans to increase uptake of vaccines at place level: • Bradford Health Improvement Plan (BHIP) coordinated by the PHPT in NHSE • BDC Multi-Agency Influenza and Covid-19 Plan • Bradford COVID-19/flu vaccine inequalities plan Memorandum of Understanding (MOU) between LA, NHS/ICB, UKHSA to respond to PH emergencies and incidents – currently under review (2025/26), to clarify roles and responsibilities for initial response to disrupting outbreaks, including funding and commissioning of response. WY ICB is scoping options for commissioning one or more providers to deliver the healthcare components of an outbreak response.	Declining uptake of COVID, flu, MMR and pertussis vaccines. High levels of vaccine hesitancy particularly in most deprived areas and among ethnic minorities and migrant groups. Unclear responsibility across H&CP partners for critical elements of local response to major outbreaks including escalation of swabbing/testing, clinical assessment, and antiviral prescribing. This gap is being adressed at WY and place levels via commissioning of an outbreak response provider and review of the local MOU on health protection respectively.	Actions from the BHIP are reviewed within the Bradford Immunisation and Screening Operational Group chaired by the NHS immunisation and screening place Lead, that meets on a quarterly basis with multiagency partners. Further subgroups have been initiated e.g. Childhood Immunisations and MMR. Any updates, issues or emerging risks are highlighted to the Bradford Health Protection Committee which is held bi-monthly and chaired by the Bradford Director of Public Health. A new responsible officer for health protection was appointed at WY ICB with a mandate to lead on the NHS health protection responsibilities and address gaps in outbreak preparedness and response identified regionally by UKHSA. A regional health protection oversight board embedded into the WY ICB governance structure is in place. A West Yorkshire Vaccination Oversight Group for all five areas across the WY ICB is being implemented.	Actions from the BHIP are reviewed within the Bradford Immunisation Operational Group chaired by PHPT Place Lead, NHSE that meets on a quarterly basis with multiagency partners. Further subgroups have been initiated e.g. Childhood Immunisations and MMR. Any updates, issues or emerging risks are highlighted to the Bradford Health Protection Committee which is held bi-monthly and chaired by the Bradford Director of Public Health. A new assistant director for health protection was appointed at WY ICB with a mandate to lead on the NHS health protection responsibilities and address gaps in outbreak preparedness and response identified regionally by UKHSA. A regional health protection oversight board embedded into the WY ICB governance structure is in place. A West Yorkshire Vaccination Oversight Group for all five areas across the WY ICB is being implemented.	Currently we have no forum such as a West Yorkshire Vaccination Oversight Group for all five areas across the WY ICB to drive forward improvements on a regional footprint and share good practice from other areas.			Static - 3 Archive(s)
2434	29/04/2024	Quality	Improve healthcare outcomes for residents	12	(I4xL3)	9	(I3xL3)	Angela Thompson	Jane Wood	There is a risk of poor quality of services and care and nursing home closure as a result of insufficient social care workforce (care workers and senior care assistants) to deliver safe and quality care services due to a lack of interest/supply from potential domestic workforce The number of overseas recruits has significantly dropped due to immigration rule, licence revocations and unsuitability of some displaced workers . Care sector terms and conditions, pay and progression are a primary reason for a lack of interest from the domestic workforce. This is potentially causing difficulty in maintaining safe services and delays in hospital discharges.	1. Robust data to monitor impact of the immigration changes in terms of reduction in numbers and increasing % of care vacancies as a result. 2. Support in place via International Recruitment Hub to support ethical and sustainable recruitment of overseas workers including bursaries, information guidance and support.	1. Data quality for social care sector can be variable, meaning oversight is based on incomplete data and anecdotal evidence including UKVI figures. 2. Time lag from data available from Skills for Care ASC-WDS prevents us giving real time picture. 3. Inability to significantly improve terms and conditions to attract more domestic workforce.	1. Quality assurance are monitored by system quality committee. 2. Joint commissioning arrangementsbetween the council and ICB which means we are monitoring quality for ICB.	N/A	People Committee has now been disbanded.			Static - 4 Archive(s)
2422	27/03/2024	Quality	Improve healthcare outcomes for residents	12	(I4xL3)	9	(I3xL3)	Andrew Milner	Faeem Lal	There is a risk that in the long term Bradford place are unable to deliver high quality health and care services to the People and Populations we serve. To date, the NHS Long Term Workforce plan has failed to deliver a sustainable domestic supply for the health and care workforce. Funding linked to LTWP is unlikely to be forthcoming in the short term due to announcement that plan will be refreshed in summer 2025 aligned with the 10 year NHS Plan.	Development of a data driven approach to identifying areas of most acute risk, meaning resource can be directed accordingly. Utilisation of system workforce fora including People Priority to develop shared approach to international recruitment. Engagement with WYICB and national partners. Consolidation of collaborative entry level recruitment (ELR) across place supported by the district's SkillsHouse Partnership (enabled through Bradford Council). This programme is now in its second phase, having shown substantial successes through the phase 1 social care ELR project. Programme to build placement capacity actss BDC system in order to develop pipeline for future registered workforce. Place based Learning Needs Analysis process in development Place based approach to operational workforce planning to be commenced early 2025 upon publication of planning guidance West Yorkshire ICB Workforce Working Group focusing on innovative workforce development has been formed, with BDC system representation.	Accurate workforce data around social care sector means assessing demand is challenging Detail of implications of three Darzi Shifts awaited as this will provide some calrity on workforce transformation and development initiatives required Lack of clarity of national funding arrangements for workforce transformation	Data quality issues mean that ability to identify most acute areas of workforce need remains limited. Phase 2 focusing on health ELR is live and continues to work on engaging all the Trusts to ensure a successful outcome. Business case for extension of Careers Ambassadors programme until March 2026 to be taken to ICB Exec on 03/10/24 for consideration.	Operational workforce plans for BDC system being developed, with second cut submitted w/c 17th March 2025. Cross system workshop scheduled for 25th April 2025 to ensure cross system alignment of plans and identify system wide priorities.	Data quality issues mean that ability to identify most acute areas of workforce need remains limited. Early indications suggest student numbers on health and care related undergraduate degree programmes have seen a decrease for 24/25 academic year.			Static - 5 Archive(s)
2420	27/03/2024	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I3xL2)	Andrew Milner	Phillipa Hubbard	There is a risk that current educational programmes are unable to meet current and future demand for registered staff across all clinical professions due poor pass rate and unsuitability for employment upon completion of studies. This generates a risk that the future clinical workforce will be insufficient to meet the increasing demands of BDC patients, service users and populations.	Establishment of programme within BDC People Priority to focus upon non-medical clinical placements and quality of clinical education. Placements project manager commenced in post 12/08/24 with remit focussed on quality improvement as well as quantity of placements. Engagement mechanisms with sectors to ensure suitability of graduates for roles within the system, with primary care an area of focus.	Quantitative information around proportion of graduates deemed unsuitable for employment.	Regular reports from placements programme on level of risk into workforce programme board (with escalation to PLT/ PLE/Partnership Board). Reporting at sectoral groups including BDC and WY primary care workforce fora. Qualitative feedback from system leads (including DoN and lead AHP) on issues within specific professions	Programme established and engagement from across partnership including social care, primary care, VCS, FE and HEI sectors has been excellent. Programme priorities agreed with full workplan established. WYICB engaged to ensure place based work is aligned with work undertaken at a West Yorkshire level. Ongoing dialogue between education providers and employing bodies to resolve any issues arising	N/A			Static - 5 Archive(s)

2419	27/03/2024	Quality	Improve healthcare outcomes for residents	12	(4x1.3)	9	(3x1.3)	Andrew Milner	Jo Harrison	Due to demand across the health and care sector and limited resource, there is a risk that traditional workforce models and pathways are not sufficiently innovative to create a sustainable workforce pipeline or efficient pathways to meet the needs of populations. This is contributed to by insufficient head room for clinical and service leads to engage, insufficient transformation funding (including the cessation of national workforce development funds) and a lack of transformational resource.	Engagement across the BDC Partnership (including through priority programmes, PLE and broader governance structure) to identify areas of pressing need so available resource can be directed accordingly. System approach to review and increase workforce transformation and OD capacity through BDC Quality and Safety and Finance Committee. Along side the workforce Programme Board. Alignment with system wide 'closing the gap' process to ensure that sufficient capacity is in place for all transformation initiatives, including those related to workforce West Yorkshire ICB Workforce Working Group focusing on innovative workforce development has been formed, with BDC system representation. Specific streams on innovation and workforce supply will contribute to workforce innovation.	1. Whilst improving, system based mechanisms for identification of need remain limited. Funding to support double running of workforce transformation schemes and increase of transformation and OD resource not currently possible. 2. Mechanisms for identifying and agreeing capacity to support workforce and service transformation are also limited. 3. Impact of operational planning guidance and wider NHS structural and capacity changes (at both provider and ICB level) means the likelihood of this risk has increased through a reduction in headcount in transformation on administrative functions coupled with focus on structural changes.	Regular updates to Programme Board and escalation route via PLT and PLE Utilisation of integrated workforce data report to identify areas for prioritisation Place based Workforce Planning Group to identify preiority areas Interaction with BDC Priority Programmes to identify areas of pressing need	1. Refreshed programme and use of data centric approach early in development and therefore progress to date is limited. 2. Operational plans for 2025/26 (currently in development) will offer clear identification of priority areas. 3. Workshop planned for late April to identify system wide priorities based upon submitted plans. 4. High level of engagement across sector through BDC Workforce Priority to date. 5. Development and publication of BDC Health and Care Strategy will help identify areas of pressing need.	Availability of data to create consistent narrative and buy-in to programme of work across the partnership. Awaiting Governmental detailed response to the Darzi report, to enable consideration of workforce implications including detail of refreshed workforce plan			Static - 5 Archive(s)
2418	27/03/2024	Quality	Improve healthcare outcomes for residents	12	(3x1.4)	6	(3x1.2)	Andrew Milner	Faeem Lal	There is a risk that the partnership is unable to optimise its role in social and economic development of BDC, specifically through failing to maximise the impact of the health and care sector in being the district's largest employer. This is due to an inability to recruit into the sector from the district's most deprived communities, resulting from a failure to create employment opportunities and career pathways which are inclusive and reflect the population of BDC. This could result in health and social care organisations not playing their part as anchor organisations to invest in their local communities and contribute to an economically vibrant district as well as having a workforce that isn't diverse, leading to services not being delivered as effectively as they could.	1. Utilisation of People Priority Programme Board to receive regular progress reports from 2 related work programmes linked to this risk. For both these controls there is a system-based approach to addressing the issues, with the programmes containing representation from across the partnership. 2. This risk is being addressed through the following programme: Pathways: Clarifying and developing Pathways into health and care careers. This has included Careers and Technical Education and Volunteering to Career, careers ambassador and workforce website, all of which are at different stages of development.	1. The pathways programme is being reviewed with a revised proposal to be taken to workforce programme board in Spring 2025. This proposal looks to align activity from across partners including BMDC and individual providers in addition to educational institutions.	1. Regular deep dives at Partnership Board. 2. System wide review of impact at BMDC run CTE Health and Care Careers and Technical Education Board. 3. Review at BDCHCP Workforce Programme Board.	1. Programmes continue to develop, with engagement achieved across the partnership.	1. Work is required to continue to strengthen links in delivery of all public services at a locality level to provide a joined-up approach to supporting our local communities in to work and careers, with a focus on H&SC. This is actively being addressed.			Static - 5 Archive(s)
2417	27/03/2024	Both FPC and QC	Improve healthcare outcomes for residents	12	(3x1.4)	9	(3x1.3)	Angela Thompson	Jane Wood	There is a risk that there will be further closures to care and nursing homes, and/or reduced capacity due to a lack of experienced registered managers (RMs) and registered nurses (RNs) impacting on quality and ability to support complex people in community potentially causing delays to patient flow from hospital to community settings.	Utilisation of partnership based fora (previously People Committee) to ensure system understanding of risk and mitigation taken.	Data quality within Social Care sector is variable, meaning gaining complete picture of workforce is not possible. Bradford Care Association offer representation within partnership fora, meaning some gaps exist when considering workforce of whole care sector. Lack of coordinated health and care workforce strategy and resourcing to support the development of kev roles.	Now People Committee disbanded should this be taken to the workforce programme board? Regular deep dives at Partnership Board.	BDC Workforce Strategy in place to support recruitment and retention of key roles. BCA supporting services with quality improvement and leadership development.	Ensure Workforce Programme Board agendas to be strengthened to focus on risks previously taken to People Committee? Bradford Care Association offer representation within partnership fora, meaning some gaps exist when considering workforce of whole care sector.			Closed - Merged with another risk (please link to merged risk)
2221	26/01/2023	Quality	Tackle inequalities in access, experience, outcome	12	(4x1.3)	8	(4x1.2)	Sohail Abbas	Duncan Cooper	Failure of the Reducing Inequalities Alliance (RIA) and partners to support and coordinate action across organisations and programmes of the BDC partnership to reduce health inequalities. Due to lack of: [1] engagement and buy-in from wider partners, seeing the remit of the Reducing Inequalities alliance in isolation from system partner actions, limiting the potential of RIA to become the system learning and coordination space, [2] reduced influence of the RIA to ensure that inequalities become a golden thread through all programmes, [3] failuare of RIA governance and membership (and team capacity) to identify & influence action & evaluation of the impact, [4] reduction in funding for specific inequalities programmes (e.g Core20PLUS5, RIC, HIPP) and for other community & prevention services that could reduce health inequalities. Resulting in Health inequalities getting wider. Health inequalities continue to be influenced by wider socio-economic effects and pressures (e.g poverty, cost of living, local authority cuts).	Reducing Inequalities Alliance established under 4 programmes 1.Setting the strategic vision, via Your role in reducing inequalities publications & events 2.Building confidence and skills in our workforce 3. Supporting best practice 4.Creating opportunities to evaluate and share learning Establishment of the Well-Being collaborative under the wellbeing board (from RIA and other system enablers, Living Well, EOI, Health Determinants Research Collaborative)	Strong working relationships between the Wellbeing collaborative & WB board partnerships (to strengthen health inequalities narrative outside health and social care). This is currently restricted by a wellbeing board partnership review (as development of the District plan / Wellbeing strategy is on hold until this review is completed). Initial work has been done to identify priorities from the ICB Joint Froward Plan to form the health inequalities section of the district plan (to which the wellbeing collaborative will contribute). Agreement of BDC partnership priority board key metrics (stratified by inequalities and linked to specific actions/priorities): this remains a challenge. Update Cycle 1 2025/26 - This has currently been restricted by a wellbeing board partnership review (as development of the District plan / Wellbeing strategy is on hold until this review was completed).	Core20PLUS5 place based programme reporting WY ICS CORE20 group, and into RIA steering group. Reducing inequalities team membership and support for BDC partnership priority boards (and with Public Health Leadership team, HDRC board) RIA associate director working within place closing the gap programme. A range of guidance documents summarising key actions and interventions for the NHS and its partners to reduce inequalities has been published and promoted.	Current RIA core team in new BDC partnership operating model to support system wide action to reduce inequalities. Assurance under 4 Reducing Inequalities Alliance 4 programmes (recent work below) - 1.Setting the strategic vision: High impact areas to reduce inequalities report and Actions for local NHS organisations to reduce health inequalities published and distributed 2024 q2 and q3 (with separate poverty briefing) . Impact/evaluation of Core20+5 programmes is in the interim stage with a dashboard for monitoring of key metrics. (board sessions with BHHFT and BDCT Trusts during Q2/3 24 to increase trust strategic intent and planning to reduce inequalities). Population health (with inequalities focus) used for chapter 1 to set direction of travel for needs based approach for new BDChealth and well being strategy (2025) 2.Build confidence and skills in our workforce. Via Equity Fellow Scheme (working with West Yorkshire ICS), and generalist training programme locally for health professionals (inequalities trainiong under Enhance programme . Inequalities bitesize sessions programme commenced to support staff capability to reduce inequalities and spread good practice and inequalities bitesize series held with monthly webinars. Co hosted national population health conference in Bradford. 3. Supporting best practice. Supporting social value in procurement work with ICB teams, JSNA and intelligence packs for WB board partnership events. Core20PLUS5 health inequalities funding (hyper local commissioning of 62 interventions across 13 Community Partnership community for clinical priorities and "plus" groups) . Developed community health model taking NHS Health Check to community venues. Developed maximising social value and reducing inequalities via procurement guide (shared with W Yorkshire colleagues for standard WYICS templates). Leading the Work and Health Acclerator for Bradford Plance with an inequalities focus, invovling community organisations 4.Creating opportunities to evaluate and share learning: Evaluated RIC services moved to business as usual or de-commissioned. Work and Health Accelerator (Bradford District and Craven) - funded national accelerator pilot in BDC to reduce health related economic inactivity (starts April 1st 2025) with strong VCSE input and inequalities focus. Supporting place Closing the Gap programme (to meet financial challenge): Co-leading on population segmentation, PHM, major health conditions needs assessment, and prioritisation approach to mitigate impact of efficiency savings and inform system review.	Inequalities and community budgets have made efficiencies due to financial challenges. The RIA core team (within BDC partnership) has lost 2 posts reducing ability to influence the system wide approach to reducing inequalities (and further risk due to March announcement of 50% cuts to ICB). Still work to be done on producing key performance indicators and metrics that measure, report and assure on inequalities - being discussed at BDC board March 2025 Discussion (April 2025) with WY ICB population health team on areas of future working (given 50% ICB cuts)			Static - 11 Archive(s)
2215	13/01/2023	Both FPC and QC	Tackle inequalities in access, experience, outcome	12	(4x1.3)	2	(2x1.1)	Shane Embleton	Mike Woodhead	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. (now completed 31/3/25). Offer of c.£50m capital received from DHSC and accepted on 29/08/25. OBC being updated for "plan B" (£49.5m). Design team appointed. Engagement ongoing with NHSE and DHSC re approval gateways, procurement strategy, profile of spend, early draw-down of cash, etc. Outline BC completed and submitted 01/01/25, approved 13/02/25 (with conditions) - allowing commencement of activities to progress Final Business Case (FBC) development. BDCT Project Board established with Governance Programme. Enabling works commended (£1.275m drawdown for early works from NHSE) - revised spend profile being established for subsequent years. Planning submission (reserved matters) has been made to Bradford Council. Detailed design (RIBA 4) & value engineering continues progress reported through Project Board monthly. FBC submission expected Sept 2025	Approved business cases. Detailed agreement on approval gateways etc, but this is expected to be agreed before end of October 2024. (intially closed following cabinet controls "assured" status & OBC approval) Project expected to exceed £50m outturn cost. Support of ICB explored to assist with funding gap to be managed locally in WY. Seeking futher advice from NHSE on re-evaluation of approval gateways. Cabinet Office approvals will now be required, potential to add 26 weeks to programme. Final Business Case (FBC) in development noting change in value. Detailed Project Plan & marketing & Comms strategy in development.	- 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 Lynfield Mount Redevelopment - full project governance structure and project delivery team in place. reporting into LMH Project Board through to Finance & Performance Committee and Trust Board.	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. Lynfield Mount Redevelopment - full project governance structure and project delivery team in place. reporting into LMH Project Board through to Finance & Performance Committee and Trust Board.	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 - 2 Archive(s)
2520	08/04/2025	Quality	Improve healthcare outcomes for residents	10	(2x1.5)	6	(2x1.3)	Vickie Milner	Grainne Eloi	There is a risk that individuals will not be reviewed in a timely manner due to challenging workforce issues resulting in increased cost to the ICB, the ICB not delivering against its statutory duties, or individuals presenting with unmet needs.	- Monthly reporting of all overdue reviews completed since 1st October 2024 - developing list of individuals not reviewed in a timely manner since 1st October 2024 - data collections is now cleansed and correct	- Inability to undertake the reviews due to gaps in clinical workforce - Inability to monitor any changes made to care packages by Local Council for those jointly funded where this results in an unnecessary cost pressure - Inability to assure the ICB of the quality and value of the care commissioned - lack of notification from LA when Provider request further uplifts in year, and LA agree them .	- Reviews undertaken monitored on a monthly basis - Data on overdue and pending reviews is now up to date and cleansed - Workforce is directed to priority areas of need, including maintaining mandated activity requirements	Fast track reviews are completed timely as these people have had no clinical assessment for CHC. We also complete reviews that are most clinically vulnerable	- Inability to manage workload with resource in place or configured in current form. - Gap in assurance of delivery of service where commissioned externally inappropriate referrals coming to the team resulting in workforce capacity being further reduced.			New - Open
2518	08/04/2025	Quality	Improve healthcare outcomes for residents	9	(3x1.3)	4	(2x1.2)	Vickie Milner	Grainne Eloi	There is a risk of the ICB not being able to source high quality and cost effective care for individuals eligible for NHS CHC due to gaps in cost for care and affordable budgets resulting in higher costs to the ICB or individuals presenting with unnecessary deterioration due to unmet needs.	- Market Management and Sustainability activity in place in collaboration with Local Council - direct conversation with Independent Sector Providers relating to gaps in local provision and areas for development - Cost setting activity is consideration of National Living Wage, Consumer Price Index as well as increased costs related to needs of someone eligible for NHS CHC.	- Inability to block contract reduces possibility of making cost effective commissioning decisions at Place - Spot Purchase costs are often higher than block contract arrangements - gaps in local markets and closures of care homes - out of area placements required for individuals with specialist needs - no ability to influence this market where at a distance from commissioner - Providers will identify alternative methods for income generation (i.e. 1-1 costs).	- Where possible, robust care management arrangements are in place to support reviews of needs. - Relationships have been developed with the Market to support ongoing working arrangements - Move to a WY ICB is supporting wider discussions regarding costs and uplifts and may support block contract arrangements in the WY area. - Contribution to the local Market Position Statement	- Case Management activity - knowledge of overdue review lists and potential impact - developing standard specifications for AACC care contracts	- Requirement for a cost setting tool to support standardised cost setting for base fees for all care home providers - risk of not accessing a placement for an individual if cost 'demands' are not met. - risk of paying more for weekly fee via 1-1 support or other over commissioned package if inflationary uplifts do not meet requirements of the sector.			New - Open
2516	08/04/2025	Both FPC and QC	Enhance productivity and value for money	9	(3x1.3)	4	(2x1.2)	Vickie Milner	Grainne Eloi	There is a risk of overspend against the AACC budget due to increasing service demand and rising care costs resulting in the Place financial targets not being met.	- Implementation of standardised Commissioning Principles via the Choice and Equity Policy - Regular staff training and supervision sessions in place to discuss implementation of Policy and Principles - Resource Allocations processes in place aligned to Standing Financial Instructions Scheme of Delegation - Regular monthly budget holder and finance meetings in place to address shifts in position - working alongside local Council to align costs where appropriate.	- Embedding Commissioning Principles is a substantial piece of work and requires a new approach to patient conversations with registered nurses - Implementation of Commissioning Principles has a significant impact upon operational processes and can delay commissioning decisions or lead to complaints and challenges. - The poor financial position of Adult Social Care Independent Sector Providers is impacting upon making placements for CHC eligible individuals at standard rates due to higher complexity and intensity of needs for this cohort. - Care Providers looking to increase income via requests or demands for 1-1 support. - Challenging financial position of Local Councils resulting in increased referrals for AACC consideration - Pressure in Acute Hospitals increases rates of individuals being Fast Tracked at full expense of ICB where Fast Track may not be appropriate.	Resource Allocation panels and processes in place with consistent completion of financial information to update AACC database - Robust clinical assessment and eligibility decision - making. - Escalated Scheme of Delegation controls in place. - Embedded credit control arrangements in place to monitor invoices against AACC financial commitment at a patient level - Informed and considered cost and budget setting in place to ensure correct budget in place. - Identified cash releasing efficiency schemes in place.	- Regular data cleansing activity in place to assure financial data held is accurate and up to date - All staff aware of responsibilities in regard to Scheme of Delegation - Decision - Makers re eligibility and commissioning decisions are fully aware of Commissioning Principles and how to implement - PHB Audit and 'claw-back' processes in place and in operation. - Packages of care to be delivered via PGH Direct Payment are carefully considered in terms of statutory duties of the ICB to deliver.	- Spend on PHB Direct Payment budgets is subject to misuse and mis-management - Potential for inappropriate decisions made on PHB packages of care following historical agreements. - Overdue reviews lead to potential lack of up to date needs and care plan, or costs for care. - Local Councils responsible for agreeing uplifts and rates for non-eligible individuals, with differing level of assurance/authority to act/evidence of exceptionality resulting in increased cost to the ICB through joint funding arrangements. - Lack of resource to support robust Case Management and therefore review of all fully funded packages and outcomes in a timely manner. - Unpredictability of the patient cohort mean significant increase in costs can occur at any time			New - Open
2423	27/03/2024	Quality	Improve healthcare outcomes for residents	9	(3x1.3)	6	(3x1.2)	Andrew Milner	Kerry Weir	There is a risk that the health and social care workforce will be insufficient to provide high quality care to all patients and service users and meet the broader objectives of the health and care partnership. This is a result of incomplete data across the health and care partnership, with particular gaps situated in the social care, primary care and VCE sectors. The gaps in data available inhibit the identification of areas of pressing need, compromising the targeting of partnership level interventions.	Development of a data centric approach to targetting interventions Reporting of workforce data via a dashboard to System Finance and Performance Committee, with bi-annual deep dive. Ongoing dialogue with external partners including NHS England, Skills for Care and WYICB on data availability. System approach to issue identification through BDC Workforce Priority. Ongoing dialogue with internal partners including social care leads, primary care leads and VCS leads to	Data centric approach will be incomplete due to variable data quality Qualitative data is valuable alternative to consistent data sets, however it is unlikely to give full summation of workforce. This increases scope for inconsistent interpretation of areas of concern.	West Yorkshire ICB Board Assurance Framework (BAF) – BdC contribution to workforce objective through West Yorkshire People Board. Reporting of workforce data via a dashboard to System Finance and Performance Committee, with bi-annual deep dive. Regulary reporting through Partnership Leadership Team/PLE with other priority programme boards Highlight reports and project plans from each of the prioritised projects in the workforce programme.	Refreshed programme and use of data centric approach early in development and therefore progress to data is limited. High level of engagement across sector through People Committee and BDC Workforce Priority to date. Agreement at Finance and Performance committee that workforce data will form a part of regular (quarterly) performance report, ensuring impact is evaluated alongside activity and finance. High level workforce data against plans now included in system dashboard. However, still limited to NHS Trust/ primary care data. Request for temporary staffing usage/ expenditure to be included made in December 2024.	n/a			Static - 5 Archive(s)
2421	27/03/2024	Quality	Improve healthcare outcomes for residents	9	(3x1.3)	6	(3x1.2)	Andrew Milner	Phillipa Hubbard	There is is a risk that capacity to host clinical placements across all professions is insufficient to train the numbers of healthcare professionals required to meet increasing demand from patients service users, and meet the demands of the NHS Long Term Workforce Plan.	Establishment of programme within BDC People Priority to focus upon non-medical clinical placements and quality of clinical education. Establishment and refinement of placements working group with emphasis on priority professions. Agreement of place wide work plan for placement activity. Placements project manager commenced in post 12/08/24 and work is ongoing. Ongoing refinement of plans.	N/A	Regular reports from placements programme on level of risk into workforce programme board (with escalation to PLT/ PLE/Partnership Board).	Programme established, engagement from across partnership including social care, primary care, VCS, FE and HEI sectors has been excellent. Placements project manager commenced in post 12/08/24 on FTC for 12 months Full workplan for BDC Placements Programme agreed in December 2024 reflecting system priorities and aligning with WYICB Placements Strategy. Emphasis on priority professions and development of placement capacity outside of acute organisations. Innovative practice has also been prioritised, with utilisation of student supported services being increased. WYICB engaged to ensure place based work is aligned with work undertaken at a West Yorkshire level.	N/A			Static - 1 Archive(s)
2528	10/04/2025	Both FPC and QC	Tackle inequalities in access, experience, outcome	6	(3x1.2)	2	(2x1.1)	Jo Howes	Sohail Abbas	There is an increased risk of data breach by some of our smaller VCSE providers (21Core20+5 project providers with funding of c£540K in 25/26) Due to the fact that they have not registered for and / or published a recent self-assessment against the NHS Data Security & Protection toolkit, which is a requirement of the NHS standard grant agreement Which could result in reputational damage for the ICB, as well as negative impact to relationships between the ICB and the local VCSE sector	1. Working with VCSE alliance BDC and WY Harnessing the power of community Team 2. Liaising with ICB contracting dept 3. Liaising with WY ICB Information Governance Lead 4. West Yorkshire wide work around contracting and procurement with the VCSE sector 5. Communicating with providers to remind them of their grant agreement requirements (Apr 2025)	1. Some smaller organisations do not have the funding, capacity, resources and skills to comply with the DSPT on a timely basis	Issue being raised at - Healthy Communities Team Meeting Reducing Inequalities Alliance Meeting Extended Management Team Meeting	1. Approx 50% of providers are compliant 2. VCSE are aware and are working on a solution	To add when identified			New - Open
2477	14/01/2025	Both FPC and QC	Improve healthcare outcomes for residents	9	(3x1.3)	4	(2x1.2)	Jane Wood	Iain MacBeath	There is a risk of significant adult social care (statutory care provision) market failure and disruption in Bradford place due to insufficient funding being available to fund the changes to the national insurance contributions employers have to make and the cost of pressures around the national living wage and inflation. This may lead to delayed discharge, displaced service users, reduced choice for service users, impact on quality of care and pressures on the wider health and social care system.	1. Collaborative approach to fee uplifts between the BCA, Council and the NHS 2. Govt has provided new financial policy statements indicating funding for adult social care (Dec 2024) 3. Joint working arrangements between the ICB and Council to manage provider closures 4. Strong contract arrangements and contract managers with individual named care homes	1. Awareness of NHS funds in the sector around 30% of totality	1. Collaborative finance forum (BCA, Council, ICB) monthly 2. Departmental management meetings 3. Meetings with finance/ department (council) 4. Joint planning and commissioning forum (finance working group) 5. Chief executive of Bradford care association is on the executive of Bradford PLE 6. Membership from North Yorkshire Council in the PLE – Head of Quality and Assurance 7. People workforce was sited on recruitment and retention of staff in the care sector	Partnership working	None identified at present, further reviews will take place at senior managers meeting.			Decreasing

2047	12/07/2022	Both FPC and QC	Tackle inequalities in access, experience, outcome	5	(5x1.1)	1	(1x1.1)	Vickie Milner	Grainne Eloi	DOLS in PCD FUNDED CASES There is a risk of legal challenge against the HCP and potential harm to patients due to unauthorised Deprivation of Liberty (DoL) in PCD funded community cases resulting in reputational and financial damage. Where people are deprived of their liberty in their own homes as a result of PCD funded packages of care, we are responsible for seeking authorisation from the court, however the court has a large backlog and these cases are outside the scope of the existing Deprivation of Liberty Safeguards (DoLS). This is a nationally recognised problem and Local Authorities and HCPs across the country are taking a risk management approach to prioritise only the most contested cases. The planned Liberty Protection Safeguards (LPS) aim to provide a statutory process for CCGs to authorise CHC funded cases, without the need for court proceedings, this activity has now been paused. Financial implication to WYICB each DOLS case cost on average £2000	The PCD use a risk management approach to identify cases where there are significant objections or unresolved areas of disagreement relating to the persons deprivation of liberty which are then prioritised for legal advice. Where necessary, an approach is made to the court of protection to authorise the deprivation of liberty. The PCD has a clinical lead in post and established systems for identifying potential DoL in CHC cases. Case numbers are monitored by the PCD. We have 80 outstanding DOL's for full assessment our Clinical Lead will be undertaking these assessments.	There is insufficient resource within the CHC team to progress all identified cases of DoL and to undertake preparatory work for the court of protection. There is also a lack of capacity within the Court of Protection nationally to deal with even the current number of cases raised by HCPs and LAs.	LPS National Guidance has been published and activity regarding the resourcing and identification of process is being led by Matt O'Connor. This is now paused Updated 01.04.2025 We have an dedicated MCA/COP lead in the CHC team who is leading DOL's however is still case managing some complex cases that need to be seen in the court arena. We use a prioritisation tool and we are looking at the screening tool in the new IEG4 system that is been used from 1.4.25	12/07/2022 Active monitoring of cases continues on a weekly basis and court activity occurs as necessary. 14/09/2022 No change in position with regard to monitoring and managing this caseload. Activity is occurring on an as necessary basis 29/11/2022 Court of Protection activity continues to occur on an as necessary basis when a Deprivation of Liberty or best interest decision is challenged 24/03/2023 No change in position with regard to monitoring and managing this caseload. Activity is occurring on an as necessary basis and we still await the national guidance on the changes to process/procedures 25/5/2023 Clinical lead has been released from CHC work to prioritise the Community DOL's, currently prioritising the cases and will undertake the DOL's assessment feeding back weekly to managers with caseload.	April 24: The joint arrangement and assurance under S75 described in the update in Feb 24 remains in place. 25/05/2023 Looking at training for nurses to undertake BIA assessor course to increase the resource within the team. 12/07/2022 PCD's ability to report remains unchanged whilst the team continue to transfer data across to it's new reporting system (adam) 14/09/2022 PCD are still progressing the data input into the new information system. reporting capability on this caseload remains unchanged and limited at present. 29/11/2022 All data has been added to the new information system and is currently being validated. A reporting process that captures all Court of Protection activity is being developed and once completed, this will allow reporting on all activity. 24/03/2023 Development of activity reporting continues and at present we wait for notice of any national reporting that may be required.			Static - 9 Archive(s)
2040	11/07/2022	Quality	Tackle inequalities in access, experience, outcome	4	(2x1.2)	3	(3x1.1)	Nagina Javaid	Helen Farmer	0-19 SERVICES: POTENTIAL NEGATIVE IMPACT ON OTHER HEALTH SERVICE DELIVERY There is a risk of negative impact on health services due to reduced capacity within redesigned health visitor, school nursing and oral health services resulting in inappropriate referrals to other services due to lack of early help and/intervention and increased waiting lists.	CBMDC Public Health services were subject to a WSOA in the Ofsted/CQC SEND inspection which took place in March 2022 which highlighted inconsistent delivery of 0 - 19 and school nursing services, along with ICB commissioned specialist nursing services. This resulted in the development of a response to the WSOA which outlines our planned service improvements and has the support of BD&C HCP. CBMDC Start for Life Family Hubs has brought partners together to deliver an integrated offer for families focusing in the first 1001 days. As a result of the SEND WSOA partners are working together to review the early help and prevention offer for children and young people to identify and address gaps in provision and to align service delivery pathways with oversight via the pillars of the CYP&F Programme Board and the SEND Strategic Partnership Board. Better Start Bradford and BDCFT Community Children's Services have worked together to ensure the legacy and continuation of the MECSH programme for Bradford families. This has resulted in a detailed roll out plan across all Localities as well as the introduction of the Infant to School Programme. The Healthy Children and Families Board has gone through a significant refresh. There are now 3 principles: 1) Every child has the best start to life 2) every child thrives 3) Every child gets the support they need. The work of the 0-19 connect to all 3 principles, particularly principle one, where there is a leadership team and working group set up which the focus, School Readiness, School Absence, ELSEC, MNVP, triangulation of data, talking Bradford, ready to relate etc. – all of which supports the 0-19 work.	There was a possibility that despite additional funding BDCFT would not be able to recruit the required staff and caseload numbers would increase and existing staff would seek alternative employment. We recognise that without increased capacity in the 0 - 19 workforce proposed service developments could not be delivered with the potential we could continue to see inappropriate referrals into other health services. The Principal Risk was shared at the Children and Families Health and Care Partnership Board in August 23 where the gravity of the impact on the Universal, Prevention and Early Help work in the district was recognised. It was further raised at the June and August meetings of the Board in 2024. Nagina Javaid is part of the review Board for the 0-19 services, currently being chaired by Iain MacBeath.	Continued dialogue between partners about the principal risk and impact on Universal, Prevention and Early Help work and families. Alongside increasing demand on services. Health related elements of the response to the response to the SEND WSOA are being dual reported via the CYP&F Pillars and the workstreams of the SEND Strategic Partnership board. Performance of the Public Health Nursing Service is reported via CMB. Performance across all trajectories of improvement (WSOA) and KPIs remains positive. The governance arrangements for the Healthy Childrens and Families Programme Board has been refreshed and strengthened. A Complex Support Needs Panel has been developed to include representation from Healthy Childrens and Families, Healthy minds and Healthy Communities to better understand complexity of cases and how the system can respond.	DCFT Public Health Nursing performance is positive across KPIs / Metrics. Principle one work (Universal, Prevention and Early Help) is progressing. Through the work to respond to SEND WSOA3 the BDCFT 0 – 19 team have made significant improvements in the achievement of key performance indicators. This has included the recruitment to roles, attendance at safeguarding meetings and the ability to review all families who are vulnerable the impact of transference to other services has significantly reduced and is fully operating to the requirements within the contract.	Conversations are ongoing with partners to understand the impact of the principal risk and possible mechanisms to mitigate or prevent the same from occurring. However it is not clear who is leading on this on behalf of the system - this has continued due to lost resources as a result of the ICB operating model changes. Update - 13/01/2025 The 0-19 contract is being renegotiated.			Static - 5 Archive(s)

Board Assurance Framework Summary, Cycle 1 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 9	Date: March 2025
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	16	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	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
(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.	Open	8	16	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	6	8	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	9	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 / Shaukat Ali Khan	Finance, Investment and Performance Committee.Transformation Committee for Digital
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Anthony Kealy	ICB Board
(3) Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	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	9	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	8	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 / Shaukat Ali Khan	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

Board Assurance Framework Summary, Cycle 1 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 9													
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	16	9	12	9	9	6	12	12	16	9	16
	1.3	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.	Open	8	16	6	12	8	12	8	12	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	6	8	4	6	4	6	4	8	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	9	2	4	2	6	2	8	2	6	2	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	16	9	16	9	16	9	12	9	12
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	4	12	4	12	8	12	4	9	4	9
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	20	6	20	6	20	6	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	9	12	4	12	4	16	4	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	8	8	8	8	12	8	12	8	12	8	8
	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

Bradford District and Craven Health and Care Partnership

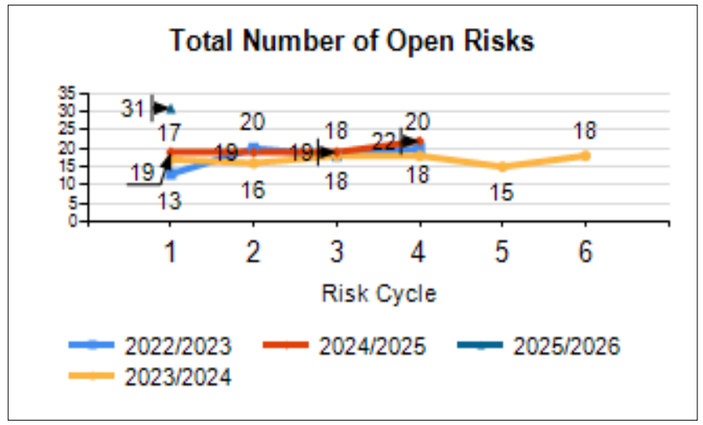
ACTasONE

Bradford District and Craven place, Risk on a Page Report Cycle 1, 2025/26

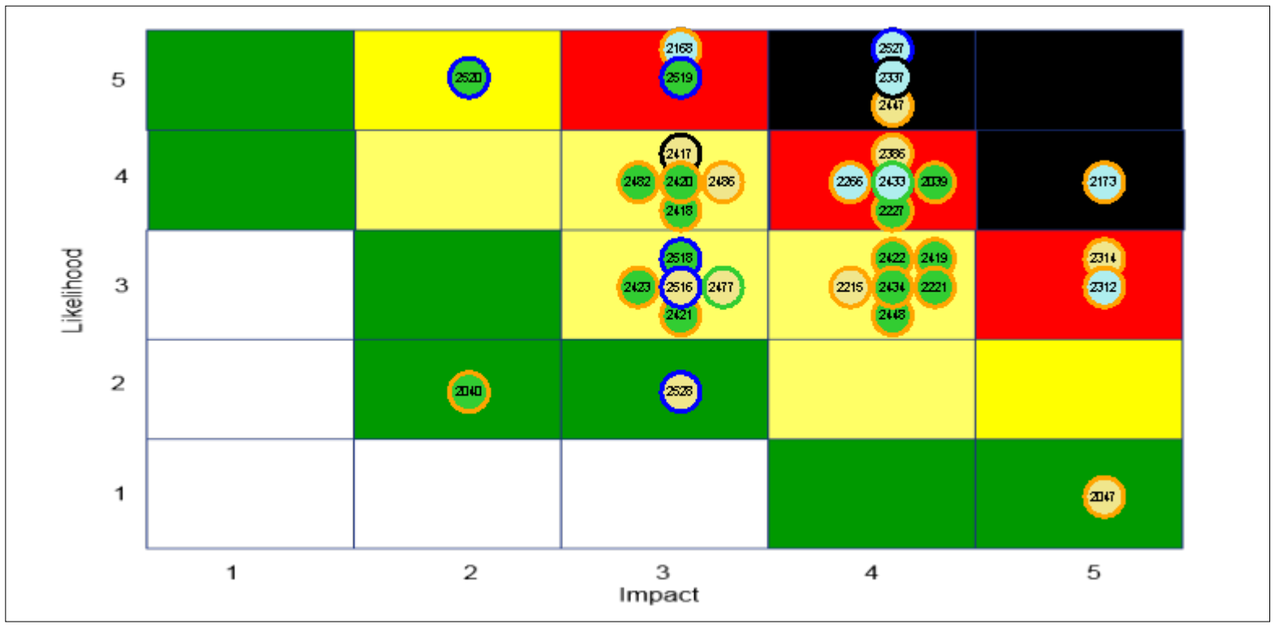
NHS West Yorkshire Integrated Care Board

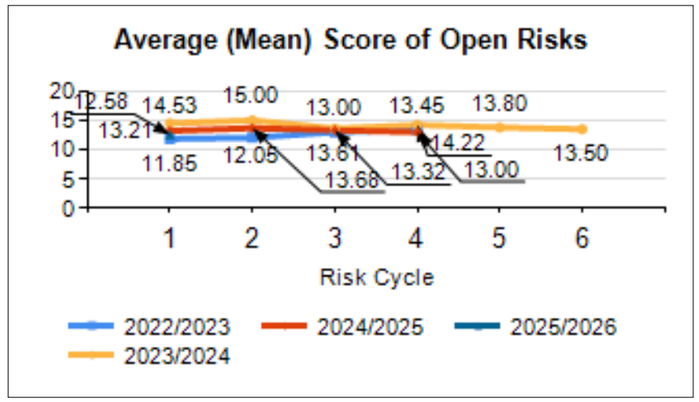
Total Place Risks	33 (31 open risks)
Finance & Performance	7 (6 open risks)
Quality	16 (16 open risks)
Finance and Quality	10 (9 open risks)

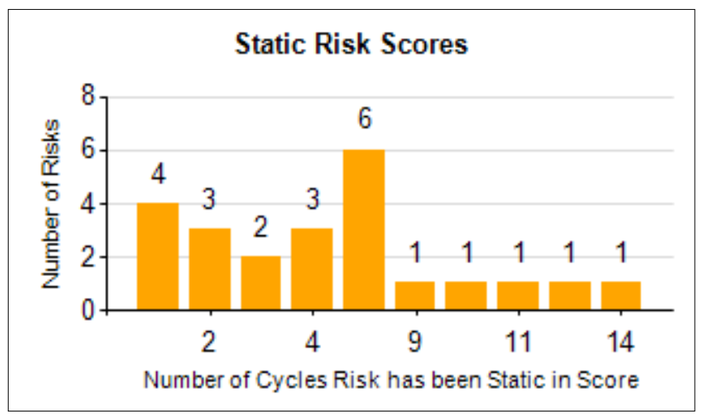
Movement of Risks		Risk Score Increasing	0
New	6	Risk Score Decreasing	2
Marked for Closure	2	Risk Score Static	23



Risk Overview (BDC place)







Key

- Quality
- Finance
- Both FPC and QC

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

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

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	9
Meeting date:	23 May 2025
Report title:	Our Plans for Health, Care, and Wellbeing
Report presented by:	Clare Smart, Associate Director
Report approved by:	Matt Sandford, Director of Partnership and Place
Report prepared by:	Clare Smart, Associate Director

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

Previous considerations

None

Executive summary and points for discussion

This plan was commissioned by Partnership Board. It considers the future state of our population and the response needed by our Health and Care Partnership in our role to:

- Improve health outcomes for all people using information, data, and insight
- Tackle inequalities in experiences, outcomes, and access
- Help support broader social and economic development
- Enhance productivity and value for money

The underlying reason for this plan is the health and wellbeing of our population. Without change, the health of our population will continue to deteriorate and our services will be unable to meet the rising and changing needs of local people.

At the heart of this plan is a recognition that we need to re-balance where and how we deliver care, with care increasingly delivered closer to where people live. We know that we can only make the greatest impact on the health of our population for generations to come by taking an increasingly preventative approach across all sectors.

This plan acts a guide for how we use our partnership resources to improve population health.

Outline how this supports our partnership vision and strategy

Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives. Our Population - Supporting the delivery of our priorities and a better experience of health and care, prioritising those with the worst outcomes. Our Place - Making our district a great place to live, work and thrive. Our Partnership - Greater value through the best use of our collective resources, minimising duplication and waste.
Recommendations
The Partnership Board is invited: 1. To receive and consider this first draft of 'Our Plans for Health, Care, and Wellbeing in Bradford District and Craven'.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Risk Register or Partnership Assurance Framework? If yes, please detail which.
None identified
Appendices
Paper: Our Plans for Health, Care, and Wellbeing in Bradford District and Craven (Draft v9 May 2025)

What are the implications for:

Residents and Communities	Local people's insights have informed this plan.
Quality and Safety	Improving quality and access is central to this paper.
Equality, Diversity and Inclusion	The paper identifies that people are adversely affected by inequitable access to care.
Finances and Use of Resources	Not directly from this paper.
Regulation and Legal Requirements	None identified.
Conflicts of Interest	None identified.
Data Protection	None identified.
Transformation and Innovation	The paper seeks to focus on integration of services, continuity of care, and improved health outcomes
Environmental and Climate Change	None identified
Future Decisions and Policy Making	The paper focuses on some of the HCP's identified challenges.
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

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

version 9 May 2025

[DRAFT for Partnership Board]

Table of Contents

Introduction 1

Our Shared Purpose 2

Our strategic intent 2

Our Population 4

Our population data and future state 4

Our citizen activation, insight, and involvement 10

Our Place 14

Our integrated neighbourhood health and care support 14

Our acute services of the future 18

Our Partnership 22

Our financial plans 22

Our workforce plans 25

Our digital plans 27

Our infrastructure plans 29

Conclusion 33

Introduction

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

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

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

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

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

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

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

We are what we do next.

Our Shared Purpose

Our strategic intent

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

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

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

The financial climate within which the Partnership operates, and the need to 'live within our means' has created a challenging environment for major service transformation to happen. We know that we will not achieve the aims of this plan without a more fundamental shift in ensuring our resources are community focused. This, in turn, requires us to work differently. By accelerating workforce transformation, we are increasing our ability to support people to recover from illness or manage multi-morbidity in their own home. A move to more personalised care.

To achieve this, we need to invest in the services and teams that operate in the community, and we need to ensure that there is more consistency (or parity) in access, experience, and outcomes of care for our population.

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

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

Our challenge

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

People's needs are changing. People are living longer but not in better health. By 2040, there will be a 51% increase in people over the age of 65 and a 38% increase in people living with a long term, life-limiting condition. The major conditions that are collectively the greatest contributors to ill-health and early death are cardio-metabolic disease, MSK (musculoskeletal) disease, cancer, mental health disorders, and dementia. These conditions are not inevitable; they are driven by modifiable risk factors (such as smoking and obesity) and living conditions (such as poverty, housing, employment, and the environment).

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

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

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

Optimising our system architecture for delivery of the 3 Big Shifts

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

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

Our Population

Our population data and future state

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

The population of **children under 15 years** is expected to fall slightly by 2040 and for 15-64 years it is broadly stable. For the population **older than 65 years** we expect a 51% increase by 2040, and 40% increase for those older than 85yrs – a high healthcare use cohort.

Our population profile

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

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

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

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

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

- Children with complex conditions make up a higher proportion of the population in Bradford East, South, and West.

If our current trends continue, the number of healthy people is predicted to fall by 1% by 2040, with those with long term conditions predicted to rise by 9%. Of concern is the large, predicted increase in those requiring palliative care support and treatment (increasing by 29%), and people with frailty and dementia (increasing by 31%).

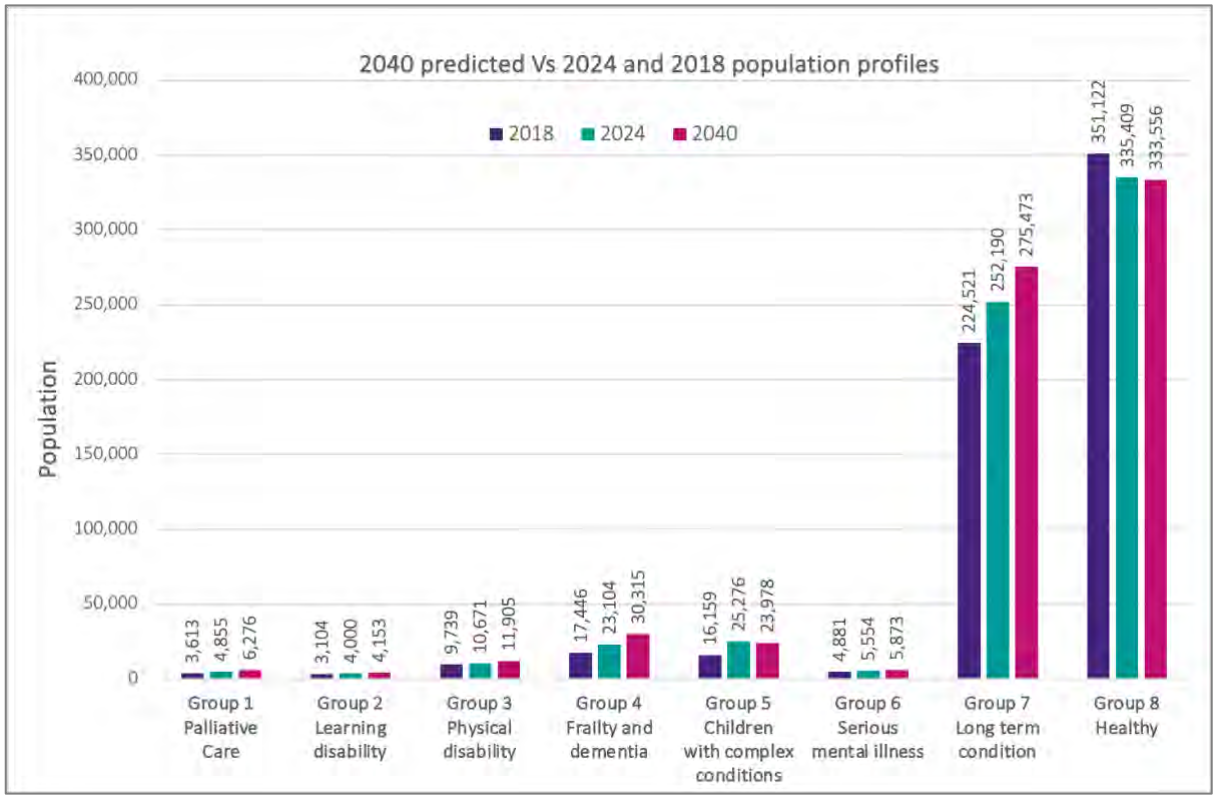


Figure 1: Predicted population profile for Bradford District and Craven 2018, 2024 and 2040

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

- People above 65 years with serious mental illness (approximately 900 patients), who have emergency admissions three times the average and six times the average bed days;
- Children with complex conditions (25,300), who have double the average secondary care use and three times more emergency admissions;
- Frailty and dementia patients above 65 years, who account for nine times the average emergency bed days;

- **Palliative care** patients account for ten times the average level of elective care, eight times the emergency admissions and 22 times emergency bed days than the average; and
- **People with learning disabilities** (4,000 patients) have twice the average levels of ED attendees, and six times the mental health admissions and service bed days.

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

Key health conditions

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

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

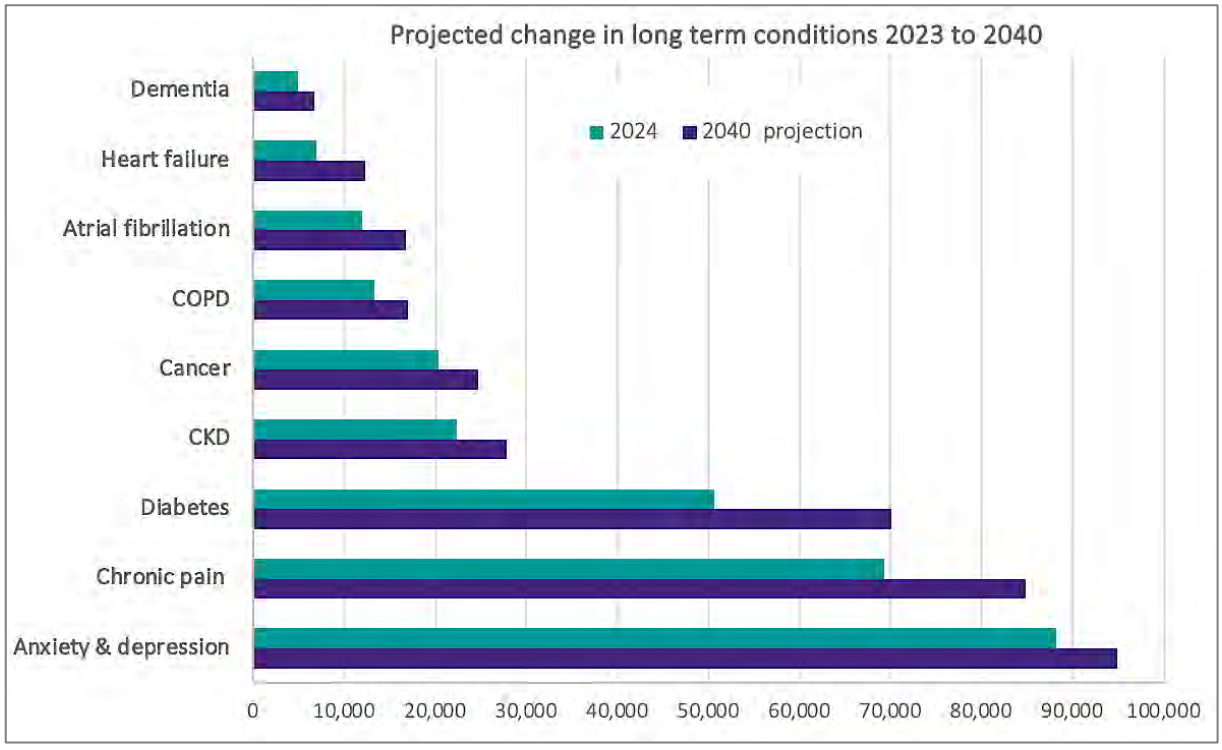


Figure 2: Projected change in long-term conditions 2023 to 2040

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

Multi-morbidity

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

Our health inequalities

Life expectancy is the average number of years a person is expected to live. Life expectancy varies 8 years for women and 10 years for men across wards in Bradford District and Craven. Healthy life expectancy is the average number of years a person is expected to live in good health. Women living in parts of central Bradford can expect 49 years of healthy life expectancy compared to 72 years in Wharfedale, a 23-year difference. For men, healthy life expectancy varies from 51 to 71 years, a 20-year gap.

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

Across our 13 Community Partnership areas (2022/2023) there is **significant variation** in lifestyle, access to healthcare, and long-term conditions including:

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

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

Lifestyle and prevention

In our district:

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

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

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

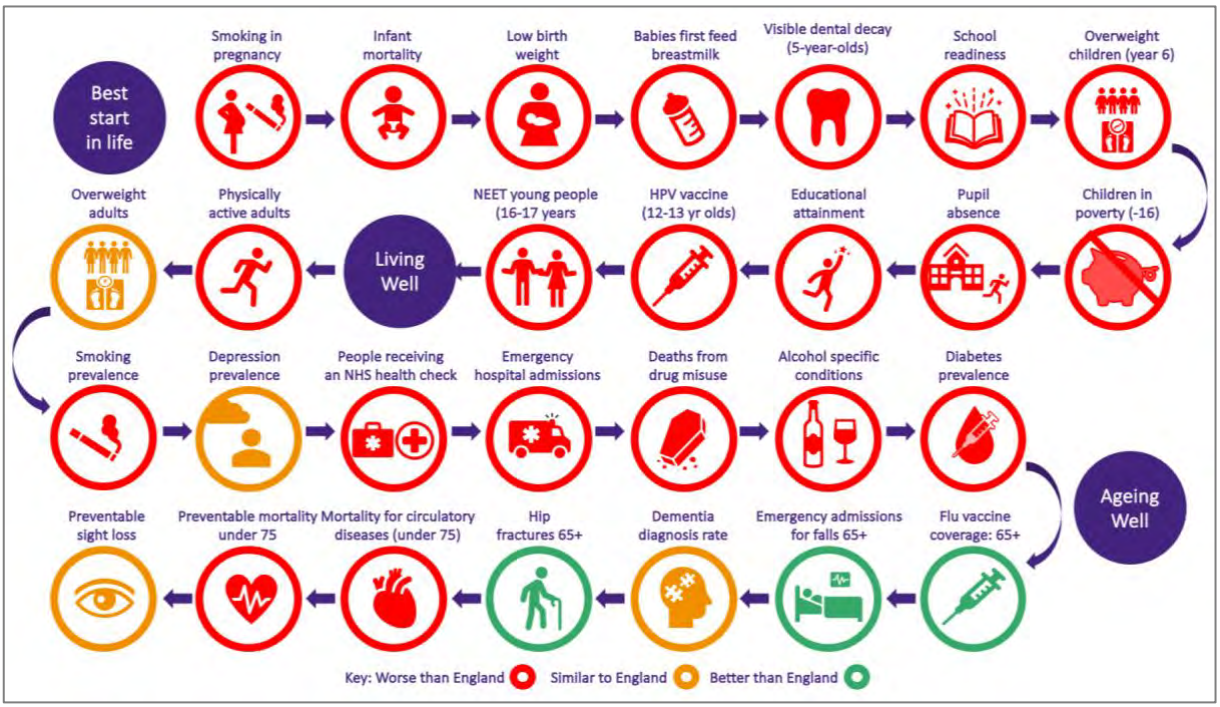


Figure 3: **Life Course Statistics** in Bradford District 2024 (not available for Craven district)

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

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

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

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

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

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

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

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

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

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

Our citizen activation, insight, and involvement

As a partnership we recognise the key role our communities play and will continue to play if we are to meet our ambitions. Through our strategy we have committed to 'inverting the power to act', this means that we devolve and share decision-making with our communities and support active citizenship. **Active citizens** don't sit around waiting for change to happen, they drive the change themselves. Active Citizens are people who feel inspired, who feel motivated and empowered to make a difference, because change can happen through us and not just to us. Our plans mean working with people as partners, shifting the relationship with people from passive recipient to **active shaper** of services.

This chapter is based on the insights we have collected most recently using a participatory approach through our deliberative events and through our **'Listen in'** programme. Listen in is an ongoing programme of involvement, with focused periods of activity to have direct conversations with the public, visiting community groups and public spaces to help us understand what matters most to local people when it comes to health and care.

Our future state…

In 2035, our Place is full of **motivated** citizens, communities relate to one another, and people take action to look after themselves and each other. We have 'let go' of some control and take risks, handing over money for communities to manage through participatory budgeting. People are **proud** of the place where they live and work; they are supported to put their ideas into practice and have confidence that they can make a difference.

Our children are **thriving** in schools, families are engaged, intergenerational links are benefitting everyone, and health and care services are designed with people in mind – the stories, voices, and experiences that we hear so we are proactively planning for the future while focusing on the now.

Our future state will be driven by our current and future populations, taking into account the changes we expect to see while still being one of the youngest places in the UK. To drive **positive health behaviours** for the future, we will focus on engaging with young people, working with schools as community anchors. We will do this by using existing structures as much as possible and programmes of work such as Child Friendly Bradford District. We will use population health data to bring to life people's **potential** future health outcomes. By working with partners to harness digital and creative approaches, we will empower our citizens to **'rewrite their stories'** and take control of their future wellbeing.

Our ambition is to have a place where we are 'doers', driven by a sense of pride in our neighbourhoods and understanding what matters to each of us in our communities.

Understanding what matters to our communities

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. Our second year of Listen in is focusing on reaching into communities of interest and understanding the differing experiences of groups of our population to provide insight to drive forward our priorities.

Earlier this year, we held deliberative events that focused on our financial challenge. The events took part in the six localities covered by our place-based partnership – Bradford East, Bradford West, Bradford South, Craven, Keighley, and Shipley. The aims of these workshops were to engage in an **open and honest discussion** with local people about the financial pressures faced by NHS partners in Bradford District and Craven.

For this plan we have highlighted some of the key points from the report.

Shift from hospital to community, what we have heard

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

Shift from analogue to digital, what we have heard

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

- People felt that if all services adopted the **same approach** and technology, it would make it easier for services to communicate with each other.
- For those who access other services digitally, there was a strong view that health and care providers could offer more efficient services through **virtual appointments**.
- People want support when using a new digital service, so they can fully understand how they can use the technology to **take control** of their health.

Shift from sickness to prevention, what we have heard

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

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

Enabling the '3 Big Shifts' and working towards citizen activation

Our plans should look to address, or work with agencies, to address the issues below, supporting our ambition of activated citizens in control of their health, care and wellbeing.

- Workforce capacity and retention – better working conditions and career pathways are needed.
- Smarter digital systems – patient records must be shared effectively to prevent delays, duplication, and frustration.
- Better hospital-to-community links – smoother discharge planning and faster follow-up care to prevent patients feeling abandoned.

- Stronger VCSE partnerships – community organisations are trusted but have highlighted that they need stable funding to deliver health support.
- Clearer access routes – people need to know where to go for care, including social prescribing and preventative services.
- Affordable and accessible transport – travel costs and poor public transport stop people from accessing healthcare, especially in rural areas.
- Support for unpaid carers – practical and emotional support for those looking after family members at home.

Citizen activation

Our work with local communities demonstrates that there is broad support. However, there are some overarching themes that continue to be shared by communities.

Overcoming mistrust –we have heard how some mistrust of big organisations can hamper the work especially around some preventative interventions. Through trusted community groups and community leaders or influencers, we can work with our local people to help them access information, advice, and support that they can trust.

Health and digital literacy –people would welcome additional support and education so that they can be more active in their own health and wellbeing. For some not only is health literacy an issue but also digital literacy and in some cases digital exclusion. To address this people have suggested how a programme of work can be established to give people greater health confidence.

Culturally appropriate services and support – there is a clear ask that the three shifts need to be culturally sensitive and appropriate, providing tailored advice especially when working with marginalised or under-represented groups. Greater efforts around adapted information and advice, support for community organisations and improved health and digital literacy would help address some of the issues.

Clear articulation of the trade-offs needed – people want to be assured that the three shifts have trade-offs that do not affect what people would view as core services and that they will be there when people need them. An ongoing participatory approach to decision making will help people be involved in decision-making. This also demonstrates the scale of the challenge in an open and transparent way and involves communities in making tough decisions.

For our strategy to achieve **real and lasting change** we need to move from passive to activated citizens. This goes beyond listening to our citizens when proposing changes to services to **actively involving** them in decision making and helping people participate in activities that improves their wellbeing as well as that of their communities.

Our Place

Our integrated neighbourhood health and care support

Our model

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

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

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

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

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

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

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

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

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

Our strong foundations

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

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

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

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

Our **voluntary and community sector** organisations play an important role in areas such as community outreach and supporting people with wider needs such as addressing social isolation. Our partners provide creative therapies, health and wellbeing coaching, alternative crisis services, housing support and debt advice**,** and transport, linking people to a wide diversity of local wellbeing services and providing peer support networks.

What are the key ingredients and what needs to happen?

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

- **A focus on people and outcomes first**, then prevention of ill health, then high quality services, supporting people to adopt healthier lifestyle behaviours to improve their wellbeing and live well for longer.
- **Ease of access** to neighbourhood health and care services where every contact counts, there is no 'wrong front door', people have a range of access options and trust where to go, there is a physical and digital single point of access.
- Care models, pathways and interventions that are informed by **a comprehensive understanding of population health data and need**, that supports optimal targeting of health and care resources, and in a format digestible and actionable for staff working in neighbourhoods. Population health management needs to become the norm.
- **Digital interoperability** for staff from different organisations working together in neighbourhoods to enable better joint-working and seamless flow of information; plus, improved **digital skills** for staff to use data, IT, and wider digital technologies.
- **Self-care Apps** (plus better and more widespread utilisation of the NHS App) that supports individuals and staff with navigating where to go for (how to access readily) the most appropriate support, and to encourage improved self-management and agency, whilst ensuring digital inclusion and inequalities are not exacerbated.
- **For our workforce** – investment and training for staff working in neighbourhoods. This will be multi-skilled, where staff train together to help further foster working relationships, plus an emphasis on developing coaching skills to support individuals to self-care. Our future estates and infrastructure developments will consider opportunities for greater co-location.
- **Proportion Universalism** – with greater intensity and scale for those facing the greatest need and poorer health outcomes, aiming to address health inequalities, in district wide programmes but also on a hyper local level.
- Building **wider partnerships** beyond the core health and care sector, e.g. with businesses and schools, that help build approaches to address the wider determinants of health.

Our initial focus

1. Ensuring there is a **shared system approach** and priority for integrated neighbourhood health across the Partnership, working to a shared vision and goals

2. Defining and agreeing the enabling **financial framework** for integrated neighbourhood health that incentivises improvement in health outcomes, proactive care, integration by providers and where 'returns on investment' from keeping people well at home and in the community flow back to those providers. We will explore ways of moving towards 'one pot' of funding for accountable care.

3. Identifying and agreeing the **set of deliverables** for integrated neighbourhood health and care, building on those that are already mandated. Developing our approach to **outcomes based accountability**, thinking and taking action to improve health.

4. Developing and implementing the **workforce transformation** approaches needed to both build sufficient staffing capacity and capability within neighbourhoods, and a 'one team' culture that fosters collaborative behaviours by staff from different employers.

Supported by 'Health on the High Street'

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

By bringing access to a range of health and wellbeing activities into the heart of our town centres, we will improve access to health and bring socio-economic benefits through increased footfall on our high streets.

Figure 4: Health on the high street

Our acute services of the future

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

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

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

Hospitals within a system reorientated towards prevention and early intervention

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

The final **unique contribution** of the hospital is the speed at which it is designed to respond to urgent clinical needs. Unlike other parts of the health system, which operate around routine and pre-scheduled appointments often during the working week, hospitals are explicitly designed to respond to urgent care, constantly re-prioritising patients based on the severity of clinical need. Hospitals are open 24/7, 365 days a year and are constantly staffed at a level that enables them to respond adequately to every type of unscheduled medical emergency.

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

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

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

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

Our future will be… hospitals without walls.

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

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

Care delivery transformation

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

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

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

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

Acute Collaboration

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

The West Yorkshire Association of Acute Trust (WYAAT) service review is enabling provider trusts to focus on several areas, in particular what can be done once either as a **geographical partnership** or as part of a networked model. Through doing this collaboratively across several trusts, there is the potential to do some rapid mobilisation, learn and adapt, and maximise the potential of our fragile and limited services across our West Yorkshire footprint.

Secondary care as a service, not a building

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

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

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

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

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

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

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

1. Our core focus

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

2. Our geographical partnerships

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

3. Our shared workforce

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

4. Our emerging model

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

Our Partnership

Our financial plans

Value and values

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

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

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

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

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

Closing the Gap

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

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

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

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

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

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

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

Each health organisation has already developed a list of difficult decisions which we need to work through in 2025/26 to implement and make savings. As we work through these, we will need to make bigger decisions for the medium term and commit to the implementation of those changes. There is a pressing need to focus more broadly on **value not simply cost**.

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

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

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

Our plans include:

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

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

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

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

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

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

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

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

Our workforce plans

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

There are currently over **40,000 people** working in health and care services across Bradford District and Craven, making us the largest employing sector in the area. Across our place, we employ over 4,000 nurses and midwives, nearly 2000 doctors and dentists, over 10,000 people providing direct social care, and over 12,000 people working across our VCSE sector.

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

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

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

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

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

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

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

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

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

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

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

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

Our digital plans

The local context

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

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

The national drivers

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

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

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

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

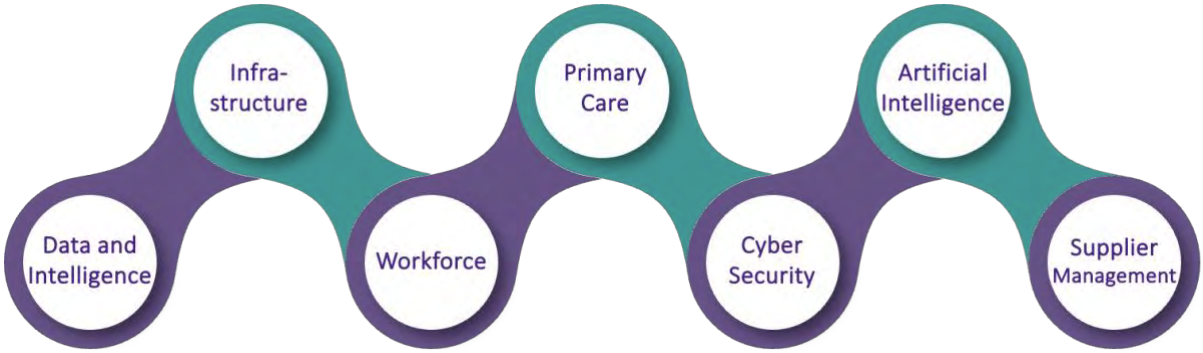


Figure 5: DDaT strategy seven key pillars

Our digital strategic principles

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

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

3. Workforce: creating an environment where our workforce is equipped and able to use technology, responding to changing needs and priorities, supporting talent management.

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

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

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

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

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

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

Our infrastructure plans

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

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

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

Current Position

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

Figure 6: Categorisation of healthcare facilities

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

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

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

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

Key Challenges

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

- Aged Estate, a significant proportion of our estate is operating beyond its expected useful life with our hospital estate (acute and mental health) carrying very high levels of backlog maintenance (£740m), of which £618m relates to critical infrastructure risk.
- Adequacy of estate and workforce to meet population growth (particularly demographic growth and the impact of additional housing) and the shift of more services into the community.
- Availability of capital, both NHS and private capital (the return on investment too low to attract investors, or results in schemes that are unaffordable).
- Securing core primary and community LIFT estate (seven sites in the Bradford District) where Lease Plus Agreements (LPA) on LIFT buildings expire starting in 2031. These buildings are modern, purpose-built healthcare facilities with no backlog maintenance that can be used flexibly with the potential for future expansion.
- Current economic climate with continuing cost inflation and high interest rates resulting in high capital development costs. Combined with the financial position of local Health and Care partners, this makes it even more challenging to address our infrastructure issues.

- No common platform for space sharing, which means that we are not able to make best use of the space that we have.

Where do we want to be?

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

To do this we will:

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

How will we get there?

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

1. Manage the demand for space within the acute hospital setting through the shift of services into the community and driving benefits from acute hospitals collaboration. This will include taking the opportunity to use community base sites differently, e.g. extending our use of space in shopping centres, or VCSE sites to provide easier access to local services;

2. **Retain** non-RAAC estate on the Airedale Hospital site for continued clinical use in line with the Place health, care and wellbeing plan;

3. **Retain** LIFT sites beyond the end of the initial concession period as key 'Core' community sites to support the development of community hubs; and

4. **Provide** additional primary care and community services capacity where required to respond to the impact of significant housing developments and replacement of estate, which is no longer fit for purpose.

Conclusion

Keeping our focus

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

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

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

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

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

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

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

We are what we do next.

Bradford District and Craven Health and Care Partnership

ACTasONE

our Vision

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

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

our Added Value

Our Population

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

Our Shared Purpose

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

Our Partnership

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

our Purpose

Narrowing the Gap

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

Our Workforce

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

Equity and Justice

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

Inverting the Power to Act

Sharing responsibility and power, for people to become active and engaged partners

Our Partnership Plan

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

our Commitments

We will all:

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

We will all:

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

We will all:

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

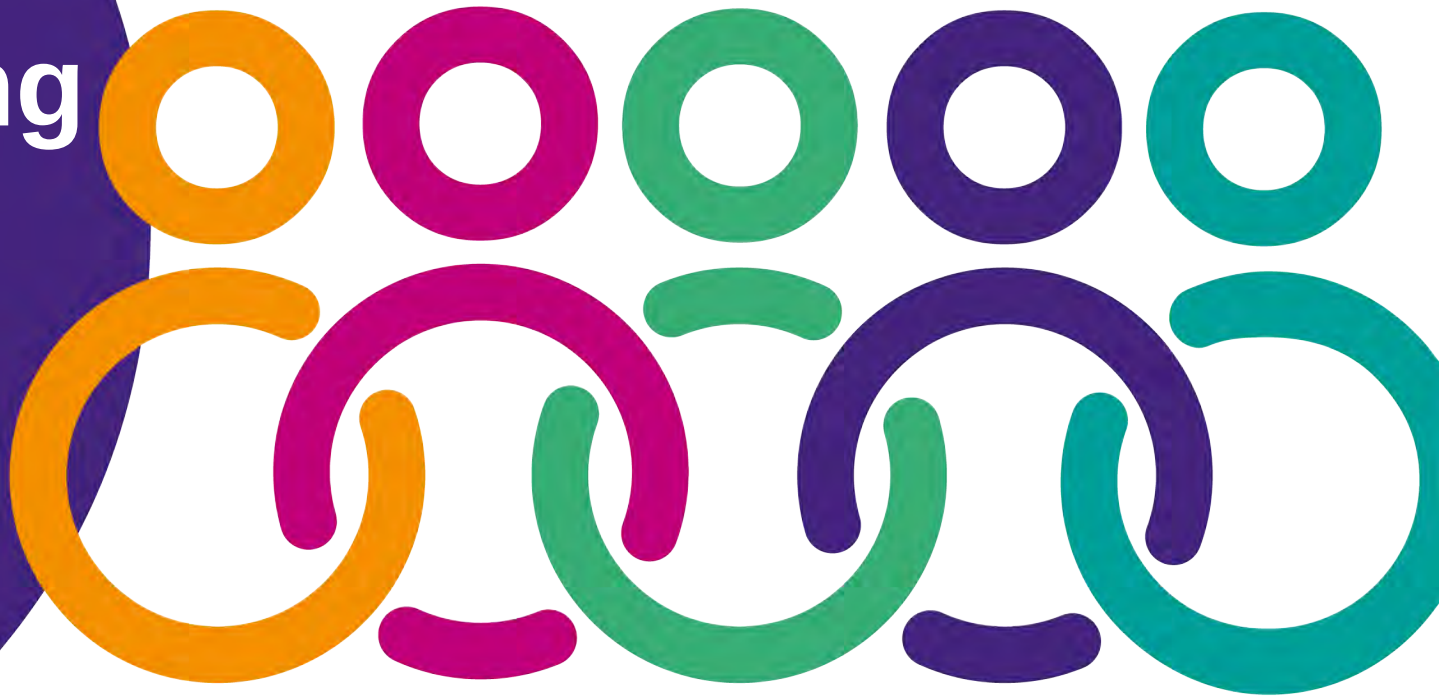
our Population → our Place → our Partnership

Report contact: clare.smart@nhs.net

Bradford District and Craven
Health and Care Partnership

ACTasONE

Financial & Operational Planning Update



Bradford District and Craven
Health and Care Partnership

Operational performance 2024/25 and 2025/26 plan

2024/25 performance

Bradford District and Craven Health and Care Partnership

Current (2024/25) performance shows:

- Continuing improvement against **elective recovery** 18-week targets with 27 waits over 65+ weeks and 2 over 78+ weeks at the end of February, although both Trusts showed further improvement in March with Airedale NHS Foundation Trust (ANHSFT) showing a significant reduction in 52+ week breaches to 49 (from 215 in February).
- **6-week diagnostic** performance continues to improve with Community Diagnostic Centre (CDC) and wider diagnostic reform continuing to progress as part of the ongoing place partnership oversight of the CDC.
- **Cancer** performance remains strong, although the biggest challenge continues to be the 62-day cancer treatment target. Cancer Alliance money for targeting the patient backlog in the form of running additional clinics is being actioned where appropriate.
- Delivering the **urgent & emergency care** metrics continues to be challenging for ANHSFT. Implementation of the Trusts recovery plan continues and a revised RAAC decant programme, to accommodate a 30 bedded winter ward going forward to mitigate the patient safety risk in winter, has been developed. Both Trusts are working closely with Yorkshire Ambulance Trust to improve handover times.
- Whilst **bed occupancy** remains relatively high at both Trusts, the number of patients with a length of stay improved in March, as did the percentage of patients with no criteria to reside. We have made progress on implementing the Intermediate Care plan that focusses on improving services to support people to get home from hospital in a safe and timely manner with the Home First Assessment Support Team continuing to be implemented across both Trusts, enabling people to have an assessment in their own home (instead of on a hospital ward) to determine any ongoing care and support.

2024/25 performance (cont)

Bradford District and Craven Health and Care Partnership

- Our **urgent community response** (UCR) and **virtual ward** (VW) services continue to support patient flow in terms of step up/step down pathways, with UCR seeing an average of 362 referrals/month (April 24 – February 25) and a VW bed occupancy of 76% in March.
- The number of **GP appointments** remains above 2024/25 planed levels and higher than the same period in 2024/23.
- Both the adult and children and young people **community services waiting lists** increased in February, with increases across a range of services at all three Trusts. However, the numbers waiting 52+ weeks improved.
- Following a spike in the number of **inappropriate mental health out of area (OOA) bed days** in March, the snapshot at month end showed a reduction from 23 to 17 inappropriate OAP patients (against a March plan of 11) with further reductions during April. This remains a challenge for Bradford District Care Foundation Trust (BDCFT) in terms of both the 2025/26 plan and financial cost.
- Performance remains above plan or national targets for the rest of our **mental health and learning disability key national metrics**.

Operational plan 2025/26

Bradford District and Craven
Health and Care Partnership

- 2025/26 plans submitted at the end of March
- Overview of final submission presented at System Finance & Performance Committee (27th March) and the Health & Care Partnership development session (28th March).
- In general, the plans deliver all the national expectations.
- Better Care Fund plans align with operational plans.
- Our current financial position and deliverability of challenging waste reduction / cost savings targets remains our most significant risk to delivering 2025/26 plans
- Workforce recruitment and staff engagement/moral also remain a risk as we try to deliver against stretching plans but with no real planned growth in staffing (in line with national expectations).

Bradford District and Craven
Health and Care Partnership

Financial performance 2024/25 and 2025/26 plan

2024/25 £ Outturn

Bradford District and Craven
Health and Care Partnership

Organisation	I&E reported Month 12 24/25		
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m
Bradford ICB	(7.8)	(17.1)	(9.3)
Calderdale ICB	0.0	2.6	2.6
Kirklees ICB	(0.0)	1.5	1.5
Leeds ICB	(12.3)	(11.5)	0.8
Wakefield ICB	(0.0)	(2.5)	(2.5)
WY ICB	21.5	32.1	10.7
West Yorkshire ICB Total	**1.4**	**5.2**	**3.8**
Airedale NHS Foundation Trust	(5.2)	(12.7)	(7.5)
Bradford District Care NHS Foundation Trust	0.0	0.2	0.2
Bradford Teaching Hospitals NHS Foundation Trust	(9.7)	(4.9)	4.8
Calderdale And Huddersfield NHS Foundation Trust	(0.9)	4.2	5.0
Leeds and York Partnership NHS Foundation Trust	1.0	1.2	0.2
Leeds Community Healthcare NHS Trust	1.0	1.9	0.9
Leeds Teaching Hospitals NHS Trust	7.9	19.9	11.9
Mid Yorkshire Hospitals NHS Trust	4.4	(15.2)	(19.6)
South West Yorkshire Partnership NHS Foundation Trust	(0.0)	0.2	0.2
Yorkshire Ambulance Service NHS Trust	0.0	0.1	0.1
West Yorkshire Provider Total	**(1.4)**	**(5.1)**	**(3.7)**
West Yorkshire ICS Total	**(0.0)**	**0.1**	**0.1**

WY ICS:

- Achieved plan (£0.1m better)
- ICB underspend £3.8m
- Provider overspend £3.7m
- Includes additional ERF funding of £30m in month 11
- Includes non-recurrent deficit support funding of c£50m.

BDC Place:

- Overall Place £11.8m overspend (£34.5m deficit), consisting of:
  - ICB £9.3m overspend (£17.1m deficit)
  - AGH overspend £7.5m (£12.7m deficit) after £10.9m support funding and £2.6m month 11 ERF funding
  - BDCT underspend/surplus £0.2m
  - BTHFT underspend £4.8m (deficit £4.9m) after £4.7m month 11 ERF funding

2025/26 £ Plan

Bradford District and Craven
Health and Care Partnership

Organisation	2025/26 Plan (£m)	2025/26 Efficiency (£m)
Airedale NHS Foundation Trust	(14.7)	20.0
Bradford District Care NHS Foundation Trust	0.0	14.3
Bradford Teaching Hospitals NHS Foundation Trust	(17.0)	33.0
Calderdale And Huddersfield NHS Foundation Trust	(42.1)	28.4
Leeds and York Partnership NHS Foundation Trust	0.0	18.5
Leeds Community Healthcare NHS Trust	0.0	14.0
Leeds Teaching Hospitals NHS Trust	0.0	89.0
Mid Yorkshire Hospitals NHS Trust	(22.8)	39.5
South West Yorkshire Partnership NHS Foundation Trust	0.0	28.2
Yorkshire Ambulance Service NHS Trust	0.0	23.1
Sub Total - Providers	**(96.5)**	**308.0**
ICB Bradford	0.0	17.2
ICB Calderdale	1.7	5.3
ICB Kirklees	3.5	9.2
ICB Leeds	0.0	30.7
ICB Wakefield	0.0	7.2
ICB WY	91.3	51.1
Sub Total - ICB	**96.5**	**120.7**
TOTAL - ICS	**(0.0)**	**428.7**

WY ICS:

- Breakeven plan
- Includes £40m additional recurrent funding
- Includes £49.2m non-recurrent deficit support funding
- £33m system risk in ICB WY line (to be redistributed)
- £428.7m efficiency target = 6.6%

BDC Place:

- Overall Place £31.7m deficit plan :
  - £14.7m AGH (5.4% of t/o) after £10.8m deficit support funding
  - £17.0m BTHFT (2.7% of t/o) after £5.7m deficit support funding
- Efficiency plans=
  - 7.3% AGH
  - 6.5% BDCT
  - 5.2% BTHFT
  - 3.8% ICB
- High risk levels

Corporate Cost Reduction Target (Providers)

Bradford District and Craven Health and Care Partnership

	50% Target £m
Airedale	1.347
Bradford Teaching	1.666
Bradford District Care	1.807
Calderdale and Huddersfield	1.868
Leeds Teaching	8.396
Mid Yorks	5.295
Leeds Community	2.916
Leeds and York Partnership	2.340
South West Yorkshire Partnership	2.190
YAS	8.465
Total	**36.290**

- Based on growth in Corporate Benchmarking returns 2018/19 vs 2023/24
- Scope:
  - Finance and procurement
  - HR and payroll
  - Digital
  - Governance, legal and risk
- Trusts looking at ***all*** support services
- Plan required by end May 2025
- Implementation Q3 2025/26
- Redundancy funding/ MARS scheme?

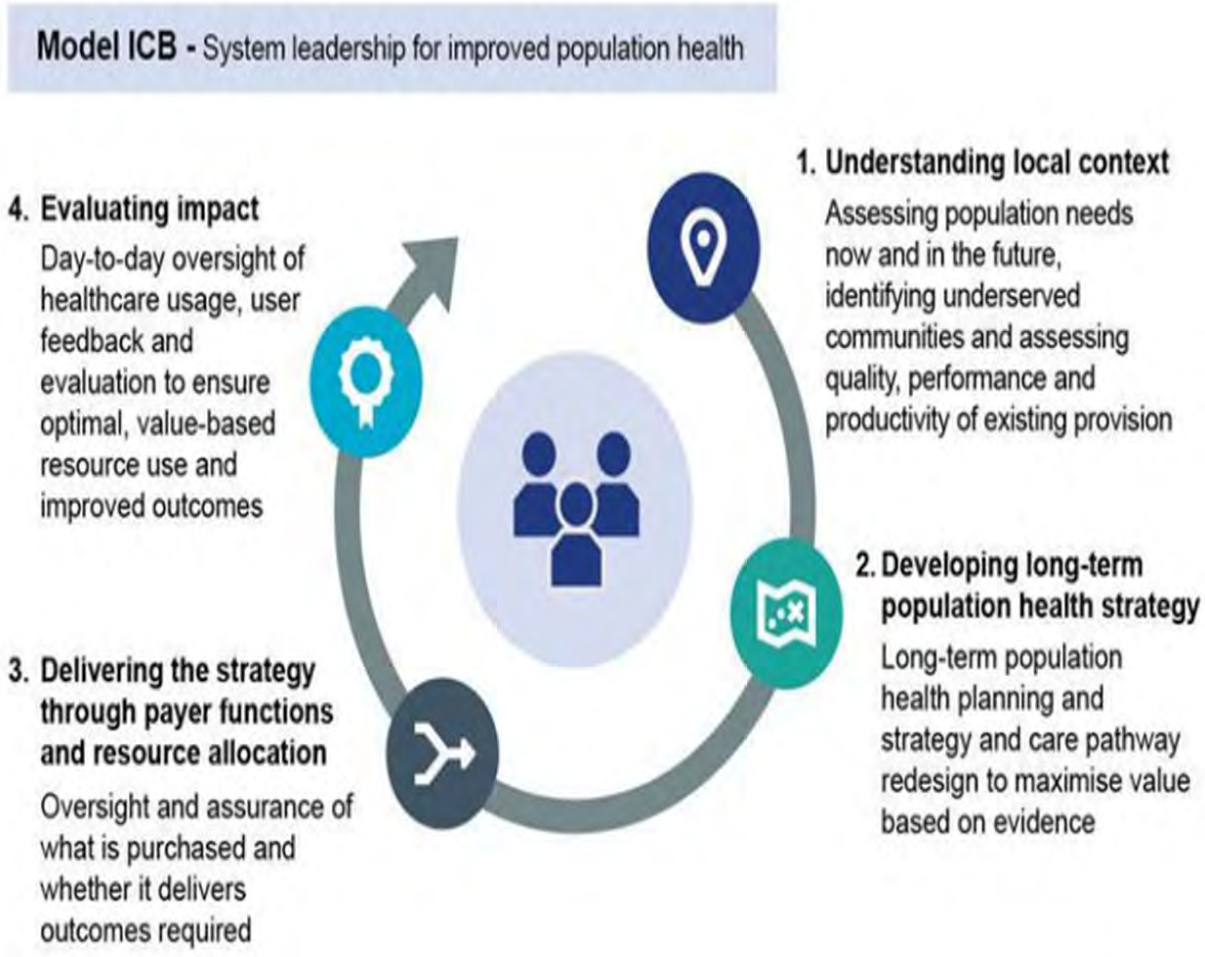
- Does not:
  - Take account of variations in 2018/19 baselines (different quality of services)
  - Correlation to funded expansion of front-line services

- Risks:
  - Self-sabotage (impacts ability to support transformation/savings/free clinical time)
  - Timescales
  - Morale
  - Disruption and wider system impact

ICB Restructure

Bradford District and Craven
Health and Care Partnership

- £18.76 per head of population has been set nationally. This is a total (after the required savings) of £51.7m for WYICB.
- WYICB was already at a slightly lower cost than average so will require approx. 45% reduction to current cost (rather than the 50% quoted in the media)
- 'Model ICB – Blueprint v1.0' published 2/5/25 – high level outline of the future functions of ICBs. What functions will remain and grow, what will reduce/adapt, what will move to Region, INHTs, or to Provider Collaboratives.
- Timescales: plans to deliver the cost envelope to be submitted to regional lead by 30 May 2025 and fully implemented by end of Q3
- Awaiting national advice on VR and MARS
- Some functions will transfer in time as require legislation changes



£33m WY system risk redistribution

Bradford District and Craven
Health and Care Partnership

Proposal to distribute to Places:

- use 2025/26 weighted place populations to create an indicative value by place
- adjust at places to recognise distance from target funding
- Places to determine how the improvement target will be disaggregated across each (by May 23rd)
- this will provide a revised plan from month 2

To support the conversations in place about opportunities and risks, there are a **range of financial metrics** and measures which have been provided through the finance network which may also be helpful:

- Efficiency plan vs productivity opportunity (benchmarks)
  - Cash releasing
  - Non-cash releasing
- Normalised forecast/ outturn
- Deficit plans (normalised)
- Efficiency as % of turnover

- 2024/25 underlying position vs plan
- Acute services contract review (vs PbR)
  - Local
  - National
- Reference costs

It is expected that sufficient regard will be taken to where the opportunities for further efficiencies and cost reduction exists, as well as the extent to which individual organisations should move towards break-even positions

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Partnership Board
Agenda item no:	11
Meeting date:	23rd May 2025
Report title:	Better Care Fund 2025-26 sign off
Report presented by:	Iain MacBeath
Report approved by:	Iain MacBeath
Report prepared by:	Javeid Karim

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

Previous considerations:

N/A

Executive summary and points for discussion:

The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have released the Policy Framework for the Better Care Fund (BCF) for 2025–26. This updated guidance introduces key changes to the national conditions and metrics governing the fund. Local areas must submit three key documents by 31st March 2025: **the Planning Template, a Supporting Narrative, and the Capacity and Demand Template.**

Notable changes to the BCF include the **amalgamation of the Discharge Fund** into the Local Authority Better Care Grant (formerly the Improved Better Care Fund) and the NHS Minimum Contribution, forming the consolidated Better Care Fund total for 2025–26. The ring-fenced portion of the ICB Discharge Fund within the NHS Minimum Contribution has been removed, with these funds now included as part of the overarching BCF total.

The Policy Framework outlines four national conditions that all BCF plans must meet for approval:

- A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.
- Implementing the two new BCF Policy Objectives:
  - To support the shift from sickness to prevention
  - To support people living independently and the shift from hospital to home
- Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care.
- Complying with oversight and support processes.

In the years ahead, we are dedicated to evaluating the core services within the BCF to achieve their full potential. **Our goal is to deliver positive, meaningful outcomes for individuals, while adhering to the policy objectives and ensuring the best possible value for money**. A key change in the 2025–26 BCF plan is the adoption of a more strategic, data-driven approach to service delivery. This approach will empower us to make informed decisions and maximise the impact of our services. We will begin this process with a comprehensive review of our Intermediate Care offer and the Community Equipment Service, BACES.

The BCF provides essential financial contributions to sustain our core services, as listed in the planning template (appendix 1). The plan has been developed by the Planning and Commissioning Forum who have ensured the expenditure continues to align with the policy framework and uphold compliance standards. The BCF funding has been pooled under a Section 75 agreement (appendix 4). Additionally, the NHS contribution to social care from the Integrated Care Board (Bradford District & Craven) has been jointly agreed and meets or exceeds the minimum expectation.

The BCF 25-26 comprises three key funding streams:

- Better Care Fund (BCF) - £55.76m
- Local Authority Better Care Grant - £28.85m
- Disabled Facilities Grant (DFG) - £6.37m
- DFG Carry Forward from previous year - £1.3m

This totals just under £91m, representing an 11% increase compared to the 2024/25 position. Finance leads from both organisations have collaborated to update the 2025–26 spending plan, ensuring it reflects priorities and aligns with strategic objectives.

Key updates to the funding allocation include:

- **Enhancements across existing BCF services:** These include expanded staffing within the Bradford Enablement Support Team (BEST), workforce upskilling across all service areas, and increased therapy and social work input for in-house residential beds (Pathway 2).
- **Improved assistive technology (TEC) offerings:** Aimed at further supporting independence and care delivery.
- **Developments in urgent community response services:** Such as Virtual Ward, Rapid Response, and the Trust Care Falls Response service.
- **Strengthening other key services:** Continued investment in services including MAST (Multi-Agency Support Team), MAIDT (Multi-Agency Integrated Discharge Team), Support for Carers, and Direct Payments to ensure their ongoing impact and alignment with core objectives.

Our performance is evaluated based on three key metrics:

- **Emergency Admissions:** This has been a consistent focus of the BCF, with reporting on this metric in previous years.
- **Discharge Delays:** A newly introduced metric and reporting requirement for the NHS. We are actively collaborating with hospital trusts to gather and refine the necessary data.

- **Residential Admissions:** Previously reported in past years, this remains an important area of measurement for BCF planning.

The BCF 25-26 plan commits to either maintaining or improving current delivery.

A Capacity and Demand plan for 2025-26 is included in the appendix. We will use this to understand our performance and support out decision making across the services.

Where appropriate, the BCF plan aligns with the Bradford District & Carven operational plan.

Prior to the final plan being presented to the HWB in June, the BCF is being discussed at a range of our Health & Care Partnership governance meetings.

Outline how this supports our partnership vision and strategy

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

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

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

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

Recommendation(s)

The Partnership Board is asked to:

1. To note the updates to the Better Care Fund 2025-26 plan
2. To provide assurance that the BCF Plan is compliant with the National Policy and Planning requirement for 2025-26

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. BCF 25-26 Planning template
2. BCF 25-26 Narrative
3. BCF 25-26 Capacity and Demand template
4. Section 75 Schedule

Acronyms and Abbreviations explained

1. BCF – Better Care Fund
2. WY - West Yorkshire
3. HWB - Health & Wellbeing Board

4. DFG - Disabled Facilities Grant
5. LA - Local Authority
6. ICB - Integrated Care Board
7. BACES – Bradford and Airedale Community Equipment Service

What are the implications for?

Residents and Communities	Delivery of services that will meet the needs of the population, and improve population health
Quality and Safety	Delivering high quality and safe services
Equality, Diversity, and Inclusion	Services accessible to all
Finances and Use of Resources	-
Regulation and Legal Requirements	-
Conflicts of Interest	-
Data Protection	-
Transformation and Innovation	Service transformation to deliver improved performance
Environmental and Climate Change	-
Future Decisions and Policy Making	Performance against strategic priorities to inform decision making
Citizen and Stakeholder Engagement	-

Integration and Better Care Fund

Bradford District Better Care Fund 2025-26 Narrative Plan

March 2025

Contents

Bradford District Better Care Fund 2025-26 Narrative Plan 1

1. **Overview** 3
2. **Background and Context** 6
3. **Governance and Approach to Joint Commissioning** 7
4. **Executive Summary** 14
5. **National Condition 1** 23
6. **Goals and Performance** 25
7. **Disabled Facilities Grant** 28
8. **Local Priorities** 30

© NHS England 2024

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

1. Overview

Health and Wellbeing Board(s)	Bradford
Local Authority	City of Bradford Metropolitan District Council
Integrated Care Board (ICB)	NHS West Yorkshire Integrated Care Board
Boundary Differences	The West Yorkshire ICB covers the geography of the five upper tier Local Authorities in West Yorkshire, plus the Craven District of North Yorkshire. Bradford District is wholly within the geography of the ICB
Date of narrative submission:	31st March 2025
Minimum required value of pooled budget for 2025/26:	**£92,278,236**
Total agreed value of pooled budget for 2025-26:	**£92,278,236**
National Conditions	This plan is compliant with the following national conditions of the BCF planning framework: **NC1:** A Jointly agreed plan **NC2:** Implementing BCF Policy Objectives **NC3:** Comply with Grant conditions (including NHS minimum contributions) **NC4:** Comply with Oversight and support processes

Authorisation and sign-off of the Bradford District Better Care Fund

This Better Care Fund Plan has been produced by local partners who work together as the Bradford District and Craven Health and Care Partnership. This consists of officers across NHS West Yorkshire Integrated Care Board (referred to as the ICB) and City of Bradford Metropolitan District Council (CBMDC), with support from the Voluntary Community and Social Enterprise Sector, Social Care Providers, Housing representatives, Disabled Facility Grant leads, and the NHS trusts—Bradford Teaching Hospitals NHS Foundation Trust, Airedale NHS Foundation Trust and Bradford District Care Trust.

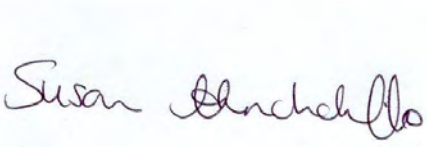
This plan has been jointly agreed by CBMDC, the ICB and the Chair of Bradford Health and Wellbeing Board. The plan has been presented at a number of forums including the Bradford District and Craven Health and Care Partnership's Partnership Board and Partnership Leadership Executive.

© NHS England 2024

Signatories

Signed on behalf of the ICB	NHS West Yorkshire Integrated Care Board
By	Rob Webster
Position	Chief Executive
Date	24 March 2025

Signed on behalf of the Council	City of Bradford MDC
By	Lorraine O'Donnell
Position	Chief Executive
Date	26th March 2025

Signed on behalf of the Health and Wellbeing Board	Bradford and District Health and Wellbeing Board 
By	Councillor Susan Hinchcliffe
Position	Chair of the Bradford Health and Wellbeing Board
Date	26th March 2025

© NHS England 2024

© NHS England 2024

2. Background and Context

The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have published a Policy Framework for the implementation of the Better Care Fund (BCF) for 2025-26. The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved.

These are:

1. A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.
2. Implementing the BCF Policy Objectives:
    - To support the shift from sickness to prevention
    - To support people living independently and the shift from hospital to home
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care
4. Complying with oversight and support processes

The Adult Social Care Discharge Fund, also known as the Discharge Fund, has been merged into the Local Authority Better Care Grant (previously called the Improved Better Care Fund) and the NHS Minimum Contribution to create the new Better Care Fund total for 2025-26. The ring-fenced portion of the ICB Discharge Fund within the NHS Minimum Contribution for 2025-26 has been removed and is now part of the broader Better Care Fund total.

The BCF is held by the Council and the ICB support schemes which sustain admission avoidance, enhanced personalisation, supporting prompt hospital discharge to return people back to their normal place of residence and improve equality and reduce health inequalities.

We have developed this narrative alongside the BCF planning template to respond to the BCF Policy Framework and BCF Planning Requirements for 2025/26.

© NHS England 2024

3. Governance and Approach to Joint Commissioning

We are dedicated to continuously improving our services to better the lives of people we support. We do this by regularly reviewing our joint working arrangements (BCF and Section 75) and provide regular updates to maintain effective service delivery.

In West Yorkshire, we are affording greater delegation to places within the NHS West Yorkshire Integrated Care Board (ICB) model, in recognition of our principles of subsidiarity. Recent changes to our ICB constitution, scheme of reservation and delegation (SoRD), and our financial scheme of delegation (FSoD) have been guided by arrangements for delegation and joint exercise of statutory functions. These changes support delegation to all five place sub-committees of the WYICB Board and place leads as signatories for the BCF and s75 agreements. These amendments were approved at WYICB Board meeting on 17 December 2024 ICB Board, and an application is due to be made to the NHS England constitution assessment team following ratification of minutes on the 18 March 2025. Therefore, for the year 2025/26 BCF submissions these will be signed-off by the CEO of the ICB, as timing of submissions for the 2025/26 BCF fall under our current constitution.

The equivalent sign-off of the BCF plan will be conducted by the Local Authority, with the Corporate Management Team, chaired by the Chief Executive of Bradford Council. This process will ensure full compliance with BCF governance requirements for local sign-off. Detailed information on our monitoring and assurance of the BCF is provided below.

3.1 System Leadership and Act as One

The Health and Wellbeing Board is the lead partnership in the Bradford District Partnership working closely with the other Strategic Delivery Partnerships.

The Health and Wellbeing Board brings together leaders from across the district including the Council, the NHS, the Police, Fire and Rescue, social housing and the Voluntary and Community sector.

Our shared ambition is:

To create a sustainable health and care economy

that supports people to be healthy, well and independent

The Board provides strategic direction to a wide range of organisations that organise health and wellbeing services, and support people to take good care of their own health and wellbeing; helping more people to take control of their lives and to have more of a say in how their health and wellbeing needs are met. We will lead real improvements in the long-term health and wellbeing of all our population.

3.2 Bradford District and Craven Partnership Board (PB)

The Bradford District and Craven Partnership Board is established as a sub-committee of the NHS West Yorkshire Integrated Care Board (ICB) and meets quarterly. Its role is to lead the Bradford District and Craven place-based health and care partnership in accordance with the Bradford District and Craven Strategic Partnering Agreement (SPA), and in accordance with the Constitution of the West Yorkshire Integrated Care Board. The Partnership Board provides assurance on the BCF to the ICB prior to sign off from both the ICB and the Health and Wellbeing Board.

The Partnership Board membership has agreed to work towards a common vision that:

- People will be healthier, happier, and have equitable access to high quality care. Our Health and Care Partnership strategy sets out the priority areas of our 'Purpose', 'Population', 'Place', and 'Partnership' as well as a 'spotlight' focus on children and young people. By working to improve on these focus areas we will address the imbalance within our system and allow equal access to health, social and wellbeing services.
- People will be in control of their health and wellbeing, and will be supported to stay healthy, well and independent through their whole life. Communities and the health and care system will co-produce health and wellbeing and will focus on prevention and early intervention.
- Reducing the widening health inequalities in Bradford District and Craven (BD&C) is a priority. We will tackle inequality in access and quality of healthcare, and we will contribute to addressing the wider causes of inequality by playing a full part in social and economic development and environmental sustainability.
- When people need access to care and support it will be available to them through a proactive and joined up health, social care and wellbeing service designed around their needs. Access to services will include digital options and will be provided as close to where they live as possible.

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

3.3 Partnership Leadership Executive (PLE)

Our Health and Care Partnership Management Forum, the PLE, has two roles.

The first is to support the NHS West Yorkshire Integrated Care Board (ICB) on issues within its remit. The second is to support the wider place partnership. Support is provided through advising and working collaboratively with all members of the partnership.

In practice, the PLE carries out both roles by reporting to the Bradford District and Craven Health and Care Partnership Board, which comprises senior leaders from the Place Partnership and is a committee of the ICB.

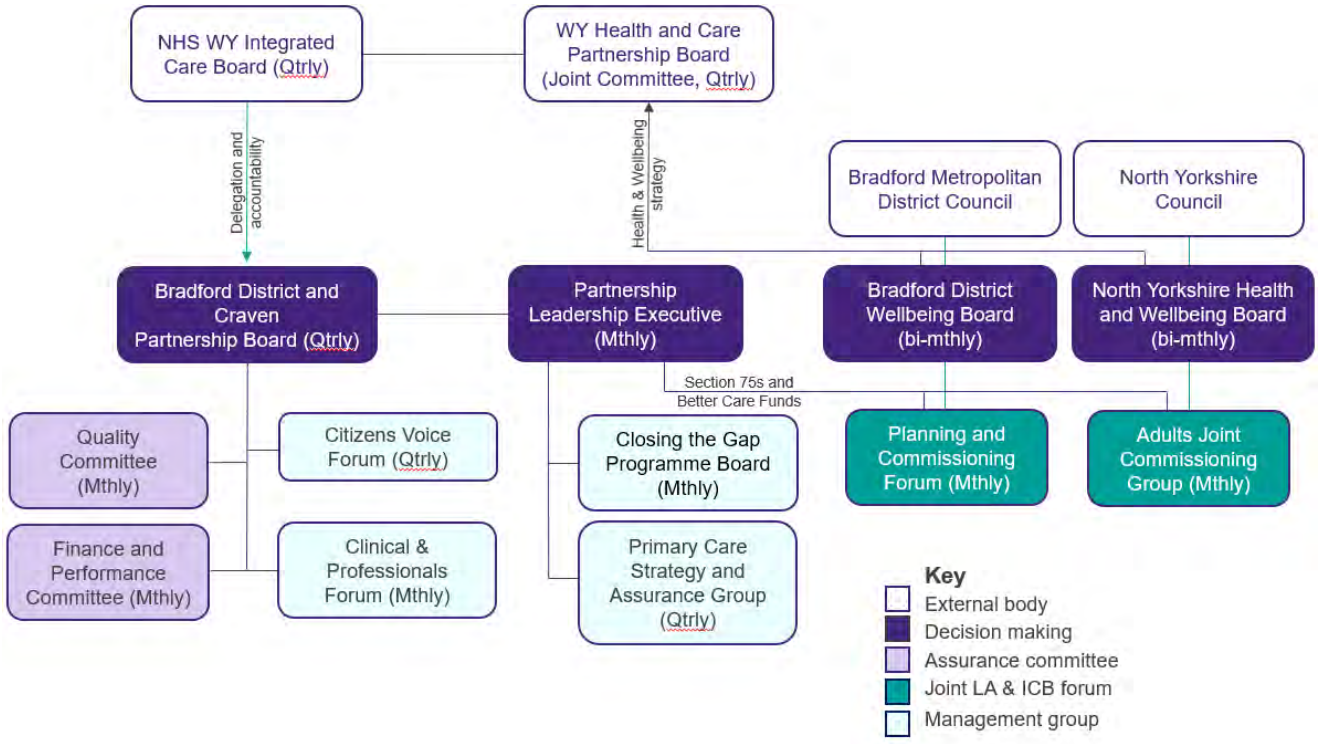
The members of the Partnership Leadership Executive are:

- The BDC Partnership Place Lead, Chair of the Partnership Leadership Executive (Chief Executive of Bradford District Care Trust).
- The Chief Executive of Airedale NHS FT
- The Chief Executive of Bradford District Care NHS FT

© NHS England 2024

- The Chief Executive of Bradford Teaching Hospitals NHS FT (Place Lead)
- The Chief Executive of City of Bradford Metropolitan District Council (CBMDC)
- The Strategic Director of Health and Wellbeing of CBMDC
- The Director of Public Health of CBMDC
- The Director of Children's Services of CBMDC
- The Chair of the BD&C Clinical Advisory Board
- The Medical Director of the Local Medical Committee
- The Chair of the BD&C Clinical Forum
- The Chief Executive of the Bradford Care Association
- The Voluntary, Community, and Social Enterprise Sector System Lead

Figure 1: Bradford District and Craven Health and Care Partnership governance arrangements



3.4 System Leadership through Act as One

'Act as One' describes our approach for our health and care partnership for Bradford District and Craven that serves a population of around 658,000 people with a health and care workforce of over 30,000 supported by over 5,000 Voluntary and Community Sector organisations. The partnership is made up of NHS, Local Authority, Healthwatch, community and Voluntary Sector organisations and independent care providers.

Our focus is on preventing ill health as much as possible. We will create opportunities that help people stay healthy, well, and independent and tackle inequalities across our communities. We will

© NHS England 2024

prioritise prevention and early intervention, fostering healthy lifestyles, self-care and nurturing active communities so that people are happier, healthier and more independent.

Our Partnership has been working together to refresh our priorities, which are:

- Healthy communities
- Access to care
- Healthy minds
- Workforce
- Children, Young People and Families

Our priorities are supported by five enabler programmes which are.

- Research and innovation
- Living well
- Digital data intelligence and insight
- Estates
- Reducing inequalities

We are committed to transforming our systems and modernising health and social care in our area so that our local communities can enjoy the right quality of service and support at the right place at the right time, provided by the right person. Our success in doing so will be determined by local people and depend on our ability to bring together and maximise the potential of our shared resources across health and social care. Our approach requires determined and purposeful leadership that recognises and steps up to the challenge of a creating and realising a new ambition.

Our partnership needs to prepare us for a sustainable future, from sharing good practice, collaborating on workforce developments, to enabling integration to support delivery. Collaboration has become an essential part of a sustainable future; allowing us to design how we will work as we move to acting as one integrated care partnership.

We Act as One in our approach to planning, recovery and priority setting in our pursuit of improved health outcomes. We are held to account, and hold ourselves to account, for the reduction in health inequalities for our population. By doing this we will move closer to our vision of people living ‘happy, healthy at home’.

The system priorities demonstrate how we agree and operationalise our approach to integration with member representation on our boards and committees from our system stakeholders. Joint initiatives such as the joint commissioning road map, development of the system Planning and Commissioning Forum and other key initiatives are leading to sustainable plans for delivery of services.

Our partnership has put reducing health inequalities centre stage in our local strategy and supported this by a dedicated team who have developed a Reducing Inequalities Alliance with NHS and other partners.

© NHS England 2024

Additionally, our Place has begun to utilise resources collectively through creation of joint posts at system level. The Strategic Director Health and Wellbeing within the Council also holds the post of Director of Integration within Bradford District Care NHS Foundation Trust.

3.5 Joint Commissioning

Our senior leadership team consists of assistant directors in the Council who work in conjunction with lead representatives from the West Yorkshire ICB. We have a single joint commissioning approach across the partnership, which is underpinned by Act as One. This is further strengthened with a recently developed People Commissioning Team within the Council.

Our joint commissioning work progresses through our Planning and Commissioning Forum. The Planning and Commissioning Forum (PCF) helps to provide system leadership and strategic direction to the joint planning and commissioning arrangements within the Act as One local framework across Bradford District.

Our strong relationships with the Independent Sector and Voluntary, Community and Social Enterprise (VCSE) and the Bradford Care Association work collaboratively to deliver the highest levels of care and support to our service users. Through our regular provider forums we identify pressures in our system and work together to tackle service challenges in the community.

3.6 Better Care Fund Management and Oversight

Governance of the Better Care Fund Programme is through the Bradford Health and Wellbeing Board, a statutory committee of Bradford Council.

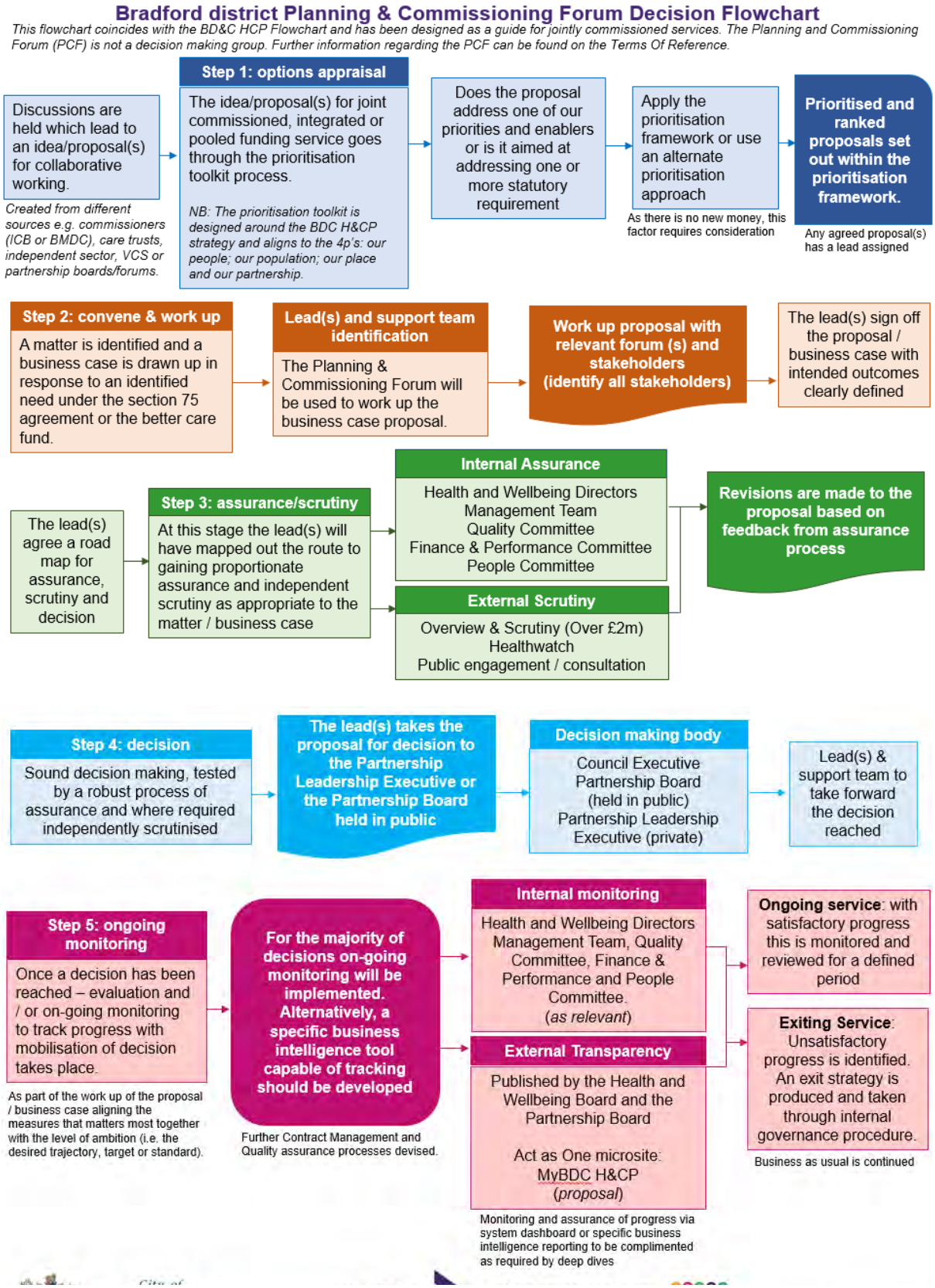
The Planning and Commissioning Forum offers pivotal leadership and strategic guidance for the joint planning and collaborative commissioning efforts within the Health and Care Partnership. This encompasses operational management of the Better Care Fund, its various initiatives, and the oversight and support mechanisms involved in BCF planning. Additionally, the Forum oversees joint commissioning arrangements established under Section 75 (S75) agreements.

Figure 2, below, demonstrate some of the key groups involved in the BCF planning. These groups provide scrutiny of the BCF plans to ensure it is meetings its intended outcomes. These groups also support in the delivery of our partnership objectives and report to the PLE and Partnership Board.

Together, these arrangements provide assurance to the Partnership Leadership Executive (3.3) and the Partnership Board (3.2).

© NHS England 2024

Figure 2: Bodies involved strategically and operationally in preparing the BCF plan



© NHS England 2024

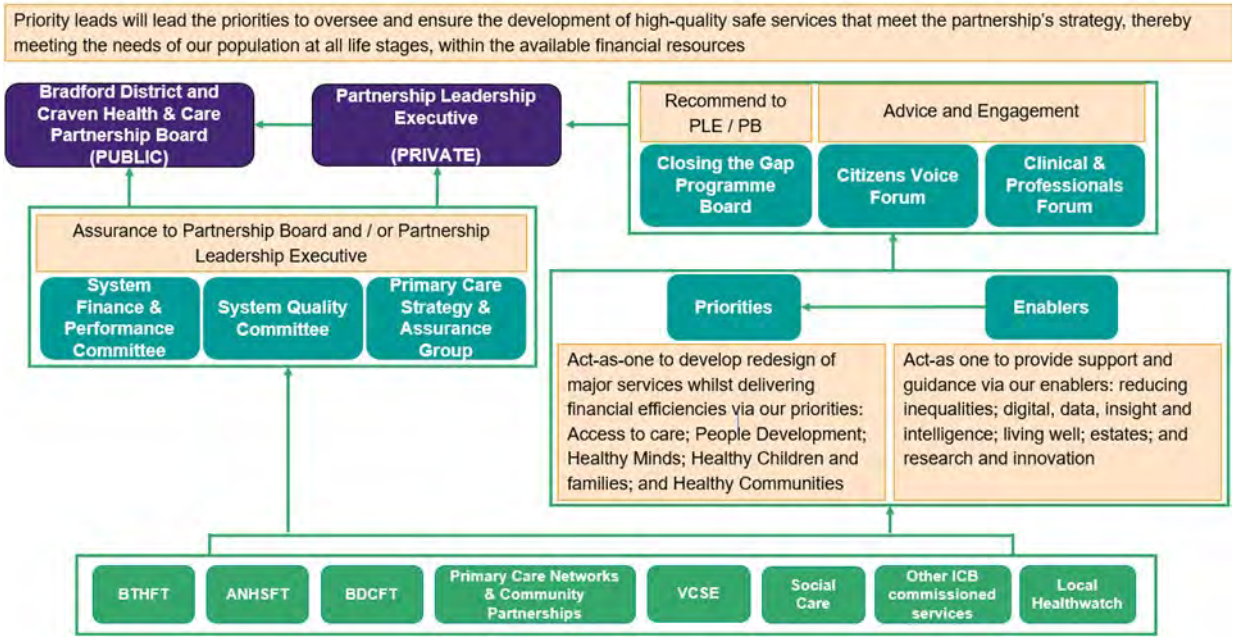
3.7 Financial Planning Principles

Where appropriate the BCF and the NHSE's published planning guidance will be utilised for financial planning, which will be aligned with the Partnership's strategy, objectives, and priorities for both the current and future years. The Partners concur that the future investment decision-making process for Bradford District and Craven should explore options and develop plans for the most effective use of available resources in an integrated manner.

Any growth funding within overall allocations can be used flexibly with agreement from the Partners (as shown in Figure 1). This includes aligning growth to the strategic priorities, funding investment decisions, and aiding disinvestment decisions for long-term gain.

A flow diagram illustrating the financial decision-making process is displayed in Figure 3. It is crucial for the Partners to have a clear understanding of the baseline/underlying financial position for Bradford District and Craven to determine the viability of additional investment or disinvestment that impacts the run rate. Any such proposal will require an appropriate business case with clearly articulated benefits, financial impact, and measurable KPIs. The designated programme lead will present the business case to the Business Case Approvals Panel, adhering to the principles outlined in the terms of reference.

Figure 3: Strategic Partnering Agreement: Annex 1 – Financial Governance Framework



© NHS England 2024

4. Executive Summary

4.1 Priorities for 2025-26

Over the past two years, we have leveraged the Better Care Fund (BCF) to transform and enhance our services, aiming for a sustainable future for Bradford. The BCF services are designed to keep people independent at home for longer, emphasising prevention over sickness, and where hospital admission is necessary, to ensure patients can return home promptly with the right level of care and support. This includes using digital tools to tailor care packages and improve outcomes and service delivery.

As a partnership, we have developed our joint workforce and intermediate care services. Our aims for 2023-2025 were to understand how our services operate and meet the demand across all services. As shown through our BCF returns during this period, we have achieved our targets and continue to work collaboratively to maximise resources.

Looking ahead, we aim to review core services within the BCF to optimise them fully, achieving positive outcomes for individuals while ensuring best value for money and reducing pressure on hospital systems. The key difference in this year's BCF plan is a targeted approach to analysing service delivery to make informed decisions on maximising outputs in meeting the BCF policy objectives.

Building on this targeted approach, our commitment to evolving and improving services within the BCF will include a comprehensive review with a focus on transitioning from analogue to digital. This will involve assessing current service delivery methods and identifying opportunities where digital tools can enhance efficiency, accessibility, and independence for individuals. By embracing digital innovation, we will ensure our services remain future-ready and inclusive, while continuing to meet the diverse needs of our community.

For 2025-2026, we decided to focus on two core service offers: the Bradford and Airedale Community Equipment Service (BACES) and our Intermediate Care Offer, critical in supporting the policy objectives as described in Section 5.

Our long-term BCF plans include:

- Enhance and grow our technology enabled care offers to enhance our service models to promote independence and self-management, empowering people and increasing their confidence in managing their own health and wellbeing.

- Continue to build and enhance our ‘Home First’ discharge to assess model with an ambition to discharge people within 24hrs of no longer meeting the criteria to reside across all discharge pathways.
- Ensure consistent implementation of discharge and Moving on Policies and follow the 5 principles of the SAFER bundle.
- Manage our health and social care intermediate care units through a standard operating procedure.
- Continue to enhance our Virtual Ward offer to ensure the right balance between step up and step-down care and interventions.
- Continue to improve integration of mental health services into our community offer.
- Maximise the use of existing Voluntary and Community Sector Enterprise Organisations.
- Review the pathways for our existing Points of Access to determine opportunities around improved integration, co-location, increased efficiency, to streamline our multiple points of access.
- Review our existing UCR services to ensure they are consistently delivering against all 9 core UCR components and identify potential gaps and develop a plan for improvement.
- Continue to build and enhance our community multidisciplinary team offer to ensure there are robust pathways to ensure people discharged on HFAST can be referred into our emerging integrated MDT model if needed to ensure ongoing care coordination and support closer to home.
- Deliver a range of service improvement projects alongside independent home support providers to enhance their knowledge and skills enabling them to make every contact count when supporting individuals in their own home.
- Continue to improve data flows and interpretation of local data to ensure service improvements are data driven and meet the needs of the population with the greatest needs to address health inequalities and equity of service delivery models.

We will strengthen our joint working through enhancements to existing BCF services and budget alignment, promoting further integration within Bradford’s health and care services. Our organisational plans prioritise upskilling staff and maximising collaborative working. We will continue to break down organisational barriers, promote cohesion through joint commissioning, and explore opportunities for integrated working.

© NHS England 2024

We will capitalise on available funding streams to reduce delayed hospital discharges, develop Urgent Community Response services, and address workforce recruitment and retention challenges. Our services will remain versatile and responsive, dedicated to older people, those with mental ill health, and people with learning disabilities.

4.2 Supporting people to remain at home

Our jointly commissioned BCF services continue to:

- work with communities to build on resources to support people outside of council funded support
- reduce the need for ongoing support from adult social care
- ensure our support builds on the strengths and abilities of people, their families and their local communities
- tailor the on-going support we provide to individuals through personal budgets, creative support planning and building on people's strengths and resources
- reduce waiting times for people contacting adult care and support

The focus in our BCF services remain in line with the BCF policy objectives through the delivery of enablement, home support and intermediate care. We continue to expand our **Tech Enabled Care (TEC)** offer and invested in equipment services which has enabled people to be independent at home for longer.

We also offer **direct payments** as part of our personalised commissioning initiatives. Direct payments offer flexibility and choice to service users by meeting their needs through a bespoke package of care delivered by a provider of their choice.

We also offer a diverse range of **daytime activity services** tailored for individuals and groups, including people of the global majority, older adults, and LGBTQ+ communities. These services provide dynamic support, fostering cultural awareness and helping individuals stay independent, active, and connected within their communities.

© NHS England 2024

4.3 Key changes since the previous BCF Plan

We have invested significant time and effort in gaining a deeper understanding of our resources while identifying opportunities for stronger collaboration. Through this process, we have carried out key service reviews over the past few years, shaping both our strategic planning and allocation of the Better Care Fund (BCF) for 2025-26.

A key example, highlighted in our BCF 2023-25 plan, was the Intermediate Care Review, which identified areas for improvement and development within our IMC offer. Building on these findings, we have since developed an IMC blueprint, providing a structured framework for driving service enhancements. As a result, IMC has been prioritised for further review in 2025-26, ensuring we maximise value for money and deliver better outcomes for service users.

Looking ahead, we plan to apply this comprehensive review approach across all services within our BCF plan in the coming years. As previously outlined, we will begin with IMC and BACES, before expanding this process to other key services. Our commitment to ongoing evaluation and refinement will enable us to make data-led decisions, ensuring effective resource utilisation and improved results for individuals in need.

There are several changes to our jointly commissioned services that meet the BCF Policy objectives and are aimed are reducing demand on hospital and community services.

Bradford Enablement Support Team (BEST) is our enablement service. It has expanded to incorporate multiple teams that assess patients in the hospitals as well as in the community. It is an integrated service that provides an assessment period for up to 6 weeks. Where long term needs are identified, the service works with the independent sector to provide a smooth transition of care from hospital to the person's usual place of residence or support with the transition to a long-term domiciliary care provider. This allows us to respond to the demand for home support from hospitals and within the community.

We have made several enhancements within BEST including the introduction of **Home First Assessment Team (H-FAST).** This service focuses on providing intensive support to individuals as soon as they are well enough to leave the hospital, allowing them to return home in a timely manner for an assessment of their ongoing needs. H-FAST encompasses a multidisciplinary team approach with therapy teams working alongside the BEST. Since its introduction, H-FAST has won the 'Pride of Airedale' award for quality and improvement and Bradford Councils Service Excellence Award for Innovation. This recognition highlights the team's exceptional work in delivering integrated care, improving outcomes for people and significantly reducing hospital stays.

The H-FAST service has made significant strides in improving care and reducing hospital stays. However, there are still areas we can focus on to enhance the service further such as:

- **Resource Allocation:** Ensuring adequate resources and staffing to meet the growing demand for the services. We also aim to further align the service with physiotherapists to maximise the outcomes of those accessing the service.
- **Enhanced Collaboration:** This includes strengthening our partnerships with local health and social care providers to ensure seamless transitions and comprehensive support for individuals.

© NHS England 2024

- **Feedback Mechanism:** Implementing robust feedback systems to gather insights from patients and their families to continually improve the quality of care.
- **Commitment to Continuous Improvement:** Emphasising a culture of ongoing learning, adaptability, and innovation to ensure the service consistently evolves to meet the needs of those it supports.

We continuously explore opportunities to train and upskill staff in our services. This enables high quality support alongside timely assessments, which in turn reduces prolonged care placements. As a result, we have seen a positive impact on system flow along with an increase of people remaining independent for longer.

As part of this development, our **Home Support Reviewing Team (HSRT)** has evolved to undertake the H-FAST assessments. Additionally, we have enhanced the HSRT to manage review requests for adjustments and variations, ensuring that every care package we commission is justified and offers the best value for money. This approach promotes independence and reduces the likelihood of individuals being admitted to the hospital, as their care package is assessed and adjusted as required in a timely manner.

Further improvements to HSRT include regular reviews of long-term care packages. This involves revisiting packages that were commissioned to the independent sector to identify opportunities to further enhance individuals' independence and, where appropriate, minimise reliance on health and social care services. For example, identifying where TEC and equipment could be used to reduce a care package. The team is currently undergoing training to conduct Mental Capacity Assessments. This initiative aims to reduce the pressure on social work teams, improve patient flow, and enhance the timeliness of assessments.

Over the past 2 years we have we have undertaken robust capacity and demand modelling to better understand the **residential care requirements**. We identified that Bradford had a significantly higher number of intermediate social care beds compared to neighbouring areas and our greatest area of demand was around Pathway 1. As a result of this we have significantly reduced our social care intermediate care bed base with the intention to deliver high quality care with the appropriate and suitable wrap around provision including social work and therapy led support in peoples own home through the HFAST service.

We undertook an audit across the health and social care IMC units to gain a collective understanding across the place in relation to how our IMC beds were being utilised, identify opportunities for improvement and/or challenges that could be addressed collectively. We continue to streamline and enhance the pathways across our health and social care intermediate units which is a focus for our 2025-26 BCF plan.

This work will include a thorough review of our existing resource to ensure we deliver more effective rehabilitation/reablement for people in these bedded settings and reduce the wait for social work assessments. The aim of this is also to reduce the impact of prolonged stays at a bedded setting which have proven to hinder people's recovery. The work within the past two years have enabled an expansion of our Telemedicine offer across all our residential settings including the independent sector. We plan to continue this alongside introducing other assistive technology to support service users to remain safe at home. The Telemedicine Service provides 24/7 care, support and

© NHS England 2024

interventions and supports both proactive and reactive models of care ensuring individuals living in care homes receive a professional, responsive, and caring service. It provides support tailored to meet individual needs by enabling timely access to appropriate health and care services and to enable individuals to live a fuller life.

Currently we have over 20 **Trusted Assessors** (TAs) and several administrative staff based across both acute trusts. TAs collaborate closely with the Multi-agency Integrated Discharge Teams (MAIDT) within the hospitals to determine the most suitable discharge pathway for patients. TAs generally work with patients on the wards to assess their long-term needs and preparing them for discharge. This facilitates quicker discharges by engaging with patients from the earliest point of admission. The TAs have helped target patients in the Emergency Department. This includes intervention where appropriate to reduce hospital admission. Throughout the development of H-FAST we have used our resources flexibly across BEST and within both acute trusts. This includes allocating some of our TAs to support the H-FAST programme, undertaking assessments in the community while the core team continue to facilitate hospital discharges.

We have introduced a new **service model for Pathway 3** for people who are likely to have complex long term care needs. This model is specifically designed to provide a short-term discharge to assess period for individuals likely to require long-term residential or nursing care. We have developed a service specification that facilitates discharges directly into the independent sector. The aim is to expedite the discharge of individuals who meet the criteria for this discharge pathway, to reduce risks around prolonged hospital stays and support them to have a period of assessment outside of a hospital setting. During the assessment period an individual's longer-term care and support needs will be assessed and agreed. This could result in an individual being eligible for a long-term placement. All individuals placed on Pathway 3 are assigned a social worker to manage their assessment post discharge. Over 50 care homes are registered to deliver this support, ensuring timely discharges and preventing unnecessary hospital stays.

To further support the success of this pathway, we have delivered comprehensive **training and education for staff**, ensuring they are well-equipped to navigate the new model effectively. Additionally, resources have been developed to improve communication between social workers, trusted assessors, patients, and carers. These resources aim to manage expectations and ensure smooth transitions of care, fostering a collaborative approach that emphasises clarity, understanding, and shared goals throughout the discharge and assessment process.

We have produced a comprehensive winter support pack for independent Home Support providers to enable them to better support individuals to live independently and improve their wellbeing. Whilst also providing top tips to promote wellbeing and self-care across staff groups during the difficult winter months.

Carer Navigators commissioned from the VCS and part of the jointly funded Carers Resource Service have worked with TAs and social workers to support unpaid carers of people receiving short term support or being transferred from hospital. These teams within the hospital form the MAIDT team, a critical service that has been enhanced through the BCF.

We continue to see great performance from our **Multi-Agency Social Team** (MAST) which is jointly commissioned from the VCS. MAST screen, assess and signpost people who attend A&E to

© NHS England 2024

appropriate support services. MAST also provide support for substance misuse and offer social prescribing, linking people to services in their communities. MAST has developed more mental health support services to offer bespoke advice and guidance to patients.

Additionally, our BCF plan maintains investment in the **supported living** for people with care and support needs, such as those with a learning disability, experiencing mental health problems and people who are neuro-divergent. These have been included in the BCF to reflect our commitment to widening our services. Many of our supported living homes offer a therapeutic space as an alternative to hospital admission working in partnership with the VCS and linking up with existing provision. They also work as a step-down facility from residential care to enable individuals experiencing mental distress to live more independently. We are aligning our accommodation offer to a Community Led Social Work approach implemented across all other client groups; ensuring that all Care Act assessments and support plans that are compliant with the Care Act 2014.

We are undergoing a full review of our **equipment provision** including our community equipment service (**BACES**) and aim to enhance Council **occupational therapy provision**. We have extended core hours within BACES to work more flexibly across 6 days per week. This includes a plan to build a central equipment store including a moving and handling suite, as well as a clinic where people could be assessed. We have also upped our offer of **assistive technology,** and the team have moved to electronic care records which help identify patients' needs more effectively and efficiently.

We have continued to enhance our health and social care **Urgent Community Response** (UCR) service to people in crisis requiring a 2hr urgent health or social care related response in the community. Referrals into this service continue to steadily increase resulting in more people being supported in their own home or a Care Home.

We have expanded and developed our **Virtual Ward** (VW) offer to facilitate early supported discharge and/or avoid hospital admissions. We have increased the VW bed base from 55 to 129 beds and these beds are being well utilised. We have expanded the range of pathways on offer, which now includes frailty and multi-specialty pathways for example general surgery, renal, acute medicine, cardiology, respiratory conditions and palliative and end of life care. We have expanded the VW model to include remote monitoring and use of technology for example Point of Care Testing.

We have invested in our **Safe and Sound** team who offer a range of assistive technology to help optimise our collaborative work with the Digital Care Hub and ambulance services. Work is ongoing to upskill care staff to deliver tasks delegated from nurses and therapists, supported by the telemedicine hub.

We continued to support the development of community-based models around the delivery of **Proactive Care** across our communities. The primary goal is to create MDTs that offer comprehensive, person-centred care in the community, ensuring that people receive timely, effective treatment closer to home. MDTs focus on preventive care, chronic disease management, mental health support, and early intervention to reduce the risk of people's conditions deteriorating or exacerbating need for hospital admissions and improve outcomes. An important feature of this MDT based approach is that it brings together health and care staff from a diversity of backgrounds - NHS, social care and the voluntary sector - who can contribute together to help support the whole needs of individuals and families.

© NHS England 2024

We will have an increased focus on how different health and care organisations work together at a local neighbourhood level to operate in a more cohesive and integrated way for the benefit of individuals, their families, and communities more generally. This will be informed by population health management (PHM) analysis and incentivised by our commissioning approaches. This is not about creating a 'one size fits all' model across all neighbourhoods but ensuring equity and quality of access, outcomes and experience, where specific approaches can be tailored by the organisations working together locally in neighbourhoods for the needs of communities.

A review of the **Enhanced Care in Care Homes** framework across our place resulted in a series of recommendations been delivered to improve outcomes for people living in Care Homes.

Several projects have been delivered including:

- **Commissioned a Nutrition Support Service** specifically for Care Homes offering a rolling training programme for care teams and catering staff alongside tailored support for individuals at risk of malnutrition.
- **Delivered a series of quality workshops** in collaboration with the system partners and the Bradford Care Association around key topics for example dementia, end of life care and falls.
- **Supported a range of community projects** alongside Voluntary Community Sector Organisations aimed at strengthening community integration by fostering partnerships between Voluntary Community Sector Anchors and Care Homes within the Community.
- **Refined and relaunched a Care Home Winter Support Pack** to help staff working in Care Homes to support individuals who have urgent care needs to access the right services at the right time over the winter period with a specific focus on utilising the Telemedicine Service. We also revised and refreshed the Care Home resource packs making them more relevant and user friendly, raising awareness of the different support and service available across our partnership.
- **Refined and relaunched the Recognition of Life Extinct pathway** which encourages care home staff to undertake a virtual verification of death utilising support from the Telemedicine Service.

These initiatives are part of Bradford's ongoing efforts to enhance the quality of care and support for its residents. These projects collectively support the BCF's overarching aims of improving health and well-being, reducing health inequalities, and ensuring that individuals receive the care they need in the most appropriate setting.

The discharge fund has been integrated into the broader BCF funding streams, ensuring continued support for the same core services as outlined in previous years' plans. The services supported by the Discharge Fund have not been discontinued or altered. Instead, they have been integrated into the appropriate funding streams within the Better Care Fund (BCF), ensuring continued support and sustainability. The services, as detailed in the planning template, encompass targeted investments in social work teams, intermediate care services, and hospital and social care provisions. Collectively, these efforts play a pivotal role in strengthening and enhancing the overall health and care system.

Through the comprehensive analysis planned in the coming years, we aim to identify opportunities to achieve maximum value for money. This strategic approach may allow us to adjust the BCF

© NHS England 2024

allocation to support a broader range of services across the system, including the introduction of innovative initiatives. An example of this is HFAST, a key component of our BEST team, which remains an integral part of our core services.

5. National Condition 1

5.1 Overall BCF plan and approach to Integration

Please refer to section 4 to find details of the key changes and enhancements made to services within the BCF that are supporting our continued approach to the integration of health and care. Section 3 describes our approach to governance and integration in detail.

As a Partnership, our ambition is to enhance collaboration across our organisations while upholding our 'home first' strategy in the joint commissioning of services. **Our 2025-2026 BCF plan will emphasise optimising services and pooling resources more effectively**. We will begin this initiative with our Intermediate Care (IMC) provision and Community Equipment service.

Over the past two years, the BCF has significantly increased the capacity and uptake of home-based support (Pathway 1), ensuring the continued success of our hospital discharge and flow initiatives. This includes expanding both our hospital teams and community resources to ensure comprehensive support for service users and their carers. The introduction of the H-FAST team has notably contributed to alleviating hospital pressures and reducing reliance on long-term care. Our goal is for all individuals who are able to be discharged home for ongoing enablement be supported by our HFAST service with the aim of meeting the current system demand which is approximately 9 discharges per day. By increasing the capacity of home-based support and expanding the H-FAST team, our initiative directly supports the Hospital to Home objective by ensuring a smooth and efficient transition for patients from hospital to home, reducing hospital pressures and improving patient outcomes.

Following the recent audit of our health and social care IMC beds it was highlighted that there was some inconsistency around how the beds operated in particular around access, complexity of individuals and the level of wraparound support that is offered. This could result in challenges around length of stay and poorer outcomes. Our ambition is to discharge 75% of people home from our IMC bed, operate at occupancy levels of 87% or above and for people to remain in the beds for an average length of stay of less than 28 days.

We aim to enhance our reablement and rehabilitation services across our health and social care IMC beds (Pathway 2). We are developing a joint standard operating procedure for use across the units. This will support improved patient outcomes, reduced reliance on long-term care, support more efficient use of resources and ultimately enhance the overall quality of care provided across our community.

As part of our continuous learning and development, we plan to implement a comprehensive performance framework for our BEST service and social care residential units. This framework will enable us to monitor performance across our services effectively, manage the length of stays, and ensure that individuals are assigned to the appropriate beds based on their needs. By doing so, we aim to enhance service quality, improve patient outcomes, and optimise resource utilisation. Additionally, this framework will support data-driven decision-making, allowing us to identify areas for improvement and implement targeted interventions promptly.

As described in section 4, we have recently introduced a new specification for residential and nursing homes for individuals likely to need long-term care (Pathway 3). The initial few months of this

pathway have proven to be successful with positive feedback and improved patient outcomes. Our ambition is to continue monitoring the effectiveness of this initiative to determine how we can further streamline systems and processes across our operational teams to provide more seamless transfers of care. This will help enhance the overall quality of care, reduce hospital readmissions, and ensure that individuals receive the right level of support at the right time, ultimately improving their long-term wellbeing.

Along with focusing on Intermediate Care, in 2025-2026 we intend to complete the Bradford and Airedale Community Equipment Service (BACES) review by thoroughly assessing the current provision and management of community equipment in residential and nursing homes, as well as hospices. Our review will clarify the relationship between BACES and care homes, establish local protocols and contracts, and provide clear guidance for commissioners and prescribers on their obligations when assessing residents for equipment. We will address key areas such as maintenance, cleaning, and decontamination of equipment, ensuring care home providers are well-informed about their responsibilities and funding obligations. By completing this review, we aim to achieve enhanced functional independence and well-being for service users, optimized resource utilization, and improved overall quality of care across our community.

In addition to these areas, we aim to embed a risk share agreement which will enable collaborative use of BCF funding to manage pressures within the health and social care systems. This agreement will foster a partnership approach, ensuring that resources are allocated efficiently to areas of greatest need. By working together, we can enhance service delivery, reduce financial risks, and create a more resilient and sustainable system. Our collective efforts will ultimately improve outcomes for individuals and communities, ensuring that everyone receives the support they need in a timely and effective manner.

5.2 Joint system approach

Details of this are outlined in Section 3. Bradford adopts a collaborative, joint system approach to design, monitor, and evaluate the services encompassed within the BCF. This approach entails seamless coordination among local health and social care commissioners, the voluntary sector, housing services, and NHS organisations. It is tailored to integrate local insights with national best practices, ensuring optimal value for money while fulfilling the objectives and priorities of the BCF.

5.3 Demonstrating a “Home First” Approach

As outlined in Section 4, Bradford’s BCF plan includes several services aligned with the 'home first' approach. Our aim is to review these services to ensure they effectively achieve the policies and objectives of the BCF, including promoting independence, reducing hospital stays, and, where appropriate, minimising reliance on long-term residential or nursing home care.

© NHS England 2024

6. Goals and Performance

6.1 Shift from Discharge to Admission Avoidance

As highlighted in Section 4, we are committed to conducting a thorough review of our BCF services to identify opportunities for optimising support, reducing reliance on long-term care, and enhancing system flow. The recent announcement of the BCF 2025–2026 policy framework, which removed the ringfence on the discharge fund, provides greater flexibility. This allows us to shift our focus from hospital discharge to admission avoidance, enabling a more proactive approach to care.

In Bradford, we are evaluating a range of services in line with updated BCF spending priorities. Among these is the development of **Home Care Innovation Sites** which is an initiative aimed at transforming home health and care services. These sites serve as collaborative platforms, bringing together leaders, innovators, and stakeholders to explore new ideas, introduce new technologies, and enhance care delivery practices. Although still in the early stages of development, the Home Care Innovation Sites are poised to complement Bradford's wide array of services. Their goal is to reduce the number of individuals requiring long-term support, alleviate pressure on hospitals, and improve UEC flow. This initiative reflects our commitment to delivering sustainable, efficient, and person-centred care solutions.

As part of our shift from sickness to prevention, we have a **Care Home Liaison Team** within the Bradford District Care Hub. This team play a vital role in supporting care home residents by addressing their mental health and well-being needs. They provide tailored mental health assessments, create personalised care plans, and deliver interventions to improve residents' quality of life. Additionally, the team offers training and guidance to care home staff to help manage residents needs effectively. The team ensures residents receive the appropriate support, reducing hospital admissions and fostering proactive care, while enhancing the skills and expertise of care home staff.

In line with our ambitions to develop our services, we continue to deliver improvements relating to the **Enhanced Care in Care Homes framework** (described in Section 4). Our services focus on improving the health and well-being of care home residents through proactive and person-centred care. They provide regular clinical input, tailored care plans, and timely interventions to manage health conditions effectively. We also deliver initiatives to strengthens the capacity of care home staff by offering training, support, and guidance, enabling them to deliver a higher standard of care. By reducing unnecessary hospital admissions and fostering collaboration across health and care services, initiatives delivered via the Enhanced Care in Care Homes ensure residents receive comprehensive support within their familiar environment.

6.2 Metrics

We have conducted a detailed analysis of our Trust's performance, encompassing both Bradford Teaching Hospital and Airedale NHS Foundation Trust, over the past few years to establish our performance targets for 2025-26. Regarding emergency admissions, the average number recorded over the 12-month period from December 2023 to November 2024 was on average 1,483. Our historical data did not indicate any significant trends in reducing these figures, encompassing both avoidable admissions and falls.

Based on this analysis, we have not planned for significant reductions at this stage. However, we remain committed to closely monitoring this metric to identify opportunities for improvement and develop targeted strategies to enhance our performance moving forward.

© NHS England 2024

Our metrics are closely aligned with the NHS plans for the trusts. We have reported comparable planned performance for the newly introduced metrics on discharge delays. As these metrics are relatively new, the data available for analysis is limited, and we are actively working to improve its reliability.

Using the data available from our trusts, we have set ambitious targets for this metric: 79% or more of patients are expected to leave the hospital on their Discharge Ready Date (DRD). For those not discharged on their DRD, the average discharge time is anticipated to be around five days.

This metric will be closely monitored throughout the year, alongside the planned review work, to identify further opportunities for improvement.

6.3 Capacity and Demand Planning

We have utilised our live performance data from 2024-25 to inform and establish our ambitions for performance against the 25-26 metrics. As part of our in-depth analysis of services, we plan to enhance data reporting across the core BCF services. Our aim is to achieve greater transparency in our data and performance, enabling us to make informed decisions that drive improved outcomes for individuals.

As anticipated, activity levels for our enablement services (Pathway 1) have increased. We analysed data from BEST, our in-house enablement team, covering the first 11 months of 2024-25. This analysis formed the basis for estimating activity levels in March 2025.

Recently, fluctuations in activity caused by high levels of staff sickness have been observed, resulting in increased reliance on external provision. This has created a capacity gap throughout the year. To address this, we have factored these challenges into our plans as part of a wider review of intermediate care. Our objective is to strengthen the BEST service so that it can handle all enablement under Pathway 1, with only a very small number of individuals requiring support from the independent sector for home care.

As a result, the data within our plan reflects actual performance from 2024-25 and serves as the foundation for our 2025-26 plans. We have also accounted for independent sector placements under spot-purchased care. This data represents the entirety of Pathway 1, encompassing all reablement and rehabilitation-at-home packages. While we continue to experience high levels of sickness across our services, reliance on the independent sector remains a significant consideration.

Building on the earlier point regarding the use of 2024-25 data, our capacity and demand plans currently indicate a surplus in capacity for Pathway 2. To address this, we are undertaking an intermediate care review to evaluate the bed base and assess the support provided across these beds. This review aims to ensure value for money and optimise resource utilisation.

© NHS England 2024

The findings from this review will also help us determine the resource levels required to effectively manage capacity and demand throughout the year. At present, our plans have been developed based on the data currently available. We will provide more detailed updates through the quarterly reports as the year progresses.

Significant progress was made in 2024-25 to streamline reporting across Pathways 2 and 3. In September, we introduced new service lines, which have greatly improved our ability to capture individual outcomes and track the length of stays in residential or nursing beds, both within in-house residential units and for externally placed individuals. While the trends observed so far align with previous years, delays within our administration team—responsible for processing cases and recording placement data—have presented challenges. Consequently, we have relied on the limited data from these new service lines to calculate an average figure as a basis for planning externally placed individuals. We will continue to report against this figure on a quarterly basis as our data improves and we address the administrative issues currently affecting the reporting.

A national shortage of therapists continues to affect recruitment within hospital trusts and enablement teams, which poses challenges for capacity planning. To address this, we are focused on understanding the demand for therapeutic interventions and aligning resources effectively to meet needs across all services. As part of this effort, we have successfully developed the H-FAST services (Pathway 1), leveraging a collaborative approach that brings together health and social care therapists to deliver positive outcomes. This model not only supports rehabilitation and reablement capacity but also provides a foundation for expanding similar approaches across other pathways. These initiatives are integral to our broader intermediate care work and ensure that therapy capacity is embedded within our overall capacity planning.

Using data from 2024-25 and valuable insights from the Council's Enablement team, we identified our Step-Up data for 'Reablement & Rehabilitation at Home'. By filtering referrals to exclude cases classified as hospital discharges, we ensured our reporting focuses solely on community referrals—highlighting individuals who require support from community-based services rather than transitioning from hospital care.

Throughout this process, our enablement team has significantly expanded, now consisting of multiple specialist teams. This growth allows us to adapt staffing flexibly to meet demand, ensuring that our capacity aligns with projected needs. As a result, we anticipate no challenges related to service capacity. Additionally, as outlined earlier, we remain committed to reviewing intermediate care services to inform future investment decisions. The same methodology and approach were applied to our intermediate care bed services, providing the Step-Up data for 'Reablement & Rehabilitation in a Bedded Setting'.

© NHS England 2024

Using live data from MAST in 2024-25, we estimated the annual number of clients we expect to support in 2025-26. This informed our Step-Up data for 'Social Support'. An overview of the MAST service can be found in Section 4.3. MAST is composed of multiple partner organisations, it is challenging to predict the exact number of clients they will support as it is based on the nature of their needs. However, these agencies collaborate closely to ensure demand is met. Based on this coordinated approach, we anticipate that support will be maintained consistently throughout the year.

7. Disabled Facilities Grant

7.1 Update on Disabled Facilities Grant

In 2023/24, DFGs in Bradford supported 457 people through the completion of adaptations to significantly improve people's health and wellbeing while aiding hospital discharge and admission avoidance. We have increased our joint working with housing colleagues to better understand some of the challenges and successes to delivering DFG's. This includes more involvement of housing representatives at our PCF meetings (detailed in governance section) and shared intentions to improve the lives of our population.

The DFG remains a statutory duty upon the council to enable disabled people to live independently in their own homes and implement creative measures to promote safety and independence in the community. Minor adaptations are provided by BACES which work alongside BEST and our community social work and occupational therapy teams (assess the need for adaptations) which are teams also funded through the BCF. These services sit alongside the delivery of the DFG to ensure people remain safe in their homes and are as independent as possible through various adaptations.

The use of the DFG is aligned to Bradford's Housing Strategy (2020-2030) which details our approach and sets the priorities for meeting the housing needs of our population. A key objective of the strategy is 'Homes for All' and to ensure provision of sufficient housing to meet the needs of people with disabilities through adaptations, and the provision of more homes with level access and homes that are able to be adapted. Our priorities include how we contribute to a more productive and inclusive economy, addressing health and social inequalities, tackling climate change and helping to build stronger communities.

The DFG in Bradford includes an array of activity for major adaptations made by our Department of Place. We receive on average 78 new referrals for DFGs each month, with as high as 110 some months. We continue to see high levels of demand for assistance with adaptation and this referral rate is a significant increase from the previous average of 48 referrals per month.

Due to the increase in demand, increase in complexity of cases and needs and the static level of grant received through the BCF, funding is insufficient to meet demand and therefore the throughput of cases is having to be managed, using a well-established and robust case management system, to ensure there is not an overspend against available funding. The Council is entirely reliant upon the DFG grant allocation provided by MHCLG.

© NHS England 2024

This is resulting in referrals being held prior to financial assessment and their processing being managed according to forecasted financial projections. Existing cases progressing towards approval are subsequently having to be held at approval, again to ensure funding is available for contractors once they are completed. However, the Council must ensure that it complies with legislative requirements and approve cases within 6 months of a full application being finalised.

At the beginning of March 2025, there were 1,121 cases (total cases at different stages of the DFG process) with an estimated total value of £18M. These cases are at various stages of DFG application, from receipt of initial referral to approved and awaiting completion of work. Of the total cases in the process of DFG application, 167 were approved where funding is committed (at a value of £2,354,864) and applicants can proceed with the work.

Outside of the issues already highlighted, there are several additional factors that impact the processing times for the grants including contractor supply, availability of materials, increase in costs of materials and labour and increasingly complex cases where clients have multiple needs. A significant factor in processing times is reliance upon the client regarding their role in the processing in the grant. This reliance is reduced by the council having a project management service which provides a contractor from a framework and a clerk of works to oversee the work. Approximately 80% of completed DFGs are delivered through the Council's Agency Service.

In order to manage increasing demand against insufficient funding and to respond to the impact this is unavoidably having, the Council have reviewed approaches, practices and procedures and have implemented a number of changes;

- **Test of Resources:** A consistent Test of Resources is now applied to all clients (except children), including smaller-value adaptations like stairlifts and ceiling track hoists.
- **Focus on Essential Works:** Specifications have been streamlined to prioritize essential works over desirable ones. For example, bathroom adaptations now focus on critical elements only, with warranties reduced closer to standard terms.
- **Collaboration & Prioritisation:** Housing and Occupational Therapy services collaborate to review grants, with OTs refining prioritization criteria to address urgent needs effectively.
- **Discretionary Funding Review:** The Council is reconsidering its discretion to fund costs exceeding the mandatory £30,000 grant, potentially limiting or ceasing such assistance.
- **Improved Communication:** Client correspondence has been increased and revised to clarify processes and manage expectations more effectively.
- **Referral Practices:** Early-stage referral processes are being reviewed to help clients make informed decisions, such as assessing financial eligibility upfront.
- **Advocacy for Funding:** The Council is engaging with MHCLG to advocate for additional funding to meet current demand and address funding challenges.

© NHS England 2024

8. Local Priorities

8.1 Promoting Health Equality and Reducing Inequalities

As described In Section 3, Bradford Health and Care Partnership aims to promote equality and addressing inequalities by embedding key principles in every aspect of our work. We adopt an ‘Act as One’ approach which fosters collaboration among NHS organisations, local authorities, voluntary groups, and community organisations. By working together, the partnership ensures that care services are not only accessible but also equitable, eliminating any barriers individuals may face due to their backgrounds or circumstances.

One of the key initiatives under this framework is the **Reducing Inequalities Alliance (RIA)**, which targets health disparities in the most deprived areas. This programme identifies groups at high risk such as individuals with long-term health conditions, refugees, and those experiencing homelessness, and provides tailored interventions to address their unique needs. By prioritising resources for those who face significant barriers, RIA demonstrate a proactive approach to equality.

In addition to this, ss part of the Bradford 2025 UK City of Culture initiative, the **Creative Health Programme** tackles health inequalities through arts and culture. By leveraging projects like social prescribing, art therapy, and community workshops, the partnership creates spaces where individuals can connect, heal, and thrive. These initiatives not only support mental and physical well-being but also foster inclusivity by engaging people from diverse backgrounds in meaningful activities.

The Partnership focus on **community engagement**, ensuring that residents have a voice in shaping the services they use. Through platforms like EngageBDC, the partnership gathers insights, ideas, and lived experiences from Bradford's diverse communities, ensuring that services are designed to reflect their needs. This joint approach empowers communities and builds ownership and trust.

The Partnership also invest in **training for staff and capacity building** which equip healthcare professionals and community leaders with the skills and knowledge to address inequalities effectively. Initiatives like the **Healthy Minds Partnership**, train individuals to work in mental health settings, expand access to cultural and therapeutic activities, which help reach individuals most in need of support.

These examples demonstrate the Bradford Health and Care Partnership's dedication to reducing inequalities and ensuring fairness in its services. By combining various programs, engaging with the community, and fostering collaboration, the Partnership has built a health and care system that is inclusive, fair, and responsive to the diverse needs of the population. These efforts clearly align with the Equality Act 2010 Public Sector Equality Duty by eliminating discrimination, advancing equality of opportunity, and fostering good relationships.

The BCF plan integrates our efforts to reduce health inequalities into strategic and operational planning. The Planning and Commissioning Forum, with equal representation from Public Health and Children’s Services, oversees the BCF plan. A key principle is addressing inequalities by designing services and interventions to meet varying levels of need. This includes removing access barriers and allocating resources proportionately to address disparities.

© NHS England 2024

By doing so, we aim to achieve more equitable outcomes, acknowledging that health conditions often appear earlier in deprived areas. This strong link between decision-making and BCF fund allocation ensures a focused approach to tackling inequalities. We continue to strengthen system-wide connections and benefit from flexible commissioning to support this goal.

Our BCF funded services are underpinned by key priorities and objectives that focus on reducing health inequalities. These priorities include:

- mitigating against digital exclusion
- ensuring datasets are complete and timely
- accelerating preventative programmes
- strengthening leadership and accountability
- restoring NHS services inclusively

We will continue to work as a partnership to ensure that advancing equality and diversity is central to how we jointly commissioned services through the BCF.

8.2 Supporting Unpaid Carers

ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

According to the latest census data, approximately **45,645 people in Bradford are unpaid carers**, representing around **9% of the population**. Of these, **3.1% provide more than 50 hours of unpaid care per week**. As a partnership, we recognise the vital role carers play in ensuring individuals in need of care experience a good quality of life. Therefore, we continue to commission a range of additional schemes through the BCF specifically aimed at supporting carers.

Bradford commissions a carers service which is jointly funded through the BCF and delivered by **Carers' Resource**. The service supports more than 3,000 adults by providing help and support for unpaid carers to have a life of their own along with their caring role. The carers resource service offers support for isolated carers, assesses carer's wellbeing to identify the help available, providing carer information tailored to individual needs and circumstances.

A **carer wellbeing grant** is also offered, which provides a small one-off payment to carers to promote their own wellbeing. The service delivers 160 peer support and worker led support groups, and gives out £120,000 in carers wellbeing grants per year. This provides support mechanisms to carers to continue their important caring role. This funding can be used flexibly to support carers in having a break from their role and support their own health and wellbeing where and when they feel needed.

The BCF is used for other services that support carers, including the **Carer Navigator service** which supports friends and families who have a cared-for person admitted to Airedale Hospital and Bradford Hospitals. This service provides support in meetings regarding discharge from hospital, help to organise social and personal care, supports emergency planning, and connects with other Carers' Resource services. This ensures that Carers are provided the right level of support to help them continue their caring role.

In addition, the **Carers Emergency Planning Service** aims to provide reassurance to carers about who will take on their caring role in the event of an emergency. The service works with carers to

© NHS England 2024

make contingency plans, regarding how the person they care for would be supported if the carer were unable to do so.

8.3 Consulting with People

Throughout this document, we highlight our commitment to meeting the requirements of the NHS Act 2006 by ensuring effective engagement and consultation with individuals and communities. As a partnership, we embed these practices within our regular commissioning cycle and joint working arrangements, such as **Section 75 agreements**. In Bradford, we operate under an overarching Section 75 agreement between the Council and West Yorkshire ICB with approximately 30 individual schedules/services.

Through our commissioning processes, we actively consult with individuals to understand community needs and preferences. This approach enables us to co-design services that achieve positive outcomes, while also conducting thorough market research to inform decision-making. This collaboration ensures that service users and their carers are integral to shaping services, in line with legal obligations for public involvement.

Additionally, our robust governance framework ensures that all commissioned services undergo a comprehensive assurance process as described in section 3. This ensures compliance with statutory requirements as well as delivery of high-quality services that effectively meet local needs and provide the best value for money. Our joined-up approach reflects a commitment to inclusivity, transparency, and accountability across all aspects of service design and delivery.

END

© NHS England 2024

Schedule 1.3 - Better Care Fund

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

In line with the requirements of the Care Act 2014 and the NHS Act 2006, a pooled fund called the Better Care Fund (BCF) has been established, the operation of which is set out in this Agreement. The aim is to facilitate the development of integrated health and social care services and to create flexibility between health and social care budgets to improve care for patients whilst making best use of resources.

The BCF provides a mechanism for joint health, housing and social care planning and commissioning.

It brings together ring-fenced budgets from the NHS West Yorkshire Integrated Care Board (referred to as the ICB) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the Local Authority Better Care Grant.

The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved. These are:

- A jointly agreed plan between local health and social care commissioners, signed off by the HWB.
- Implementing the two new BCF Policy Objectives:
    - To support the shift from sickness to prevention
    - To support people living independently and the shift from hospital to home
- Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care.
- Complying with oversight and support processes.

The 2025-26 planning template outlines the spend areas of the BCF. Notable changes to the BCF include the amalgamation of the Discharge Fund into the Local Authority Better Care Grant (formerly the Improved Better Care Fund) and the NHS Minimum Contribution, forming the consolidated Better Care Fund total for 2025–26.

2 AIMS AND OUTCOMES

The overall aim and vision set out within the Better Care Fund Plan is to create a sustainable health and care economy that enables people to be healthy, well and independent.

To achieve this vision, we will:

- Promote self-care and illness prevention and improve the general health and wellbeing of the population of Bradford District and Craven
- Transform primary and community services and place the patient at the centre of their care
- Implement a 24/7 integrated care system across health and care economy- this is the particular focus of the BCF
- Develop and deliver a sustainable system wide model for urgent care services
- Develop and implement a system wide model for delivery of planned care interventions

Our ambition is to move to a system of resource allocation across the whole health and care economy and informed by level of need and population segmentation, collectively allocate resources at our joint disposal to maximise value and outcomes for service users.

Our vision is of a health and social care system which empowers people including carers to take control, enabling them to set their own personal goals and to become the architect of their own support package with services which are responsive when people need care.

The care provided will be patient centred, co-ordinated and safe, meeting the needs of individuals and their carers. This presents an opportunity to rethink how we support people with long term conditions and the frail elderly, our largest groups of people requiring care (as evidenced through risk stratification and population segmentation), ensuring a consistency of offer seven days a week.

Care will be integrated around the needs of the individual, not organisations. Services will wrap around the person and be enabled by use of technology which will help accelerate achievement of personal goals. We will make optimum use of the resources available thereby ensuring effective use of the financial resource.
When people have set their own goals they will be supported to achieve these, self-care will be the starting point and people will be empowered to engage in this. Care will be more proactive rather than reactive and ensure appropriate responses, including promoting health and wellbeing.
The health and social care system will use real time data to identify people who are likely to need more care and identify interventions that will maintain their wellbeing. This will decrease reliance on traditional high cost medical and social services and will free-up resources for re-investment and expansion in community services.

People who have complex needs, that need support from a number of professionals, will be supported by multi-disciplinary, multi-functional integrated teams which will agree a personalised care plan with the person, taking their goals and wishes into account. We are already implementing such models of care.

Professionals will be able to share and access information through a shared IT system where one person, one record will become a reality. This will improve decision making and avoid the same questions having to be asked over again. Voluntary and Community Services will be involved in this health and care planning, so that more people can be supported in their local communities and build strong relationships that are empowering.

When needed, these multi-disciplinary integrated teams will work alongside other local agencies, such as the police, housing, faith organisations, leisure services and education, to address an individual's needs in a way that is encompassing and centred around their unique circumstances.

Enabling home care services and rehabilitation support will be available to help people be safe and competent in their own homes. Where appropriate, technology will be used to support the delivery of care in people's homes. This integrated approach will enable people to be more independent, for longer. People's care will be coordinated by a Lead Practitioner who will be the most relevant member of staff involved in the person's care for example a nurse, therapist, social care worker, GP or voluntary worker. The default setting for the delivery of integrated care will be the person's own home. When people do need to go into hospital, the people who support them in the community will be in contact with the hospital team and, keeping the patient and their wishes at the fore, agree a package of support that will enable the quickest possible return home.

Intermediate care services, such as community nursing and occupational therapy, will work alongside enabling home care services to get people back on their feet and enjoying life in a way that is right for them. For those who cannot recover, care at the end of life will respect each person's individual wishes. Given the growing ageing population, increasing public expectations, challenging financial outlook and the opportunities technology brings, we need to seize this opportunity to do something radically different to better meet the needs of our local community. By working together to meet the challenges we face, we can ensure that we continue to benefit from the best health and social care, sustain our communities and empower more people to enjoy fulfilling lives.

Our ambition as commissioners is to develop commissioning, contracting and payment models that enable services and systems to transform and integrate, delivering high quality, safe, local outcomes-focused services, seven days a week.

The Better Care Fund 2025-26 has the following metrics which it must meet:

- **Reducing avoidable hospital admissions:** This involves minimizing the number of unplanned admissions to hospitals, emphasising preventative care and community-based support.

- **Improving discharge outcomes:** Ensuring timely and effective discharge from hospitals, particularly for individuals with complex needs, to support recovery and independence.
- **Enhancing long-term care outcomes:** Promoting independence and reducing reliance on long-term residential or nursing care by providing integrated and person-centred care.

We will continue to develop our services and our BCF plan to fulfil the requirements of the funding and adhere to the government guidelines regarding the reporting expectations of the BCF. We will make changes where required by the BCF team to maintain compliance with the guidance.

3 THE ARRANGEMENTS

The Better Care Fund Scheme will be treated as a Pooled Fund with Aligned Budgets and lead commissioning arrangements. The Partners have worked together to agree the purpose, aims and outcomes for the Better Care Fund which shall be delivered in accordance with each individual scheme specification.

4 FUNCTIONS

The Council and the ICB will use the BCF to facilitate the development of integrated health and social care services and to create flexibility between health and social care budgets to improve care for patients whilst making best use of resources.

The functions which may be exercised under this agreement are:

- The prescribed NHS functions of the ICB under regulation 5 (a), (b), (ba), (bb), bc) and (c) of the NHS Bodies and Local Authorities (partnership arrangements regulations 2000 (SI no 617 of 2000)

The Health related functions of the Council prescribed under regulations 6 (a), (aa), (b), (k) (l) and (m) of the aforementioned regulations.

5 SERVICES

A number of services will be provided under the BCF scheme. Access arrangements will be as set out in the individual service specifications.

Services provided within the Better Care Fund are as follows:

- Prevention and Early Intervention
- Intermediate and Integrated Care and Support
- Grants and Adaptations
- Support for Carers
- Community and Domiciliary Care
- Equipment and Assistive Technology
- Other

A detailed breakdown is included in section 7 below.

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Each Scheme within the Better Care Fund Service shall operate under Lead Commissioning arrangements. Respective Lead Commissioners for each scheme are detailed in section 7 below.

Individual Schemes joint commissioned under the lead commissioner arrangements, will include all elements of the commissioning cycle, from the identification of need at a population level through to the monitoring, review and quality assurance of provision. Joint commissioning will also include market shaping and market management, the development of fee structures and provider negotiations, tendering, contract and relationship management and proactive quality improvement activity.

Other schemes are a contribution towards budgetary costs within that area. Commissioning for these areas will be outside the remit of the Better Care Fund and budgetary control responsibility for the day-to-day management of these services within budget remains with the relevant budget holders within the partner organisation which is spending the money.

Scheme leads are responsible for leading and coordinating the development of new activities and developments which may change patterns of spending. Lead Commissioners will undertake the work in accordance with normal operating procedures of their own organisation.

Contracting Arrangements

The Lead Commissioner will engage with partners to agree the conditions and specification of each contract for commissioned services within their normal operating procedures with the aim of commissioning high quality services that meet the populations needs whilst delivering value for money. Contract management and reviews will be as per the Commissioners normal processes and procedures, with engagement from partners, as agreed.

Contracts shall only be assigned to another partner on the agreement of both Partners.

Access

Services are commissioned to meet the needs of the population of Bradford City and District. Eligibility of individuals for access to each particular Service shall be set out in the relevant Scheme Specification. Material changes to eligibility shall not be made without consultation with the other party.

7 FINANCIAL CONTRIBUTIONS

Financial Year 2025/2026	WY ICB contribution	Council Contribution
Pooled Fund BCF	£55,767,440	£36,527,650 (LA Better Care Grant and DFG)

Financial resources in subsequent years to be determined in accordance with the Agreement

Table 1 – Overall funding contributions:

BCF Funding Contribution	2025/26
Minimum NHS (ICB) contribution	£55,767,440
Disabled Facilities Grant	£7,674,349
Grant allocation for adult social care (LA Better Care Grant).	£28,853,301
Total	**£92,295,090**

Table 2 - Detail of the schemes funded via the Better Care Fund (25-26):

WY ICB Schemes (2025-26)	BCF
Virtual Ward/Urgent Community Response (UCR)	£7,588,190
Discharge support and infrastructure – Staffing in Transfer of Care Hub	£130,560
Residential Placement – Nursing Home	£2,483,453
Bed Based Intermediate Care	£8,046,270
End of Life Care – REACT	£1,114,799
Local Prevention and Independence Schemes	£1,248,288
Trust Reablement Contract	£701,155
Contribution to BACES	£1,843,988
Pathway 1 Therapy Support	£200,000
Home Based Packages for Continuing Health Care	£882,000
Total	**£24,238,703**

LA Schemes (2025-26)	BCF	LA BCG	Total
Equipment Services	£1,413,900	£1,100,000	£2,513,900
Social Work Teams	£2,107,200	£2,458,100	£4,565,300
Support to Carers	£1,053,600		£1,053,600
Respite Services	£297,000		£297,000
Residential Care	£8,678,300	£4,191,000	£12,869,300
LA IMC Beds	£2,570,300	£1,534,000	£4,104,300
Reablement Services	£7,995,600	£320,000	£8,315,600
MAST	£316,300		£316,300
Nursing	£2,480,900		£2,480,900
Home Support	£3,227,037	£12,530,505	£15,757,542
Commissioning Infrastructure	£188,600		£188,600
Direct Payments		£254,600	£254,600
DTA Pathway 3	£1,200,000		£1,200,000
Supported Living		£6,465,096	£6,465,096
Total	**£31,528,737**	**£28,853,301**	£60,382,038

DFG (2025-26)	Total	Notes
Disabled Facilities Grant	£6,374,349	Including funding increase
Carry Forward from 24-25	£1,300,000	Confirmed carry forward from previous year
Total	£7,674,349	

Total BCF Funding (2025/26)	BCF	LA BCG
Total BCF excluding DFG	£55,767,440	
Total BCF including DFG	£63,441,789	
Total Better Care Grant		£28,853,301

8 FINANCIAL GOVERNANCE ARRANGEMENTS

(1) As in the Agreement with the following changes:

Management of the Pooled Fund:

- Finance report – submitted quarterly to the ICB and the BCF national team. This is signed and approved by the Health and Wellbeing Board
- Annual report from Planning and commissioning Forum to the Partnership Leadership Executive

(2) Management of the Pooled Fund

For the purposes of this schedule, lead commissioners for each area set out in section 7 will act as a 'Pooled Fund Manager'. The Pooled Fund Manager shall have the following duties and responsibilities:

- the day to day operation and management of the Pooled Fund;
- ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this agreement and the BCF expenditure plan;
- maintaining an overview of all joint financial issues affecting the Partners in relation to the services and the Pooled Fund;
- ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

- ensuring action is taken to manage any projected under or overspends related to the Pooled Fund in accordance with this Agreement;
- preparing and submitting to the Partnership Board quarterly reports and an annual return covering the financial position of the Pooled Fund and the performance metrics relating to the schemes, together with such other information as may be required by the Partnership Board to monitor the effectiveness of the Pooled Fund.
- the Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.
- preparing and submitting reports to the HWB as may be required by it and any relevant National Guidance, including the quarterly reports referred to in section 10 of this schedule;
- any other duties and responsibilities agreed by the Partnership Board.

(3) Audit Arrangements	
What Audit arrangements are needed?	Financial auditing arrangements will be in line with the Lead Commissioner's financial policies and procedures. The Host Partner shall be responsible for preparing the annual return for the Better Care Fund as determined by National Guidance. If National Guidance requires this return to be subject to external audit, the Host Partner shall arrange this. The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance.
(4) Financial Management	
Which financial systems will be used?	The financial management systems of the lead commissioner organisation will be used.
What monitoring arrangements are in place?	Monitoring arrangements for the overall BCF programme shall be followed as set out by the Planning and Commissioning Forum. Monitoring of individual schemes shall be at the request of the board.
Who will produce monitoring reports?	The lead commissioner will produce reports as required. The Support & Integration Manager (BCF lead) will prepare reports on behalf of the board for submission to any external monitoring process.
What is the frequency of monitoring reports?	TBA
What are the rules for managing overspends?	N/A
Do budget managers have delegated powers to overspend?	See part 16 of this schedule.
Who is responsible for means testing?	N/A
Who will own capital assets?	N/A
How will capital investments be financed?	N/A
What management costs can legitimately be charged to pool?	N/A
What re the arrangement for overheads?	N/A
What closure of accounts arrangement need to be applied?	N/A

9 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

Which Partners VAT regime will apply?	The VAT regime of the relevant Lead Commissioner will apply.
Is one Partner acting as 'agent' for another?	NA
Have Partners confirmed the format of documentation, reporting and accounting to be used?	NA

10 GOVERNANCE ARRANGEMENTS

Relevant reporting shall be prepared and coordinated by the commissioning leads as appropriate, in line with the reporting requirements set out by the Planning and Commissioning Forum, Bradford Health and Wellbeing Board and the requirements Better Care Fund Reporting requirements set out in the BCF Policy Framework.

11 NON FINANCIAL RESOURCES

Council contribution	Details	Charging arrangements	Comments
Premises	NA	NA	NA
Assets and equipment	NA	NA	NA
Contracts	NA	NA	NA
Central support services	NA	NA	NA

WY ICB Contribution	Details	Charging arrangements	Comments
Premises	NA	NA	NA
Assets and equipment	NA	NA	NA
Contracts	NA	NA	NA
Central support services	NA	NA	NA

12 STAFF

The Support & Integration Manager (BCF Lead) will be made available to provide support to both parties, with respect of preparation and coordination and submission of any planning and reporting requirements set out nationally in relation to the Better Care Fund.

The Council and the ICB will make available respective service leads and finance leads in order to appropriately undertake these tasks.

Where joint commissioning is taking place under a lead commissioner arrangement, the other party will make available appropriate staffing resources to effectively commission services.

13 ASSURANCE AND MONITORING

The arrangements covered by this schedule shall be monitored and assured by the Lead Commissioner, in accordance with the individual monitoring requirements of each area of commissioning activity. Monitoring and assurance will take the form of quantitative and qualitative assessment, provider reporting, formal contract meetings, and proactive and reactive activity.

Commissioners will ensure that service outcomes are in line with the broader strategic outcomes of The Better Care Fund Plan, and that monitoring, and assurance activity demonstrates the extent to which the outcomes are being achieved.

Reporting of performance and the achievement of outcomes will be to the Planning and Commissioning Forum, in a form and frequency determined by the Planning and Commissioning Forum.

14 LEAD OFFICERS

Partner	Name of Lead Officer	Position	Address	Telephone Number	Email Address
Council	Jane Wood	Assistant Director of People Commissioning & Business support	Britannia House	01274 437312	Jane.wood@bradford.gov.uk
WY ICB	Helen Farmer	Director of System Transformation	Scorex House	07932 946494	Helen.Farmer@bradford.nhs.uk

15 INTERNAL APPROVALS

In accordance with the Planning and Commissioning Forum Terms of Reference and the constitutions and Schemes of Delegation of the Council and the ICB.

16 RISK AND BENEFIT SHARE ARRANGEMENTS

The risk of financial underspend and overspend shall be borne by the Host Partner for each relevant Individual Scheme within this Service. The exception being where BCF is making a contribution to a service which an Individual Scheme within this Agreement. In this circumstance the primary schedule for that service will apply, e.g. BACES.

17 REGULATORY REQUIREMENTS

Commissioner to ensure regulatory and registration requirements are met for individual service.

18 INFORMATION SHARING AND COMMUNICATION

The Council and the ICB will shall share and supply information in respect of the services as each party may reasonably require.

19 DURATION AND EXIT STRATEGY

General provisions for the termination of the Agreement are set out in section 22 of the Agreement.

Those termination provisions will also apply to Individual Schemes within this BCF Service where both Partners agree to such a partial termination.

However, where either Partner does not agree to the partial termination then the Individual Scheme will either need to be terminated in its entirety or continued in its entirety.

20 OTHER PROVISIONS

NA

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	12a
Meeting date:	23 May 2025
Report title:	End of year review
Report presented by:	Sue Baxter, Head of Partnership Governance, NHS WY ICB
Report approved by:	Sue Baxter, Head of Partnership Governance, NHS WY ICB
Report prepared by:	Catherine Smith, Governance Manager, NHS WY ICB

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

Previous considerations:

N/A

Executive summary and points for discussion:

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

The report includes a summary of the findings from the review of effectiveness of the Partnership Board and committee and groups within the governance arrangements of the Bradford District and Craven Health and Care Partnership (BD&C H&CP).

The review of effectiveness has informed the production of an annual report and a review of terms of reference for the Partnership Board and the relevant committees and groups as part of the year-end arrangements. Appended to this report are the annual report, terms of reference and workplan for 2025/26 for the Partnership Board – the Board is asked to approve its annual report which will be submitted to the WY ICB Board for assurance and recommend its terms of reference and workplan for 2025/26 for approval by the WY ICB Board. The Partnership Board is asked to receive the annual reports from the committees and groups within its governance structure and approve their terms of reference.

Outline how this supports our partnership vision and strategy

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

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

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

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

Recommendation(s)

The Bradford District and Craven Partnership Board is asked to:

1. **APPROVE** its annual report 2024/25 for submission to the WY ICB Board
2. **APPROVE** its terms of reference and workplan (to be recommend for approval by the WY ICB Board)
3. **APPROVE** the annual reports from the System Finance and Performance Committee, the System Quality Committee, Clinical Forum and Partnership Leadership Executive
4. **APPROVE** the terms of reference for the System Finance and Performance Committee, the System Quality Committee, Citizen Voice Forum and Clinical Forum

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. Review of committee effectiveness 2024/25
2. BD&C Partnership Board annual report 2024/25
3. BD&C Partnership Board terms of reference
4. BD&C Partnership Board workplan 2025/26
5. Citizen Voice Forum terms of reference
6. Clinical Forum annual report 2024/25
7. Clinical Forum terms of reference
8. Partnership Leadership Executive annual report 2024/25
9. System Finance and Performance Committee annual report 2024/25
10. System Finance and Performance Committee terms of reference
11. System Quality Committee annual report 2024/25
12. System Quality Committee terms of reference

Acronyms and Abbreviations explained

1. West Yorkshire Integrated Care Board (WY ICB)
2. Bradford District and Craven Health and Care Partnership (BD&C H&CP)

What are the implications for?

Residents and Communities	No direct implications
Quality and Safety	No direct implications
Equality, Diversity and Inclusion	No direct implications
Finances and Use of Resources	No direct implications
Regulation and Legal Requirements	No direct implications
Conflicts of Interest	None identified
Data Protection	No direct implications
Transformation and Innovation	No direct implications
Environmental and Climate Change	No direct implications
Future Decisions and Policy Making	No direct implications
Citizen and Stakeholder Engagement	No direct implications

Bradford District and Craven Health and Care Partnership
Review of committee effectiveness 2024/25

1. Introduction

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

In March 2025 members and attendees of the Partnership Board, its two sub-committees (Finance and Performance, and Quality), Partnership Leadership Executive and the Planning and Commissioning Forum received a link to an online survey which contained a series of questions related to the effectiveness of their group. The questions focused on the following areas - committee focus, teamwork and effectiveness; committee leadership; committee management; and committee achievements and areas for improvement. It was agreed with the current Chair of the Clinical Forum that as the group had not met for a number of months in 2024/25 and had a change of chair during the year they would not be included in the committee effectiveness review.

During April 2025 the board / committees / groups received the feedback from their reviews and were encouraged to consider using the findings to shape the future arrangements and consider any changes to their terms of reference following the review.

A summary of the responses can be found below -

2. Partnership Board effectiveness summary (19 responses out of 30 members / attendees - 63%)

Overall, the responses were positive in relation to the current arrangements. A member emphasised a strength of the board as the maintenance of the positive quality of partnership relationships during challenging times with the board providing space and opportunity for partners to think together. Comments were made in relation to the excellent chairing which kept the board focused and the leadership which extended beyond the meetings. The focus on Craven was welcomed – this will continue into 2025/26 with a focus on Craven biannually.

The ‘listen in’ programme was highlighted by members as a key achievement in 2024/25 noting it as a strength that there was an opportunity to engage with people and communities experiencing services in Bradford district and Craven. It was suggested that there is the development of a clear plan or outcomes from reports from the ‘listen in’ programme with assurance provided from the relevant programme leads / directors on areas related to the priorities of the partnership.

Other areas cited as highlights of the work through the year related to the development of the place health, care and wellbeing strategy and the support for the new Airedale Hospital.

Suggested improvements for the Board included clarity on its role, remit and responsibilities, referencing those set out in the terms of reference. It was suggested that there is a need for greater clarity on decision-making within the governance arrangements. It was also suggested that the Board focuses on more concerted action on key issues. It was identified that there is also need for a stronger focus on the financial challenges faced by the partnership.

3. Committees / groups effectiveness summary

Below details a summary of the feedback provided throughout the effectiveness review process for the specific committees and groups.

Finance and Performance Committee (5 responses out of 14 members / attendees - 36%)
Achievements for the committee in 2024/25 were noted as assurance of plans, finance and performance monitoring, receiving assurance on the partnership risk register and the WY ICB’s Board Assurance Framework and having a collective view of the position of the partnership. Members agreed on the need for further clarity on the roles and responsibilities of the committee and how it fits into the overall governance structure with consideration for shared ownership if it is a system partnership committee. It was suggested that there is further to work to ensure that the committee receive the right reports with a clear ask from the committee with the forward planner clarified. Additional focus on the actions in the Closing the Gap programme was suggested.

Quality Committee (7 responses out of 27 members / attendees – 26%)
Responses noted the benefits of the deep dives of priority areas, clear escalation of issues and risks, valuable informative presentations, the continual seeking of assurance with issues not being closed until sufficient assurance had been received and highlighted that the System Quality, Insight, Assurance, and Improvement Group escalated issues to the committee proactively. Suggested improvements included having greater clarity on priorities within the quality portfolio with subsequent reporting into the committee and clarity on escalation and areas of responsibility.

Partnership Leadership Executive (9 responses out of 18 members / attendees – 50%)
Responses noted good partnership working and leadership with queries on the purpose of the group and its decision-making powers with the need for increased ownership, accountability and challenge and bolder, streamlined decision-making. As a result of recommendations from an independent review of the leadership of the partnership, it was agreed that the group in its current form would be stepped down and be replaced by a smaller engine room group of CEOs / lead representatives.

Planning and Commissioning Forum (6 responses out of 16 members / attendees = 37.5%)
Responses referred to the forum as a very well managed group with a clear plan and direction that has made a positive impact on the system. Responses highlighted achievements in terms of the planning and management of the Better Care Fund and Section 75. Successes of the group included the transparency and openness of the group, the focus on partnership working and the connection between commissioners working together to manage the governance of joint funding with a whole system view. Suggested improvements referred to a change of meeting arrangements to find a more suitable date/time for members and attendees, the need to have clear pathways for the sign-off of joint arrangements and the identification of leads across the local authority and the NHS to allow for more partnership working and discussions.

4. Next steps

The chairs of the committees and groups have been encouraged to consider using the feedback from the review to shape the future cycles of business and arrangements and consider any changes to their Terms of Reference and the forward planners. Feedback is also being used to inform the review of the governance arrangements.

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Bradford District and Craven Health and Care Partnership Board (Place Committee) ANNUAL REPORT 2024/25

INTRODUCTION

The Bradford District and Craven (BD&C) Health and Care Partnership Board was established as a Committee of the NHS West Yorkshire Integrated Care Board (ICB), in accordance with the ICB's constitution, standing orders and scheme of reservation and delegation. The role of the BD&C Partnership Board is to lead the Bradford District and Craven place-based partnership in accordance with the BD&C strategic partnering agreement, and in accordance with the constitution of the West Yorkshire ICB.

MEMBERSHIP

Members

- Elaine Applebee, independent chair of the BD&C Partnership Board (Chair)
- Foluke Ajayi, chief executive of Airedale NHS Foundation Trust
- Louise Bestwick, chief executive of Bradford Care Association
- Marina Bloj, professor of health research, University of Bradford
- David Crampsey, chair of the BD&C Health and Care (H&C) Partnership Clinical and Professional Forum
- Andrew Gold, chair of Airedale NHS Foundation Trust (until November 2024)
- Ashley Green, chief executive of Healthwatch North Yorkshire
- Richard Haddad, chair of the Clinical Advisory Board (PCNs)
- Danielle Hann, chair of the Local Medical Council
- Marium Haque, strategic director of children of the City of Bradford Metropolitan District Council
- Melanie Hudson, non-executive chair of the People Committee of the BD&C H&C Partnership (until July 2024)
- Sarah Jones, chair of Bradford Teaching Hospitals NHS Foundation Trust
- Sam Keighley, voluntary, community and social enterprise (VCSE) sector lead for Bradford district
- Jonathan Kerr, representative of the VCSE sector in Craven (until February 2025)
- Julie Lawreniuk, non-executive chair of the Finance and Performance Committee of the BD&C H&C Partnership
- Iain MacBeath, strategic director of adult social care and health of the City of Bradford Metropolitan District Council

- Sarah Muckle, director of public health of the City of Bradford Metropolitan District Council (until September 2024)
- Lorraine O'Donnell, chief executive of the City of Bradford Metropolitan District Council
- Therese Patten, BD&C H&C Partnership Place Lead and chief executive of Bradford District Care NHS Foundation Trust
- Linda Patterson, chair of Bradford District Care NHS Foundation Trust
- John Pattinson, chief executive officer of North Yorkshire Independent Care Group
- Mel Pickup, chief executive of Bradford Teaching Hospitals NHS Foundation Trust
- Helen Rushworth, chief executive of Healthwatch Bradford District
- Louise Wallace, director of public health of North Yorkshire Council
- Richard Webb, corporate director health and adult services of North Yorkshire Council
- Andrew Withers, non-executive chair of the Quality Committee of the BD&C H&C Partnership / interim chair of Airedale NHS Foundation Trust from November 2024

Deputies

- Victoria Turner, public health consultant of North Yorkshire Council (deputy for Louise Wallace)
- Jane Wood, assistant director – people commissioning and business support of City of Bradford Metropolitan District Council (deputy for Iain MacBeath)

MEETINGS HELD

17 May 2024
6 September 2024
15 November 2024
14 February 2025

ATTENDANCE

Member	Attendance – number of meetings (meetings eligible to attend)	Attendance as %
Elaine Appelbee, independent chair of BD&C H&CP Board (chair)	4 (4)	100%
Foluke Ajayi, chief executive of Airedale NHS FT	4 (4)	100%

Member	Attendance – number of meetings (meetings eligible to attend)	Attendance as %
Louise Bestwick, chief executive of Bradford Care Association	3 (4)	75%
Marina Bloj, professor of health research, University of Bradford	3 (4)	75%
David Crampsey, chair of Clinical and Professional Forum (until September 2024)	2 (2)	100%
Andrew Gold, chair of Airedale NHS FT (until November 2024)	0 (2)	0%
Ashley Green, chief executive of Healthwatch North Yorkshire	3 (4)	75%
Richard Haddad, chair of the Clinical Advisory Board	4 (4)	100%
Danielle Hann, deputy chair of the YOR Local Medical Council	3 (4)	75%
Marium Haque, strategic director children of the City of Bradford Metropolitan District Council	1 (4)	25%
Melanie Hudson, non-executive chair of the People Committee (until July 2024)	1 (1)	100%
Sarah Jones, chair of Bradford Teaching Hospitals NHS FT	3 (4)	75%
Sam Keighley, VCSE system lead for Bradford district	4 (4)	100%
Jonathan Kerr, VCSE Craven representative (until February 2025)	2 (3)	66.7%
Julie Lawreniuk, non-executive chair of the Finance and Performance Committee	1 (4)	25%
Iain MacBeath, strategic director adult social care and health of the City of Bradford Metropolitan District Council *Deputy – Jane Wood	2 (4) 1 (1)	50% (75% including deputisation)
Sarah Muckle, director of public health of the City of Bradford Metropolitan District Council (until September 2024)	1 (1)	100%
Charlotte McKeown, VCSE Craven representative (from February 2025)	1 (1)	100%
Lorraine O'Donnell, chief executive of the City of Bradford Metropolitan District Council	0 (4)	0%

Member	Attendance – number of meetings (meetings eligible to attend)	Attendance as %
Therese Patten, BD&C H&CP place lead / chief executive of Bradford District Care NHS FT	4 (4)	100%
Linda Patterson, chair of Bradford District Care NHS FT	4 (4)	100%
John Pattinson, chief executive officer of North Yorkshire Independent Care Group	3 (4)	75%
Mel Pickup, chief executive of Bradford Teaching Hospitals NHS FT	3 (4)	75%
Helen Rushworth, chief executive of Healthwatch Bradford District	3 (4)	75%
Louise Wallace, director of public health of North Yorkshire Council *Deputy – Victoria Turner	1 (4) 4 (4)	25% (100% including deputisation)
Richard Webb, corporate director of health and adult services of North Yorkshire Council	0 (1)	0%
Andrew Withers, non-executive chair of the Quality Committee (Chair of Airedale NHS FT from October 2024)	4 (4)	100%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2024/25

- Received updates from the Listen in programme which is an ongoing programme of involvement with focused periods of activity involving direct conversations with the public, visiting community groups and public spaces to help the BD&C H&CP understand what matters most to local people when it comes to health and care. 2024/25 was the second year of Listen in and it focused on reaching into communities of interest and understanding the differing experiences of groups of our population. In each meeting the Board received a 'What are we hearing' report which described the themes that surfaced under each of the partnership priorities alongside existing insight reports that provided context and additional learning following each cycle of engagement and involvement.
- Received a presentation focused on 'understanding ourselves in Craven' by colleagues from North Yorkshire Council which focused on the following areas - health in Craven, public health, adult social care, wider system transformation and localities.
- Received regular updates from the place lead which summarised key activities and points to note arising from the activity of the BD&C H&CP and the wider West Yorkshire Health and Care Partnership.

- Received regular assurance updates from the place committees (System Finance and Performance and System Quality Committees) and the Clinical and Professional forum through the triple A (alert, advise, assure) reports.
- Received the BD&C risk report detailing the serious and critical risks to the partnership, the NHS West Yorkshire ICB risk register, information on the common risks across the five places in West Yorkshire and the West Yorkshire ICB Board Assurance Framework in each cycle of 2024/25. A deep dive into a number of key and emerging risks took place in order for the Board to explore specific risks and understand the mitigations in place.
- Received regular updates on the financial position, of the BD&C H&C Partnership, the West Yorkshire ICB and Integrated Care System (ICS), noting actions to mitigate the position, including work through the Closing the Gap programme. The Board also received updates on NHS operational and financial planning for 2024/25 and 2025/26.
- Received a report which described a refresh of the Section 75 agreement and approved the variation of the agreement to accurately reflect the current partnership arrangements.
- Received an update on the Better Care Fund refresh submission and the draft updated capacity and demand plan for 2024/25. The Board agreed to delegate the approval of the Better Care Fund plan for 2024/25 to the place lead due to the timing of the deadline for submission. Received the Better Care Fund plan for 2023/25 from North Yorkshire Council and noted the updated plan for 2024/25 which had been refreshed for the second year of the plan.
- Received and noted the North Yorkshire Joint Local Health and Wellbeing Strategy.
- Discussed and noted the refreshed BD&C Joint Forward Plan for 2024/25.
- Received a report to confirm that Shipley Hospital was vacant and following handover to NHS Property Services would be placed on the open market for sale with proceeds of the sale invested in the Shipley health and wellbeing campus.
- The development sessions focused on strengthening the link to the priority programmes and local strategies, including a deep dive session on workforce, the developing BD&C health, care and wellbeing strategy and supported the development of the new hospital in Airedale.

AREAS FOR DEVELOPMENT IN 2025/26

- The Board to have more focus on the financial challenges faced by the partnership.
- Continued focus on Craven – with a ‘focus on Craven’ item to be on agenda every six months in order to explore issues pertinent to Craven, alongside the encouragement of business items relevant to Craven throughout the year.
- The Board to consider and explore how to gain more clarity on the role, purpose and remit of the Board alongside greater clarity on decision-making in the NHS

West Yorkshire ICB and H&CP and where it sits within the governance arrangements of the partnership and the ICB.

- The Board to support the development of a clear plan / outcomes from the reports from the Listen in programme to be developed with assurance provided from the relevant programme leads / directors on areas related to the priorities of the partnership.

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

Version control

Version:	2.1
Approved by:	NHS West Yorkshire Integrated Care Board (ICB)
Date Approved:	tbc (ICB Board on 24.06.25)
Responsible Officer:	Matt Sandford, Director of Partnership and Place, NHS WY ICB (BD&C)
Date Issued:	1 July 2022
Date to be reviewed:	June 2026

Change history

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

Version number	Changes applied	By	Date
1.3	Changes to secretariat support and publication of approved minutes	Carrie Haywood	ICB Board to approve on the 25 June 2024
2.0	Annual review following end of year effectiveness self-assessment	Approved by Board	25.06.2024
2.1	Annual review following end of year effectiveness self-assessment and review of membership to reflect current membership		For approval by Partnership Board on 23.05.2025 and NHS WY ICB Board on 24.06.25

Partnership Board Terms of Reference

1. Introduction

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

2. General

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

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

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

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

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

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

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

3. Remit and responsibilities

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

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

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

Its responsibilities are to:

i. establish governance arrangements to support collective accountability between partner organisations for Bradford District and Craven Health and Care Partnership (Partnership) delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations
ii. agree a plan to meet the health, wellbeing and care needs of the population within Bradford District and Craven, having regard to the partnership's integrated care strategy and health and wellbeing strategies across Bradford District and Craven
iii. allocate resources to deliver the plan in Bradford District and Craven, determining what resources should be available to meet population need and underpinned by the partnership's financial and risk management principles (SPA schedule 5), for how they should be allocated across services and providers (both revenue and capital)
iv. arrange for the provision of health and care services in Bradford District and Craven in line with the resources allocated across the Integrated Care System (ICS), through a range of activities including:
    a) putting contracts and agreements in place to secure delivery of its plan by providers
    b) convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes
    c) support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships, including through investment in PCN management support, data and digital capabilities, workforce development and estates
    d) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including

assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care

v. approve decisions on the review, planning and procurement of primary medical care services
vi. approve the operating structure for the Bradford District and Craven Health and Care Partnership
vii. agree implementation of the people priorities across the Partnership
viii. agree place action on digital, data, intelligence and insight: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care
ix. agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money in place and support wider goals of development and sustainability
x. develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within NHS West Yorkshire ICB and the Bradford District and Craven Health and Care Partnership plan
xi. develop arrangements for risk sharing and /or risk pooling with other organisations (for example pooled budget arrangements under section 75 of the NHS Act 2006), for approval by the NHS West Yorkshire ICB Board and the Councils
xii. Approve arrangements for senior / executive staff appointments (for PB and sub-PB level posts)
xiii. Agree clinical pathways, clinical thresholds, service specifications and service standards for matters that **do not** meet one or more of the '3 tests' for working at scale
xiv. Approve **partnership**-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.
xv. make arrangements to implement in place NHS West Yorkshire ICB and Partnership risk management arrangements and
xvi. agree implementation in place of the arrangements for complying with the NHS Provider Selection Regime
xvii. Approve place tenders and contracts
xviii. Review all strategic risks on the Place Board Assurance Framework and provide to the NHS WY Integrated Care Board on the management of these risks.

4. Membership

The Members of the Partnership Board are the:

- independent chair of the BD&C Partnership Board

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

5. Required attendees

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

- ~~chief operating officer of the BD&C Health & Care Partnership~~
- lead finance director of the BD&C Health & Care Partnership
- ~~director of partnership development of the BD&C Health & Care Partnership~~
- director of quality and nursing of the NHS WY ICB (BD&C) (also holds the role of director of nursing at Bradford District Care NHS Foundation Trust)
- ~~assistant director of governance and assurance of the BD&C Health & Care Partnership~~
- strategic communications and stakeholder engagement lead of the BD&C Health & Care Partnership
- associate director of partnership delivery of the NHS West Yorkshire ICB (BD&C)
- head of partnership governance of the NHS West Yorkshire ICB (BD&C)

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

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

6. Deputies

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

7. Chair

[See **4. Membership** for selection of the Chair]
The meetings will be run by the chair. In the event of the chair of the Partnership Board being unable to attend all or part of the meeting, another member of the Partnership Board shall chair the meeting

8. Quoracy

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

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

For the sake of clarity:

a) no person can act in more than one capacity when determining the quorum
b) an individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum

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

9. Conduct of meetings

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

a. all members of the Partnership Board who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the committee are set out at section 4; attendees and observers do not have voting rights.)
b. absent members may not vote by proxy. Absence is defined as not being present at the time of the vote
c. a resolution will be passed if more votes are cast for the resolution than against it
d. if an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the deputy chair presiding over the meeting) will have a second and casting vote and
e. should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting

10. Frequency of meetings

The Partnership Board will meet quarterly. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to members of the Partnership Board.

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

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

11. Urgent decisions

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

a) powers which are delegated to the Partnership Board, may for an urgent decision be exercised by the Chair of the Partnership Board and the Place Lead for Bradford District and Craven Health and Care Partnership and
b) exercise of such powers shall be reported to the next formal meeting of the Partnership Board for formal ratification, where the Chair will explain the reason for the action taken, and the NHS West Yorkshire ICB's Audit Committee will be notified, for oversight.

12. Admissions of the press and public

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

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

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

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

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

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

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

13. Declarations of interest

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

14. Support to the Partnership Board

The Partnership Board's lead manager is the Director of Partnership and Place / Deputy Accountable Officer of the NHS West Yorkshire ICB (BD&C). Administrative support will be provided to the Partnership Board by officers of NHS West Yorkshire ICB. This will include:

- agreement of the agenda with the Chair in consultation with the Lead Manager, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward
- maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions
- agenda setting meetings to be scheduled between governance support / chair of meeting / lead director for meeting at least three weeks in advance of meeting
- Draft agenda to be issued to committee/board members and report authors two weeks before the deadline for papers
- sending out agendas and supporting papers to members five working days before the meeting
- drafting minutes for approval by the Chair and ICB Lead Manager within ten working days of the meeting
- chair/Lead Director to review and respond with any amendments within the next 5 working days
- draft minutes distributed to all attendees of the meeting following this – within one calendar month of the meeting (this applies to bi-monthly/quarterly meetings)
- minutes to be formally approved at the subsequent Committee/Board meeting
- an annual work plan to be updated and maintained on a quarterly basis

15. Authority

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

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

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

The Partnership Board is authorised to create sub-committees or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Partnership Board may not delegate executive powers delegated to it within these terms of reference (unless expressly authorised by the NHS West Yorkshire ICB Board as set out within the

BD&C HCP Scheme of Reservation and Delegation) and remains accountable for the work of any such group.

16. Reporting

- The Partnership Board shall submit its ratified minutes to each formal NHS West Yorkshire ICB Board meeting
- report within two weeks of the Partnership Board meeting to the NHS West Yorkshire ICB Board using the committee assurance report framework 'Triple A' (alert, advise and assure summarising key items at the meeting)
- provide the NHS West Yorkshire ICB Board meeting with a copy of the Partnership Board meeting forward plan annually
- the Chair shall draw to the attention of the NHS West Yorkshire ICB Board any significant issues or risks relevant to the ICB
- the Partnership Board's minutes will be published on the NHS West Yorkshire ICB website once ratified
- the Partnership Board shall submit an annual report to the NHS West Yorkshire ICB Audit Committee and the NHS West Yorkshire ICB Board and
- the Partnership Board will receive for information ~~the minutes~~ the Triple A reports (alert, advise, assure) of other meetings which are captured in the Partnership Board workplan e.g. sub-committees

17. Conduct of the Partnership Board

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

18. Amendments

1
2

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

19. Review Date

After 1 year.

Bradford District and Craven Health and Care Partnership

ACTasONE

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

NHS West Yorkshire Integrated Care Board

Bradford District and Craven Health and Care Partnership Board
2025/26 Work Plan

Item	Frequency	Purpose	Lead	Source	23 May 2025	5 September 2025	14 November 2025	13 February 2026
Opening Items:								
Welcome, introductions, apologies and quoracy	Each meeting	To Note	Elaine Appelbee, Chair	Verbal	X	X	X	X
Declarations of interest		Update	Elaine Appelbee, Chair	Verbal and Link to register	X	X	X	X
• Draft minutes of the previous meeting for approval • Action log / matters arising • Previous Partnership Board Triple A report		Approval	Elaine Appelbee, Chair	Paper	X	X	X	X
Public questions		Information	Elaine Appelbee, Chair	Verbal	X	X	X	X
Place Lead's update		Information / Discussion	Therese Patten, Place Lead	Paper	X	X	X	X
Focus items								
Public voice – engagement and feedback	Each meeting	Information / discussion	Victoria Simmons, Senior Head of Communications and Involvement	Paper	X	X	X	X
Updates on performance and finance	Each meeting	Assurance	Mike Woodhead, Place Director of Finance Kerry Weir, Associate Director, Planning,	Paper	X	X	X	X

			Performance and Business Intelligence					
Financial and operational plans	Bi-annual	Assure/approval	Mike Woodhead, Place Director of Finance Kerry Weir, Associate Director, Planning, Performance and Business Intelligence	Paper	X			X
Focus on Craven	Every six months	Information/discussion	Tbc	Paper		X		X
Health, Care and Wellbeing Strategy	tbc	Assurance	Matt Sandford, Director of Partnership and Place	Paper	X			
Better Care Fund 2025-26 sign-off	Annual	Approval	Iain MacBeath, Strategic Director, Adult Social Care and Health	Paper	X			
System Assurance and Committee Reporting:								
High Level Risk Register	Each meeting	Assurance	Asma Sacha, West Yorkshire ICB Risk Manager	Paper	X	X	X	X
Reports from committees and fora - Clinical Forum - System Finance and Performance Committee - System Quality Committee	Each meeting	Assurance	Sohail Abbas, Chair of Clinical Forum Julie Lawreniuk, Chair of System Finance and Performance Committee Andy Withers, Chair of System Quality Committee	Paper	X	X	X	X
Governance and Assurance:								
Board Assurance Framework	Every six month	Assurance	Asma Sacha, West Yorkshire ICB Risk Manager	Paper		X		X

Strategic Partnering Agreement	Annual	Assurance / approval	Sue Baxter, Head of Partnership Governance	Paper	X			
Governance Handbook	Annual	Assurance / approval	Sue Baxter, Head of Partnership Governance	Paper	X			
Partnership governance arrangements for 2025/26	Annual	Approval	Sue Baxter, Head of Partnership Governance	Paper	X			
End of Year Committee Effectiveness (including receipt of annual report, review of terms of reference and work plan)	Annual	Assurance / approval	Sue Baxter, Head of Partnership Governance	Paper	X			
End of Year Effectiveness of the following (including approval of annual report, terms of reference and work plan) • Clinical Forum • System Finance and Performance Committee System Quality Committee	Annual	Assurance / approval	Sue Baxter, Head of Partnership Governance	Paper	X			
Closing Items:								
Any Other Business	Each meeting	Discussion	Elaine Appelbee, Chair	Verbal	X	X	X	X
Escalations to West Yorkshire ICB Board and review of meeting		Discussion	Elaine Appelbee, Chair	Verbal	X	X	X	X
Date and Time of the Next Meeting		Information	Elaine Appelbee, Chair	Verbal	X	X	X	X

Terms of reference
Citizen Voice Forum

Version control

Version:	2.1
Approved by:	Bradford District and Craven Health and Care Partnership Board
Date Approved:	September 2024
Responsible Officer:	Victoria Simmons
Date Issued:	9 September 2024
Date to be reviewed:	1 September 2025

Change history

Version number	Changes applied	By	Date
1.0	Initial draft	Victoria Simmons	01/11/2022
1.1	Feedback from members	Victoria Simmons	05/01/2023
1.2	Approval from Chair	Helen Rushworth	09/01/2023
2.0	Updated following development sessions and discussions at Partnership Board	Victoria Simmons	12/04/2024
2.1	Updated following CVOG launch session and comments from members – for approval at 17 Sept 2024 meeting	Victoria Simmons	16/07/2024

1. Introduction and Context

Bradford District and Craven Health and Care Partnership firmly believes that our communities have the most power to create health and should be equal partners when it comes to decision making. We want to create opportunities for people to be involved in our decision-making processes and do this in innovative ways.

The Citizen Voice Forum is established to lead work across our partnership that continually improves the way we involve people and communities (sometimes referred to as engagement, participation or co-production).

2. Purpose

Citizen Voice Forum is supported by underpinning workstreams and involvement projects that support the ambitions of our partnership. The Citizen Voice Forum oversees this work and through its connections with partners, communities and citizens is able to provide advice to the Partnership Board and other committees of the ICB at place to ensure that we fulfil our involvement duties.

Set the strategic direction for citizen's voice across BDCHCP

- Working with key decision making groups to understand how citizens' voice can best influence their decision making and planning – co developing minimum expectations for involving citizens and ensuring insight from communities is acted upon
- Working with partner organisations towards the development of a joint strategy on citizen's voice, including exploring the relationship with Foundation Trust Governors and other elected representatives
- Working with Programme Boards and decision making groups to help shape plans, provide insight, feedback and challenge and influence the strategy and delivery of the partnership from a citizen's perspective
- Working with the Citizen's Forum Operational Group to identify key themes relating to strategic priorities and communities of interest

Work with priority boards and decision-making groups across BDCHCP to obtain assurance that involvement duties are met and that citizen voice is having an impact.

- Supporting self-assessment of Programme Boards and decision-making groups within the partnership against co developed minimum standards of involvement
- Supporting Programme Boards and decision making groups to implement mitigating actions to enable minimum standards to be met
- Supporting Programme Boards to engage with citizen's voices as part of the Quality Impact Assessment process
- Supporting Programme Boards to identify impact metrics relating to citizen's engagement and experience which are monitored as part of the wider portfolio of impact / benefit metrics

Oversee programmes to support and further amplify citizen voice and true coproduction by activating the Citizen Voice Operational Group.

- Developing a joint understanding of citizen's concerns and feedback which can be used to support decision making and to influence planning. This includes work to link the voice of different forums
- Facilitating seamless access to data relating to the voice of the citizen – acting as a coordinated route for Programme Boards and decision making groups across BDC H&CP to hear the citizen's voice
- Sharing experience and expertise on engagement and coproduction
- Overseeing communications strategies to ensure that the partnership is visibly communicating the outcomes of engagement and co production with citizens

3. Responsibilities

The forum is not a decision-making committee but has an advisory role in our place-based governance. The remit of the BD&C Citizen Voice Forum is to provide advice and/or recommendations in the following areas to the Partnership Board:

- Actively participating in the development of the communication and involvement strategy for Bradford District and Craven Health and Care Partnership.
- Ensuring that all plans within the Bradford District and Craven are informed by the views and experiences of people and communities we serve.
- Maintaining and embedding co-production as a core principle of the partnership.
- Supporting collaboration and strengthening partnerships between colleagues working in involvement, engagement, coproduction, or experience, in our place.
- Providing oversight and alignment of involvement, engagement, coproduction, or experience initiatives across Bradford District and Craven.
- Making use of shared intelligence to provide citizen perspectives on the quality of health and care services.
- Providing a mechanism for partner organisations to hold each other to account on how we act on citizen voice.
- Making appropriate links with other committees in place to support the work of the partnership.

4. Membership and attendees

Membership

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

- **BDCHCP Programme Director (Chair)**
- BDCHCP Associate Director of Communications and Involvement
- Healthwatch Bradford District lead officer
- Healthwatch North Yorkshire lead officer
- BDCFT Deputy Director: Patient Safety, Compliance and Risk
- BTHFT Assistant Chief Nurse & lead for patient experience

- Airedale NHSFT, Deputy Chief Nurse & lead for patient experience
- VCSE activation contract representative for citizen voice
- Bradford Council, Assistant Director Neighbourhoods & Community Services
- Bradford Council, People Commissioning Transformation Lead
- Bradford Children and Families Trust TBC
- North Yorkshire Council, Localities Manager for Craven
- BDCHCP Equality, Diversity, and Inclusion Lead

The Forum will be chaired by a programme/priority director on a rotational basis, to ensuring strong connection to strategic decision making. Managerial support will be provided by BDCHCP Senior head of communications and involvement.

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

BDCHCP's Partnership Board member with responsibility for citizen voice ('Chief Listening Officer') will be invited to attend meetings and will receive all papers in order to provide assurance and escalations to the Board.

5. Arrangements for the conduct of business.

Chairing meetings

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

Quoracy

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

5.3 For the sake of clarity:

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

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

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

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

Frequency of meetings

5.6 The steering group will meet quarterly. The Chair may call an additional meeting at any time by giving not less than 7 calendar days' notice in writing to members.
Twice yearly development sessions will be held jointly with the Citizen Voice Operational group.

Declarations of interest

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

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

Support to the Forum

5.9 The steering group's lead manager is the Place Based Partnership Senior head of communications and involvement. Administrative support will be provided to the steering group by officers of the Place Based Partnership. This will include

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

6. Reporting

6.1 The steering group is accountable to Partnership Board, which provides the formal leadership and coordination of the local health and care system.

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

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

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

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

7. Conduct of the Citizen Voice Forum steering group

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

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

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

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

Bradford District & Craven- Clinical Forum

ANNUAL REPORT 2024-25

INTRODUCTION

The Bradford District & Craven Clinical Forum has two roles.

The first is to support the ICB on issues within its remit. If this BD&C Forum makes recommendations on behalf of the ICB (see section 5 below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this BD&C Forum.

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

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

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

MEMBERSHIP

The membership of the forum comprises:

- David Crampsey (Chair) - Deputy Chief Executive | Executive Medical Director ANHSFT (April 2024-Sept 2024)
- Sal Uka- The Interim Medical Director of Airedale NHS FT (Dec 2024- present)
- David Sims - Medical Director & representative from BDCT
- Ray Smith - Chief Medical Officer & representative from BTHT
- Phillipa Hubbard - BD&C Partnership Director of Quality and Nursing (distributed leadership model which is covered by system chief nurse)
- Sohail Abbas - - Clinical commissioner representative and Deputy MD (ICB)
- Phillipa Hubbard – The Chief Nurse of Bradford District Care NHS FT
- Lianne Robinson– The Interim Chief Nurse of Airedale NHS FT
- Karen Dawber – The Chief Nurse of Bradford Teaching Hospitals NHS FT

- One Allied Health Professional representative from each Trust - TBC
- Richard Haddad (BCA), Danielle Hann (LMC), Sara Humphrey, & Stephen Patterson (LMC) - representatives of GP at scale practice
- Sarah Muckle - Director of Public Health
- Iain Macbeath - Strategic Director, Health and Wellbeing (BMDC)- Bradford Metropolitan District Council – Social Care
- TBC - Representative Community Pharmacy West Yorkshire
- Sohail Abbas - representative the Inequalities Alliance (Chair Jan 2025- present)
- From April 2023 has included representatives from Optometry and Dental

In addition – attendees include

- John Hartley – Assistant Director Quality Improvement - BdC Health and Care Partnership
- Michael McCooe - Associate Medical Director BTHFT, Improvement Academy
- Claire Kilburn - Head of Medicines Optimisation - BdC Health and Care Partnership
- Himanshu Garg - Associate medical director/ consultant psychiatrist (BDCFT)
- Ciaran O'Neill - Leadership fellow - Improvement academy
- Raj Billoo - Optometry
- Chris Davey - Optometry, Secretary of LOC
- Victoria Turner - Public health representative - NYCC
- Jaspreet Sohal - Chief Pharmacist BDCFT, (Deputy Chair, April 2024-present)
- Carrie Haywood - Senior Governance Manager BdC Health and Care Partnership
- Natalie Cooper Illingworth - Principal Social Worker - NYCC
- Iram Amin Quality Lead - BdC Health and Care Partnership

MEETINGS HELD

9th April 2024
15th May 2024
13th August 2024
5th February 2025
12th March 2025

ATTENDANCE

Member	Job Title	Attendance (number of meetings attended)	Attendance (% out of 5 meetings)
Bev Denton	Governance Manager (BdC P'Ship)	1	20%
Carrie Haywood	Senior Governance Manager (BdC)	2	40%
Chris Davey	Optometry, Secretary of LOC	0	0%
Ciaran O'Neill	Leadership fellow at Improvement academy	0	0%
Claire Kilburn	Head of Medicines Optimisation (BdC P'Ship)	2	40%
Dannielle Hann	GP and Deputy Chair of Bfd YORLMC Ltd	2	40%
David Crampsey	Deputy CEO Medical Director (ANHSFT)	1	20%
David Simms	Medical Director (BDCFT)	4	80%
Himanshu Garg	Associate medical director/ consultant psychiatrist (BDCFT)	1	20%
Iain Macbeath	Strategic Director, Health, and Wellbeing (BMDC)	0	0%
Iram Amin	Quality Team (BdC P'Ship)	3	60%
Jaspreet Sohal	Chief Pharmacist (BDCFT)	5	100%
John Hartley	Assistant Director of Quality & SEND (BdC P'Ship)	5	100%
Lianne Robinson	Chief Nurse, ANHSFT	1	20%
Karen Dawber	Chief Nurse, BTHFT	0	0%
Michael McCooe	Associate Medical Director BTHFT, (BHIR)	1	20%
Phil Hubbard	Associate Director of Quality (BdC P'Ship)	2	40%
Ray Smith	Medical Director (BTHFT) (BdC P'Ship)	3	60%
Richard Haddad	CEO CAB (GP)	4	80%
Sara Humphrey	GP/ACD/frailty, dementia, and LD	3	60%
Sohail Abbas	Deputy Clinical Chair and Strategic Clinical Director Population Health & Wellbeing (BdC P'Ship)	2	40%
Steve Patterson	Chair of Bfd YORLMC Ltd	2	40%
Victoria Turner	Public health N Yorks	3	60%
Sal Uka	Interim Medical Director- ANSHFT	2	40%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2024 – 25

A number of areas of work have been received, discussed and supported within 2024/2025. These include.

- Updates from Medicines management, Human Normal Immunoglobulin (HNIG) in primary care, Patients Records- Access and impact on GPs, Born in Bradford and Connected Bradford, Primary/secondary care interface, Workforce Update – Enhance, and Structured Judgement Reviews
- Deep dives into specific areas which gave insight into the identified areas. This enabled support from the system and an opportunity for learning and sharing.
- Information sharing from other meetings as papers from the WY ICB Clinical Forum were circulated within the pack.
- Providing regular updates to the Partnership Board in relation to activities and items within the forums remit via the AAA updates.

The Clinical Forum took the decision to pause the meetings during 2024/ 2025 until the new chair was appointed, focusing on refreshing the BDC Clinical Forum's role and developing the BDC Place Strategy.

AREAS FOR DEVELOPMENT IN 2024 - 25

- A development session for the forum is planned to take place in April 2025 with the focus on developing the Bradford District & Craven Health and Care Services Strategy (also known as the Clinical Strategy).
- Future planned areas of review include:
    - Core20Plus5 evaluation report
    - WYAAT service review

Terms of Reference: Bradford District and Craven Clinical Forum

Version control

Version: 3.1

Approved by: BdC Partnership Board

Date Approved: TBC

Responsible Officer: John Hartley, Assistant Director Quality & SEND

Date Issued: 1 August 2022

Date to be reviewed: 1 April 2026

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	John Hartley	02 August 2022
0.2	Transfer to Accessible version	Carrie Haywood	14 September 2022
0.3	Updated with final feedback	John Hartley	10 October 2022
1.0	Approved	Bd&C Partnership Board	
2.0	Annual Review 2023 - draft	John Hartley	27 September 2023
2.0	Approved	Bd&C Partnership Board	10th November 2023
3.0	Approved	Bd&C Partnership Board	17 May 2024

3.1	Annual Review draft - 2025	Iram Amin, John Hartley, Sohail Abbas	May 2025

Bradford District and Craven Clinical Forum Terms of Reference

1. Introduction

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

2. General

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

- West Yorkshire ICB Conflict of Interest Policy
- West Yorkshire ICB Constitution
- West Yorkshire Standing Order or Standing Orders

Other capitalised terms have the meaning set out below:

- "Attendee" refers to a participant of this BD&C Committee as listed in paragraph 7
- "BD&C Forum" refers to this Forum.
- "Chair" means the chair of this BD&C Forum
- "ICB" means the NHS West Yorkshire Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated.

- "ICB Business" has the meaning given to it at paragraph 5 below - "ICB Committee" means a committee of the ICB.
- "ICB Policies" means any policy, process or procedure formally adopted by the ICB.
- "Member" refers to a member of this BD&C Forum as listed in paragraph 6.
- "NHS Foundation Trust Partner" means Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and/or Bradford Teaching Hospitals NHS Foundation Trust
- "Partner" refers to a partner organisation in the Place Partnership which is also a party to the SPA.
- "Partnership Business" has the meaning given to it at paragraph 5 below.
- "Partnership Board" means the Bradford District and Craven ICB Committee as described in the Constitution.
- "Place Lead" means that individual appointed by the ICB to oversee and help develop the Place Partnership
- "Place Partnership" means the partnership of organisations described in the SPA
- "SPA" means the Strategic Partnering Agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Bradford District and Craven
- "Working Days" means a weekday that is not a bank holiday in England
- "Written Resolution Procedure" is the written resolution procedure described at paragraph 11 below.
- This BD&C Forum shall operate in accordance with the vision, objectives and principles set out in the terms of reference of the BD&C Partnership Board. When advising or making recommendations on behalf of the ICB, it will comply with relevant ICB policies.
- The ICB Standing Orders shall apply to this BD&C Forum unless these Terms of Reference expressly make alternative provision that they do not

3. Reports to

This BD&C Committee reports to BD&C Partnership Board and the ICB Clinical Forum.

DRAFT

Members and attendees may also report back to their respective Partner organisations.

4. Purpose

This BD&C Forum has two roles.

The first is to support the ICB on issues within its remit. If this BD&C Forum makes recommendations on behalf of the ICB (see section 5 below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this BD&C Forum.

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

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

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

5. Remit and responsibilities

The remit of this BD&C Forum is to:

a) Make the following decisions on behalf of the ICB, following delegation of this responsibility from the ICB to the Partnership Board and from the Partnership Board to this BD&C Forum: None currently delegated.
b) Provide advice and/or recommendations in the following areas to the Partnership Board, for the benefit of the ICB ((a) and (b) together "ICB Business"):

DRAFT

- Actively participating in the development of a clinical strategy and associated narrative for Bradford District and Craven
- Ensuring that all plans within the Bradford District and Craven are clinically led, evidence based, and configured to improve patient and population outcomes.
- Ensuring the voice of the patients, service users and citizens is heard and reflected in all clinical forum discussions.
- Maintaining and embedding clinical co-production as a core principle of the partnership.
- Supporting collaboration and strengthening partnerships between clinical colleagues.
- Exhibiting clinical leadership and galvanising professional colleagues and partner organisations to agree models of care which support delivery to close the three gaps (health, care and finance) in Bradford District and Craven.
- Championing change and evidence-based innovation within organisations and at Place.
- Supporting the transition to new models of care, where appropriate.
- Providing oversight and alignment of all clinical initiatives across Bradford District and Craven and across West Yorkshire ICS.
- Supporting regular communication and engagement with all stakeholders
- Supporting through review the evaluation and impact of all workstreams and plans
- Providing innovative solutions to system-wide challenges, particularly where there are interdependencies between workstreams (including enablers) and local plans.
- Providing input and support to the clinical representation on each of the workstreams.
- Providing a clinical lens on system performance on the quality of health and care services and providing a mechanism for partner organisations to hold each other to account on quality, making appropriate links with other committees in place to support the work of the partnership.

c) Provide advice to other members of the Partnership Board “Partnership Business”:

6. Members

DRAFT

Members contribute to discussion, participate in making recommendations and are accountable for the dissemination of information back into their host organisation as required.

The Members of this Forum are:

Senior clinicians (normally clinical commissioners, GPs, medical directors, directors of nursing, senior allied health professionals) nominated by the relevant organisation or partnership group.

The membership will comprise:

- A Chair (nominated by members from the Forum and ratified by BDC Partnership Board)
- Medical Director/ Nursing Director from BTHFT
- Medical Director/ Nursing Director from ANHSFT
- Medical Director/ Nursing Director from BDCFT
- ~~Medical Director /representative from BDCT~~
- ~~Medical Director /representative from AFT~~
- ~~Medical Director /representative from BTHT~~
- ~~Clinical commissioner representative~~
- BDC HCP Clinical Representative
- ~~One Nursing / Quality Lead from BDCT~~
- ~~One Nursing / Quality Lead from AFT~~
- ~~One Nursing / Quality Lead from BHFT~~
- One Allied Health Professional representative from each Trust
- 1-4 representatives of GP at scale practice (e.g., GP at scale practices/ federation /Locality CDs)
- One Director of Public Health
- One representative from Bradford Metropolitan District Council – Social Care
- One representative from North Yorkshire County Council – Social Care
- One representative from Community Pharmacy West Yorkshire & one pharmacist representing provider Trusts.

DRAFT

- One representative from Local Medical Committee
- One representative from the Inequalities Alliance
- One representative from Optometry
- One representative Dental
- ~~One representative – Healthcare Scientist~~

A deputy Chair will be agreed from among nominated members.

~~The first Members of this BD&C Forum shall be appointed by the BD&C Partnership Board.~~ There is no specific term of membership for this forum, any terms will be agreed on an individual basis ~~should this be required.~~

7. Attendees

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

The Attendees of this Forum are:

- Assistant Director Quality & SEND - BD&C Health and Care Partnership
- Head of Research – West Yorkshire Integrated Care System
- Governance Manager – West Yorkshire Integrated Care System

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

Any individual wishing to attend a meeting of this BD&C Forum should make a request to the Chair by writing to Assistant Director Quality & SEND or member of the partnership administration team (administrators to the Forum) to be received at least three Working Days prior to the meeting. Attendance is at the Chair's discretion.

8. Deputies

In accordance with Standing Order [4.7], with the permission of the Chair, a member may nominate a deputy to attend a meeting of the Forum that the Member is unable to attend. The deputy may speak on their behalf. The decision of the meeting Chair regarding acceptance of nominated deputies is final.

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

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

9. Chair

The Chair of this BD&C Forum shall be selected as follows.

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

Subsequent Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by this BD&C Forum, for the avoidance of doubt candidates are permitted to vote in such selections.

One person may not serve more than three consecutive terms as Chair.

If the Chair is unable to attend a meeting or carry out the role of the Chair between meetings this shall be taken on by the Deputy Chair.

The Deputy Chair of this BD&C Forum shall be selected as follows.

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

DRAFT

Subsequent Deputy Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by this BD&C Forum, for the avoidance of doubt candidates are permitted to vote in such selections.

One person may not serve more than three consecutive terms as Deputy Chair.

If both the Chair and the Deputy Chair are absent then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.

10. Quoracy

No recommendations shall be made unless at least half the members are present.

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

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

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

11. Conduct of meetings

Meetings of this BD&C Forum will be run by the Chair.

The expectation is that Members will attend meetings in person or virtually as required.

However, in accordance with Standing Order 4.8, the Chair shall have discretion to permit a Member or Attendee to participate in a meeting by telephone, video or by other

electronic means where they are available and the Chair is satisfied that there is good reason for the request, such as clinical commitments. Participation by any of these means shall be constitute presence in person at the meeting provided all Members and Attendees in attendance can be heard and hear one another.

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

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

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

a. All Members of this BD&C Forum who are present at the meeting will be eligible to cast one vote each.
b. Absent members may not vote by proxy. Absence is defined as being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. However, they are able to appoint a deputy in accordance with paragraph 8.
c. A resolution will be passed if more votes are cast for the resolution than against it.
d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote.
e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

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

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

- confirms the resolution(s) that the Members are being asked to approve;

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

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

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

Exceptions:

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

Passing the written resolution:

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

DRAFT

each resolution, any abstentions and details of any Member that did not respond by the deadline.

12. Frequency of meetings

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

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

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

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

13. Urgent decisions

Not applicable

14. Admissions of the press and public

Not applicable

15. Declarations of interest

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

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

16. Support to the committee

Administrative support will be provided to this BD&C Forum by the Assistant Director Quality & SEND and a ~~or~~ nominated member of the partnership administration team. This will include:

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

Notifications and requests to the Chair must be sent to either john.hartley@bradford.nhs.uk ~~or Beverley.Denton@bradford.nhs.uk~~

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

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

17. Authority

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

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

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

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

This BD&C Forum has no working groups, which report to it. Should specific working groups be required to support this BD&C Forum they will not be time-limited. This BD&C Forum shall determine their membership, scope and work programme and ensure that these are recorded in writing, regularly reviewed and understood by all participants. A working group may be dissolved by the BD&C Forum but permanent working groups cannot be created by this BD&C Forum without the agreement of the Partnership Board, as outlined below.

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

18. Reporting

This BD&C Forum shall provide an update as required to agreed Partnership Board meetings. These shall be published by the Partnership Board as part of its meeting.

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

This BD&C Forum shall submit an annual report to the Partnership Board.

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

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

19. Conduct of the Forum

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

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

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

Members and Attendees must demonstrably consider the equality and diversity implications of recommendations they make and consider whether any new

recommended approach achieves positive change around inclusion, equality and diversity.

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

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

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

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

- That individual fails to comply with these terms of reference;
- That individual has behaved in a way, or is threatening to behave in a way, that is likely to bring this BD&C Forum, the Partnership Board and/or the ICB into disrepute;
- That individual has attended less than 75% of the meetings of this BD&C Forum in any 12 month period;
- The individual no longer meets the relevant membership requirement set out at paragraph 6, for example because they no longer hold a particular post or work for a particular organisation; or
- They qualify for membership of this BD&C Forum through their host organisation and that host organisation leaves the Place Partnership

20. Amendments

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

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

21. Review date

These terms of reference shall be reviewed annually.

22. Implementation

DRAFT

These terms of reference come into effect on 01 August 2022

DRAFT

ANNUAL REPORT 2024-25
Partnership Leadership Executive

INTRODUCTION

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

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

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

Therese Patten took the position of PLE Chair on 1 April 25.

MEMBERSHIP

Member	
Therese Patten	CEO BDCFT (Chair)
Mel Pickup	Place Based Lead, CEO BTHFT
Richard Haddad	Chair, Clinical Advisory Board.
Iain MacBeath	Strategic Director of Health and Wellbeing, Bradford Metropolitan District Council (BMDC)
Sam Keighley	VCSE Sector Lead and CEO of VCS Alliance
David Crampsey	Chair of BdC Clinical Forum *(until October 2024)*
Charlotte Ramsden	CEO Bradford Children and Families Trust
Louise Bestwick	CEO Bradford Care Association Ltd
Lorraine O' Donnell	CEO, (BMDC)
Foluke Ajayi	CEO, Airedale NHS Foundation Trust
Marium Haque	Strategic Director - Children's Services (BMDC)
Sarah Muckle	Director Public Health *(until October 2024)*
Rose Dunlop	Interim Director Public Health *(from October 2024)*
Dannielle Hann	Medical Director and Deputy Chair, LMC
Richard Webb	North Yorkshire Council
Phil Hubbard	Director of Quality and Nursing
Mike Woodhead	System Finance Director
Sohail Abbas	Director - Population Health and Inequalities (BdC HCP)

In addition, regular attendees (not members) include:

Nancy O'Neill	Director partnership delivery/COO, BdC HCP *(up to Sept 25)*
Matt Sandford	Director partnership and place/COO, BdC HCP *(from Sept 25)*
Helen Farmer	Director of transformation, BdC HCP
Shak Rafiq	Associate Director Communications and Involvement, BdC HCP

Alison Bullock Partnership Manager, BdC HCP

MEETINGS HELD

26/04/24	23/08/24	20/12/24
24/04/24	27/09/24	24/01/25
28/06/24	25/10/24	28/02/25
26/07/24	22/11/24	28/03/25

ATTENDANCE

Member		meetings eligible to attend	% Meetings attended (out of 12 meetings)
Therese Patten	Place Based Lead / CEO BDCFT *(Chair)*	12	75%
Mel Pickup	CEO Bradford Teaching Hospitals (BTHFT)	12	83%
Richard Haddad	Chair, Clinical Advisory Board.	12	75%
Iain MacBeath	Strategic Director of Health and Wellbeing (CBMDC)	12	67%
Sam Keighley	VCSE Sector Lead and CEO of VCS Alliance	12	67%
David Crampsey	Chair of BdC Clinical Forum *(until October 2024)*	6	100%
Charlotte Ramsden	CEO Bradford Children and Families Trust	12	83%
Louise Bestwick	CEO Bradford Care Association Ltd	12	100%
Lorraine O' Donnell	CEO, (CBMDC)	12	0
Foluke Ajayi	CEO, Airedale NHS Foundation Trust	12	58%
Marium Haque	Strategic Director - Children's Services (CBMDC)	12	33%
Sarah Muckle	Director Public Health *(until October 2024)*	6	67%
Rose Dunlop	Interim Director Public Health *(from October 2024)*	6	83%
Dannielle Hann	Medical Director and Deputy Chair, LMC	12	75%
Richard Webb	North Yorkshire Council	12	0
Phil Hubbard	Director of Quality and Nursing	12	92%
Mike Woodhead	System Finance Director	12	92%
Sohail Abbas	Director - Population Health and Inequalities	12	83%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2024 – 25

- Approved the Terms of reference for the Closing the Gap Programme Board and Closing the Gap Business Case Appraisal Panel.

Received updates and commented on:

- Special Education Needs and or Disabilities (SEND) Health & ICB responsibilities.
- Better Care Fund 24-25 Plan update
- The five priority programmes in line with the work to review their programmes with a view to re-focusing work to help close the financial gap in 2024/25 and beyond and reviewed the opportunities identified.
- the development of the next Bradford District Strategy and discussed how PLE could be involved in setting strategic actions and metrics related to health

- Innovation Hub sustainability
- Creative Health and Bradford City of Culture 2025
- State of the Voluntary Care Sector Alliance
- Airedale New Hospital Strategic Outline Case
- Children in Care and Care Leavers Annual Report
- Carers Strategy for 2024-2029
- Inclusion Health in BdC: Health Needs Assessment
- Independent report by Mike Farrar – Steps to achieve financial sustainability
- The development of the BdC Health and Care Wellbeing Strategy
- Received regular updates from the Priorities and Enables
- Received regular updates on the Partnership Risk Register
- Received regular updates on Finance and planning

As part of the Business Case Appraisal Panel recommendations, PLE discussed:

- Children in Care Review Health Assessment Capacity
- Children and Young People's Autism and ADHD Assessment Capacity
- Special Education Needs and Disabilities Information Advice and Support Service (SENDIASS)
- Mediation Services between parents or young people and local authorities over Education Health and Care needs assessments and plans.
- The Voice of Parents and Carers
- supported a recommendation not to reinstate the Wellbeing Hub funding
- telemedicine in care homes
- specialist children's weight management.

PLE supported:

- A two-year contract proposal for West Yorkshire CYP Mental health overnight crisis support/line provision - Night Owls.
- A proposal in which the partnership could further the ambition of supporting students from the University of Bradford in securing work-based experience to support their future careers.
- The implementation of the Oliver McGowan mandatory training package over the next 3 years across BdC HCP.
- A proposal for BdC place to engage with the WY ICB AHP Fellowship for 5-6 fellows to be recruited across BDC to complete the 12-month fellowship
- A proposal for an Intermediate Care Summit to help progress the work around Intermediate Care service review
- the progression of a lead provider model for Autism and ADHD support services
- the development of the bid to develop additional children's home provision for children aged 15-18 with complex needs.

AREAS FOR DEVELOPMENT IN 2025 – 26

As a result of recommendations from the Mike Farrar Independent report, it was agreed PLE in its current form would be stepped down and be replaced by a smaller engine room group of CEO's/Lead representatives – Partnership Leadership Operative.

The last formal meeting of the Partnership Leadership Executive was held on 28 March 2025. It was agreed PLE should be reconstituted to provide a wider leadership forum / development session which would meet less frequently.

COMMITTEE EFFECTIVENESS SURVEY FOR 2024/25

In March 2025 members and attendees of PLE were invited to complete a survey which was designed to review the effectiveness of the group throughout 2024/25. A total of 9 surveys were completed which equates to participation by 50% of regular members/attendees.

The survey provided questions within the following categories - committee focus, teamwork and effectiveness; committee leadership; committee management; and committee achievements and areas for improvement.

Responses noted good partnership working and leadership with queries on the purpose of PLE and its decision-making powers with the need for increased ownership, accountability and challenge and bolder, streamlined decision-making.

Bradford District and Craven System Finance and Performance Committee
ANNUAL REPORT 2024/25

INTRODUCTION

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

MEMBERSHIP

Members

- Julie Lawreniuk (chair) - Non-Executive Director, Bradford Teaching Hospitals NHS FT
- Mike Woodhead (vice-chair) - Place Director of Finance for Bradford District and Craven Health and Care Partnership / Chief Finance Officer, Bradford District Care NHS FT
- Mike Savage - Director of Finance, Airedale NHS FT
- Leanne Cooper - Chief Operating Officer, Airedale NHS FT
- Claire Risdon - Operational Director of Finance, Bradford District Care NHS FT
- Kelly Barker - Chief Operating Officer, Bradford District Care NHS FT
- Ben Roberts - Director of Finance, Bradford Teaching Hospitals NHS FT (from September 2024)
- Matthew Horner - Director of Finance, Bradford Teaching Hospitals NHS FT (until June 2024)
- Sajid Azeb - Chief Operating Officer, Bradford Teaching Hospitals NHS FT
- Steven Mair - Director of Finance, Bradford Metropolitan District Council
- Iain MacBeath - Strategic Director, Adult Social Care & Health, Bradford Metropolitan District Council
- Dr Stephen Patterson - Chair, Bradford and Airedale Branch of YOR LMC
- Karen Parkin - Operational Director of Finance, Bradford District and Craven Health and Care Partnership (WY ICB) (from June 2024)

- Robert Maden, Operational Director of Finance, Bradford District and Craven Health and Care Partnership (WY ICB) (until July 2024)
- Kerry Weir - Associate Director of Performance, Bradford District and Craven Health and Care Partnership (WY ICB)
- Helen Farmer - Director for System Transformation, Bradford District and Craven Health and Care Partnership (WY ICB)
- Matt Sandford - Director of Partnership and Place, Bradford District and Craven Health and Care Partnership (WY ICB) (from September 2024)
- Nancy O'Neill - Chief Operating Officer, Bradford District and Craven Health and Care Partnership (WY ICB) (until September 2024)

Attendees

- Andrew Milner – Assistant Director – Workforce, Bradford District and Craven Health and Care Partnership (WY ICB) (attendance in line with committee workplan)
- Matt Chandler - Trustee, VCS Alliance (from March 2025)
- Carrie Haywood / Catherine Smith - Governance Manager / Officer, WY ICB

MEETINGS HELD

25th April 2024
30th May 2024
27th June 2024
25th July 2024
29th August 2024
26th September 2024
31st October 2024
28th November 2024
19th December 2024
30th January 2025
27th February 2025
27th March 2025

ATTENDANCE

Member	**Attendance – number of meetings** **(meetings eligible to attend)**	**Attendance as %**
Julie Lawreniuk	9 (12)	75%
Mike Woodhead	12 (12)	100%
Mike Savage *Deputy – Matt Chandler	11 (12) 2 (2)	92%
Leanne Cooper	7 (12)	58%

*Deputy – Becky Friar	2 (2)	
Claire Risdon	5 (12)	42%
Kelly Barker	4 (12)	33%
Ben Roberts (from September 2024) *Deputy – Chris Smith	6 (7) 1 (1)	86%
Matthew Horner (until July 2024) *Deputy – Chris Smith	2 (3) 1 (1)	67%
Sajid Azeb *Deputies – James Taylor Carl Stephenson	10 (12) 1 (1) 1 (1)	83%
Steven Mair	1 (12)	8%
Iain MacBeath	5 (12)	42%
Dr Stephen Patterson	2 (12)	17%
Karen Parkin * Deputy – Amy Paffett	9 (10) 1 (1)	90%
Robert Maden	4 (4)	100%
Kerry Weir	9 (12)	75%
Helen Farmer	5 (12)	42%
Matt Sandford	3 (7)	43%
Nancy O'Neill	6 (6)	100%
Andrew Milner	1 (1)	100%
Matt Chandler	1 (1)	100%
Carrie Haywood	9 (9)	100%
Catherine Smith	10 (12)	83%

Results of the Committee Effectiveness Survey

In March 2025 members and attendees of the System Finance and Performance Committee were invited to complete a survey which was designed to review the effectiveness of the Committee throughout 2024/25. The results were then used to inform this annual report and inform future development and provide assurance to the Partnership Board. A total of 5 surveys were completed which equates to participation by 36% of regular members/attendees.

The survey provided questions within the following categories:

- Committee focus, teamwork and effectiveness
- Committee leadership
- Committee management
- Committee achievements and areas for improvement

A full breakdown of responses to the survey can be found in appendix one and have been included in the following sections – highlights from the committee's work in 2024/25 and areas highlighted for development in 2025/26.

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2024/25

- Received the system performance dashboard and updates on the latest position against national requirements (key constitutional standards and operational planning targets and recovery) and local priorities on a monthly basis.
- Received updates on the financial plans and positions of the Bradford District and Craven Health and Care Partnership, the Bradford District and Craven ICB, WY ICS and WY ICB on a monthly basis.
- Regularly reviewed the Bradford District and Craven Health and Care Partnership risk register, with a specific focus on the risks aligned to the Committee, as well as the WY ICB corporate risk register and the WY ICB Board Assurance Framework.
- Received regular updates on progress in the Closing the Gap programme and the work under each objective in the programme.
- Received a report from the Business Case Appraisal Panel detailing two business cases that had been reviewed.
- Received updates on the operational and financial planning submissions for 2024/25 and 2025/26.
- Received a presentation ahead of a peer review of 2024/25 annual planning.
- Received a presentation which provided a summary of the key findings of the Trust service reviews.
- Agreed to accept the proposed transfer of responsibilities relating to workforce risks and activity from the People Committee following the agreement by the Partnership Board to disband the committee as part of the governance efficiency plan.
- Received an update on workforce in relation to assurance in line with the workforce elements of the system planning process. The committee agreed to receive an annual oversight of workforce operational plans and a mid-year review of delivery against plan with workforce metrics discussed in more detail on a quarterly basis.
- Received a revised children and young people's autism and ADHD business case and supported the principle of the revised model and the development of a detailed performance, finance and investment plan.
- Received a presentation which described the financial position of Bradford Metropolitan District Council and the development of the Medium-Term Financial Plan.
- Received a presentation which provided a summary of Airedale NHS FT's urgent and emergency care improvement plan (2023/24 to 2024/25).
- Received an update on the rollout of EPR (electronic patient record) in Airedale NHS FT.
- Received a presentation on Airedale NHS FT's Strategic Outline Case as part of the New Hospital Programme. The committee agreed on the need for a system-wide clinical strategy and an update was received in a future meeting on the development of the health, care and wellbeing strategy.

- Noted the update on the development of the Outline Business Case for Lynfield Mount Hospital.
- Received updates related to the Better Care Fund (BCF) – these included a report detailing the end of year position for 2023/24, an update ahead of the requirement to agree and submit a plan for 2025/26 and an update which detailed changes to the BCF for 2025/26 following the release of the Policy Framework for the BCF for 2025/26. The committee requested further consideration for whether the BCF resource could be used differently.
- Received updates on the Medium-Term Financial Plans of the NHS organisations.
- Received an update on the review of the Section 75 (S75) agreement, which had been updated to reflect partnership working and the inclusion of new S75 schedules. The update noted a review of governance arrangements to define the roles and responsibilities of the Planning and Commissioning Forum (PCF) as well as greater reporting to PLE and the sign-off of future variations by the Partnership Board.
- Discussed a presentation which detailed the draft operational and financial plans for 2025/26.
- Reviewed the terms of reference noting particular changes related to the transfer of responsibilities from the People Committee and the inclusion of the Closing the Gap programme.

AREAS FOR DEVELOPMENT IN 2025/26

Through the self-assessment process the following were highlighted as areas for development in 2025/26 -

- Further clarity on the roles and responsibilities of the committee and how it fits into the overall governance structure considering shared ownership if it is a system partnership committee.
- Work to develop the forward planner.
- Work to ensure the right reports from the right people are presented to the committee (with the ask from the committee clarified).
- Focus on low attendance.
- More focus on actions in the Closing the Gap programme.
- Suggestion of an induction for new members of the committee to highlight the roles and responsibilities.
- The need for clear actions with the right leads identified.

Bradford Health and Care Partnership

System Finance and Performance Committee

Terms of Reference

Version control

Version:	1.1
Approved by: Board	Bradford District and Craven Health and Care Partnership
Date Approved:	17.05.24
Responsible Officer:	Mike Woodhead, Place Director of Finance for Bradford District and Craven Health and Care Partnership
Date Issued:	17.05.24
Date to be reviewed:	After 1 year

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	Robert Maden	12.05.22
1.0	Approved	BD&C Partnership Board	17.05.24
1.1	Handover of People Committee responsibilities including membership	Carrie Haywood	01.08.24
1.2	Amendments made as part of end of year review and agreed by System FPC	System FPC	24.04.25

1. Introduction and Context

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

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

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

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

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

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

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

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

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

2. Purpose

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

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

It will provide financial leadership and oversight of the delivery of the Closing the Gap programme. Members will hold each other collectively to account for financial and operational plans and financial and performance reporting.

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

2.3 The Committee will be supported by the Local Directors of Finance working group, the local Chief Operating Officers group and the Finance Deputies working group. ~~and the Performance Leads working group~~

3. Responsibilities

The Committee will advise and support the H&CP Board as follows:

3.1 Financial Planning

- Support the development of an operational finance and activity plan for the Place.
- Support the development of a medium and long-term Place financial plan which demonstrates ongoing value and sustainability.
- Consider business cases (in conjunction with the System Quality Committee) as appropriate and recommended by the Business Case Appraisal Panel

(BCAP) which now considers all cases for system-scale investment/disinvestment. The BCAP makes recommendations to the Partnership Leadership Executive (PLE) for a decision. The System Finance and Performance Committee then hold PLE accountable for those decisions.

3.2 Financial Performance

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

3.3 Service Transformation

- Maintain oversight of Place transformation programmes and provide assurance on business case implementation and delivery of the expected benefits.
- Consider the evaluation of business cases as recommended by the Business Case Appraisal Panel and provide assurance as appropriate to the H&CP Board.
- Make recommendations to the H&CP Board on resource shifts to support service change in line with Place Resource Principles and the Place Strategic Partnering Agreement.

3.4 Closing the Gap programme

- Hold each other mutually accountable for optimising efficiency and productivity at organisation level.
- Have oversight of the system-level Closing the Gap programme including but not limited to system-wide service transformation, service rationalisation and interdependent commissioning and service reform decisions.
- Be sighted on the impact of Closing the Gap programme decisions on individual organisation performance and finances.

3.5 Performance

- Provide assurance and reporting on performance against operational plan trajectories and NHS System Oversight Framework requirements.
- Provide oversight and assurance of the workforce elements of the system planning process and associated workforce narrative for the BD&C Place for recommendation and ratification by the Partnership Board.
- To take an overview of Place performance and transformation in relation to ICS objectives and priorities.
- To seek and provide assurance on the sufficiency of workforce in line with the approved workforce plan across Place and stated objectives of the BD&C Health and Care Partnership, utilising relevant intelligence sources where appropriate.
- To develop and maintain connections with other Place forums which have a role in performance development and improvement, including the System Quality Committee.

3.6 **Risk**

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

4 Membership.

4.1 The membership will comprise:

Membership

- **Chair** – Local NHS Trust Non-Executive Director
- ~~**Vice-Chair** – Local NHS Trust Non-Executive Director~~
- Vice-Chair - Place Director of Finance for Bradford District and Craven Health and Care Partnership
- Airedale NHS FT – Chief Operating Officer, Director of Finance
- Bradford District Care NHS FT – Chief Operating Officer, Chief Finance Officer, Operational Director of Finance
- Bradford Hospitals NHS FT – Chief Operating Officer, Director of Finance
- Bradford Metropolitan District Council – Director of Adult Social Services, Senior Operational Director, Director of Finance
- Primary Care – Federation / LMC Representative
- Bradford District and Craven Health and Care Partnership (WY ICB) – ~~Chief Operating Officer, Director of Strategy and Transformation~~, ~~Lead Director of Finance for Place~~,Operational Director of Finance (ICB), Associate Director

of Performance, Director for System Transformation, Director of Partnership and Place
- HR Director Local NHS Trust (bi - annual attendance required in line with Committee workplan)

Attendees
- Finance Deputies Working Group Representative
- ~~Performance Leads Working Group Representative~~
- Trustee, VCS Alliance
- Assistant Director – Workforce (attendance in line with Committee workplan)
- Governance Manager / Officer (WY ICB)

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

5. Arrangements for the conduct of business

Chairing meetings

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

Quoracy

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

5.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

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

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

Voting

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

a. All members of the committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the committee are set out at paragraph 4.1; attendees and observers do not have voting rights.)
b. Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.
c. A resolution will be passed if more votes are cast for the resolution than against it.
d. If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Frequency of meetings

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

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

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

Declarations of interest

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

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

Support to the Committee

5.11 The Committee's lead manager is Lead Director of Finance for Place. Administrative support will be provided to the Committee by the West Yorkshire ICB Governance Team. This will include -

- Agreement of the agenda with the Chair in consultation with the Lead Manager, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward.
- Maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions.
- The minutes of the meeting will be drafted, and quality checked by the relevant lead officer, within ten working days of the meeting.
- The draft minutes will be sent to the relevant lead Director and Chair for review within a further five working days.
- An annual work plan to be updated and maintained as required.

6. Reporting

6.1 The Committee is accountable to HCP Board, which provides the formal leadership and coordination of the local health and care system.

6.2 The Committee shall submit a Triple A assurance report to each formal HCP Board meeting.

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

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

6.5 The Committee will receive for information the minutes or Triple A reports as appropriate of other meetings which are captured in the Committee work plan.

7. Conduct of the committee

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

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

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

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

Bradford District & Craven- System Quality Committee
ANNUAL REPORT 2024-25

INTRODUCTION

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

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

MEMBERSHIP

- Andy Withers (Chair) Non-executive director
- Sally Napper (Deputy Chair)- Non-executive director (April 2024-May 2024)
- Philippa Hubbard- BD&C Partnership Director of Quality and Nursing (distributed leadership model which is covered by system chief nurse)
- Lianne Robinson- The Interim Chief Nurse of Airedale NHS FT
- Philippa Hubbard- The Chief Nurse of Bradford District Care NHS FT
- Karen Dawber- The Chief Nurse of Bradford Teaching Hospitals NHS FT
- David Crampsey- The Medical Director of Airedale NHS FT (April 2024-Sept 2024)
- Julie O'Riordan- The Interim Medical Director of Airedale NHS FT (Sept 2024-Dec 2024)
- Sal Uka- The Interim Medical Director of Airedale NHS FT (Dec 2024- present)
- David Sims- The Medical Director of Bradford District Care NHS FT
- Ray Smith- The Medical Director of Bradford Teaching Hospitals NHS FT
- Sarah Muckle- A Consultant in Public Health - City of Bradford MDC
- Iain McBeath- The Director of Health and Wellbeing- City of Bradford MDC
- Helen Rushworth- Chief Executive of Healthwatch Bradford District
- Soo Nevison- Chief Executive of The VCS Alliance
- Louise Bestwick- Chief Executive of Bradford Care Association
- Danielle Hann- Medical Director Local Medical Committee
- Helen Rushworth- Chair of Citizen's Forum

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

- Grainne Eloi- Associate Director of Quality and Nursing – BD&C Partnership
- John Hartley- Assistant Director Quality Improvement – BD&C Partnership
- Rebecca Le Hair- Deputy Director of Patient Safety, Compliance and Risk – Bradford District Care NHS Foundation Trust
- Judith Connor- Associate Director of Quality – Bradford Teaching Hospitals NHS Foundation Trust
- Deborah Fox- Assistant Chief Nurse, Patient Safety- Airedale NHS Foundation Trust
- Iram Amin, Quality Lead, BD&C Partnership
- Jacqueline Rigby, Head of Quality, BD&C Partnership
- Carrie Haywood, Senior Governance Manager, BD&C Partnership
- Catherine Smith, Governance Officer, BD&C Partnership
- Jorge Zepeda, Head of Public Health, Health Protection & Health Improvement BMDC
- Jane Wood, Assistant Director, Commissioning and Integration, BMDC

MEETINGS HELD

9th May 2024
13th June 2024
11th July 2024
12th September 2024
10th October 2024
14th November 2024
12th December 2024
9th January 2025
13th February 2025
13th March 2025

ATTENDANCE

Member	Job Title	Attendance (number of meetings attended)	Attendance (% out of 10 meetings)
Andrew Withers	Non-Executive Director, ANHSFT (Chair)	7	70%
Asma Sacha	Governance Manager, BD&C HCP	2	20%
Danielle Hann	GP and Deputy Chair of BDC LMC	1	10%
David Crampsey	Deputy Chief Executive, Executive Medical Director, ANHSFT	0	0%
David Sims	Medical Director, BDCFT	1	10%
Deborah Fox	Assistant Chief Nurse, Patient Safety, ANHSFT	3	30%

Carrie Haywood	Senior Assurance and Governance Manager BD&C HCP	7	70%
Catherine Smith	Governance Officer, BD&C HCP	10	100%
Grainne Eloi	Deputy Director of Quality & Nursing BD&C HCP	4	40%
Helen Farmer	Programme Director BD&C HCP	5	50%
Helen Rushworth	Lead Officer, Healthwatch Bradford & Chair of Citizens Forum	4	40%
Iram Amin	Quality Lead, BD&C HCP	8	80%
Jane Wood	Assistant Director, Commissioning and Integration, BMDC	5	50%
Jacqueline Rigby	Head of Quality, BD&C HCP	3	30%
Jo Hilton	Director of Nursing / Deputy Chief Nurse, BTHFT	3	30%
John Hartley	Assistant Director Quality & SEND, BD&C HCP	10	100%
Jorge Zepeda	Head of Public Health, Health Protection & Health Improvement BMDC	7	70%
Judith Connor	Associate Director of Quality, BTHFT	7	70%
Julie O'Riordan	Acting MD, ANHSFT	2	20%
Karen Dawber	Chief Nurse, BTHFT	3	30%
Kerry Weir	Associate Director, Planning, Performance and Business Intelligence, BD&C H&CP	8	80%
Lianne Robinson	Chief Nurse, ANHSFT	4	40%
Louise Bestwick	Chief Executive Officer, BCA	7	70%
Luke Myers	Head of Strategic Contracts & Quality, BMDC	5	50%
Maria Pedley	Senior Strategic Head of Primary Care and Transformation BD&C HCP	4	40%
Philippa Hubbard	Director of Nursing, Professions/Care Standards, DIPC, Deputy Chief Executive at Bradford District Care NHS Foundation Trust	8	80%
Ray Smith	Chief Medical Officer BTHFT	7	70%
Rebecca Le Hair	Deputy Director of Patient Safety, Compliance, BDCFT	8	80%
Sally Napper	Non-Executive Director, BDCFT	1	10%
Sal Uka	Interim Medical Director, ANHSFT	4	40%

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2024 – 25

Highlights from the committee's work in 2024-2025 included:

- Deep dives into specific areas which gave insight into the identified areas. This enabled support from the system and an opportunity for learning and sharing.
- Incorporating the work of the workforce programme alongside the Finance and Performance Committee
- Information sharing from other meetings as papers from the WY ICB Quality Committee, WY ICB Clinical Forum, BDC Clinical Forum and BDC System, finance & performance were circulated within the pack.
- Providing regular assurance to the Partnership Board and WY ICB Quality Committee in relation to activities and items within the committees remit via the AAA updates.
- Updates from and support to Priority areas, enablers and workstreams including: Closing the Gap Programme, People Committee Responsibilities, Children and Young People Priority update, Workforce programme update, Access to Care Bd&C Health and Care Partnership priority programme and an update on the role of the Medical Examiner in Bradford District and Craven.
- Committee received updates on:
    - Non- surgical oncology programme
    - Risk cycle reports
    - SEND update
    - BDC Quality, Equality Impact Assessment
    - Airedale Paediatric Audiology Service review
    - BTHFT MRSA neonatal and MNSI cases update
    - Airedale EPR roll out
    - Stroke update
    - Care Home and Staffing update
    - Board Assurance Framework
    - Autism and ADHD waits
    - Assurance statement following a double mental health homicide independent investigation (NHSE) for BDCFT.
    - Annual reports: Safeguarding, Children Looked After

AREAS FOR DEVELOPMENT IN 2025 – 26

- Ongoing development and review of the role of the SQIAIG sub-group
- Ongoing review of the role of the System Quality Committee in line with governance and assurance requirements at place through the Partnership Board and wider through the delegated requirements of the ICB

- Future planned areas of review include:
    - 5 priority areas: Healthy communities, Access to care, Healthy minds, Workforce development, Children & Young people.
    - 4 enables: Reducing health inequalities, Living well, Research & Development, Digital & Information intelligence.
    - Closing the gap
- SQC continue to receive annual reports from: Children Looked After, Safeguarding, Health Protection and CDOP

COMMITTEE EFFECTIVENESS SURVEY FOR 2024/25

In March 2026 members and attendees of the System Quality Committee were invited to complete a survey which was designed to review the effectiveness of the Committee throughout 2024/25. The results were then used to inform this annual report, assist in the review of the terms of reference, inform future development and provide assurance to the Partnership Board. A total of 7 surveys were completed which equates to participation by 26% of members/attendees.

The survey provided questions within the following categories:

- Committee focus, teamwork and effectiveness
- Committee leadership
- Committee management
- Committee achievements and areas for improvement

Responses noted the benefits of the deep dives of priority areas, clear escalation of issues and risks, valuable informative presentations, the continual seeking of assurance with issues not being closed until sufficient assurance had been received and highlighted that the System Quality, Insight, Assurance and Improvement Group (SQIAIG) escalated issues to the Committee proactively. Suggested improvements included having greater clarity on priorities within the quality portfolio with subsequent reporting into the Committee and clarity on escalation and areas of responsibility.

Terms of reference – Bradford District and Craven quality committee

Version control

Version: 3.1

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

Date Approved: 1 July 2022

Responsible Officer: Assistant Director of Quality & SEND

Date Issued: 12 July 2022

Date to be reviewed: 1st April 2026

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	James Drury	8 June 2022
1.0	Approved	ICB	1 July 2022
1.0	Approved	BD&C Partnership Board	12 July 2022
2.0	Final draft	SQC	October 2023
2.0	Approved	BD&C Partnership Board	10th November 2023
3.0	Approved	BD&C Partnership Board	17th May 2024
3.1	Final Draft	SQC	April 2025

1. General

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

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

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

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

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

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

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

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

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

Other capitalised terms have the meaning set out below:

- “Attendee” refers to a participant of this BD&C Committee as listed in paragraph 7
- “BD&C Committee” refers to this Committee
- “Chair” means the chair of this BD&C Committee
- “ICB” means the NHS West Yorkshire Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated
- “ICB Business” has the meaning given to it at paragraph 5“ICB Committee” means a committee of the ICB
- “ICB Policies” means any policy, process or procedure formally adopted by the ICB
- “Member” refers to a member of this BD&C Committee as listed in paragraph 6
- “NHS Foundation Trust Partner” means Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and/or Bradford Teaching Hospitals NHS Foundation Trust
- “Partner” refers to a partner organisation in the Place Partnership which is also a party to the SPA
- “Partnership Business” has the meaning given to it at paragraph 5
- “Partnership Board” means the Bradford District and Craven ICB Committee as described in the Constitution
- “Place Lead” means that individual appointed by the ICB to oversee and help develop the Place Partnership
- “Place Partnership” means the partnership of organisations described in the SPA
- “SPA” means the Strategic Partnering Agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Bradford District and Craven
- “Working Days” means a weekday that is not a bank holiday in England

- “Written Resolution Procedure” is the written resolution procedure described at
- paragraph 11.

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

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

2. Reports to

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

3. Purpose

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

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

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

This BD&C Committee has two roles:

- The first is to support the ICB on issues within its remit. If this BD&C Committee makes decisions on behalf of the ICB (see section 5 below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this BD&C Committee.

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

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

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

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

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

5. To provide support to the creation, maintenance and development of a patient-focused culture within the BD&C Partnership

How we work across the Place – our Quality principles

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

4. Remit and Responsibilities

The remit of this BD&C Committee is to:

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

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

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

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

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

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

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

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

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

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

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

vii. Oversee and monitor delivery of the key statutory requirements relating to quality and patient safety and the Partnership's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained. This will include the Patient Safety Incident Response Framework (PSIRF).

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

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

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

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

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

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

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

5. Members

Members contribute to discussion, participate in decision making and are accountable for decisions made. If a matter goes to a vote, then each Member has one vote save that the Chair shall have a casting vote, as set out in paragraph 9.

The Members of this Committee are:

- ~~Two~~ One non-executive director to be selected by the BD&C Partnership Board, who will be the Chair of the Committee
- The BD&C Partnership Director of Quality and Nursing (noting the distributed leadership model which is covered by system chief nurses)
- The Chief Nurse of Airedale NHS FT

- The Chief Nurse of Bradford District Care NHS FT
- The Chief Nurse of Bradford Teaching Hospitals NHS FT
- The Medical Director of Airedale NHS FT
- The Medical Director of Bradford District Care NHS FT
- The Medical Director of Bradford Teaching Hospitals NHS FT
- A Consultant in Public Health - City of Bradford MDC
- Strategic Director Adult Social Care & Health - City of Bradford MDC
- Director for Systems Transformation BDC HCP
- Chief Executive of Healthwatch Bradford District
- Chief Executive of The VCS Alliance
- Chief Executive of Bradford Care Association
- Representative from Local Medical Committee
- Chair of Citizen's Forum
- ~~Director of Partnerships~~
- Chair of Clinical Forum
- Representative from North Yorkshire County Council- Social Care

A deputy Chair will be agreed from among nominated members.

6. Attendees

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

- Associate Director of Quality and Nursing – BD&C Partnership
- Assistant Director Quality & SEND – BD&C Partnership
- Head of Quality- BD&C Partnership
- Governance Manager- WY ICB (Place representative)
- Assistant Director of Workforce- BD&C Partnership
- Assistant Director – People Commissioning & Business Support- City of Bradford MDC

- Senior Head of Safety, Compliance & Risk- Bradford District Care NHS Foundation Trust
- Associate Director of Quality – Bradford Teaching Hospitals NHS Foundation Trust
- Deputy Chief Nurse, Patient Safety- Airedale NHS Foundation Trust

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

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

7. Deputies

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

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

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

8. Chair

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

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

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

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

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

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

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

9. Quoracy

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

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

The expectation of the Partners is that this BD&C Committee will meet regularly as scheduled. The Partners recognise that even if a meeting is not quorate, useful

discussions may take place. However, if the Chair has received apologies for a meeting in advance that indicate that a quorum will not present, the Chair may cancel the meeting if they are satisfied that this is the more appropriate use of Members' time.

10. Conduct of meetings

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

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

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

a. All Members of this BD&C Committee who are present at the meeting will be eligible to cast one vote each.
b. Absent members may not vote by proxy. Absence is defined as being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. However, they are able to appoint a deputy in accordance with paragraph 8.
c. A resolution will be passed if more votes are cast for the resolution than against it.
d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote.

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

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

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

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

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

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

Exceptions:

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

Passing the written resolution:

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

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

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

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

11. Frequency of meetings

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

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

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

12. Urgent decisions

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

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

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

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

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

13. Declarations of Interest

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

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

14. Support to the Committee

Administrative support will be provided to this BD&C Committee by the WY ICB Corporate team (place-based representative). This will include:

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

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

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

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

15. Authority

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

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

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

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

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

16. Reporting

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

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

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

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

17. Conduct of the Committee

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

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

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

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

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

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

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

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

- That individual fails to comply with these terms of reference;
- That individual has behaved in a way, or is threatening to behave in a way, that is likely to bring this BD&C Committee, the Partnership Board and/or the ICB into disrepute;
- That individual has attended less than [75%] of the meetings of this BD&C Committee in any [12 month] period;
- The individual no longer meets the relevant membership requirement set out at paragraph 6, for example because they no longer hold a particular post or work for a particular organisation; or

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

18. Amendments

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

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

19. Review date

These terms of reference shall be reviewed annually.

20. Implementation

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

Meeting name:	Partnership Board
Agenda item no:	12b
Meeting date:	23 May 2025
Report title:	Partnership governance arrangements for 2025/26
Report presented by:	Sue Baxter, Head of Partnership Governance
Report approved by:	Therese Patten, Place Lead
Report prepared by:	Matt Sandford, Director of Partnership and Place, Deputy Accountable Officer BDC ICB; and Sue Baxter, Head of Partnership Governance

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

Previous considerations:

- Not applicable

Executive summary and points for discussion:

Bradford District and Craven Health and Care Partnership (BDC HCP) governance arrangements have been established since July 2022, building on local partnership arrangements since the introduction of sustainability and transformation partnerships in 2016, integrated care systems in 2018 and the signing of the BDC HCP Strategic Partnering Agreement in 2019.

1. Review of Place governance arrangements 2024/25

Changes made to the partnership governance arrangements ahead of 2025/26 include –

- Proposed changes to the Partnership Leadership Executive with the development of a new Partnership Oversight Executive;
- Frequency of business cycles – moved from Monthly to meet Quarterly for both the System Quality Committee and the System Finance and Performance Committee from 1 April 2025, in line with the business cycles of the ICB (see Appendix 1); and

- Primary Care Operations Group continues to meet however has been removed from the Partnership Governance Structure due to no longer holding assurance responsibilities.

2. Strategic Partnering Agreement and Governance Handbook (1 April 2025 refresh)

A review of the Strategic Partnering Agreement and associated changes to the Governance handbook for 2025/26 have been completed (see appendix 2). Changes to the Strategic Partnering Agreement, include:

- the addition of North Yorkshire Council Adult Social Care Joint Commissioning Group
- schedule 2: governance arrangements and structure
- schedule 5: financial and risk management principles including annex 1: financial governance framework
- schedule 8: SPA workplan

The list of signatories to the SPA is available at appendix 3. Subject to approval of the SPA, Hill Dickinson will support e-signing of the SPA.

The Bradford District and Craven Health and Care Partnership Governance handbook will be updated following agreement of the SPA and annual review of the partnership's boards, committees and forums ToR. The contents page outlines what is included in the governance handbook and can be found at appendix 4. To support with communications a slide set that provides an overview of the SPA and governance arrangements can be found at Appendix 5.

3. Changes planned through 2025/26

Following recent government announcements reflecting the size and work of Integrated Care Boards, work is underway across West Yorkshire to reflect the new requirements, with all changes expected to be implemented by the end of December 2025. Work will continue to further develop PLE into a formal Partnership Oversight Executive, alongside work to develop a Provider Partnership model for Bradford District and Craven Place.

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: • **APPROVE** the amended business cycles of both the System Quality Committee and the System Finance and Performance Committee from 1 April 2025, and **NOTE** the proposed changes to the partnership governance arrangements • **APPROVE** the amendments to the Strategic Partnering Agreement and **NOTE** that the Governance Handbook will be refreshed following approval of the updates to governance arrangements and Terms of Reference
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Risk Register? If yes, please detail which:
N/A
Appendices
1. Place governance arrangements (2-slides 2024/25 and 2025/26) 2. Strategic Partnering Agreement 3. Signatories to the Strategic Partnering Agreement 4. Governance Handbook – contents page 5. SPA and Governance Handbook slides

Partnership governance effectiveness & efficiency, a proposal for longer-term partnership governance arrangements

1.0 Introduction

Building on local partnership arrangements since the introduction of sustainability and transformation partnerships in 2016, integrated care systems in 2018 and the signing of the BDC HCP Strategic Partnering Agreement in 2019. Following the Health and Care Act 2022 which signalled the establishment of Integrated Care Boards, as part of its subsidiarity principle Bradford District and Craven Health and Care Partnership (BDC HCP) governance arrangements have been operating since the 1 July 2022.

2.0 Review of Place governance arrangements 2024/25

2.1 Partnership Leadership Executive and POE

Following the independent review of Bradford District and Craven Health and Craven Partnership system governance undertaken by Mike Farrar, work has been underway, led by the Chief Executives of all BDC Partner organisations, to review and revise the arrangements for the current Bradford District and Craven Partnership Leadership Executive, which include the creation of a new Partnership Oversight Executive.

Alongside this, work is also underway to develop and mobilise a Bradford District and Craven NHS Provider Partnership.

As this work progresses, further updates will be provided to the BDC Health and Care Partnership Board.

2.2 Frequency of business cycles - Quarterly

Following the ICB operating model review efficiencies were made to the partnership governance arrangements, for 2024/25. With the place review led by Anthony Kealy, a move in-line with the other four places to quarterly business cycles for 2025/26 in relation to the **System Quality Committee** and the **System Finance and Performance Committee** has been agreed. Appendix 1 provides slides that show the partnership governance arrangements for the previous year and the partnership governance arrangements for 2025/26).

2.3 Primary Care Strategy and Assurance Group

From September 2024 the Primary Strategy and Assurance Group has been renamed to the Primary Care Operations Group with the intention of meeting through 2025/26.

The purpose of the group is to provide advice on procurement and contracting decisions, and on reviewing quality and performance issues. Although the group continues to meet, because the group no longer holds an assurance function it has been removed from the Partnership Governance Structure.

Recommendation:

- **APPROVE** the amended business cycles of both the System Quality Committee and the System Finance and Performance Committee from 1 April 2025, and **NOTE** the proposed changes to the partnership governance arrangements

4.0 Strategic Partnering Agreement and Governance Handbook (1 April 2025 refresh)

The Strategic Partnering Agreement (SPA) is the key governance document that facilitates the Bradford District and Craven Health and Care Partnership. The SPA sets out the key terms that Partners have agreed to work together in a collaborative and integrated way on a Best for Bradford District and Craven basis. It describes an approach to shared decision making and how resources are committed.

At the end of 2023/24 following a governance review the SPA was refreshed to reflect the changes following the Health and Care Act 2022, to take account of changes resulting from NHS West Yorkshire ICB's new operating model, and the partnership governance effectiveness and efficiency review. Changes to the Strategic Partnering Agreement (see appendix 2), include:

- the addition of North Yorkshire Council Adult Social Care Joint Commissioning Group
- schedule 2: governance arrangements and structure
- schedule 5: financial and risk management principles including annex 1: financial governance framework
- schedule 8: SPA workplan

Note: Bradford District and Craven Health and Care Partnership's forms part of NHS West Yorkshire Integrated Care Board's (ICB) governance arrangements and the SPA is complimentary to governance arrangements of the ICB and should be read alongside the NHS West Yorkshire Integrated Care Board's Constitution and Governance Handbook.

Changes to the SPA take account of the NHS England guidance arrangements for delegation and joint exercise of statutory functions. This guidance was published to support ICBs, NHS Trusts and Foundations Trusts and provides an overview of collaborative working arrangements that the Health and Care Act 2022 introduced to the NHS Act 2006. We await any update to the current position of NHS England that there should be a 'Hold' on delegation from ICBs to NHS providers.

Following agreement of the SPA by partners and the partnership committee effectiveness review and annual refresh of Terms of Reference Bradford District and Craven Health and Care Partnership Governance Handbook will be refreshed and re-published on the partnership's website.

In line with the future direction of greater autonomy for places, amendments to the ICB's constitution have been made, and were approved by the ICB Board on 17 December 2024. These constitution changes are subject to an NHS England application for approval before becoming live and provide for:

- greater delegation to Place Committees for Better Care Fund submissions
- approval of Place-based s65Z5 (joint working and delegation agreements)
- s65Z6 (joint committees and pooled funds) and
- s75 (arrangements between NHS bodies and Local Authorities)

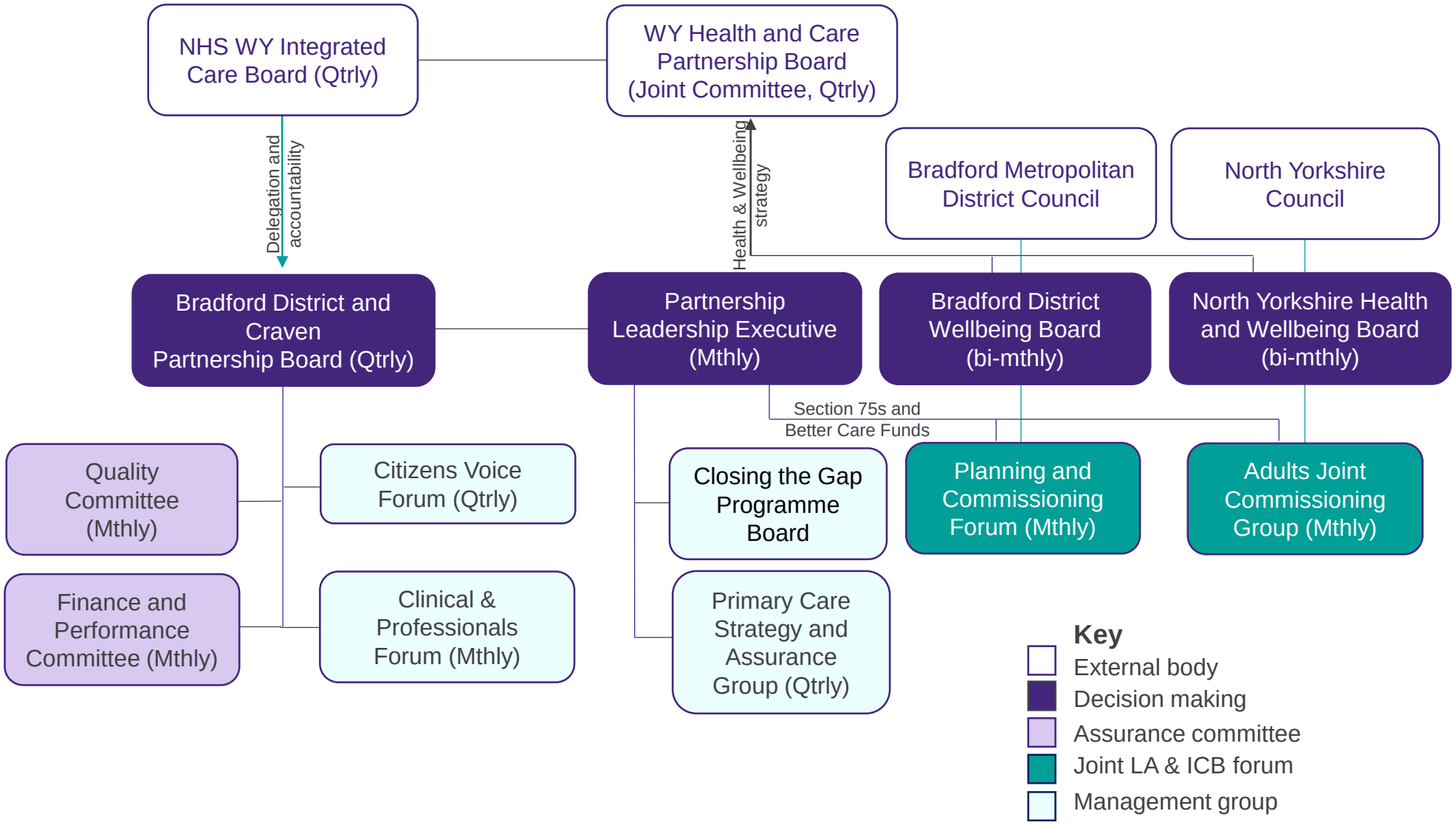
Through 2025/26 changes resulting from the Mike Farrar place review and the drive to establish to Place Based Provider Collaborative arrangements will require further detailed review of the SPA and may signal a change of name. Subsequent to this 2025/26 detailed review of the SPA, review cycles are recommended at 3 yearly intervals thereafter.

The SPA has 12 organisations listed as signatories to it, and in future, North Yorkshire Council, the University of Bradford and the Bradford Children and Families Trust may also choose to become signatories.

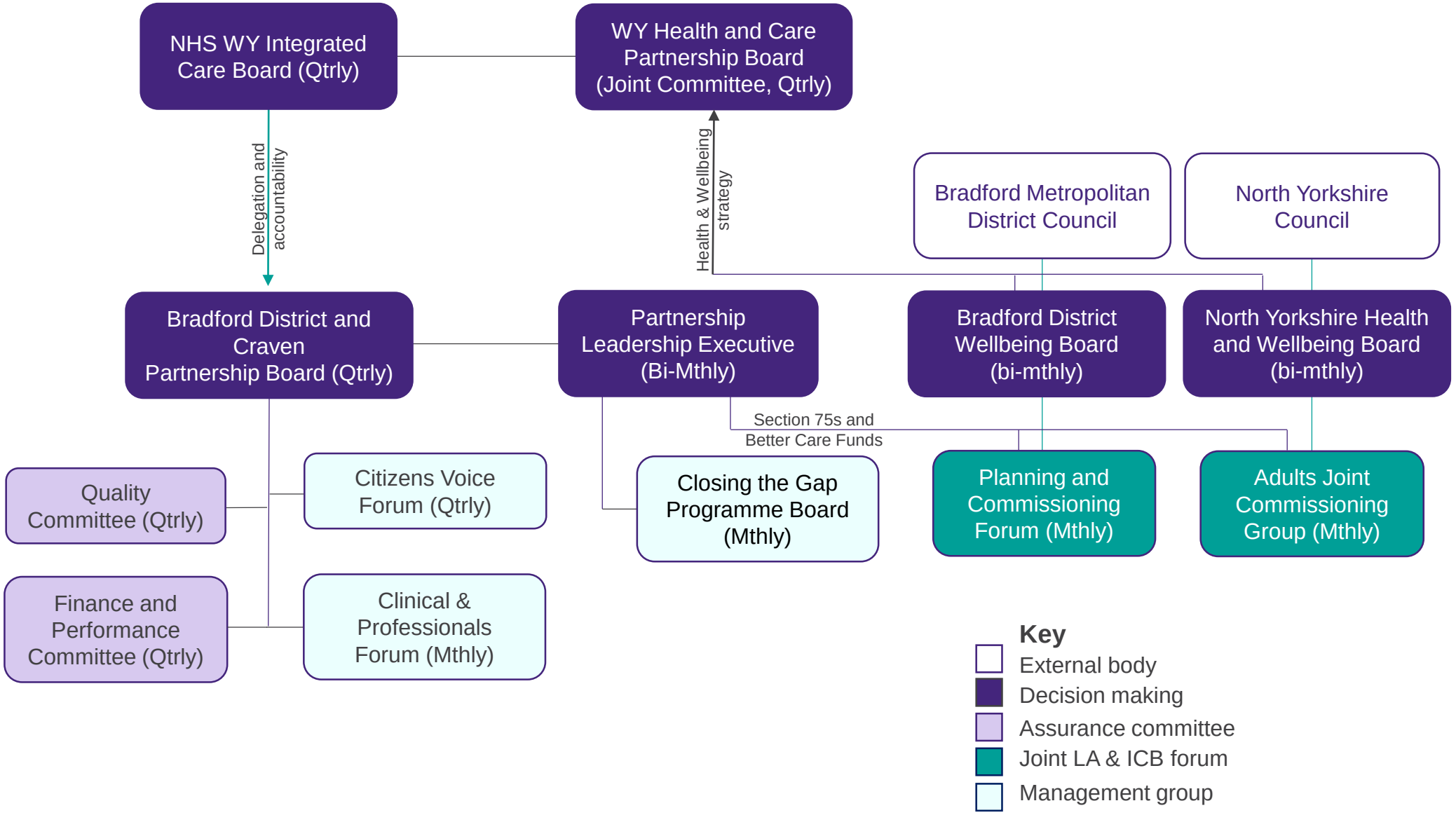
Recommendation:

- **APPROVE** the amendments to the Strategic Partnering Agreement and **NOTE** that the Governance Handbook will be refreshed following approval of the updates to governance arrangements and Terms of Reference

Appendix 1: partnership governance arrangements 2024/25
*new partnership governance structure



Appendix 1: partnership governance arrangements 2025/26 *new partnership governance structure



BRADFORD DISTRICT AND CRAVEN HEATLH AND CARE PARTNERSHIP STRATEGIC PARTNERING AGREEMENT: SIGNATORIES

name	Job title	organisation	email
Rob Webster	ICB CEO	**NHS WEST YORKSHIRE INTEGRATED CARE BOARD**	rob.webster1@nhs.net
Therese Pattern	Place lead	**BRADFORD DISTRICT AND CRAVEN PLACE**	Therese.Patten@bdct.nhs.uk
Foluke Ajayi	Chief Executive	**AIREDALE NHS FOUNDATION TRUST**	Foluke.ajayi@nhs.net
Therese Pattern	Chief Executive	**BRADFORD DISTRICT CARE NHS FOUNDATION TRUST**	Therese.Patten@bdct.nhs.uk
Mel Pickup	Chief Executive	**BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST**	Mel.Pickup@bthft.nhs.uk
Lorraine O'Donnell	Chief Executive	**CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL**	Lorraine.o'donnell@bradford.gov.uk
Vicki Beere / Sam Keighley	Chair / Chief Executive	**BRADFORD VCS ALLIANCE LIMITED**	Vicki.Beere@project6.org.uk OR sam@thevcsalliance.org.uk
Louise Bestwick	Chief Executive	**BRADFORD CARE ASSOCIATION LIMITED**	louise@bradfordcareassociation.org
Helen Carr	Chief Executive	**LOCAL CARE DIRECT**	Helen.Carr@lcdwestyorks.nhs.uk
Richard Haddad	Chair	**BRADFORD CARE ALLIANCE COMMUNITY INTEREST COMPANY**	Richard.Haddad@bradford.nhs.uk
Brendan Kennedy	Executive Partner	**MODALITY PARTNERSHIP**	Brendan.kennedy@bradford.nhs.uk
Laura Molyneux	Clinical Director	**WHARFEDALE, AIREDALE AND CRAVEN ALLIANCE**	Laura.Molyneux2@bradford.nhs.uk
Nick Hayward	Clinical Director	**AFFINITY CARE**	Nick.Hayward@bradford.nhs.uk
		UNIVERSITY OF BRADFORD	

Bradford District and Craven Health and Care Partnership Governance Handbook

Contents	Page No.
1. Background / introduction (purpose of handbook and links to Strategic Partnering Agreement)	
2. West Yorkshire Integrated Care Board Scheme of Reservation and Delegation	
3. Committee decision map (a diagram of the scheme of reservation and delegation)	
4. West Yorkshire Integrated Care Board Financial scheme of delegation	
5. Bradford District and Craven committee structure chart	
6. Bradford District and Craven operating model	
7. Bradford District and Craven Health & Care Partnership (place) 6-step decision flowchart	
8. Planning and Commissioning Forum - Health and Care 5-step decision flowchart	
9. Financial governance framework	
10. Decision flowchart example – reducing inequalities in communities	
11. Planning and Commissioning Forum decision flowchart example – Better Care Fund	
12. Composition of the Partnership Board	
13. West Yorkshire governance structure illustrating Bradford District and Craven Health and Care Partnership are one of the five places	
BDC Place ICB Committee and sub committees Terms of Reference	
14a. Partnership Board	
14b. Finance and Performance Committee	
14c. Quality Committee	
14d. Citizens Voice Forum	
14e. Clinical and Care Professional Forum	
14f. Partnership Oversight Executive	
14g. Strategy Delivery Boards – - Children and Young People Strategy Delivery Board - Healthy Citizens Strategy Delivery Board - Integrated Neighbourhood Health and Care Support Strategy Delivery Board - Integrated Acute Care Strategy Delivery Board	
14h. Closing the Gap Programme Board Closing the Gap Business Case Appraisal Panel	
14i. Planning and Commissioning Forum	
14j. North Yorkshire Adults Joint Planning and Commissioning Group	
15. NHS West Yorkshire ICB conflicts of interest policy	

Appendix 3

Bradford District and Craven
Health and Care Partnership

ACTasONE

SPA and Governance handbook

April 2025

Bradford District and Craven
Health and Care Partnership

February 2018
Integrated care system

November 2021
Integrated Care System of the Year (HSJ Awards)

2022/2023
Refreshed five year plan

March 2016
Sustainability and transformation partnerships

2019
BDC
SPA

February 2020
Launch of the Partnership's five-year plan and big ten ambitions

2022
Statutory integrated care board and integrated care partnership arrangements

December 2022

Joint Forward Plans

Integrated Care systems (ICSs)

Key planning and partnership bodies from 1 July 2022

Bradford District and Craven Health and Care Partnership

Office for Standards in Education, Children's Services and Skills (OFSTED) inspect and regulate services that care for children and young people

NHS England
Performance manages and supports the NHS bodies working with and through the ICS

Care Quality Commission
Independently reviews and rates the ICSs

Integrated care board (ICB)

Membership: independent chair; non-executive directors; members selected from nominations made by NHS trusts/FTs, local authorities, general practice, an individual with expertise and knowledge of mental illness

Role: allocates NHS budget and commissions services, produces five-year system plan for health services

Influence

Statutory ICS

Cross-body membership influence and alignment

Integrated care partnership (ICP)

Membership: representatives from local authorities, ICB, Healthwatch and other partners

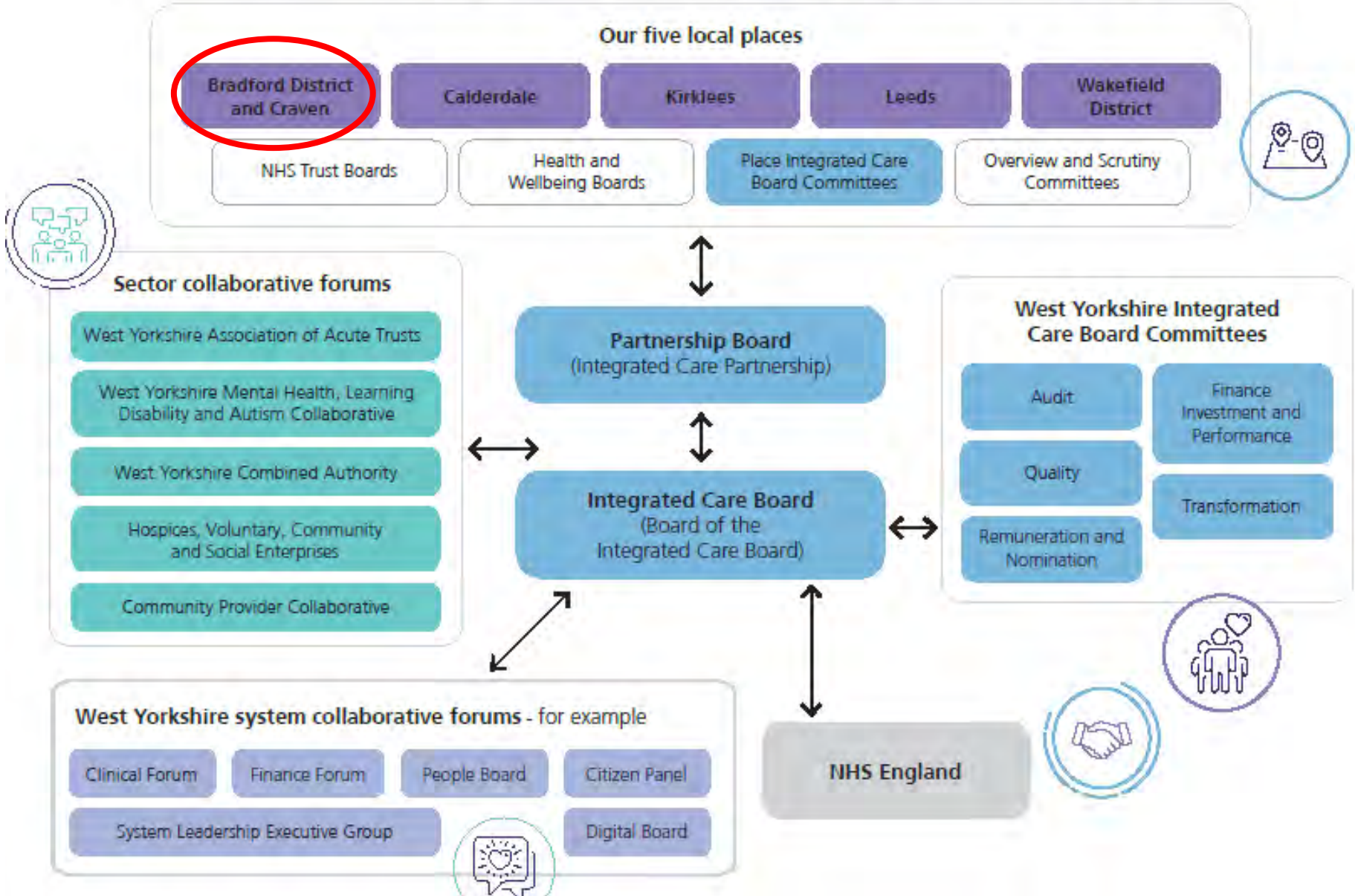
Role: planning to meet wider health, public health and social care needs; develops and leads integrated care strategy but does not commission services.

Influence

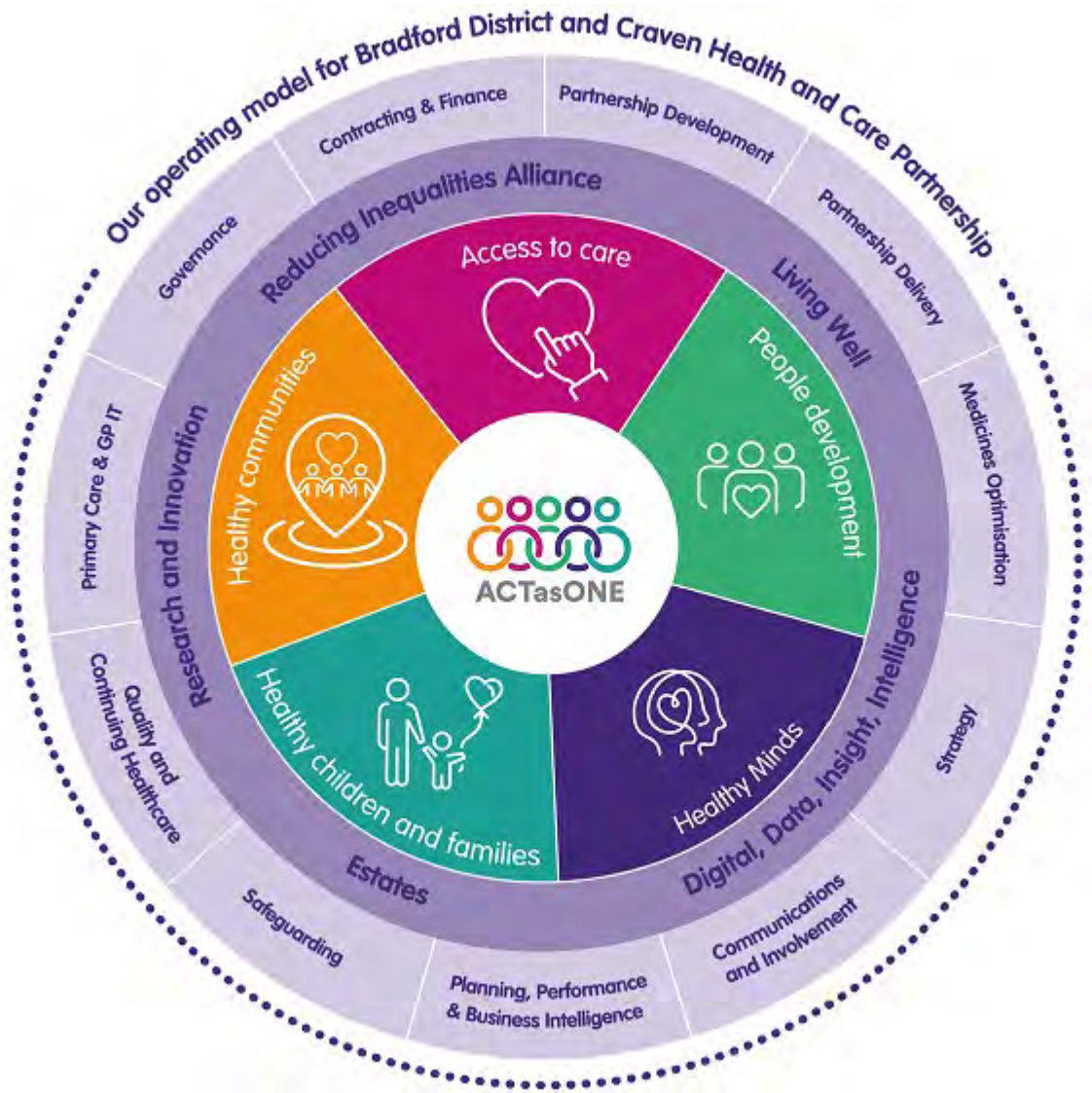
Geographical footprint	Partnership and delivery structures	
	Name	Participating organisations
System usually covers a population of 1-2 million	**Provider collaboratives**	NHS trusts (including acute, specialist and mental health) and as appropriate voluntary, community and social enterprise (VCSE) organisations and the independent sector; can also operate at place level
Place usually covers a population of 250-500,000	**Health and wellbeing boards**	ICS, Healthwatch, local authorities and wider membership as appropriate, can also operate at system level
Neighbourhood usually covers a population of 30-50,000	**Primary care networks**	Community partnerships and general practice, community pharmacy, dentistry, opticians

[source: Kings Fund June 2022]

West Yorkshire Health and Care Partnership (integrated care system) - Governance and Accountability



New operating model



Bradford District and Craven
Health and Care Partnership

Bradford District and Craven Health and Care Partnership: strategic partnering agreement

Bradford District and Craven
Health and Care Partnership

Happy, healthy at home

Every health and care organisation in our area is working to a shared vision for the people we serve…

This means:

- People will be **healthier, happier** and have access to high quality care
- People will be **supported to stay healthy**, well and independent throughout their whole life
- When people need to access care and support, it will be a **joined up health, care and wellbeing service** designed around their needs, as close to home as possible

Bradford District and Craven
Health and Care Partnership

Purpose of the SPA

By working better together across health, care, community and voluntary services, we can look at everything that affects the health and wellbeing of a person, the SPA:

- is a collaborative agreement to deliver better health outcomes for the population of Bradford District and Craven
- sets out how our partnership have agreed to work together in a collaborative and integrated way on a Best for Bradford District and Craven basis and
- supports the development and implementation of the Bradford District and Craven Health and Care Partnership at place

Strategic Partnering Agreement – at-a-glance

Bradford District and Craven Health and Care Partnership

Vision

Happy, healthy at home

Every health and care organisation in our area is working to a shared vision for the people we serve…

Purpose

By working better together across health, care, community and voluntary services, we can look at everything that affects the health and wellbeing of a person, the SPA:

- is a collaborative agreement to deliver better health outcomes for the population of Bradford District and Craven
- sets out how our partnership have agreed to work together in a collaborative and integrated way on a Best for Bradford District and Craven basis and
- supports the development and implementation of the Bradford District and Craven Health and Care Partnership at place
- is not legally binding

Principles

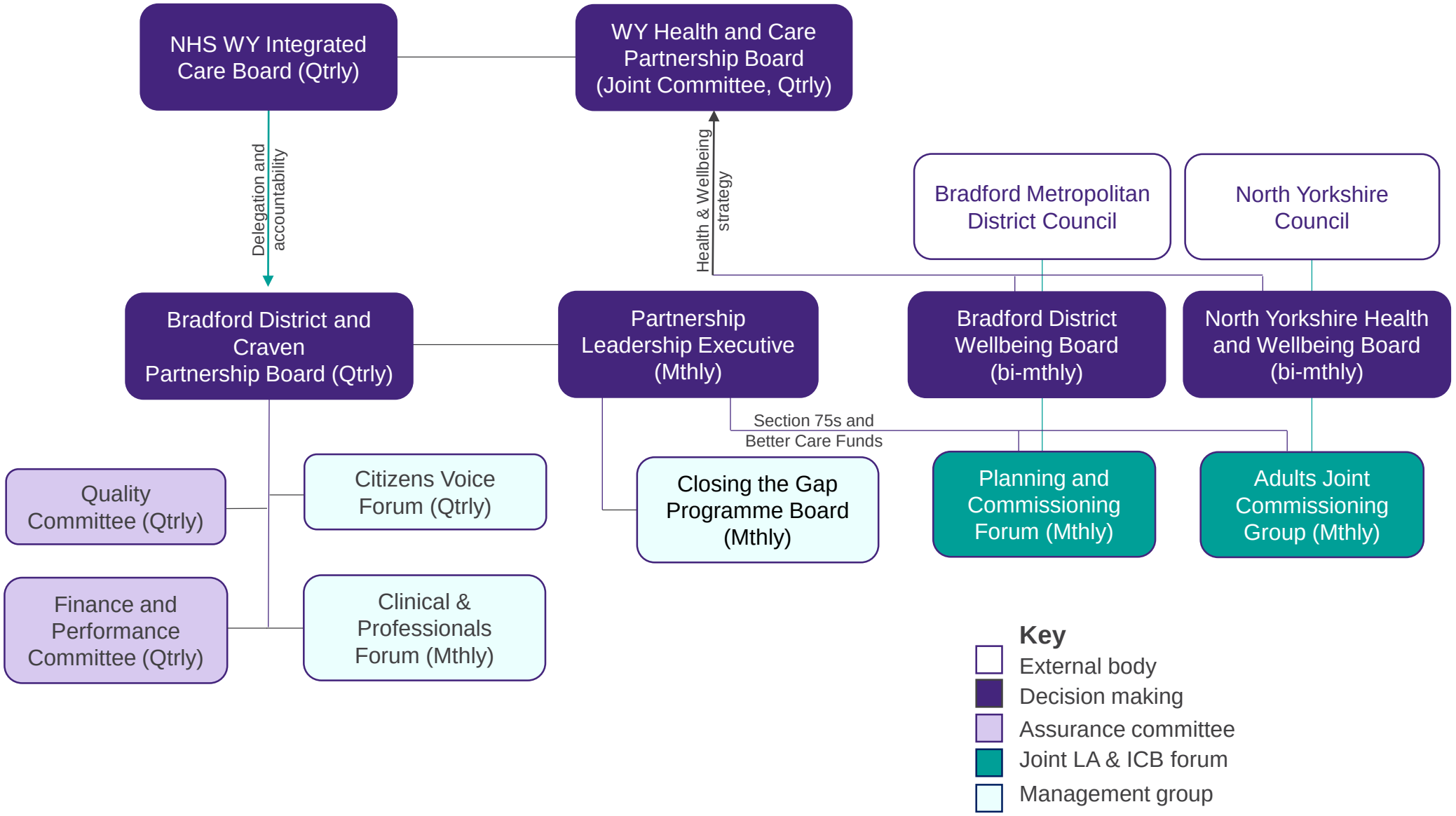
The principles are that the Partners will work together in good faith and, unless the provisions in this SPA state otherwise, the Partners will behave consistently as leaders in ways which model and promote the following shared values:

- act as one team, pursuing one vision, united in our greater purpose to improve population health outcomes; we will be ambitious for the people we serve and the staff we employ
- exercise leadership for the whole of our Place Partnership, as well as for our individual organisations and for West Yorkshire, behaving in ways which model our shared values
- assume good intentions, and support each other to work collaboratively in the spirit of continuous improvement
- act with honesty and integrity, challenging constructively when we need to, and trusting each other to do the same
- implement shared priorities and decisions, holding each other to account for delivery of improved outcomes and reduced inequalities
- listen to people and act on their feedback
- understand that we are stewards of the health and care system on behalf of our citizens, now and for future generations; so we will build constructive relationships with communities, groups and organisations for the long term to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing
- do the work once – duplication of systems, processes and work should be avoided as a wasteful and potential source of conflict
- undertake shared analysis of problems and issues as the basis of taking action apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible (these principles together with the Financial Principles and Workforce Principles are the "Principles") and
- we will engender a culture that is grounded in civility and kindness that makes our partnership an outstanding place to work and where everyone has a real sense of belonging

Governance Handbook

April 2025

*New partnership governance structure



Scheme of Reservation and Delegation

West Yorkshire Partnership Board and NHS West Yorkshire Integrated Care Board

Agrees and delivers the West Yorkshire Integrated Care Strategy: built from local place health and wellbeing strategies

strategy

Health and Wellbeing Boards (CoBDMC & NYC)

provides strategic direction to a wide range of organisations that organise health and wellbeing services. Leading real improvements in the long-term health and wellbeing of all our population

delegation

BD&C Partnership Board

Agrees BDC partnership strategy based on Health & Wellbeing Strategy, the West Yorkshire ICB ten ambitions and the NHS Long term Plan

- annual plan to deliver the health and wellbeing and Partnership Board strategy
- arranges health services in local places
- deployment and management of local place financial allocation
- assuring and improving the quality of services in local places
- deployment and management of place-based integrated care board staff
- agrees place plans (for example, workforce, data and digital)

delivery

Partnership Leadership Executive

- to support the BDC Partnership Board on issues within its remit
- to support the wider BDC Place Partnership, which comprises the ICB and various other organisations, on issues within the BD&C Management Forum's remit

assurance and advice

Quality Committee

Finance & Performance Committee

assurance

Clinical & Professional Forum

Citizen's voice Forum

advice and engagement

delivery priorities

Healthy Children and Families

Healthy Minds

Healthy Communities

Access to Care

People Development

Delivery enablers

Planning & Commissioning Forum

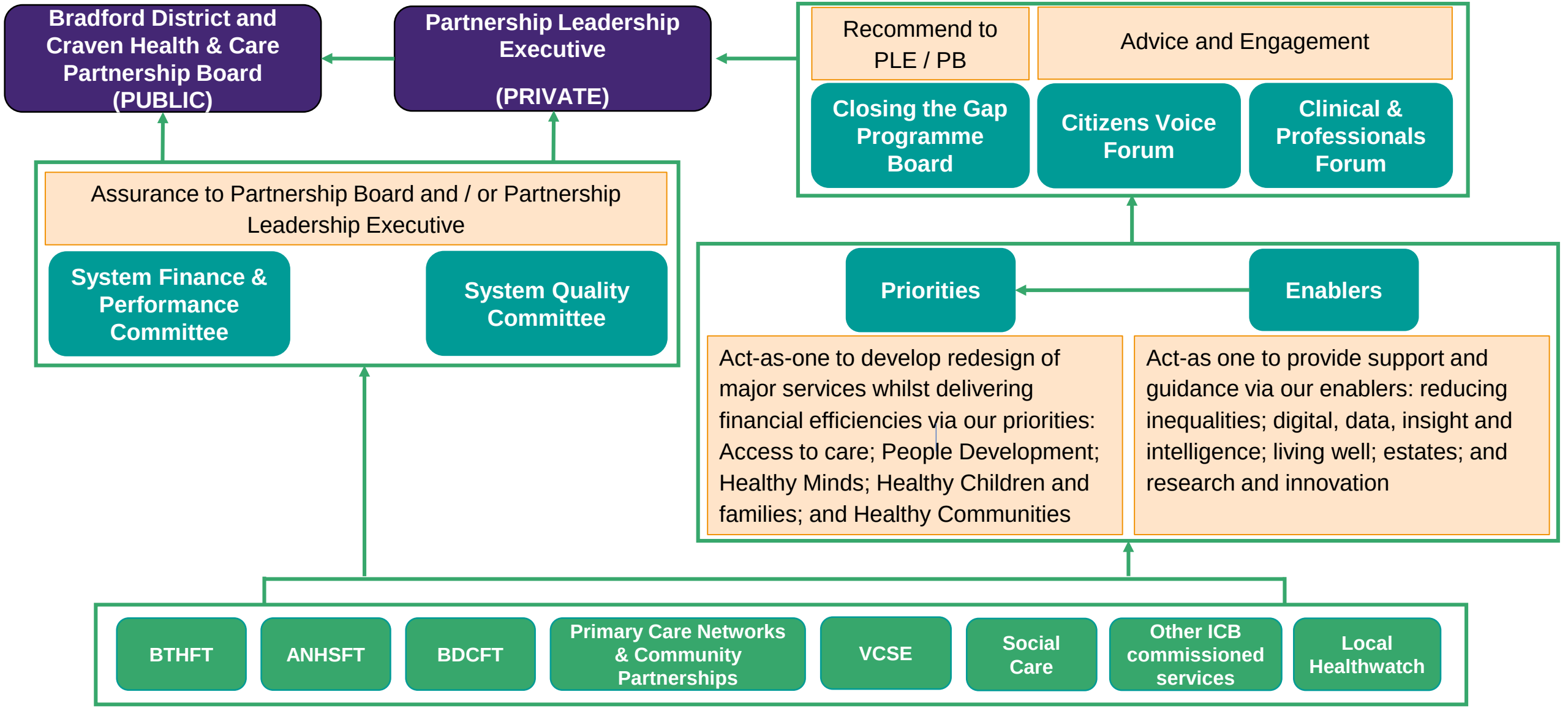
Reducing inequalities

Living well

Digital, Data, Insight & intelligence

Estates

Research & Innovation

Strategic Partnering Agreement: Annex 1 – Financial Governance Framework

Priority leads will lead the priorities to oversee and ensure the development of high-quality safe services that meet the partnership's strategy, thereby meeting the needs of our population at all life stages, within the available financial resources