

Bradford District and Craven Partnership Board

5 September 2025

10:00 – 13:00

Belle Vue Suite, Belle Vue Square, Broughton Road, Skipton, BD23 1FJ

AGENDA

Item	Lead	Purpose	Time	Page No.	Links to Board Assurance Framework strategic risks
1. Welcome, introductions, apologies and quoracy	Chair	Information	10:00		
2. Declarations of interest – a register of Board members can be found at mydeclarations.co.uk	Chair	Assurance	10:10		
3. a. Minutes of the meeting held on 23 May 2025 b. Action log / matters arising c. Previous BD&C Partnership Board Triple A report	Chair	Approve / to note	10:10	4	
4. Public questions	Chair	Information	10:20		
5. Listen in report	Victoria Simmons	Discussion	10:25	21	Topics link to multiple BAF strategic risks
6. Place Lead's update	Therese Patten	Information	10:45	40	Topics link to multiple BAF strategic risks
7. Finance / performance update	Mike Woodhead / Kerry Weir	Information	11:10	51	1.2, 2.1, 2.3, 3.1, 3.2, 3.3
Break 11:30-11:40					
8. Health, Care, and Wellbeing Strategy	Matt Sandford	Approve	11:40	86	1.1, 1.2, 1.3, 3.1, 4.1
9. Reports from committees and fora	Committee and Forum Chairs	Information / approve	11:45	121	1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 2.4, 3.1, 3.2, 3.3, 4.1



Item	Lead	Purpose	Time	Page No	Links to Board Assurance Framework strategic risks
10. Focus on Craven - update on North Yorkshire Health Collaborative	Richard Webb	Information	11:55	133	1.1, 1.2, 1.3, 3.1, 3.2, 3.3
11. Focus on Craven - Healthwatch report 'ploughing through barriers'	Ashley Green	Information	12:20	146	1.1, 1.2, 1.3
12. Partnership high level risk report / Board Assurance Framework	Asma Sacha	Assurance	12:45	162	Includes oversight of all BAF strategic risks
13. Any other business	All	Information	12:55		
14. Reports/escalations to WY ICB and review of meeting	Chair	Information	12:58		

Date and time of next meeting –

10:00 – 13:00

14 November 2025

G7 / G8, Scorex House, 1 Bolton Road, Bradford, BD1 4AS

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

Board Assurance Framework summary – cycle two 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 11	Date: Sept 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	Lou Auger	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	Lou Auger	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	Lou Auger / 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

Meeting name:	Bradford District and Craven (BD&C) Partnership Board
Agenda item no:	3
Meeting date:	5 September 2025
Report title:	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: 24 June 2025 – BD&C 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 23 May 2025 - BD&C Partnership Board action log - BD&C Partnership Board Triple A report submitted to the NHS WY ICB Board meeting on 24 June 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 Bradford District and Craven Partnership Board is asked to: - Approve the draft minutes from the BD&C Partnership Board meeting held on 23 May 2025; - Discuss any open actions on the action log; - 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 23 May 2025
2. BD&C Partnership Board action log
3. BD&C Partnership Board Triple A report submitted for the WY ICB Board meeting on 24 June 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

Bradford District and Craven Health and Care Partnership Board

10:00-1:00, Friday 23 May 2025

G7/G8, Scorex House

Members	Initials	Role
Elaine Appelbee (chair)	EA	Independent Chair of Bradford District and Craven Health and Care Partnership (BD&C H&CP)
Sohail Abbas	SA	Chair of the Clinical and Professional Forum, NHS West Yorkshire ICB (WY ICB) (BD&C)
Sajid Azeb	SAz	Chief Operating Officer / Deputy Chief Executive Officer, Bradford Teaching Hospitals NHS FT (deputising for Mel Pickup)
Kerrie-lee Barr	KLB	Chief Operating Officer, VCS Alliance (deputising for Sam Keighley)
Louise Bestwick	LB	Chief Executive, Bradford Care Association
Iain MacBeath	IM	Strategic Director, Adult Social Care and Health, Bradford Metropolitan District Council (BMDC) (item 5 onwards)
Sarah Jones	SJ	Chair, Bradford Teaching Hospitals NHS FT
Helen Rushworth	HR	Chief Executive, Healthwatch Bradford District
Matt Sandford	MS	Deputy Accountable Officer / Director of Partnership and Place, NHS WY ICB (BD&C)
Stuart Shaw	SS	Executive Director of Strategy, Planning and Partnerships, Airedale NHS FT (deputising for Foluke Ajayi)
Victoria Turner	VT	Public Health Consultant, North Yorkshire Council (deputising for Louise Wallace)
In attendance		
Sue Baxter	SB	Head of Partnership Governance, NHS WY ICB
Helen Farmer	HF	Director of System Transformation, NHS WY ICB (BD&C)
Saeed Khan	SK	Insight and Involvement Manager, NHS WY ICB (BD&C) (item 5)
Shak Rafiq	SR	Associate Director of Communications and Involvement, BD&C H&CP
Asma Sacha	AS	Risk Manager, NHS WY ICB
Victoria Simmons	VS	Senior Head of Communications and Involvement, NHS WY ICB (BD&C)
Clare Smart	CS	Associate Director, NHS WY ICB (BD&C)

Catherine Smith	CSmi	Governance Manager, NHS WY ICB (minutes)
Lesley Tillotson	LT	Associate Director, Partnership Delivery, WY ICB (BD&C)
Mike Woodhead	MW	Lead Finance Director, BD&C H&CP / Director of Finance, Contracting and Estates, Bradford District Care NHS Foundation Trust (item 5 onwards)
Apologies		
Foluke Ajayi	FA	Chief Executive, Airedale NHS Foundation Trust
Sharon Hudson	SH	Communications Customer Services and Partnerships Manager, North Yorkshire Council
Dena Dalton	DD	Head of Health Collaboration, Community First Yorkshire
Ashley Green	AG	Chief Executive, Healthwatch North Yorkshire
Karen Gullon	KG	Assistant Director of Adult Social Care, North Yorkshire Council
Richard Haddad	RH	Chair of the Clinical Advisory Board (CAB)
Danielle Hann	DH	Deputy Chair, Bradford and Airedale Branch of YORLMC
Marium Haque	MH	Strategic Director – Children, BMDC
Phillipa Hubbard	PH	Director of Nursing and Quality for BD&C H&CP
Sam Keighley	SK	VCSE System Lead
Julie Lawreniuk	JL	Non-executive chair of the Finance and Performance Committee of the BD&C H&CP
Lorraine O'Donnell	LoD	Chief Executive, BMDC
John Pattinson	JP	Chief Executive, Independent Care Group
Therese Patten	TP	BD&C H&CP Place Lead / Chief Executive, Bradford District Care NHS Foundation Trust
Linda Patterson	LP	Chair, Bradford District Care NHS Foundation Trust
Mel Pickup	MP	Chief Executive, Bradford Teaching Hospitals NHS FT
Louise Wallace	LW	Director of Public Health, North Yorkshire Council
Richard Webb	RW	Corporate Director, Health and Adult Services, North Yorkshire Council
Andy Withers	AW	Interim Chair, Airedale NHS Foundation Trust and Non-Executive Chair of the Quality Committee of the BD&C H&CP

Members of the public - 1

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. It was noted that the meeting was not quorate so any items that needed a decision could be approved for recommendation by attending members but would need to be ratified by absent members.

02 DECLARATIONS OF INTEREST

It was noted that members providing a service under the Better Care Fund had a direct financial interest in item 11 – Better Care Fund 2025/26 – however the intention of the item was for the Board to note the updates to the Better Care Fund plan for 2025/26 and to provide assurance that the plan was compliant with the national policy and planning requirement for 2025/26 so it was agreed that no further action was needed and all members could participate in the discussion.

03 MEETING BUSINESS

a) Minutes of the meeting held on 14 February 2025

The Board received the minutes of the meeting held in public on 14 February 2025.

The Bradford District and Craven Partnership Board **APPROVED** the draft minutes of the Partnership Board meeting held on 14 February 2025 and **CONFIRMED** they were an accurate record of the meeting.

b) Action log / matters arising

The Chair referred to the three open actions on the action log -

- 2024/05 – the communication and engagement team to explore a kindness campaign, in reference to Airedale NHS FT's campaign. Matt Sandford (MS) explained that there was ongoing consideration for a future approach to the campaign and it was agreed that the action would remain open.
- 2024/07 – BD&C H&CP leadership and governance review undertaken by Mike Farrar to be considered and brought to the next meeting of the Partnership Board in May 2025. MS updated that this would be covered in the agenda items on the Health, Care, and Wellbeing Strategy (item 8) and governance (item 12) so the action could close.
- 2024/08 – North Yorkshire Council Section 75 to be added to the Partnership Board workplan. It was agreed that the action would remain open as the date was to be confirmed.

No further matters arising were raised.

c) Previous BD&C Partnership Board Triple A report

The Bradford District and Craven Partnership Board:

- **RECEIVED** the previous Triple A report for information.

04 PUBLIC QUESTIONS

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

05 LISTEN IN

Victoria Simmons (VS) presented a report which described how the insights from the Listen in programme and other involvement activities, such as the deliberative events, had built an understanding of local population needs in terms of their health and wellbeing. The insights from this work were analysed by an independent market research agency in order to highlight a number of lines of enquiry - themes to inform the Health, Care and Wellbeing Strategy; a focus on the three Darzi shifts of hospital to community care, analogue to digital services and treatment to prevention; and how citizens and communities could take an active role as partners in developing a shared vision for local health and wellbeing and take ownership of their own health. VS referred to the development of personas, which were based on real people, in order to bring the insights to life and illustrate different parts of the population based on population health segmentation with considerations for the future of the personas and how health needs might change.

VS summarised the themes from the insight in terms of positive comments and concerns related to the Darzi shifts, acute care, integrated neighbourhood health and care services, and what citizen activation means for people. Members were asked to consider how the partnership could challenge itself to ensure that the Health, Care and Wellbeing Strategy would be grounded in the outputs from the listening activities.

In terms of the Darzi shift from hospital to community, Sarah Jones (SJ) referred to opportunities to co-locate services in the high street or embed services into communities. Shak Rafiq (SR) advised being mindful of cultural sensitives in regard to placing services in communities but agreed on the need to make services easily accessible in terms of travel. Sohail Abbas (SA) queried the level of understanding of future challenges in health and care services in communities. VS explained that there was a higher understanding in the deliberative events due to the method of engagement and suggested that the approach could be used to further increase understanding of the challenges faced. VS referred to the deliberative events as an opportunity to work with communities to talk about their future health and take care of their own health and wellbeing. Members welcomed the use of personas to communicate real stories.

SJ suggested that the Place fracture liaison service, which provided checks for the risks of falls and bone density scans to assess future bone health, could be showcased as a great example of the impact on future health by primary prevention. EA suggested consideration for how this approach could be maximised across the system.

MW joined the meeting.

The Bradford District and Craven Partnership Board:

- **CONSIDERED** the suggested lines of enquiry arising from the work to analyse the findings from the involvement activities, to ensure that the strategy stayed rooted in what had been heard.

06 PLACE LEAD'S UPDATE

Matt Sandford (MS) 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.

MS noted that following the UK Supreme Court ruling that the legal definition of a woman was based on biological sex, Therese Patten as Place Lead wrote a statement on behalf of the Partnership confirming the importance of showing allyship with people from the trans community and the responsibilities of the NHS West Yorkshire Integrated Care Board (WY ICB) under the Equality Act 2010.

MS referred to the merging of NHS England with the Department for Health and Social Care over a two-year period in order to reduce running costs in the NHS and noted that more information would follow. Sir James Mackey commenced his new role as Chief Executive for NHS England on 1 April 2025 with other changes made to the leadership team to support work to transition to a merged organisation. It was noted that the government's 10-Year Health Plan would be published in June 2025 and would focus on the three Darzi shifts, as detailed in the previous item. Existing engagement mechanisms had been used to engage on the plan locally with the three shifts having informed the Partnership's Health, Care and Wellbeing Strategy.

IM joined the meeting.

MS referred to the national announcement made in March 2025 that all ICBs must reduce their running costs by 50% by the end of quarter three of 2025/26. The Model ICB Blueprint was published on 2 May 2025 by NHS England which set out the core functions of ICBs as strategic commissioners with the expectation that a narrative of plans and high-level financial modelling would be submitted to NHS England by 31 May 2025. It was anticipated that there would be a 45-day consultation with staff and a voluntary redundancy process (when confirmed nationally) starting in June / July 2025. Work on what the Blueprint would mean for the NHS WY ICB alongside a draft structure and more detail on the functions of the ICB was continuing at pace.

It was noted that the final submission of the operational and financial plans was made by 20 March 2025, following delegation of approval of the plans to the Chair, Place Lead, Chair of the System Finance and Performance Committee, System Lead for Finance and the Director of Operational Finance.

It was noted that Cathy Elliott would stand down from her role as Chair of the ICB at the end of May 2025 to start a new role as Chief Executive of NHS Cheshire and Merseyside ICB. Professor Nadira Mirza had been appointed as the interim Chair of the ICB for a period of six months from 1 June 2025. MS congratulated Foluke Ajayi, Chief Executive of Airedale NHS Foundation Trust, on her appointment as Vice-Chair of the NHS Confederation.

Mike Woodhead (MW) referred to the impact on partner organisations due to the reduction in ICB running costs and an associated risk related to the ability for transformation across the system. It was noted that NHS trusts were also facing challenges due to the need to save 50% of corporate costs.

The Chair congratulated colleagues who had won awards, as detailed in the paper, and thanked colleagues across the system for their continued hard work during a challenging and difficult time.

The Bradford District and Craven Partnership Board **RECEIVED** and **NOTED** the Place Lead's update.

07 FINANCIAL AND OPERATIONAL PLANNING UPDATE

MW took members through a presentation which detailed the operational and financial plans for 2024/25 and 2025/26. In terms of 2024/25 performance, he highlighted continued improvement against elective recovery targets and 6 week diagnostic performance, strong performance against cancer standards, challenges in urgent and emergency care, improvements with lengths of stay and no criteria to reside, above plan GP appointments and continued pressures in mental health out of area beds. The operational plans for 2025/26 detailed delivery of the national expectations with risks relating to the financial position and workforce highlighted.

In terms of the financial position for 2024/25 MW highlighted that the WY Integrated Care System (ICS) achieved its plan after non-recurrent deficit support funding of approximately £50m and additional Elective Recovery Funding (ERF) of £30m. BD&C Place had a deficit of £34.5m which was worse than plan by £11.8m after £18.2m of support funding and ERF funding.

In the financial plans for 2025/26 BD&C Place had a £31.7m deficit plan and the WY ICS had a breakeven plan which included £40m of additional recurrent funding and £49.2m of non-recurrent deficit support funding. Challenges to the plans included an unidentified stretch target of £33m in NHS WY ICB, high efficiency targets in the providers (between 5-7%) and the need for providers to reduce their corporate costs by 50% (ANHSFT £1.3m, BTHFT £1.6m and BDCFT £1.8m). In terms of the stretch target of £33m BD&C Place had a share of £12m and there was a proposal to divide this by £5.3m for BTHFT, £3.1m for ANHSFT, £2m for BDCFT and £1.6m for the ICB. It was highlighted that there was a risk of not achieving the target and losing access to additional recurrent deficit support funding.

The Bradford District and Craven Partnership Board **NOTED** the update on financial and operational planning.

08 OUR PLANS FOR THE HEALTH, CARE, AND WELLBEING STRATEGY

MS introduced the Health, Care and Wellbeing Strategy as a plan which supported the Partnership vision of 'happy, healthy at home' and had been developed in response to the need to transform health, care and wellbeing services to meet the changing needs of the population and the three Darzi shifts. He referred to various methods to develop the strategy, such through PLE development sessions using an appreciative enquiry approach, engagement with colleagues across the Partnership and communities through the Listen in mechanisms. The strategy would be included as a health chapter in the District Plan for both BMDC and North Yorkshire Council and would also support the development at Lynfield Mount Hospital, the new hospital at Airedale NHS FT and the forming of Provider Partnerships.

CS talked through a presentation which described the context and development of the strategy in terms of population data and future state, integrated neighbourhood health and acute services of the future. The strategy was based on predictive modelling which described population segment changes between 2018 and 2024 vs 2040 and a predicted 11.5% growth in population. The strategy referred to integrated neighbourhood health in terms of developing an understanding of local needs and related services and providing care closer to home, such as the development of a 'health on the high street' model. The strategy also referred to acute services of the future with most of peoples care taking place in their community with hospitals being used for specialised or emergency care with digitally-powered care delivery.

SJ referred to an opportunity to use the information on the life course statistics in Bradford District for 2024 to consider how to make the statistics better than England's average in terms of how the Partnership acts now and its influence. IM referred to the lifestyle factors for children and young people in the statistics and the need to focus specifically on children's health. SA explained that children are part of all of the segments noting that children's health starts before they are born and maternal health can impact on long term conditions and mental health.

VT referred to links with Craven in terms of similarities and an opportunity to link with the North Yorkshire Local Plan and the North Yorkshire Council Town Investment Plan. KLB suggested consideration for how the strategy would be socialised and the inclusion of what the strategy means for personas in terms of outcomes. HR noted that the aims and objectives of the strategy were achievable if the Partnership worked collectively.

SJ offered to provide a link with the Bradford Institute of Health Research which had a significant amount of data on children, such as from the Born in Bradford programme. Better Start Bradford as another opportunity for data on children was also suggested.

It was noted that the strategy would be presented to the Health and Wellbeing Board of both the Bradford Metropolitan District Council and North Yorkshire Council and further engagement with partners was suggested.

The Chair thanked CS and MS for their work to develop the strategy and noted that there would be an opportunity for members to provide further comments in a future Board development session.

The Bradford District and Craven Partnership Board **RECEIVED** and **CONSIDERED** the first draft of the Health, Care, and Wellbeing Strategy for Bradford District and Craven.

09 REPORTS FROM COMMITTEES AND FORA

The Chair explained that each committee 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.

The reports were taken as read and received by the Board. SA highlighted that the Clinical and Professional Forum had recently been relaunched and had held a development session to discuss the Health, Care and Wellbeing Strategy.

The Bradford District and Craven Partnership Board **RECEIVED** the committee and fora Triple A reports.

10 PARTNERSHIP HIGH LEVEL RISK REPORT

Asma Sacha (AS) presented a report which detailed the high-level risks (scoring 15 and above) on the Partnership risk register during cycle one of 2025/26. The report included a summary of the Board Assurance Framework (BAF) and a risk on a page / heat map. It was reported that there were 33 risks and 31 open risks on the risk register. There were six new risks, two risks that had decreased in score and two risks had been closed. The six new risks were summarised – one related to the underlying financial deficit for 2025/26, four related to continuing healthcare and one related to an increased risk of a data breach by smaller voluntary, community and social enterprise (VCSE) providers due to not being compliant with the NHS Data Security and Protection Toolkit. SA explained that there was work between the VCS alliance and the WY Harnessing Power of Communities programme on how to manage this. KLB added that all VCS organisations had received the formal notification and questionnaire in order to get more information on the implications for VCSE providers and how they could be supported.

The two risks that had decreased were noted as, in-year financial performance which had decreased in score from 20 to 15 in line with the WY ICB corporate risk register and the risk related to significant adult social care market failure and disruption due to insufficient funding to fund increases to the national insurance contributions and national living wage. It was noted that although an uplift had been agreed by BMDC and the ICB the full impact of the uplift had not been realised so the risk score would be reviewed in the next cycle.

The two closed risks related to the underlying deficit for 2024/25 and the closure to care and nursing homes due to a lack of experienced registered managers and registered nurses which had merged with the risk related to insufficient social care workforce.

AS noted that emerging risks related to the ICB organisational change programme would be developed with Place Leads in the next cycle. Helen Farmer (HF) added that a risk related to shared care would be developed, following ongoing negotiations with primary care.

AS added that there would be work to consolidate some risks on the risk register in cycle two and an intention for the System Quality Committee to undertake focused work on risks in each meeting with the risks related to continuing healthcare as the first area. It was noted that the BAF would be reviewed by the WY ICB Executive Management Team in the current cycle and presented to the ICB Board on 24 June 2025. It would be reviewed by Place risk owners in cycle two.

The Bradford District and Craven Partnership Board **RECEIVED** and **NOTED** the high-level risk report, risk log, and risk on a page report as an accurate representation of the BD&C place risk position. It was **ASSURED** in respect of the effective management of the risks, controls and assurances in place. It **RECEIVED** the Board Assurance Framework summary for cycle one 2025/26.

11 BETTER CARE FUND 2025/26 PLAN SUBMISSION

IM presented a paper which referred to updated national guidance on the Better Care Fund (BCF) for Bradford which included the Policy Framework for the BCF for 2025/26 which introduced key changes to the national conditions and metrics governing the fund and outlined four national conditions that all BCF plans must meet for approval. The plan had been developed by the Planning and Commissioning Forum who had ensured that that the expenditure continued to align with the Policy Framework and uphold compliance standards. It was noted that the total of the BCF for 2025/26 totalled approximately £91m which was an 11% increase compared to the 2024/25 position. IM referred to work to evaluate the core services within the BCF to achieve their potential and ensure value for money, which was backed up by key changes in the plan in terms of adopting of a more strategic, data-driven approach to service delivery. The paper detailed the key updates to the funding allocation for the BCF and the three key metrics that performance was evaluated on.

HF noted thanks to Javeid Karim, Support and Integration Manager in BMDC, for his ongoing work on the BCF.

The Bradford District and Craven Partnership Board **NOTED** the updates to the Better Care Fund 2025/26 plan and **PROVIDED** assurance that the BCF plan is compliant with the National Policy and Planning requirement for 2025/26.

12 GOVERNANCE

End of year review

Sue Baxter (SB) presented a paper which included a summary of the findings from the review of effectiveness of the Partnership Board, committees and the groups within the governance arrangements of Partnership. The review informed the production of the annual report and a review of the terms of reference for the Partnership Board / committees / groups as part of the year-end arrangements. It was noted that the annual report for the Partnership Board for 2024/25 would be submitted for assurance and the terms of reference and workplan for 2025/26 for approval to the WY ICB Board. The Partnership Board were asked to receive the annual reports from the committees and groups and approve their terms of reference.

In terms of the review of the effectiveness of the Partnership Board SB highlighted that there had been 19 responses (63% response rate) to the survey with generally positive responses in relation to the current arrangements with members highlighting strengths of the Board as the maintenance of the positive partnership relationships and the excellent chairing. Achievements of the Board were highlighted as a welcome focus on Craven and the ongoing Listen in programme with improvements suggested as the development of a clear plan or outcomes from reports from the Listen in programme, collective action on key issues and a stronger focus on financial challenges.

The Bradford District and Craven Partnership Board **APPROVED** its annual report for 2024/25 for submission to the WY ICB Board; **APPROVED** its terms of reference and workplan (to be recommended for approval by the WY ICB Board); **APPROVED** the annual reports from the System Finance and Performance Committee, the System Quality Committee, Clinical Forum and Partnership Leadership Executive; and **APPROVED** the terms of reference for the System Finance and Performance Committee, System Quality Committee, Citizens Voice Forum and Clinical and Professional Forum.

Partnership governance arrangements 2025/26 including Strategic Partnering Agreement and Governance Handbook

SB explained that a review of the Strategic Partnering Agreement, which was the key governance document that facilitated the Partnership, had been undertaken due to the changes following the WY ICB's new operating model and the partnership governance effectiveness and efficiency review. The changes were summarised as - the addition of the North Yorkshire Council Adult Social Care Joint Commissioning Group, changes to the governance arrangements and structure, inclusion of the financial and risk management principles, reference to the Closing the Gap programme and updates to the SPA workplan. It was noted that the revised agreement would come into effect from 1 July 2025 and would be accompanied by an e-signature process by partners following the document being discussed and approved in partners governance arrangements. SB added that the Governance Handbook would be updated following agreement of the SPA and the approval of the terms of reference as described in the end of year review.

MS referred to a review of Place governance arrangements which included proposed

changes to the Partnership Leadership Executive with the development of a new Partnership Oversight Executive. There would be significant work to develop governance structures as part of the Provider Partnership model for BD&C Place. As part of the review, it was proposed that the System Quality Committee and System Finance and Performance Committee move from monthly to quarterly meetings in line with the business cycles of the ICB.

The Bradford District and Craven Partnership Board **APPROVED** the amended business cycles of both the System Quality Committee and the System Finance and Performance Committee from 1 April 2025; **NOTED** the proposed changes to the Partnership governance arrangements; **APPROVED** the amendments to the Strategic Partnering Agreement; and **NOTED** that the Governance Handbook would be refreshed following approval of the updates to governance arrangements and terms of reference.

13 ANY OTHER BUSINESS

The Chair noted that it was SR's last meeting before he moved onto a new role in BTHFT. The Board thanked him for his contributions to the meetings and wished him well in his new role.

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

SB summarised the key messages which would be included in the triple A report from the meeting.

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

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	23/05/25: Agreed to keep the action open as there was ongoing consideration for a future campaign.
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	Closed	23/05/25: Covered in the agenda items on the Health, Care, and Wellbeing Strategy (item 8) and governance (item 12).
2024/08	14-Feb-25	6 - Section 65 agreement variation	NYC Section 75 (Ambtious for Health) to be added to the Partnership Board workplan.	Louise Wallace/Catherine Smith	05-Sep-25	Propose to close	On the agenda for 5 Sept meeting.

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 23 May 2025

Report to: WY ICB Board on the 24 June 2025

Report completed by: Sue Baxter on behalf of Elaine Appelbee (independent chair); Therese Patten (Bradford District and Craven place lead); and Matt Sandford (Director of Partnership and Place and Deputy Accountable Officer Bradford District and Craven ICB)

Date: 27 May 2025

Key escalation and discussion points from the meeting
Alert: 2024/25 financial position at month 12: £34.5m deficit: BDC ICB place £17.1m deficit; AFT £12.7m deficit; BTHFT £4.9m deficit; and BDCFT underspend £0.2m. (BAF 3.1 & 3.2, RR 2337 & 2527) Financial plan for 2025/26 for West Yorkshire ICB has submitted a balanced plan for 2025/26 - - Efficiency plans: AFT= 7.36%; BDCFT=6.5%; BTHFT=5.2%; and ICB=3.8%. - As part of the West Yorkshire system plan submission Bradford District and Craven has submitted a £31.7m deficit plan (AFT £14.7m deficit plan; and BTHFT deficit £17m). After deficit support funding the place deficit plan reduces to a planned deficit of £16.5m. 50% running costs reductions: AFT £1.347m; BTHFT=£1.666m; and BDCFT=£1.807m. - In addition, an ICB system stretch target allocation of £12m had been applied to Bradford District and Craven place with agreement of allocation across NHS partners to be confirmed. As a result of these pressures, it was recognised that BDC system financial plans had a high level of risk and the Partnership Board agreed that the in-year financial performance risk 2433 score of 16 was too low and would be revised in cycle two. The financial imperative informed discussions on the draft Health, Care & Wellbeing Strategy. (BAF 3.1 & 3.2, RR 2337, 2433 & 2527).
Advise: A first draft review of the Health, Care & Wellbeing Strategy for Bradford District and Craven Health and Care Partnership was received. To inform development of the partnership's strategy a secondary analysis of the Listen In outputs and reports looked across all insight gathered over the past two years 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?”

At the heart of the strategy 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 strategy acts a guide for how we use our partnership resources to improve population health. The partnership's strategy will form the Health Chapter of the BMDC District Plan, will be considered as part of the NYC Council Plan; and will support the Airedale Hospital new hospitals programme submission. (BAF 1.3 & 2.4; and RR 2312 & 2314, 2215 & 2422)

- **Noted for assurance the Better Care Fund plan 2025/26 submission** with a pool fund of £92m was compliant and received positive feedback from NHS England as the most integrated plan submitted in this region. Where appropriate, the BCF plan aligns with the Bradford District & Craven operational plan 2025/26. The plan has been developed by the Planning and Commissioning Forum who have ensured the expenditure continues to align with the policy framework and upholds compliance standards. (BAF 1.3, 3.1 & 3.2, RR 2168, 2173 & 2337)

Assure:

- Changes to the ICB as a result of the **50% running costs reductions**, include a draft range of functions which should be set out and shared with NHSE by the end of May 2025 and be implemented during quarter 3 (October-December) of 2025-26. Staff consultation is expected to begin w/c 30 June and last for 45 days.
- The Partnership Board noted **oversight and assurance** including but not limited to:
 - closing the gap programme is provided by the System Finance and Performance Committee
 - regulation 28 for BDCFT case 'access for assessment'; regulation 28 for Care Home case Harbour Healthcare; SHMI data at AFT and BTHFT; and deep dive into falls by the System Quality Committee.
- The Partnership Board recognised the appointment of **Foluke Ajayi** (Chief Executive of Airedale NHS Foundation Trust) to the role of **vice-chair of NHS Confederation**.
- **Decisions approved by the Bradford District and Craven Health and Care Partnership Board**
 - Noted for assurance the delegated decision to approve **the operational and financial planning 2025/26** ahead of submission on 20 March. (BAF 3.1 & 3.2, RR 2168)
 - **APPROVED** the changes to the Strategic Partnering Agreement on behalf of the partners represented and included largely housekeeping amendments as well as taking into account the changes to partnership financial arrangements including the financial framework and closing the gap approach
 - **APPROVED** the BDC HCP Partnership Board system committees **Terms of Reference**: Citizens Voice Forum; Clinical & Professional Forum; System

Finance and Performance Committee (SFPC); and System Quality Committee (SQC). Changes included reducing the two assurance committees (SFPC and SQC), frequency to quarterly, as well as the PLE changing its remit to bi-monthly meetings to be replaced over time by the Partnership Oversight Executive.

- **NOTED** the Partnership Board's annual report and **RECOMMENDED** to the ICB Board approval of changes to the Partnership Board's **Terms of Reference**.

Meeting name:	Partnership Board		
Agenda item no:	5		
Meeting date:	5 September 2025		
Report title:	Listen in – racially minoritised communities - what are we hearing?		
Report presented by:	Victoria Simmons, Senior head of communications and involvement, WY ICB (Bradford District and Craven) Natasha Noor, Communications and Engagement Manager: Healthy Minds, Bradford District and Craven		
Report approved by:	Matt Sandford, Director of Partnership and Place, WY ICB (Bradford District and Craven)		
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 - Listen in – how what we are hearing is shaping our strategy, Presented at Partnership Board meeting May 2025			
Executive summary and points for discussion:			
Listen in is an ongoing programme of involvement, with focused periods of activity to have direct conversations with the public, visiting community groups and public spaces to help us understand what matters most to local people when it comes to health and care. This year, Listen in is focused on reaching into communities of interest and understanding the differing experiences of groups in our population. Since last reporting to Partnership Board, we have completed a cycle of activity focused on hearing from people from racially minoritised communities, particularly recent migrants from African and Middle Eastern countries. The appended <i>What are we hearing</i> report describes the themes that surfaced under five priorities – although the partnership is no longer working to this framework, we are keeping the format for the rest of this year's cycles to make it easier to compare findings across different communities of interest. As with previous cycles, we also issued a call for evidence to capture existing insight that provides context and additional learning – this includes findings from the			

Centre for Mental Health's *Pursuing Racial Justice in Mental Health* report and recent local developments such as the specialist mental health contract to improve support for ethnically and culturally diverse communities.

For this cycle, most sessions involved our team attending existing community group meetings or events, working alongside trusted VCSE partners to reach people in familiar, safe spaces. Some were one-to-one conversations, while others were small group discussions. Although we worked with VCSE and council partners to try and reach into Craven, we were unable to identify opportunities to engage with racially minoritised communities here – highlighting a gap in visible and accessible support in that locality.

Racially minoritised communities – what are we hearing?

- Barriers to healthcare access: difficulties with digital-first systems, language barriers, and lack of accessible information make it harder to book appointments and get timely care.
- Trust and familiarity: people prefer services delivered in community hubs by trusted professionals or those introduced through known networks.
- Value of community hubs: hubs provide holistic support – from health information and advice to help with housing, employment, and navigating other services.
- Housing and health: insecure housing, particularly in the private rented sector, leaves people vulnerable to poor living conditions that can worsen existing health problems.
- Maternity services: positive experiences were reported when services proactively engaged with communities, for example through midwives attending community hubs.
- Mental health stigma: stigma remains a major barrier, with many people preferring to seek informal support from within their community rather than from statutory services.
- Employment and digital inclusion: lack of digital access, skills, and awareness of free local resources such as libraries limits opportunities for training and job-seeking.
- Service design: a perception that most services are 'one size fits all', with a need for culturally competent approaches tailored to the needs of diverse communities.

Upcoming Listen in activity

The next cycle of the Listen in programme is underway, focusing on hearing from men from traditionally working-class White British communities. Due to organisational changes on the horizon and reduced capacity in the partnership communications and involvement team, no further activity has yet been planned.

The Listen in programme has been in place since 2022 and has become a core part of how we work in Bradford District and Craven, underpinning the recently updated strategy. The long-term commitment we have made to this way of working is now showing real impact. The Listen in identity is well recognised, and reaching into communities is gradually becoming easier because of the trust built through sustained engagement. This investment of time, energy, and social capital has helped to build strong relationships, gather insight that genuinely shapes decision-making, and turn the ambition for meaningful involvement into something tangible in our place.

We would welcome Board members' views on how the approach and learning from Listen in can be sustained within the emergent governance arrangements for place, to ensure that this trust and momentum is not lost. As part of this, it will be important to maintain clear accountability for acting on the insight we have already gathered, so that communities can see and feel the impact of the time and experience they have shared with us.

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. Consider the ideas and insights from this Listen in cycle 2. Make recommendations for how emergent place governance and strategy delivery groups can embed learning from Listen in
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
n/a
Appendices
1. Listen in. Racially minoritised communities – what are we hearing?
Acronyms and Abbreviations explained
We purposefully avoid the acronym BAME (<i>Black, Asian, and Minority Ethnic</i>) because it groups together very diverse communities and experiences under one broad label, which can obscure important differences in culture, history, and health inequalities. We use the term <i>racially minoritised communities</i> to emphasise that marginalisation is the result of social and systemic processes, rather than an inherent characteristic of the people or communities themselves.

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.

Listen

Racially minoritised communities

What are we hearing?



18 August 2025, report authors:

Natasha Noor, Communications and Engagement Manager: Healthy Minds Bradford District and Craven

Victoria Simmons, Senior head of communications and involvement

Contact: communications@bradford.nhs.uk

Listen in – our approach

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

In our third year of Listen in cycles we are focusing on reaching into communities of interest and understanding the differing experiences of groups of our population. This report will focus specifically on our Listen in cycle for racially minoritised communities, in particular the African communities and Syrian community.

Our approach:

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

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

Our involvement responsibilities, including legal requirements

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

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

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

Fit for the future: 10 Year Health Plan for England

We are pleased to see that the [10 Year Health Plan](#) places significant importance on understanding and acting upon patient insight, which will help to shape the future of NHS services, personalised care, as well as drive quality improvement. This highlights the importance of our Listen in work to date, which has been a key driver in shaping our partnership strategy for Bradford District and Craven.

What did we hear?

This report uses the same format as previous ones, with insights organised around the five priority areas in health and care. Although the partnership is no longer working to this framework, we are keeping the format for the rest of this year's cycles to make it easier to compare findings across different communities of interest. The findings in this report highlight common themes, illustrative examples, and direct quotes where appropriate.

Hot topics

Barriers to healthcare access: Contacting health services was a challenge for many people: long waiting times to get through to a GP practice on the phone; digital exclusion issues; language barriers; and, difficulty navigating an unfamiliar system.

Importance of community hubs: People described how local social groups and accessible spaces reduced isolation, promoted health, helped build a connection with the local community, offered a safe space, and provided practical resources—such as meals and peer-led activities.

Maternity services: We heard about excellent care received at Bradford Teaching Hospitals NHS Foundation Trust to mothers and babies, and expectant mothers praised the support they received from doulas.

Housing and health link: People shared frustration about lengthy waiting lists for council housing, and people felt they are not being kept up to date on progress. People spoke about poor quality private rented accommodation and the impact on health and wellbeing.

Specific challenges around mental health: We heard about stigma around mental health in particular with African communities. Community groups bring in external people to talk about mental health and the support people can access. Most Syrians said they avoid seeking professional support, as they feel the support from their community group is sufficient.

Support around special educational needs and disabilities (SEND): People told us they wanted more understanding about SEND, making people aware of what support they can access, and what schools should be providing to a child or a young person with special educational needs and disabilities.

Employment and health link: We heard that people struggle to find a job because they don't have the right UK qualifications; people who do secure jobs tend to be on zero-hour contracts, and this creates a lot of uncertainty.

Cost of living: Many people we spoke to rely on food banks as the cost of food has increased significantly for a lot of people. They talked about the difficult decisions they have to make to try to make ends meet. People spoke about how expensive they found public transport, especially when having to travel to health appointments.

Access to care

Barriers to timely healthcare access

Individuals highlighted barriers to accessing timely healthcare services, in particular when trying to book a GP appointment. They shared their frustration on getting through to their practice and being put in a queue, only to be told to ring back the following day as all appointments were taken. Some participants mentioned that if they were unable to secure an appointment, they would call NHS 111 once the practice closed. Or, if they felt it's an urgent healthcare concern, they would resort to Accident and Emergency.

“We know GPs are working hard, but this morning system of appointments does not work and has not been working for a while. Something needs to change.”

Antibiotics and expectations around prescribing

Some people spoke about how they source antibiotics from their home country when feeling unwell, as they know it will be difficult getting an GP appointment.

“We have been buying antibiotics from our home country and sharing amongst friends and family. We do this because of the length of time it takes to get an appointment.”

Some people had experience of healthcare systems where antibiotics are given more readily, so they felt frustrated when NHS prescribers did not offer them. A few said they had bought antibiotics privately and felt they helped. These views reflect different expectations shaped by past systems.

Long-running campaigns about antimicrobial resistance mean many people in the UK are familiar with the “only when needed” message. Newer communities may not have had the same exposure and can start from a different place with public health messages. Antibiotics are one example, but this pattern can also apply to topics like vaccination, screening, self-care and choosing the right service. Recognising these different starting points can help us tailor information and support without judgement.

Access to secondary care

Many participants—familiar with systems without a primary care ‘front door’—expected rapid access to specialists once referred. Some women told us they have been waiting over six months for gynaecology appointments, which contrasts with those expectations.

“Not sure why it takes so long, as it makes the condition worse. When asking the GP why it's taking so long, we get told they're busy. We receive no treatment whilst waiting to be seen.”

Dental care

People talked about how they are struggling to find an NHS dentist; most dentists are not taking on NHS patients. There are some that have been on waiting lists for nearly two years. People shared experiences of needing urgent dental care but weren't sure where to go for immediate treatment, some rang their GP and were told to call NHS 111. One person shared her experience of being in agony with her tooth over the weekend, and when she spoke to her GP receptionist on the Monday, she was told to call NHS 111. She didn't know anything about NHS 111, and it was the first time she heard of the service, the GP receptionist explained to her how they could help her in getting an emergency appointment.

Challenges in navigating and communicating with services

People talked about how they didn't understand the NHS and why there wasn't a single point of contact for all services. A lot of the people find it hard to navigate the NHS, most of them assumed their GP was the main point of contact for everything.

Some individuals spoke about the difficulty in communicating with their GP and practice staff due to language barriers. If a translator is provided, this could add a delay of around two weeks, which isn't helpful especially when you're feeling unwell and need to see the GP as soon as possible.

Access to care: getting it right for racially minoritised communities

Treatment quality and patient experience:

People told us that while they recognise GPs are working under a lot of pressure, the way appointments are arranged needs to change. Improving the appointment system so it is easier and fairer to use would help people get the care they need without unnecessary frustration.

Once in hospital care, people spoke highly of the quality and professionalism of staff at Bradford Teaching Hospitals NHS Foundation Trust. They valued the time staff took to listen, explain next steps clearly, and make sure they understood their treatment. We want this caring, person-centred approach to be the norm across all services.

"The nurse at the emergency department was really nice, she was very caring and also pulled a few jokes which was nice to see, as you tend to think most healthcare professionals are serious. The staff at the x-ray department were ace, I got talking to one of them about football."

"Very pleased with staff attitude at St. Lukes Hospital when I went for my mammogram, the staff were lovely and polite."

To get it right, we need to protect the time and create a culture that enables all staff to listen, explain, and show kindness at every stage.

Healthy communities

Digital access to primary care

There was particular concern about the reliance on digital tools such as PATCHS (contact your GP practice online to receive health advice, request an appointment, and ask health questions). Many people struggled to use PATCHS because of limited digital skills or a lack of access to the right equipment.

For some, the challenge was practical — not having a smartphone, computer, Wi-Fi, or enough mobile data to complete the forms. For others, the barriers were about literacy and language. Completing a detailed form in a second or third language can be daunting, especially when people are unsure of medical terms or how to explain symptoms in writing. The need to choose from a complex set of options in English, without support, left some people feeling anxious about “getting it wrong” and being refused an appointment.

‘Me and other members from my community have struggled to use PATCHS, as we have limited data on our phones and some find it difficult to understand. Staff at the practice are so busy they don’t have the time to show us how register onto PATCHS and how to use it.’

Community hubs

People consistently highlighted the vital role of community hubs in supporting their health and wellbeing. These groups are often described as an “extended family” — a trusted place to turn for both practical help and emotional support.

Alongside health-related activities, hubs provide guidance on a wide range of everyday challenges, from applying for immigration status in the UK, to encouraging toddlers to eat fruit and vegetables, to managing children’s challenging behaviour.

For many recent arrivals from Syria, African countries and elsewhere, the emotional support offered in these spaces is just as important as the practical help. Being far from their own families, participants valued having a place where they felt understood, connected, and less alone.

“My community group provides everything from English lessons to baby groups, there’s so much happening. Few weeks ago we had someone help us prepare for the ‘Life in the UK’ test, as well as starting to prepare us for B1 CEFR level English language requirements.”

Community hubs that were attended by the Syrian community, food was available at almost all of the sessions. Food is central to Syrians as it embodies social connection, cultural identity, and sense of normalcy, particularly during times of uncertainty and displacement.

Housing and health

People from the communities we spoke with are more likely to be in insecure housing because of their immigration status and personal circumstances. Limited choice and control over where they live often means accepting properties that are in poor condition or unsuitable for their needs.

People shared their worries about the lengthy waiting list for council housing that leaves some families in temporary or unstable arrangements for extended periods, adding to feelings of uncertainty and stress. People that were renting privately felt they were unable to say anything about repairs or damp in the house, as they were afraid of being evicted.

This lack of security makes people from racially minoritised communities more vulnerable to housing-related health problems. Participants with existing conditions such as asthma were especially concerned about the impact of damp and poor ventilation, and some said they could see a clear link between their home environment and worsening health — but felt powerless to change it.

Experience of maternity services:

Women and families from these communities described very positive experiences of maternity care at Bradford Teaching Hospitals NHS Foundation Trust. They felt supported, listened to, and well cared for throughout pregnancy, birth, and postnatal care.

A particular strength was the Trust's proactive approach to engaging with racially minoritised and migrant women. Midwives attend community hubs to talk directly with women about their experiences and invite feedback on how services could be improved. Women valued this personal contact and the opportunity to share their views in a familiar and trusted environment, where they felt comfortable speaking openly in their own language or with interpreting support. They saw it as a genuine sign that the Trust cares about listening to families and using that feedback to improve services for others.

“The first time I used the NHS was for maternity, the whole experience was remarkable. The midwives and the doctors were excellent, they treated me with respect and would check up on me regularly, to make sure me and baby were ok.”

“Experience with the NHS has been excellent. The midwife and the doula were amazing and felt well supported throughout my pregnancy, and after birth.”

Providing services that meet the needs of diverse communities

People felt that most health and care services are designed with a “one size fits all” approach, without taking into account the different needs, expectations, and experiences of diverse communities. This often leaves people feeling that services are not for them, or that they have to adapt to fit the system rather than the system adapting to meet their needs.

Participants emphasised the importance of designing and developing services that are culturally competent — recognising and respecting different cultural norms, health beliefs, and ways of communicating. They wanted to see services that reflect the communities they serve, with staff who understand the barriers people face and are equipped to provide care that is both clinically effective and culturally sensitive.

Language accessibility

For many people in these communities, language remains a major barrier to accessing care. Most written information — such as appointment letters, service leaflets, and health advice — is only available in English. Participants said this often meant they did not fully understand the information they were given, leading to delays in seeking care, missed appointments, or uncertainty about treatment.

Relying on friends or family to interpret can cause embarrassment, reduce privacy, and risk miscommunication. People wanted timely access to translated materials and professional interpreting, as well as more use of visual information, audio, or video community languages to help ensure everyone can understand and act on important health information.

Healthy Communities: getting it right for racially minoritised communities

Community hubs are trusted spaces where people feel safe, welcome, and supported — many described them as a “one stop shop” for advice, services, and connection. We could build on this by delivering more healthcare in these settings, such as vaccinations, health checks, and talks from healthcare professionals on how to look after your health and wellbeing. For some participants, attending appointments in their community hub would remove the need to travel to unfamiliar locations and make it easier to engage with services.

Colleagues who took part in this Listen in cycle heard first-hand how much people value having their voices heard without judgement. Maintaining this approach — spending time in communities, listening openly, and building trust — will help us design services that people feel confident using.

“Great to see NHS and voluntary and community sector staff coming out talking to people about our experiences of health and care. Listening is important and good to know how our feedback will improve services.”

People also said they would benefit from practical help to use digital healthcare tools. Offering training sessions in community hubs, GP practices, or other familiar settings on how to use PATCHS and the NHS App could reduce anxiety and help people feel more confident when asked to use these systems.

Healthy Minds

Mental health stigma

Within African communities, stigma around mental health remains a significant barrier to seeking support. People described it as a deeply rooted issue, shaped by historical, cultural, and societal factors. For some, mental health problems are seen as something to be hidden or “brushed under the carpet,” and conversations on the topic are often shut down quickly. This can make it difficult for individuals to acknowledge when they are struggling, let alone seek help.

A number of participants spoke about a lack of trust in healthcare professionals when it comes to mental health, preferring instead to confide in family members or trusted people in their local community. The sense of safety and understanding in these relationships often outweighed the perceived benefits of approaching formal services.

Peer support in mental health

Many people said they would rather seek help from community hubs or peer networks than from formal mental health services. Hubs are seen as safe, non-judgemental spaces where people can share their experiences and receive emotional support without fear of stigma. This preference highlights the important role of community-based support in reaching people who might otherwise avoid professional help.

“Most people who attend our groups don’t really access mental health support services. They tend to get advice from one and another, as they see it as a minor bump and are able to lift themselves back up.”

Support around special educational needs and disability (SEND)

Some parents told us they felt unsure about what help they could access for their children with SEND. Being asked to contact multiple services and navigate different systems left them feeling confused and overwhelmed. This lack of a clear, coordinated pathway made it harder for families to get timely support and added unnecessary stress at an already challenging time.

Cost of living, employment, and mental health

People also spoke about the toll that the rising cost of living and the struggle to secure work was having on their mental health. Worrying about money, paying bills, and finding stable employment left many feeling anxious and under constant pressure. Despite this, there was a strong reluctance to seek professional mental health support — often due to stigma, mistrust, or the belief that services would not understand or address the realities of their lives.

Healthy Minds: getting it right for racially minoritised communities

Community hubs told us that many people would not feel comfortable contacting mental health services on their own, but they will attend sessions if these are delivered in a trusted space by someone they know or have been introduced to. Inviting professionals — such as a local GP or an independent mental health practitioner — to deliver talks, answer questions, and offer advice within community hubs can make it easier for people to start conversations about mental health and seek help when needed.

Hubs also emphasised the importance of having culturally responsive mental health services that understand and reflect the needs of the communities they serve. Services like the Hope and Light programme, which provides tailored mental health support for Black African, Black Caribbean, Central and Eastern European (including Roma), and South Asian communities, were seen as a positive example of this approach.

Through our Listen in visits, we have been able to share information (via the Healthy Minds website) about Hope and Light directly with community hubs, and to connect hub leaders with the service so they can arrange visits. This joined-up working helps ensure that people hear about culturally appropriate mental health support in a place where they already feel safe and supported.

People Development

“Unable to find employment, as I have been looking for a job. If I don’t find one soon, I’ll be homeless and I’m willing to do any job, as I need a roof over my head.”

Many people we spoke to were struggling to secure full-time work. They felt they could be better supported by Job Centre staff, particularly with practical help such as finding suitable vacancies and completing applications. Some were already receiving valuable one-to-one support from their community hubs, which was helping them to apply for jobs in a more supported and confident way.

Digital poverty was a major barrier. People described not having access to devices, having limited or no internet data, and lacking the digital skills needed to search and apply for jobs online. The rising cost of living was seen as the main reason why they could not afford the technology, broadband, or mobile data they needed.

People felt that Job Centres could play a bigger role in providing training on CV writing, preparing covering letters, and navigating job websites. However, some were reluctant to ask for this support because of language barriers, worrying they would not be able to fully understand or follow the training.

There was also a lack of awareness about the role libraries can play in digital inclusion. Many did not know that local libraries provide free access to computers, Wi-Fi, and digital skills training. Some had assumed they would have to pay to use these services. People felt that Job Centre staff should be routinely sharing this information and encouraging them to use libraries as a free, accessible resource for job searching and skills development.

Who did we hear from?

During this cycle of Listen in, we took part in 12 sessions across Bradford District between May and April 2025.

We worked with VCSE and council partners to try and reach into Craven but were unable to identify opportunities to engage with racially minoritised communities in this locality. Despite several attempts to make initial arrangements, we were not able to establish sessions. This highlights a gap in visible and accessible support for racially minoritised communities in Craven and the need to strengthen local connections to enable future engagement.

Some of these sessions involved our team attending existing groups or events, and literally 'listening in' to discussions. Thank you to staff, volunteers, and participants at the following organisations for their support in helping us hear from people during this cycle:

- All Saints Church
- Bevan House
- Bradford Foundation Trust
- Girdlington Community Centre
- Intouch Foundation
- Keighley College
- Peacemaker International
- St Columba's Church
- University of Bradford
- WomenZone

We engaged with approximately 110 people during this cycle.

We did not collect equality monitoring data; however, our activity was planned to connect with people in African and Syrian communities. We talked to people:

- Aged approximately 20 to 75
- Predominately from African communities and Syrian community, but also people from other backgrounds recently arrived in the UK
- With a broad range of needs and experience of the health and care system

We also gathered insights from people working at community hubs, who shared rich insight into their understanding of the lives and experiences of people they support.

Briefing session delivered by colleagues from the Hope and Light service

We want to take this opportunity to thank Daniel Sintim-Aboagye and Aston Knight from the Hope and Light service, who delivered a briefing session for this Listen in cycle. The briefing session was intended to help colleagues within the partnership to understand the cultural sensitivities with African communities and that can also be applied to other communities.

What we already know

Ahead of each cycle we try to capture recent insight reports and engagement projects relevant to the community of interest. This gives additional context to what we're hearing and over time will enable our partnership to build up a repository of intelligence from our communities that can be shared more effectively across the system. All the reports are available to download from our involvement portal www.engagebdc.com/listen-in-call-for-evidence

Listen in insights

This report builds on what we have heard in previous Listen in cycles, where people from racially minoritised communities have consistently shared experiences that highlight both strengths in our local health and care system and areas where change is needed. Insights from Bradford West, Keighley and other localities, as well as reports from other communities of interest show recurring themes that are also reflected in this cycle's findings.

- **Barriers to access** – Digital-first systems, complex booking processes, and lack of information in community languages make it harder for some people to get care, particularly those with limited English or digital access.
- **Trust and familiarity** – People are more likely to engage with services delivered in safe, familiar settings such as community hubs, where they feel respected and understood.
- **Value of community hubs** – Grassroots groups often provide essential support beyond healthcare, including help with housing, employment, and accessing other public services.
- **Cultural competence** – Services are most effective when they understand and reflect the cultural and social contexts of the communities they serve.
- **Partnership working** – Embedding services within community spaces and building relationships strengthens trust and improves uptake.

Centre for Mental Health – pursuing racial justice in mental health (Jan 2024)

The Centre for Mental Health's report Pursuing Racial Justice in Mental Health highlights how racism harms mental health and creates barriers to support. It found that racism contributes to psychological trauma, anxiety, and depression, while structural inequalities—such as lack of interpreting, inaccessible information, and the impact of poverty—make it harder to access help. These findings align with what we have heard locally through Listen in, reinforcing the need for services that are culturally competent, proactive in building trust, and designed to dismantle systemic barriers.

Dept of Health and Social Care's mental health call for evidence (June 2022)

The key findings from our place-based response to the Department of Health and Social Care's mental health call for evidence, included promoting positive mental health, preventing mental ill-health, early intervention, improving mental health services, and promotion and availability of crisis services. Some of this aligns to what we heard through Listen in and making sure we connect community hubs to the Hope and Light service.

Appendix A – our partnership’s duties

Meeting name:	Bradford District and Craven Partnership Board		
Agenda item no:	6		
Meeting date:	5 September 2025		
Report title:	Place Lead's Update		
Report presented by:	Therese Patten, Place Lead for Bradford District and Craven		
Report approved by:	Therese Patten, Place Lead for Bradford District and Craven		
Report prepared by:	Victoria Simmons, Senior head of communications and involvement, NHS WY ICB (Bradford District and Craven)		
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 Bradford District and Craven 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.	WY West Yorkshire
3.	WY HCP West Yorkshire health and care partnership
4.	BD&C Bradford District and Craven
5.	DHSC Department for Health and Social Care
6.	NHSE NHS England
7.	ICP integrated care partnership
8.	AGH Airedale General Hospital
9.	ADHD attention deficit hyperactivity disorder
10.	SDB Strategy Delivery Board
11.	SEND special educational needs and disability
12.	HSJ Health Service Journal

National context and policy development

Launch of NHS 10 Year Plan – fit for the future

The government's 10-Year Health Plan has been published setting out a long-term vision for transforming health and care in England. Central to the plan are three major system shifts: from sickness to prevention, from hospital to community, and from analogue to digital. These shifts are intended to reorient the NHS around long-term population health improvement, greater use of technology, and care that is more integrated, proactive, and locally delivered.

The plan reinforces the role of Integrated Care Boards (ICBs) as strategic commissioners, with responsibility for ensuring that public resources are used to improve outcomes and experience for patients and communities. It places a strong emphasis on reducing health inequalities, strengthening neighbourhood teams, and embedding prevention throughout the health and care system. ICBs will be expected to lead long-term planning aligned to these shifts and to work closely with providers, local authorities and voluntary and community partners to ensure delivery reflects both national priorities and local context.

In West Yorkshire, the 10-Year Plan is being used as a key framework to shape future service models and commissioning functions. More than 78,000 people across West Yorkshire contributed to the development of the plan between November 2024 and May 2025, sharing their experiences, insights and aspirations for the future of care. This included both online and in-person engagement with local residents, staff and partners – including through a series of deliberative events held across Bradford District and Craven. A dedicated webpage has been set up as a dedicated hub to all of the insights, views, and good practice examples collected across West Yorkshire so far from the 10 Year Plan, with more analysis still to come, to support teams and partners get a head start on developing their response to the plan when it is published [What we've found out :: West Yorkshire Health & Care Partnership](#)

Closure of Healthwatch

In late June 2025, the government confirmed that Healthwatch England and all local Healthwatch organisations are slated for abolition under the recently published 10-Year Health Plan. Although full details are not confirmed, it is anticipated that their patient representation and feedback functions would be transferred to ICBs and/or local authorities.

Formal timelines are awaited pending legislation likely in late 2026, local Healthwatch have stated they will continue operations under existing statutory duties until any repeal of the 2012 Act.

NHS England & DHSC structures

Department of Health and Social Care (DHSC) and NHS England (NHSE) are moving towards a single merged structure, with a new national executive team announced in June 2025 and high-level organisational structure published. This includes 13 director generals, five national priority programme leads, and seven regional directors, some of whom will report jointly to both the DHSC Permanent Secretary and the NHS Chief Executive. This structural integration is expected to further align national priorities with local implementation.

Good Food Cycle launch in Bradford

On 15 July 2025, the government launched its national Good Food Cycle policy framework – with the launch event held at the newly opened Darley Street Market in Bradford. The event, attended by Food Minister Daniel Zeichner, highlighted ten priority outcomes for building a healthier, more sustainable, and affordable food system. Bradford was showcased for its innovative local food initiatives, including school-based growing, cooking, and inclusive food spaces, which align closely with the national objectives.

Impact of industrial action

Nationally, the recent industrial action by resident doctors caused widespread disruption to NHS services, with thousands of appointments and procedures rescheduled. NHS England reported that, despite the challenges, more appointments were protected compared with previous strikes through strengthened contingency planning and coordination across hospitals and community services. Bradford District and Craven partners worked together across the system to coordinate contingency plans, redeploy staff, and maintain safe services wherever possible. Thanks to the hard work and flexibility of teams in all parts of the system, the impact on patients was kept to a minimum, though the action inevitably added pressure to already stretched services.

National review into tackling LGBT+ health inequalities

NHS England has launched its first national review into tackling LGBT+ health inequalities, aiming to identify and address the barriers that LGBT+ people face in accessing high-quality care. The review will gather evidence from patients, staff, and community organisations to shape recommendations for improving services and reducing disparities in health outcomes. This work connects to findings our local *Listen In* report on LGBTQ+ communities, which highlighted themes and priorities at a Bradford District and Craven level.

West Yorkshire Health and Care Partnership activity

Medicines Waste Campaign: “Only order what you need”

Launched in early July 2025, the WY HCP campaign “**Only order what you need**” aims to reduce the estimated **£18 million** per year lost in West Yorkshire on unused medicines. It urges patients and carers to review their existing supplies before reordering, hand back any unneeded items when they collect their prescription from the pharmacy and avoid stockpiling. This effort not only conserves NHS funds but also reduces environmental impact and supports fairer distribution of essential medicines. [Only order what you need: West Yorkshire Health & Care Partnership](#)

Healthy Working Life programme launched

Healthy Working Life is the joint programme of the Combined Authority and the NHS West Yorkshire Integrated Care Board (ICB) that will deliver one of eight nationally funded trailblazers set out in the Government White Paper (November 2024 – [Getting Britain Working](#)). West Yorkshire will receive £37 million in total to deliver the programme which runs until April 2026.

This investment will enable us to work together to help us reduce health inequalities and improve health outcomes in some of our most deprived communities.

[Healthy Working Life :: West Yorkshire Health & Care Partnership](#)

In Bradford District and Craven, we will be providing support to our population and the health and social care workforce, to help them manage their health in a workplace environment. Our pilot projects will:

- support people experiencing pain, musculoskeletal problems, and people with certain mental health conditions;
- provide person-centred support for health and social factors which involves both NHS medical and other community-based support;
- be based on the needs of the person (symptoms rather than disease led); and
- provide a range of entry points to the services (including self-referral) so people can access support in a way that is responsive to their needs.

Routes & Routines: Support for Children, Young People & Families

In June 2025, WY HCP launched “Routes & Routines”, a resource suite co-produced with families to aid neurodivergent children and young people (especially those with autism or ADHD) in transitioning between school and home. Part of the #LetsConnect campaign within the children’s services plan, it includes videos and practical tools designed to empower families with routines and strategies to promote wellbeing and educational stability. [Routes and Routines: a resource for children, young people and their families :: West Yorkshire Health & Care Partnership](#)

Weight Management – NHS Rollout of Mounjaro (Tirzepatide)

As part of the government's focus on prevention and early intervention, a phased NHS rollout of tirzepatide (Mounjaro) began in June 2025. This new weight management medication is being introduced through a small number of GP practices in line with national eligibility criteria. Patients must have a BMI of 40 or more (lower for some ethnic groups) and at least four serious weight-related health conditions, and must also participate in a structured support programme that includes healthy eating and physical activity. There is no need for individuals to contact their GP—eligible patients will be contacted directly by their practice or the NHS. [Mounjaro® \(tirzepatide\) and weight management in West Yorkshire :: West Yorkshire Health & Care Partnership](#)

Acting Chair – NHS West Yorkshire ICB

On 1 June 2025, Prof. Nadira Mirza was appointed as Acting Chair of the NHS West Yorkshire Integrated Care Board for six months. Previously non-executive member for Citizens and Future Generations, Prof. Mirza brings over 25 years of leadership experience in health and education, reinforcing the ICB's focus on equity and inclusion during the search for a permanent chair—paused amid broader system restructuring. [Appointment of Acting Chair, NHS West Yorkshire Integrated Care Board :: West Yorkshire Health & Care Partnership](#)

ICB running cost reductions and organisational change

As part of the government's restructuring of the NHS landscape, NHS West Yorkshire ICB continues to progress the actions required to meet national expectations around cost reduction and structural reform. Following the submission of West Yorkshire's proposed structure on 30 May 2025, the ICB is still awaiting formal feedback from NHS England. In the meantime, engagement with partners and system leaders has taken place throughout July and August to explore what the new ICB model should look like.

NHSE model region blueprint is not expected until the end of August 2025 and will be shared in a future update once published. This document will be important in testing whether the assumptions made about the ICB's future functions are consistent with plans for the future role of regions, and whether staff will transfer directly into NHS England in areas such as provider oversight, digital and workforce. It will also have implications for providers, particularly in relation to operational workforce, operational digital and provider oversight arrangements. Following the formal submissions of every ICB plan on 30 May 2025, further detail was requested and submitted by all ICBs earlier this summer. NHSE is now working through these submissions, and feedback is expected after the NHSE model region blueprint is published.

There is no expectation of national resources to fund a voluntary redundancy scheme in 2025/26, and the mechanisms for funding compulsory redundancy have

yet to be clarified. A clear position on redundancies will be needed before a launch date for staff consultation can be confirmed. No expressions of interest process will run at this time.

Clarity is also awaited from NHSE on the national process for the recruitment of ICB Chairs.

At its August meeting, the Transition Committee discussed these issues and agreed to write to NHSE confirming that consultation with staff cannot launch on 3 September as planned due to the number of unknowns. At this stage, there is no agreed amended launch date.

Bradford District & Craven Partnership progress and issues to note

GP IT systems outage

On 28 July 2025, a business continuity incident was initiated due to an outage which caused significant disruption to GP clinical and business systems across Bradford District and Craven. The outage lasted for several days, limiting access to patient records, appointment scheduling, and other essential functions. During this period, system partners came together to coordinate the response, identify and implement appropriate workarounds, and ensure that urgent referrals and other critical processes could still be managed. GP practices used business continuity measures to maintain urgent care, but some routine services were delayed. As part of the agreed approach to enable technical teams to focus on the fix, Enhanced Access provision was cancelled over the weekend of 2/3 August.

Following intensive work to identify the root cause, implement and test solutions, most systems were back online on Monday 4 August. While this marked the end of the immediate disruption, some practices continue to work through the resulting backlog. Next steps include a system-wide review to identify learning, strengthen contingency plans, and address the underlying issues to reduce the risk of recurrence.

Leadership update

Helen Farmer has left her role as Director of System Transformation within the ICB to take up a new joint position as Director of Collaboration at Bradford Teaching Hospitals NHS Foundation Trust and Airedale NHS Foundation Trust. We thank Helen for her leadership and contribution to system working and wish her well in her new role.

Bradford District and Craven Health, Care and Wellbeing Strategy

Our Health, Care and Wellbeing Strategy for Bradford District and Craven sets a clear direction for our shared priorities at place. It outlines the intended impact of the

integrator function within the context of system transformation and partnership working.

The strategy draws on strong population health intelligence from our Business Intelligence and Reducing Inequalities teams, incorporates insight gathered through the Listen in engagement programme, and is informed by the wider context of financial and estates challenges. It represents a collaborative effort across partners and sectors.

The draft has been presented to a number of governance forums, including the Bradford Wellbeing Board, the West Yorkshire Integrated Care Board, and local NHS Trust Boards. The final document will be shared more widely following formal approval at the Bradford District and Craven Partnership Board in September 2025.

Neighbourhood health programme application

In early July, DHSC and NHSE launched the National Neighbourhood Health Implementation Programme (NNHIP), a 12-month initiative to accelerate the roll-out of neighbourhood health services across communities in England. Bradford District and Craven, alongside Leeds and Wakefield, has submitted an application to join the first wave.

The programme takes a ‘test, learn and grow’ approach, with an initial focus on adults living with multiple long-term conditions and co-morbidities, and includes:

- wrapping single, named multi-disciplinary teams around communities, people and households
- activating resourcefulness of individuals and making better use of technology
- empowering community-led and owned initiatives
- supporting a systematic approach through governance, financial flows and IT.

NHSE has indicated that applicants will be notified of the outcome in early September. Our application is closely aligned with the ambitions of the Bradford District and Craven health, care and wellbeing strategy, particularly in tackling health inequalities and strengthening neighbourhood working.

Establishment of Strategy Delivery Boards

As part of ongoing efforts to align system resources with our core priorities, three new **Strategy Delivery Boards (SDBs)** are being established. These will provide structured oversight and coordination for the following areas:

- Integrated acute care
- Integrated neighbourhood health
- Integrated corporate support and closing the gap

Over the coming weeks, each board will develop its scope and terms of reference. This work will help to clarify how we are deploying our limited capacity to focus on priority areas, while also enabling other partners across the system to lead in areas where they are best placed to do so.

These boards will operate within the wider governance landscape and are not intended to replace existing statutory or operational groups. Functions such as the SEND governance arrangements and the Urgent and Emergency Care Board will continue as required, alongside other task-specific and time-limited groups established to support programme delivery.

Long COVID-19 self referral service

A dedicated long COVID service in Bradford District and Craven treats symptoms like fatigue and heart palpitations. Since 2021, it has helped over 1,500 people. In July 2025, a self-referral service launched for patients in Primary Care Networks covering the central Bradford areas with highest incidence, offering online therapy groups and face-to-face support to reduce symptoms and aid recovery. Over the next year, this service will be open to all residents of Bradford District and Craven. Visit bdcpartnership.co.uk/long-covid-service/

Lung health checks

Lung health checks, part of the lung cancer screening programme, are being rolled out to eligible people in parts of Bradford District and Craven to help detect lung cancer sooner through the NHS mobile CT scanning service. In May and June 2025, the partnership hosted two lung health events with giant lungs alongside Roy Castle Lung Cancer Foundation and continues to run geo-targeted Meta advertising - resulting in fully booked lung health check appointments in the last three locations. [Inflatable lungs touring Bradford District to promote lung cancer screening - Bradford District and Craven Health and Care Partnership](#)

RIA team members present at this year's NHS ConfedExpo

Members of the Reducing Inequalities Alliance, Sohail Abbas, Jo Howes and Jill Duffy have taken part in the session: 'Making prevention everybody's business: community-led prevention' at this year's NHS ConfedExpo in Manchester. They shared details on the partnership's work to deliver local, small-scale health and wellbeing projects via NHS England's CORE20Plus5 programme, which aims to support children and adults who are vulnerable to health inequalities. Some of the projects include community health checks and myHappyMind, a mental health project for primary school children.

New Chair announced for Airedale

On 1 August 2025, Airedale NHS Foundation Trust welcomed John Lawlor OBE as its new Chair. John brings extensive NHS leadership experience, including previous roles as Chief Executive of Harrogate and District NHS Foundation Trust and of

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. The Trust highlighted John's deep knowledge of the West Yorkshire system and commitment to working with staff, patients, and partners to deliver high-quality, compassionate care for the communities Airedale serves.

John succeeds Andrew Gold, whose term as Chair concluded in September 2024, and Dr Andy Withers who provided interim leadership in his role as Deputy Chair - we'd like to take this opportunity to thank Andy for his leadership and input to the Partnership Board during this time.

Public invited to help shape design of new Airedale Hospital

Airedale NHS Foundation Trust has launched a public engagement exercise inviting local people to help shape the design of the new Airedale Hospital. The Trust is seeking views on what matters most to patients, visitors, and staff in creating a modern, sustainable facility that meets future healthcare needs. Feedback will be gathered through drop-in events, surveys, and community outreach, and will inform the development of the hospital's design ahead of a formal planning application.

New antenatal maternity clinic in Bradford

Bradford Royal Infirmary has opened a newly created antenatal maternity clinic designed to improve care for pregnant women and families. The clinic brings together a range of services in one location, enabling easier access to specialist care, reducing waiting times, and providing a more comfortable and welcoming environment. It forms part of the hospital's ongoing investment in maternity services, ensuring personalised, high-quality care for expectant parents across Bradford.

Bradford District Care Trust awarded Veteran Aware accreditation

Armed Forces veterans in Bradford District and Craven can expect high standards of care following Veteran Aware accreditation for Bradford District Care NHS Foundation Trust. The accreditation recognises the Trust's commitment to improving care for veterans, including staff training, signposting to support, and tailored mental health services.

Airedale Hospital Pride of Airedale Awards

Staff members and volunteers from across Airedale NHS Foundation Trust and AGH Solutions were honoured at a special event last week (5 June). The Pride of Airedale awards were created to recognise the amazing hard work and dedication staff at the Trust have shown over the past year.

Health visiting team achieves UNICEF gold

The Health Visiting team at Bradford District Care NHS Foundation Trust has been awarded UNICEF's most prestigious award, marking their continuing excellence in supporting local families with feeding and developing close, loving relationships with their babies.

JU:MP programme success in Bradford

The JU:MP programme is delivering world-leading results in Bradford! New research from Born in Bradford and the University of Bradford, shows that Active Bradford's programme improved children's total physical activity by over 70 minutes per week - bigger than any other long-term population level physical activity intervention for children.

JU:MP has reached over 30,000 children and families over five years through community-led interventions and Sport England has renewed its commitment to Bradford with a new £4 million investment and three-year partnership. The success is credited to a place-based way of working that brings together local organisations and leaders who understand their communities' specific needs, with Sport England having invested around £12 million in this approach in Bradford since 2018.

HSJ award short list announced

We are delighted to see Bradford District and Craven teams and projects shortlisted in this year's HSJ Awards. Congratulations and good luck to all those shortlisted:

- **Digitising Primary Care Award:** Bradford District Care NHS Foundation Trust and Bradford District & Craven Health and Care Partnership – improving the patient experience in talking therapies with clinical AI
- **HSJ Partnership of the Year:** DrDoctor and Bradford Teaching Hospitals – rheumatology nurse advice line
- **Staff Wellbeing Award:** Bradford Teaching Hospitals NHS Foundation Trust – outstanding theatre service

NHS West Yorkshire ICB

Bradford District & Craven Place Financial Position

Month 04 2025/26



Bradford Place Month 04 Financial Position



Bradford Place - Month 04 Financial Position



NHS West Yorkshire
Integrated Care Board

Organisation	YEAR TO DATE - M4			FORECAST - M01 to M12		
	I&E reported Month 4 25/26			I&E forecast		
	Plan £m	Actual Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m
Bradford ICB	1.6	(1.1)	(3)	4.7	(0.3)	(5)
Airedale NHS Foundation Trust	(5.3)	(6.8)	(2)	(3.6)	(3.6)	0
Bradford District Care NHS Foundation Trust	(0.8)	(0.7)	0	2.0	2.0	0
Bradford Teaching Hospitals NHS Foundation Trust	(7.8)	(8.3)	(1)	(2.7)	(2.7)	0
Bradford Place Total	(12.3)	(16.9)	(5)	0.4	(4.6)	0

Organisation	YTD Plan	YTD Saving	YTD Variance	Annual Plan	Forecast Saving	FOT Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Bradford ICB	6,265	4,345	(1,920)	18,804	18,804	0
Airedale NHS Foundation Trust	4,438	3,186	(1,252)	23,100	20,335	(2,765)
Bradford District Care NHS Foundation Trust	4,606	3,939	(667)	18,346	18,345	(1)
Bradford Teaching Hospitals NHS Foundation Trust	9,058	4,235	(4,823)	38,300	38,300	0
Total	24,368	15,705	(8,663)	98,550	95,784	(2,766)

Proud to be part of West Yorkshire
Health and Care Partnership

ICB in Bradford and Craven Month 04 – Key headlines

Overall, the forecast deficit has increased since month 3 by £1m. This movement is made up of the following:

Acute – Deterioration of £1.3m from month 3.

- £0.7m of this relates to Oviva Weight Management activity. Based on the activity received to date, a straight line forecast indicates a £1m overtrade. However, work is progressing across West Yorkshire for tighter control of activity and it is currently assumed that some benefit of this will be delivered within the last quarter of the year.
- £0.6m independent sector activity – as a result of the delay in implementing indicative activity plans for the IS contracts, there has been a YTD overtrade against the plan. It is currently assumed that the contract will trade in line with the IAPs for the rest of the year.

MH – Deterioration of £0.7m

- This is solely as a result of the high number of right to choose ND assessments that we are receiving invoices for. That budget is forecast to overtrade by £1.5m however there are under trades in other services that are mitigating the risk to £0.7m.

CHC – remains the same

Even though this has not moved, there has been a significant amount of work undertaken throughout the month in order to assure the forecast. The current year forecast is currently predicted to be in line with budget however there are significant prior year costs being seen as the payment arrangement with the local authority is being brought to a close. Work is still ongoing to understand and assure these charges.

Programme Reserves – Improvement of £0.7m from month 3.

- £0.2m weight management drug funding – the place received an allocation to support with weight management. Part of this was to support with service costs for weight management and part for the drugs costs. At month 4, the drug element was released to offset the increasing Oviva costs (includes recharges for drugs).
- £0.5m non-recurrent WY flexibility – the Bradford and Craven place received their fair share of a non-recurrent prior year benefit identified for West Yorkshire.

Other - Improvement of £0.4m from month 3

- This improvement relates to ongoing staffing savings as a result of the organisational change and vacancy freeze.

Bradford District Care Foundation Trust Month 04 – Key Headlines



NHS West Yorkshire
Integrated Care Board

Financial Position

We are reporting slightly better than plan at Month 4, and at this early stage in the year we are forecasting to meet our planned surplus of £2m at the year end and actively scoping plans to fully de-risk the position.

In support of the wider ICS to deliver financial balance, the Trust has agreed its indicative shares of the WY ICS gap of £33.2m, with BDCFT share of this being £2m (BD&C Place share - £12m). The plan has been updated to reflect the stretch target in Month 4 reporting, with the Trust now planning for a £2m surplus and a £18.3m efficiency programme.

The Place approach to address the additional £12m efficiency will target improvements through 3 structured work programmes. The Integrated Neighbourhood Care (INC) work programme will support the BDCFT and Place ICB to deliver their savings targets. Local plans are also being developed to cover the risk that the INC programme savings are not realised in year.

The main risk area in achieving the financial position is the delivery of the efficiency programme, with a likely risk that plans will be offtrack by £4.4m. The drivers of risk continue to be demand for mental health inpatient services and patient acuity which is driving higher than planned levels of out of area placements and temporary staffing spend.

In addition to the efficiency delivery risk, there are further risks in MH Provider Collaboratives; pay award funding gap and depreciation funding, taking the gross risk that requires focused attention to £6.2m. After taking account of the planned contingency of £3m, net risks are £3.2m.

Plans continue to be developed to target solutions to fully de-risk the position, with plans in the pipeline expected to reduce the risk over the coming months.

Focus is now turning to the planning activities for 2026/27 and the 5 year medium term financial plan. The underlying deficit going into 2026/27 is c£5m, mainly from non recurrent and undelivered CIP programmes. A high level estimate of the efficiency target for 2026/27 is between c£12m and c£15m.

Capital Expenditure

The Trust is confident that the operational capital programme will be delivered as planned.

Work is underway to develop the Full Business Case for Lynfield Mount, indicative PDC of £25m is included in the 25/26 programme for the draw down from the earmarked national £50m funding. Discussions are underway with DHSC to reprofile costs in line with the new timeline/ cost profile, which will significantly change the profile of spend in 2025/26.

The total costs for the LMH Capital development are expected to be in the region of £65m. A direct award will be made for the new Modular build, costs will be known during September; and tenders are live for the refurbishment element of the business case, with tenders due back early November. BDCFT have received confirmation that WY ICS will provide support for the additional £15m capital needed to fund the development, through ICS operational capital over the term of the development.

Bradford Teaching Hospitals Month 04 – Key Headlines

While the overall position for M4 remains on plan, a year-to-date adverse variance of £1m has been reported. The swing in the YTD position this month is due to costs incurred to cover the recent industrial action and lost ERF income due to cancellations on strike days.

Additional financial controls and non-recurrent efficiencies or technical solutions are being investigated to mitigate the adverse financial impact of the industrial action. Far fewer elective and outpatient activities were cancelled during July's strike than in previous years' periods of industrial action, which has minimised the estimated ERF impact in the reported M4 position.

If further periods of industrial action are taken by either the Resident Doctors or other staff groups, it will become increasingly difficult to absorb the additional costs and lost income within the I&E plan.

The delivery of our closing the gap plan is behind where the plan at M4, due to schemes starting later than originally planned, but is being offset by underspends in other areas.

Actions taken to deliver the financial plan:

- An Exec led, multidisciplinary Closing The Gap steering group met for the first time in July with a further meeting scheduled for September.
- Accountability meetings happening with CSUs where forecasts are off plan.
- Increased CTG reporting, included risk rated delivery.
- Identification of further schemes to close the risk rated gap.
- Review of recording and coding to reduce ERF risk.
- Collaboration with Airedale and BDCT to identify savings to offset any risks attached to the share of £33m ICB improvement.
- Reviewing the finance training for budget holders and updating to shift focus from budget, actual, variance, to forecast, run rate and CTG delivery.
- Continued focus on the use of temporary staffing, and additional support to CSUs to help them reduce sickness levels.

West Yorkshire ICS Month 04 Financial Position



West Yorkshire ICS Financial position - Month 04



NHS West Yorkshire
Integrated Care Board

	YEAR TO DATE - M4			FORECAST - M01 to M12						
	I&E reported Month 4 25/26			I&E forecast			Scenarios - Organisation assessment			
Organisation	Plan £m	Actual Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m	Best Case Variance £m	Likely Case Variance £m	Likely Case (Mitigated) £m	Worse Case Variance £m
Bradford ICB	1.6	(1.1)	(2.7)	4.7	(0.3)	(5.0)	(3.1)	0.0	(5.0)	(23.8)
Calderdale ICB	1.5	1.6	0.1	4.4	4.9	0.5	0.0	0.0	0.5	(2.6)
Kirklees ICB	2.9	2.9	0.0	8.7	8.7	0.0	0.0	0.0	0.0	(7.1)
Leeds ICB	1.7	(0.1)	(1.8)	5.2	5.2	0.0	0.0	0.0	0.0	(23.4)
Wakefield ICB	0.9	(0.7)	(1.6)	2.6	0.4	(2.2)	0.0	0.0	(2.2)	(13.9)
WY ICB	(3.4)	(0.5)	2.9	(10.1)	(3.4)	6.7	3.2	0.0	6.7	18.1
West Yorkshire ICB Total	5.1	2.1	(3.1)	15.4	15.4	(0.0)	-	-	-	(52.7)
Airedale NHS Foundation Trust	(5.3)	(6.8)	(1.5)	(3.6)	(3.6)	0.0	0.0	0.0	(12.5)	(15.9)
Bradford District Care NHS Foundation Trust	(0.8)	(0.7)	0.1	2.0	2.0	0.0	0.0	0.0	(3.3)	(4.0)
Bradford Teaching Hospitals NHS Foundation Trust	(7.8)	(8.3)	(0.5)	(2.7)	(2.7)	0.0	0.0	0.0	(4.2)	(19.0)
Calderdale And Huddersfield NHS Foundation Trust	(2.4)	(2.4)	0.0	(3.0)	(3.0)	0.0	0.0	0.0	0.0	(21.5)
Leeds and York Partnership NHS Foundation Trust	0.0	0.1	0.1	0.0	0.0	0.0	0.9	0.0	0.0	(3.2)
Leeds Community Healthcare NHS Trust	0.0	0.1	0.1	0.0	0.0	0.0	0.6	0.0	0.0	(2.3)
Leeds Teaching Hospitals NHS Trust	(12.8)	(18.4)	(5.6)	0.0	0.0	0.0	0.0	0.0	(54.2)	(101.8)
Mid Yorkshire Hospitals NHS Trust	0.9	(1.4)	(2.3)	(8.1)	(8.1)	0.0	0.0	0.0	(3.9)	(16.1)
South West Yorkshire Partnership NHS Foundation Trust	(2.4)	(2.0)	0.4	0.0	0.0	0.0	0.0	0.0	0.0	(9.9)
Yorkshire Ambulance Service NHS Trust	0.4	0.8	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
West Yorkshire Provider Total	(30.1)	(38.9)	(8.8)	(15.4)	(15.4)	-	1.5	-	(78.0)	(193.7)
West Yorkshire ICS Total	(25.0)	(36.8)	(11.9)	0.0	0.0	(0.0)	1.5	-	(78.0)	(246.4)

Proud to be part of West Yorkshire
Health and Care Partnership

West Yorkshire ICS Month 04 – Key Headlines

West Yorkshire Integrated Care System (ICS)

- The month 4 **year-to-date** position for the ICS was an **actual £36.8m deficit** against a **planned £24.9m deficit**; a shortfall/adverse variance against plan of **£11.9m**.
- The month 4 adverse variance of **£11.9m** has deteriorated from the adverse variance at month 3 of **£4.0m**, a deterioration of **£7.9m**.
- The deterioration in month is driven predominantly by **£3.7m cost of industrial action** which will not be covered by national funding, and **£3.2m of pay overspends**.
- The other drivers of the month 4 adverse variance continue to be **slippage on delivery of waste reduction/efficiencies**, part offset by underspends in other areas.
- Above position includes **assumed receipt of Deficit Support funding of £16.4m** (4/12ths of total annual value of £49.2m)
- The ICS continues to forecast a balanced plan to NHSE at Month 4 (based on receipt of £49.2m deficit support funding).

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	7b
Meeting date:	5 September 2025
Report title:	Performance Report
Report presented by:	Kerry Weir, Associate Director Planning, Performance & Business Intelligence, WY ICB (Bradford District and Craven)
Report approved by:	Mike Woodhead, Lead Director of Finance, Bradford District & Craven Health & Care Partnership
Report prepared by:	Kerry Weir, Associate Director Planning, Performance & Business Intelligence, WY ICB (Bradford District and Craven)

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate)	Information ☐
Previous considerations:			
An update on our 2025/26 operational plans was presented to the board in May 2025.			
Executive summary and points for discussion:			
The following gives an update on progress against plans and includes reference to winter planning for 2025/26, as presented in Appendix 1. Key points to note are: Performance - Elective recovery is ongoing and performance against the 18-week national target continues to improve. However, the number of patients waiting over 52+ weeks, whilst below plan, is increasing with plans in place at Bradford Teaching Hospital Trust (BTHFT) to address ongoing issues in Ear Nose and Throat and Respiratory Medicine. Activity at BTHFT continues to be impacted by the Day Case Unit delay and despite the Community Diagnostics Centre continuing to provide capacity for all commissioned modalities, diagnostic performance remains a concern; - Whilst there have been some challenges delivering the cancer 2-week wait standard, both Trusts are delivering the 28-day faster diagnosis standard and 31-day cancer performance is in line with plans. Delivery of the 62-day 85% national standard remains the biggest challenge predominantly due to complex diagnostic pathways, patients needing multiple investigations and/or MDT discussions before a treatment can commence, patient compliance (mainly in gynaecology and urology) and delays in reporting histology; - There was a further improvement in A&E 4-hour performance at Airedale NHS Foundation Trusts (ANHSFT) in July although pressures remain high due to increased patient acuity and attendances exceeding planned levels. Performance against the 12-hour total time in			

department target in July was better than plan and average ambulance handover times also continue to improve;

- Whilst bed occupancy levels remain above the maximum target of 92% at ANHSFT, they continue to be below recent average levels as the Trust reduces patients with a length of stay of 21 days or more and those not meeting the criteria to reside. The % of patients discharged at their discharge ready date (DRD) and the average number of days delayed (post DRD) were better than plan at both Trusts in June, although care capacity in the Local Authority continues to have an impact;
- Delivery of the operational planning mental health and learning disability trajectories remains better than plan in June with a significant improvement in inappropriate out of area mental health placements compared to the end of March;
- There has been 1.2 million GP appointments year to date to June, of which 88% were seen within 2 weeks. This is slightly below our planned position. We have been delivering a high number of appointments for a significant time, and whilst we still deliver a high rate, we are now encouraging increased quality over quantity;
- Both adult and children and young people's Community Services waiting lists continue to increase with pressures in dietetics, physiotherapy and speech & language. However, our Urgent Community Response services continue to see over 90% of patients within 2 hours, avoiding A&E/hospital admission, which remains better than the national and West Yorkshire averages; and
- Delivery of workforce trajectories remains in line with plans, with all 3 Trusts focussing on improving retention and reducing the use of temporary staffing. To promote staff health and wellbeing and reduce sickness/absence rates, there is a range of support available including occupational health, mental health first aiders, physiotherapy services, peer support and wellbeing/people experience champions. Staff are also supported to receive their Covid-19 and flu vaccines to reduce the likelihood of staff absence due to outbreaks.

Winter planning

- National guidance sets out a number of strategic priorities which winter plans should address in 2025/26, alongside a set of key performance indicators;
- There are also a set of additional requirements that plans must cover in relation to: Respiratory Pathways; Community Pharmacy & Vaccination; Mental Health Crisis Response; Infection Prevention & Control; Elective Care & Diagnostics; Communications & Engagement; and Governance & Oversight;
- Delivery of these requirements is being supported nationally via improvements in digital & data infrastructure, capital investment of £370m, a focus on prevention and community and performance management;
- Our system winter plan has been refreshed in line with the above national guidance (in the format of a West Yorkshire ICB template). Development and sign off of the plan is undertaken by the Bradford District & Craven (BDC) Urgent Care Board (UCB), a multi-partner group, on behalf of the Health & Care Partnership (HCP);
- Overall performance will be reviewed at the System Finance & Performance Committee and key quality risks e.g. infection control and vaccination uptake are considered by the System Quality Committee. The UCB will continue to have oversight of system winter pressures and delivery against plan; and

West Yorkshire ICB is requesting that assurance is provided by the 5 place-based HCPs to support the sign off of a West Yorkshire plan (Appendix 2).

Outline how this supports our partnership vision and strategy

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

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

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

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

Recommendation(s)

The Bradford District and Craven Partnership Board is asked to:

1. Note the update on performance and winter planning; and
2. Approve the Winter Board Assurance submission to West Yorkshire ICB

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:

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.

Appendices

1. Planning and Performance Update
2. Winter Board Assurance Statement

Acronyms and Abbreviations explained

1. HCP - Health & Care Partnership
2. BDC – Bradford District & Craven
3. ANHSFT - Airedale NHS Foundation Trust
4. BTHFT - Bradford Teaching Hospitals Foundation Trust
5. DRD - Discharge Ready Date
6. ICB – Integrated Care Board
7. MDT - Multidisciplinary Team
8. UCB - Urgent Care Board

What are the implications for?

Residents and Communities	Delivery of services that fulfil NHS constitutional requirements, meet the needs of the population, and improve population health
Quality and Safety	Delivering high quality and safe services
Equality, Diversity and Inclusion	Services accessible to all
Finances and Use of Resources	-
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	-

Planning & Performance Update

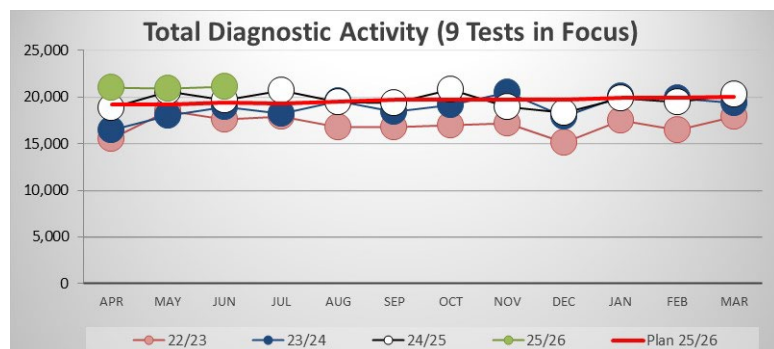
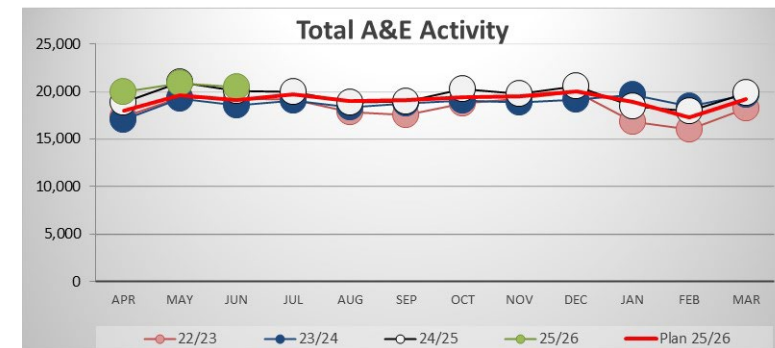
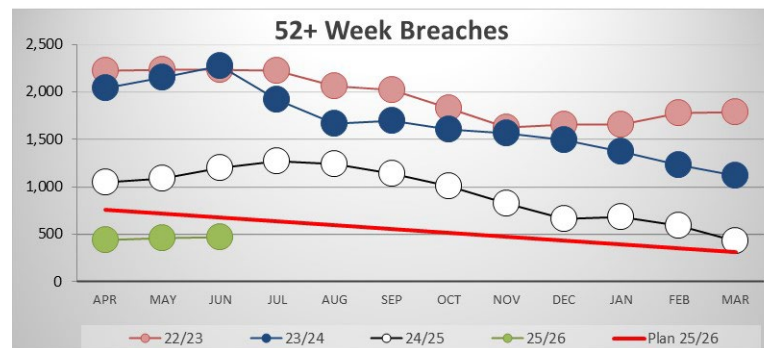
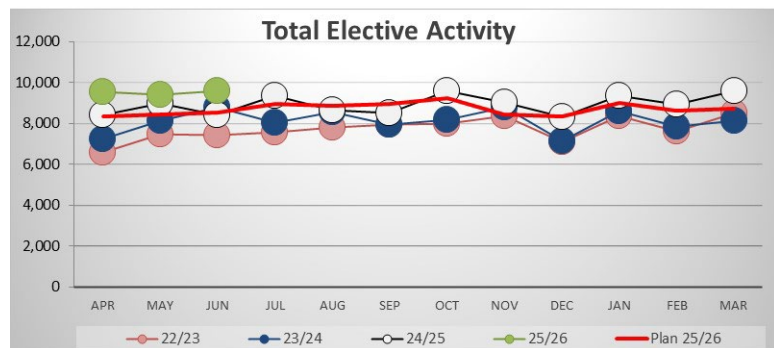
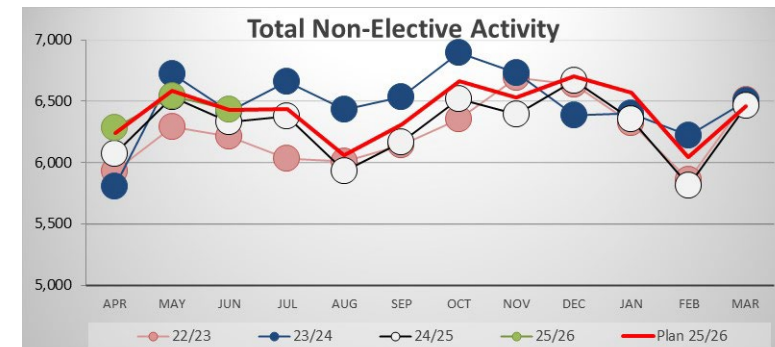
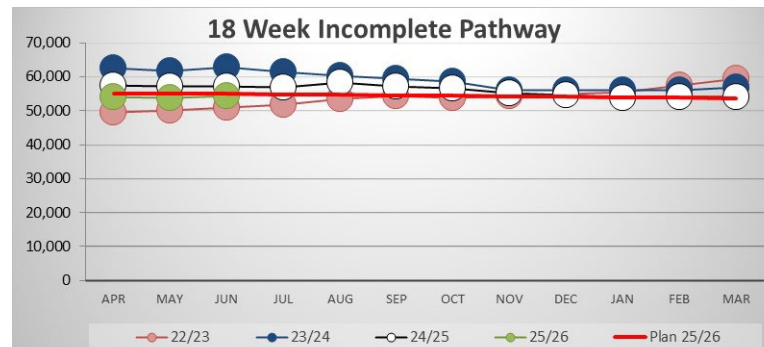
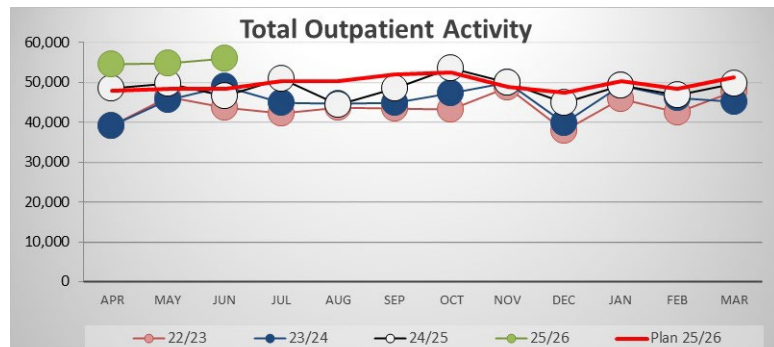
Bradford District and Craven Partnership Board

5th September 2025



Elective Recovery

Latest Bradford District & Craven (BDC) June 2025 position



- **Referral to Treatment (RTT) target:** Performance continues to improve and the overall 18-week waiting list remains below planned levels.
- **52+ week breaches:** The number of patients waiting over 52+ weeks, whilst below plan, is increasing, mainly at Bradford Teaching Hospital Trust (BTHFT), The Yorkshire Clinic (YC) and Leeds Teaching Hospitals NHS Trust (LTHT). Recovery plans are being intensively supported by colleagues within the Senior Operations Leadership Team at BTHFT to address ongoing issues in Ear Nose and Throat (ENT) and Respiratory Medicine but the number of long waiters in Trauma & Orthopaedics (T&O) continues to reduce following similar support. Recovery plans includes a combination of mutual aid, additional capacity, pathway improvements and the use of outsourcing to the independent sector (IS) where necessary.
- **Activity:** Overall elective activity is in line with planned levels although activity at BTHFT remains challenged due primarily to the Day Case Unit delay. Mitigation includes weekend lists and activity is forecast to increase in line with this work during July.
- **Diagnostics:** Performance continued to fall in June with pressures remaining in Non-obstetric Ultrasound (NOUS), Audiology, Echo-cardiology and Endoscopy. Performance remains a concern at BTHFT, and activity is also below plan despite the Community Diagnostics Centre (CDC) continuing to provide capacity for all commissioned modalities. All recovery and long-term sustainability plans have been reviewed and additional assurance sought from the operational leads for each area on the associated timescales.

- **Faster diagnosis (FDS):** Airedale NHS Foundation Trusts (ANHSFT) cancer 2-week (2WW) wait performance continues above target, driven by the improvement plan in the Breast Service which has delivered in line with expectations. BTHFT's performance is forecast to be 82.9% in June, with ongoing issues in Breast, Gynaecology, Haematology, Head & Neck and Lower GI. Additional one stop clinics for Breast are taking place in August to help improve their 2WW position. Patient compliance remains a challenge with initiatives such as proactive phone calls to patients likely to DNA, bus tickets to encourage attendance and targeted engagement work in Endoscopy in place. DNA rates have reduced recently as a result. Both Trusts are delivering the 28-day FDS standard.
- **31 days:** Performance is in line with plans and just below the 96% national standard.
- **62-days:** Delivery of the 62-day 85% national standard remains the biggest challenge. Performance at BTHFT was above plan in May but is showing deterioration with growth in 62-day breaches, predominantly due to complex diagnostic pathways, patients needing multiple investigations and/or MDT discussions before a treatment can commence, patient compliance (mainly in gynaecology and urology) and delays in reporting histology. Civica go live remains planned from September. Benefits include Personalised Stratified Follow Up (PSFU) and digital remote monitoring system (RMS) for patients after cancer treatment, which will reduce unnecessary follow-ups. Civica will also provide the data needed to better review services against best practice time pathways and identify areas for further improvement, building on existing pathway improvement and MDT optimisation workstreams. ANHSFT's performance for June was above the 2025/26 planning requirement of 75%.

Urgent care

- **4-hour A&E waiting time:** There was a further improvement in A&E 4-hour performance at ANHSFT in July to 72.8%. However, pressures remain high due to increased patient acuity and attendances exceeding planned levels. Of particular concern is the sustained volume of very urgent cases, which remain at winter levels. The Trust has implemented several actions, including opening 14 additional surge beds, extending Urgent Treatment Centre (UTC) hours, and launching the W45 (withdraw at 45 minutes) ambulance handover collaborative. Whilst daily attendances have also increased at BTHFT, performance has remained stable at circa 83%.
- **12 hour waits:** ANHSFT's performance against the 12-hour total time in department target in July was better than plan. Oversight of long waiting patients in the department and ambulance handover performance is provided at the 4 times daily site meetings. BTHFT also saw an improvement in performance supported by an increase in Acute Medical Unit (AMU) discharges helping to reduce AMU bed waits. The Ambulatory Emergency Care Unit (AECU) also continues to positively impact on a range of ED and hospital admission metrics.
- **Average ambulance handover times:** Average ambulance handover times also continue to improve. The launch of the W45 initiative at ANHSFT has had a positive impact. W45 includes the increased use of 'fit to sit' and self-handover processes, the application of surge and escalation protocols within ED, and a coordinated response across the wider Trust. The W45 initiative will be rolled out at BTHFT at the beginning of September.

Urgent care

- **Bed Occupancy:** Whilst bed occupancy levels remain above the maximum target of 92% at ANHSFT, they continue to be below recent average levels. This is partially attributed to the reduction in patients with a length of stay (LoS) of 21 days or more which is largely driven by a continued reduction in patients not meeting the criteria to reside (NCTR). BTHFT bed occupancy for June reduced to 88.9%. This is better than forecast levels and aligned to improvements in LoS and timely discharge, alongside seasonal changes. Work is underway to embed a new LoS process utilising Consultant, Complex Discharge Lead & Patient Flow Clinical Lead support, which aims to support wards to challenge existing processes and implement alternative solutions to improve early discharge.
- **Discharges:** The % of patients discharged at their discharge ready date (DRD) and the average number of days delayed (post DRD) were better than plan at both Trusts in June. Delays continue to be associated with Pathway 1 (rehabilitation at home) patients due to care capacity in the Local Authority. ANHSFT has plans to open a winter ward to manage seasonal pressures, expand Discharge to Assess (D2A) models in North Yorkshire, and increasing day case rates across medical, surgical, and frailty pathways. Patients with NCTR at BTHFT, as a percentage of occupied beds remains at the improved levels. Home First (H-FAST) discharges remain at 4 per day (down from 6) due to ongoing BEST team staffing constraints. Recruitment to expand therapy resources is expected to be fulfilled by the end of June 2025, with start dates to be confirmed.
- **Virtual ward capacity:** Bed occupancy has fallen in the past 2 months to 70.5% in June (below plan). There were 265 admissions in June of which 50% were step down from inpatient beds to support hospital flow.

Mental Health (MH) & Learning Disabilities (LD)



- **Inappropriate out of area (OOA) placements:** OOA bed days continue to reduce as result of Bradford District Care Foundation Trust's (BDCFT) Production and Purposeful Mental Health programme (18 in June) with no inappropriate OOA placements at the end of the month, a significant improvement on the 17 reported at the end of March.
- **Average Length of Stay in Adult Acute MH Beds:** There was also a reduction in the average LoS in June to below planned levels.
- **Access to Children & Young People's (CYP) MH services:** Access to CYP MH performance continues to be above plan with 12,035 CYP receiving at least one contact in the 12 months to June 2025.
- **Talking Therapies:** The percentage of patients reporting reliable recovery and improvement following access to Talking Therapy services remains above plan.
- **Perinatal:** June saw a further improvement in the numbers accessing Perinatal MH services, with the rolling 12-month position now 465 against a planned level of 350.
- **Individual Placement & Support (IPS):** In the 12-month period to June 2025, 370 individuals with mental health issues were supported to secure and maintain competitive employment against a plan of 247.
- **LD Health Checks:** June data continues to show delivery above plan for LD health checks.

- **GP appointments:** There has been 1.2 million GP appointments year to date to June, of which 88% were seen within 2 weeks. This is slightly below our planned position. Our primary care team is working with practices to improve appointment mapping and data quality, and this work will continue as we seek to identify and address any unwarranted variation. We have been delivering a high number of appointments in BDC for a significant time, and whilst we still deliver a high rate, we are now encouraging increased quality over quantity.
- **52+ week community waits:** The Adult Community Services waiting list has continued to increase to 8,129 at the end of May and the overall number waiting 52+ weeks, whilst below plan, is now 19. Nine of our 52+ week breaches are for dietetics, with 4 breaches for both physiotherapy and speech & language (S&L). The number of CYP on the waiting list has also increased to 2,417 at the end of May and the number waiting 52+ weeks increased from 5 in March to 9 (5 dietetics and 4 S&L).
- **Urgent Community Response:** There were 345 referrals to our Urgent Community Response (UCR) service in June, avoiding A&E/hospital admission, with 92% seen within 2 hours. This remains better than the national and West Yorkshire averages.

Workforce Planning

- **ANHSFT:** June WTE substantive workforce is 3550.45 against a plan of 3,309.35. However, the Trust has 278 hosted post that were not included in the 2025/26 plan, which, when excluded, bring numbers back in line. Bank spend was high in month 2 (although reduced from month 1) impacted by high demand on services through the Emergency Department and Acute Assessment Unit coupled with sickness absence in those areas. There is long term work to reduce the overall baseline of temporary staffing used; all temporary staffing is monitored weekly within the Trust with review to understand drivers and actions to control costs.
- **BTHFT:** June WTE substantive workforce is 6,729.24 against a plan of 6,794.31. The Trust expects substantive costs to continue to increase in the coming months while they continue to flip people from bank/agency to substantive, to ensure they meet their bank & agency targets.
- **BDCFT:** June WTE substantive workforce is 3,011.29 against a plan of 3,046.90. The run rates for substantive staff are back in line with the average at Month 3. The Trust is expecting substantive costs to increase over the year to reflect recruitment activities, with an offset with a reduction in bank costs.
- **Primary care:** There were 2331.8 WTE staff working in primary care against a plan of 2359.28.

Workforce Planning

- **Turnover:** Turnover rates were slightly higher than plan at ANHSFT in May (9.5% compared to a plan of 9.2%) The Trust is undertaking deep dives into the areas with high turnover to develop action plans and have a particular focus on flexible working given 'work life balance' is the biggest reason for individuals leaving and trialling different types of rostering etc. However, it is anticipated that turnover levels would likely increase given the national context which is reflected in their workforce plan KPIs.
- BDCFT also has work underway to support services with a higher turnover to understand what the route cause is and if there are any interventions from Organisational Development/People Services to help improve this in services with concerns.
- **Sickness/absence:** BTHFT sickness rates are reducing but currently remain high. The Trust is reviewing their sickness policies, following a focused week on workforce efficiency in June, and reducing sickness remains a priority for the People Committee and the organisation. BDCFT sickness rates were also above plan in May at 6.9% (6.3% plan).
- Across BDC there is a range of staff health and wellbeing support available including occupational health, mental health first aiders, physiotherapy services, peer support and wellbeing/people experience champions. Staff are also supported to receive their Covid-19 and flu vaccines to reduce the likelihood of staff absence due to outbreaks.

Winter 2025/26: Strategic Planning Priorities



System-Wide Goals

- Restore constitutional standards: 78% of A&E patients seen within 4 hours
- Ambulance response: Category 2 calls targeted at 30-minute average
- Mental health crisis care: No ED waits over 24 hours for a mental health bed

Key Priorities

- Eliminate corridor care and handover delays (max 45 minutes)
- Accelerate discharge: Reduce 30,000+ long-stay patients (21+ days)
- Expand urgent care capacity outside hospitals:
 - Virtual wards
 - Same Day Emergency Care (SDEC)
 - Urgent Community Response

Leadership & Accountability

- ICSs must sign off winter plans by Summer 2025
- Trust boards and ICBs to ensure daily visible support to frontline teams

Winter 2025/26: Core KPIs

ED

- Emergency Department (ED) Performance
- 78% of A&E patients to be admitted, transferred, or discharged within 4 hours
- <10% of patients waiting over 12 hours in ED for admission or discharge
- Zero patients waiting over 24 hours in ED for a mental health bed

Ambulance services

- Category 2 response times (e.g. stroke, heart attack) to average 30 minutes (down from 35)
- Ambulance handover delays to be eliminated, with a maximum 45-minute standard

Hospital flow and discharge

- Reduce long-stay patients: Targeting the 30,000 patients staying 21+ days beyond discharge readiness
- Internal discharge delays: No patient should wait more than 48 hours post-discharge readiness
- Length of stay for overnight emergency admissions to be reduced by at least 0.4 days

Community & virtual care: Increase patients treated via Urgent Community Response teams, Virtual wards and Same Day Emergency Care (SDEC)

Vaccination uptake: Staff flu and RSV vaccination rates to improve by at least 5 percentage points over 2024/25

Mental health integration: Reduce re-admissions and length of stay in mental health inpatient settings

Local System KPIs: ICSs must set local performance targets by pathway, including: Discharge times; Corridor care elimination; and Flow through hospitals

Winter 2025/26: Additional Actions

Respiratory Pathway Enhancements

- Expand Acute Respiratory Infection (ARI) Hubs
- Increase Hospital @ Home (Virtual Wards) capacity for respiratory and frailty patients

Community Pharmacy & Vaccination

- Improve access to community pharmacy for minor ailments and urgent prescriptions
- Staff vaccination campaigns to reduce workforce sickness

Mental Health Crisis Response

- Alternative pathways to ED including crisis assessment centres
- 24/7 mental health liaison teams embedded in acute trusts

Infection Prevention & Control (IPC): Implement best practice IPC protocols to reduce nosocomial infections

Elective Care & Diagnostics

- Protect elective capacity through ring-fenced resources
- Deploy rapid diagnostics to support same-day discharge

Communications & Engagement

- Public messaging campaigns to guide patients to appropriate care settings
- Staff engagement plans to support morale and retention

Governance & Oversight

- Local A&E Delivery Boards to oversee winter readiness
- Winter Planning Assurance & Delivery Groups to monitor progress

Winter 2025/26: Enablers & Operational Actions



Digital & Data Infrastructure

- £20M for Connected Care Records: real-time access for ambulance crews
- Federated Data Platform to 85% of acute trusts by March 2026
- New dashboards and performance tools to track flow and discharge

Capital & Investment (£370m)

- £250M for SDEC and UTC expansion
- £75M for mental health inpatient capacity
- £26M for crisis assessment centres

Prevention & Community Focus

- Expanded flu and RSV vaccination programmes
- “Call before convey” model for paramedics to treat at home
- Community beds and tech-enabled care to reduce admissions

Performance Management

- Local targets by pathway
- High-performing sites to mentor others
- National “one-team” support for struggling systems

Winter 2025/26: Local approach

- Our system winter plan has been refreshed in line with the above national guidance (in the format of a West Yorkshire ICB template)
- Development and sign off of the plan is undertaken by the BDC Urgent Care Board (UCB) on behalf of the Health & Care Partnership (HCP). The UCB is a multi-partner group with input from all providers who attend the surge and escalation meetings over the winter period.
- West Yorkshire testing of winter plans is taking place on 3rd September. However, the system winter plan is a refresh of our existing plan which has been tested previously and subject to an annual review and learning exercise
- Our system resilience dashboard (currently circulated every Monday, Wednesday and Friday to partners) will be reviewed and updated to ensure we are sighted on the relevant system pressures linked to the refreshed plan.
- Overall performance will be reviewed at the System Finance & Performance Committee and key quality risks e.g. infection control and vaccination uptake are considered by the System Quality Committee. The UCB will continue to have oversight of system winter pressures and delivery against plan.
- Each partner organisation has developed their own plans to address how they individually will manage internal capacity and peaks in demand during the period. Whilst the document incorporates those plans, and references where applicable, its main focus is to outline how partners will work together to: ensure key services and pathways effectively manage demand and keep patients at home; avoid unnecessary admission to hospital and improve patient flow; and; where admission is necessary, patients are discharged back to their usual place of residence as quickly as possible.
- West Yorkshire ICB is requesting that assurance is provided by the 5 place-based HCPs to support the sign off of a West Yorkshire plan.



Winter Planning 25/26

Board Assurance Statement (BAS)

Integrated Care Board (ICB)





Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Integrated Care Board's (ICB) name.

This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025**.

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the ICB Winter Plan for 2025/26.	Yes	Development and sign off of the system winter plan is undertaken by the BDC Urgent Care Board (UCB) on behalf of the Bradford District & Craven (BDC) Health & Care Partnership (HCP)
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	No	The winter plan is not new but a document which is refreshed annually and available for use all year. It is expected WY colleagues will complete a QEIA on behalf of all places on the collective plan.
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	Developed by the UCB which is a multi-partner group with input from all providers who attend the surge and escalation meetings over the winter period.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes 3 rd Sept	West Yorkshire testing taking place on 3 rd September. However, the system winter plan is a refresh of our existing plan which has been tested previously and subject to an annual review and learning exercise

Integrated Care Board:

Bradford District & Craven Health & Care Partnership

The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	
<i>Plan content and delivery</i>		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.	Yes	The plan is refreshed annually in line with any new national guidance and requirements.
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	The plan is refreshed annually. Key quality risks e.g. infection control and vaccination uptake are considered by the System Quality Committee.
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	West Yorkshire system control centre (SCC in place)

ICB CEO/AO name	Date	ICB Chair name	Date
Therese Patten	5/09/2025	Elaine Appelbee	05/09/2025

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	Yes	BDC vaccination plan in place
2. In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.	Yes	BDC vaccination plan in place
3. Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.		Range of admission avoidance interventions in place e.g. Urgent Community Response
Capacity		
4. The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.	Yes	Trust winter plans
5. Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.	Yes	Discharge profiles considered as part of developing the Better Care Fund capacity and demand plan.

6. Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.		The plan is refreshed annually in line with any new national guidance and requirements. Elective recovery is monitored via the System Finance & Performance Committee
Leadership		
7. On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
8. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	SCC RAIDR tool

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	8
Meeting date:	5 September 2025
Report title:	Our plans for health, care, and wellbeing in Bradford District and Craven
Report presented by:	Matt Sandford, Director of Partnership and Place, WY ICB (Bradford District and Craven)
Report approved by:	Matt Sandford, Director of Partnership and Place, WY ICB (Bradford District and Craven)
Report prepared by:	Clare Smart, Associate Director of Strategy, WY ICB (Bradford District and Craven)

Purpose and Action			
Assurance ☒	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/ comment/discuss/escalate)	Information ☐
Previous considerations			
A draft version of the Plan has been received by the Partnership Board and Bradford's Wellbeing Board.			
Executive summary and points for discussion			
This plan acts as a guide for how we use our partnership resource to improve population health. 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 experience, outcomes, and access; - Help support broader social and economic development; and - Enhance productivity and value for money. It recognises that without change, services will be unable to meet the future health needs of the District's population and it sets out future projected needs of the District. The plan was commissioned by the Partnership Board.			
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

The Bradford District and Craven Partnership Board is invited:

1. To approve '*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.

N/A

Appendices

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

Acronyms and abbreviations explained

Acronyms and abbreviations are explained within the document.

What are the implications for?

Residents and communities	Citizens are actively engaged in our plans
Quality and safety	N/A
Equality, diversity, and Inclusion	N/A
Finance and use of resources	Guides the Partnership in its use of resources
Regulation and legal requirements	N/A
Conflicts of interest	N/A
Data protection	N/A
Transformation and innovation	Guides the Partnership in its transformation of services
Environmental and climate change	N/A
Future decisions and policy making	Guides our investment decisions based on our values
Citizen and stakeholder engagement	The Plan is informed by our <i>Listen in</i> engagement programme

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

September 2025



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Foreword by our Chair

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

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

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

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

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

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

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

Elaine Appelbee

**Chair, Bradford District and Craven
Health and Care Partnership**



Introduction

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

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

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

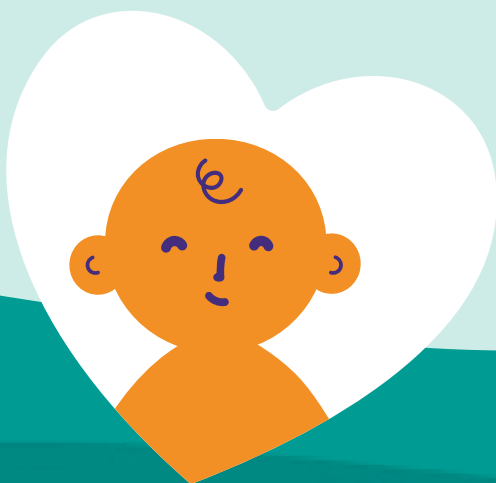
The underlying reason for this plan is the health and wellbeing of our population. While we have a relatively young population, when we look forward to **2040** our population demographic changes significantly. Our use of predictive modelling to **foresee the future** has shown us why we need to transform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

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

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

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

We are what we do next.



Our Shared Purpose

Our strategic intent

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

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

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

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

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

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

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

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

Our challenge

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

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

We are not delivering 'best value' healthcare.

One in six hospital admissions are driven by conditions that could have been avoided through timely and coordinated community-based care. One in five primary care encounters are considered non-medical and are driven by social issues like loneliness, housing concerns, debt, or relationship problems. The segment of our population with the most complex needs accounts for two-thirds of non-elective activity. We must use our resources in a way that maximises value, away from reactive care.

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

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

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

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

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



Our Population

Our population data and future state

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

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

Our population profile

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

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

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

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

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

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

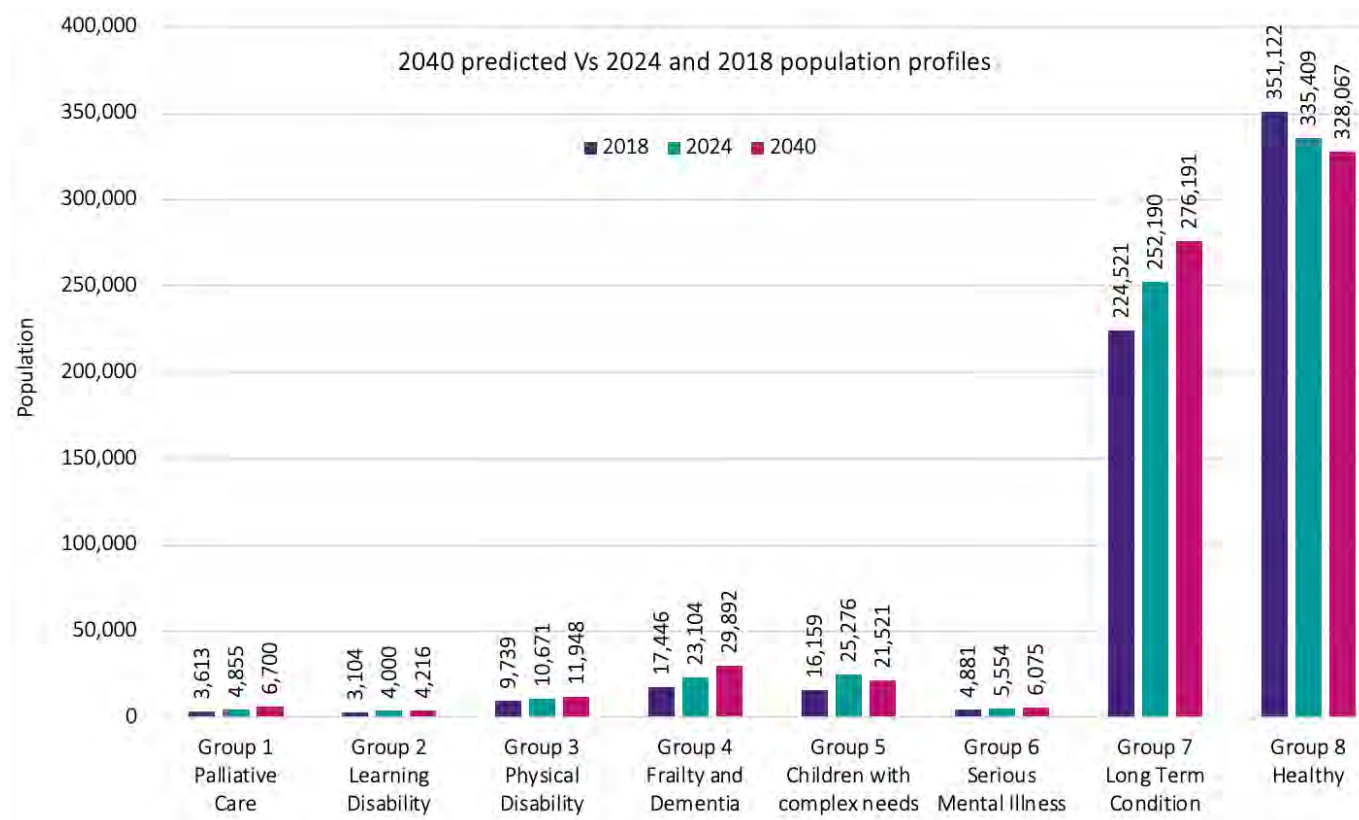


Figure 1: Predicted population profile for Bradford District and Craven 2018, 2024 and 2040

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

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

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

Key health conditions

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

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

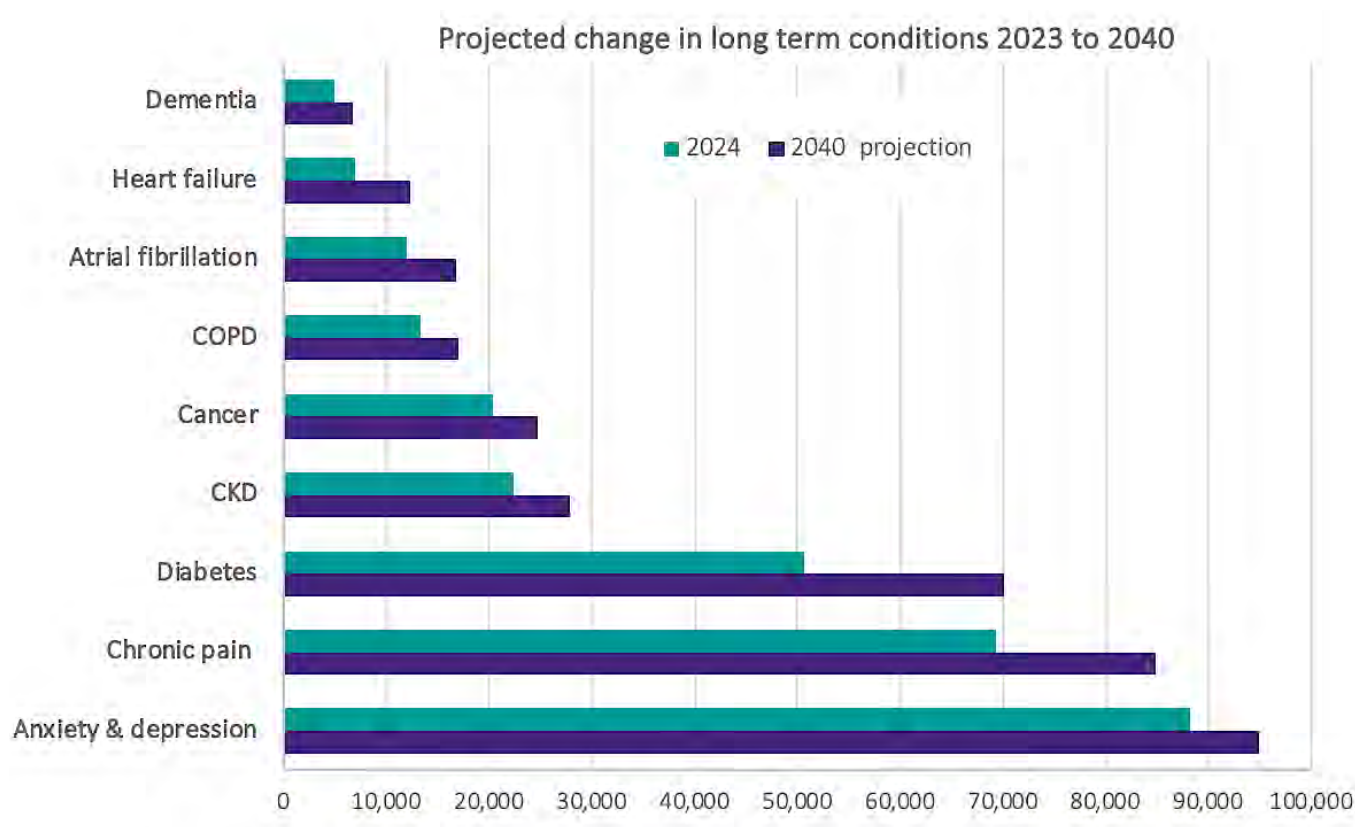


Figure 2: Projected change in long-term conditions 2023 to 2040

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

Multi-morbidity

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

Our health inequalities

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

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

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



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

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

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



Lifestyle and prevention

In our district:

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

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

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



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

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

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

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

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

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

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

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

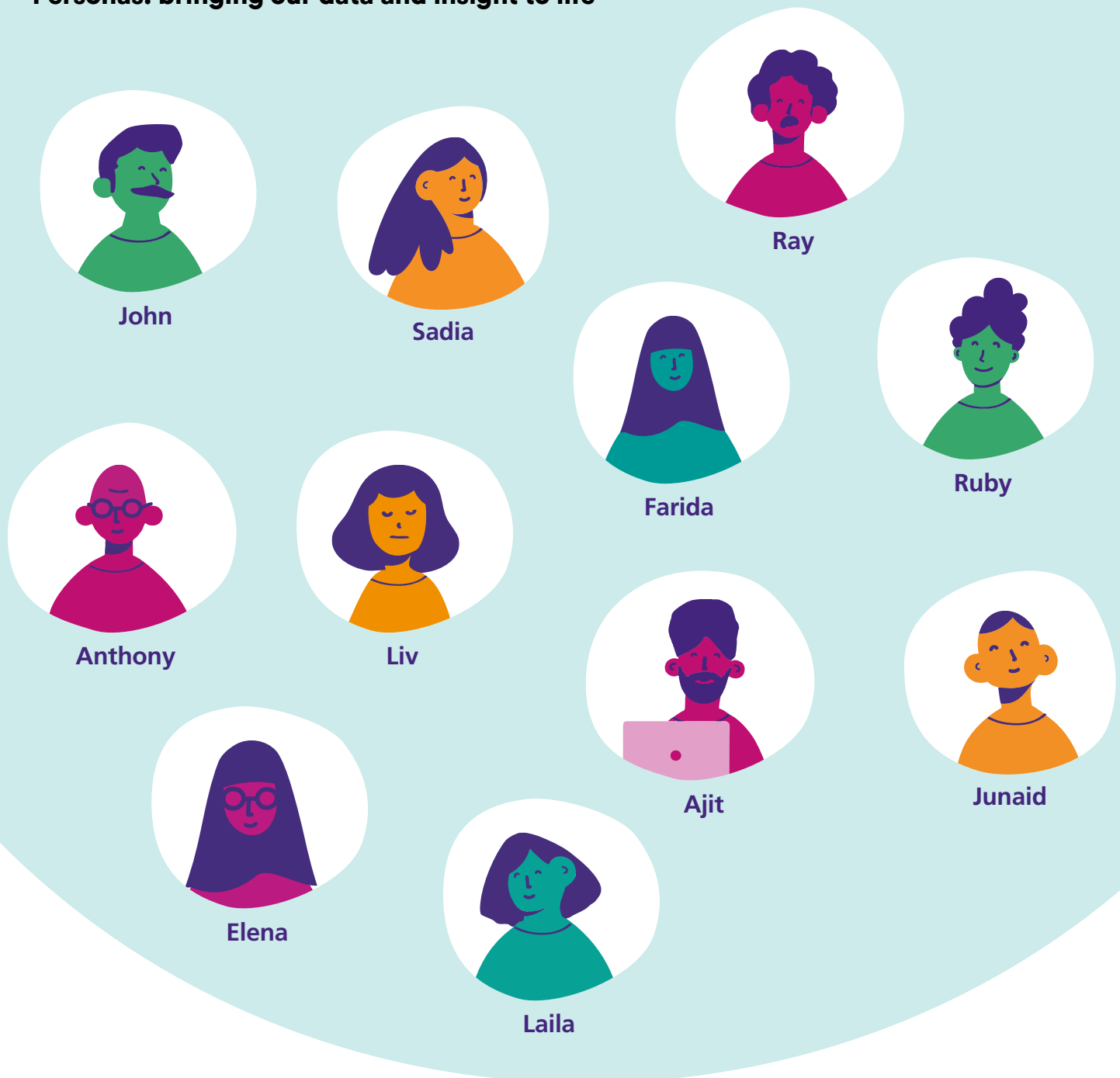
7. Support self-management. Increasing the availability of, and access to, support tools will help people to be more actively involved in their care plans and to be more confident in managing symptoms and exacerbations. This includes the use of digital technologies where appropriate. Offers may need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

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

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



Personas: bringing our data and insight to life



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

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

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

Our citizen activation, insight, and involvement

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

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

Understanding what matters to our communities

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

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

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

What have we heard

Shift from hospital to community



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

Shift from analogue to digital



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



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

Shift from sickness to prevention



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

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

From insight to action: enabling the shifts

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

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



Citizen activation

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

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

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

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

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



Our integrated neighbourhood health and care support

Our model

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

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

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

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

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

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

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

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



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

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

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

Our strong foundations

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

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

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

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

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

What are the key ingredients and what needs to happen?

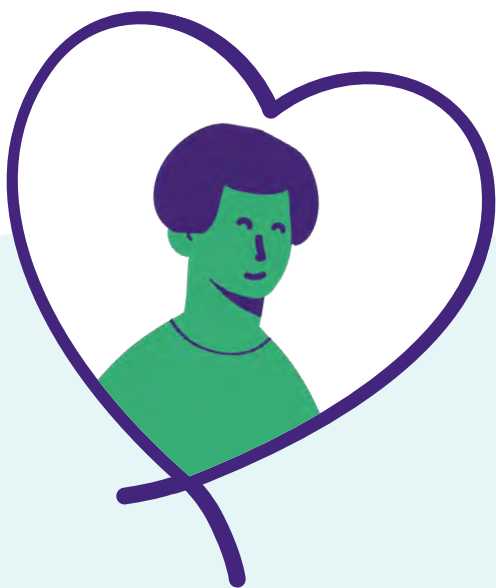
At the centre of this is building a 'One Team' approach within neighbourhoods around:

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

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

Our initial focus

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



Supported by 'Health on the High Street'

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

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



Figure 4: Health on the high street



Our acute services of the future

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

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

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

Hospitals within a system reorientated towards prevention and early intervention

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

The final **unique contribution** of the hospital is the speed at which it is designed to respond to urgent clinical needs. Unlike other parts of the health system, which operate around routine and pre-

scheduled appointments often during the working week, hospitals are explicitly designed to respond to urgent care, constantly re-prioritising patients based on the severity of clinical need. Hospitals are open 24 hours a day, 365 days a year and are constantly staffed at a level that enables them to respond adequately to every type of unscheduled medical emergency.

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

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

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

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

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

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

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

Care delivery transformation

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

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

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

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

Acute collaboration

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

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

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

Secondary care as a service, not a building

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

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

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

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

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

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

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

1. Our core focus

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

2. Our geographical partnerships

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

3. Our shared workforce

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

4. Our emerging model

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



Our financial plans

Value and values

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

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

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

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

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



Closing the Gap

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

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

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

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

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

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

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

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

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

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

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



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

Our plans include:

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

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

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

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

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

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

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



Our workforce plans

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

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

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

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

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

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

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

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

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

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

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

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

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

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



Our digital plans

The local context

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

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

The national drivers

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

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

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

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

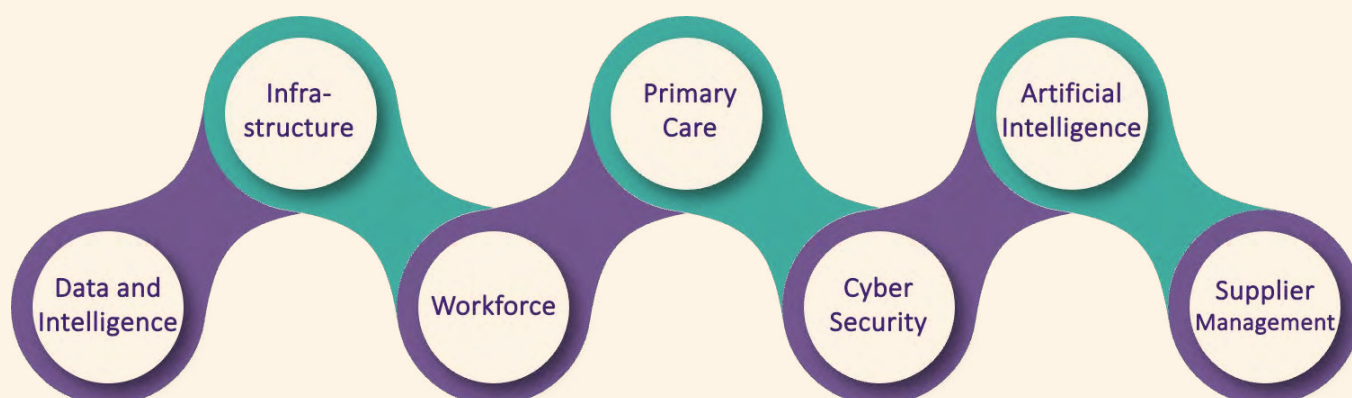


Figure 5: DDaT strategy seven key pillars

Our digital strategic principles

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

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

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

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

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

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

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

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

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

Our infrastructure plans

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

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

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

Current position

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



Figure 6: Categorisation of healthcare facilities

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

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

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

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

Key challenges

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

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



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

Where do we want to be?

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

To do this we will:

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

How will we get there?

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

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



Conclusion

Keeping our focus

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

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

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

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

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

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

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

We are what we do next.



our 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



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 Workforce

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



Our Partnership Plan

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

our Commitments

We will all:

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

We will all:

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

We will all:

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

our Population

our Place

our Partnership

Bradford District and Craven
Health and Care Partnership



Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	9
Meeting date:	5 September 2025
Report title:	Sub-committee Triple A Reports
Report presented by:	Sub-committee Chairs
Report approved by:	Sub-committee Chairs
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 System Finance and Performance Committee and System Quality Committee, as sub-committees of the Bradford District and Craven Partnership Board, have each compiled a Triple A (alert, advise, assure) report to support information flow from each of the meetings within this governance cycle. It is presented to the Partnership Board for assurance purposes and to allow committee chairs to alert the Board to any significant risks and asks. The Clinical and Professional Forum have not submitted a report as the Forum have not met since May 2025 – the meetings now take place bi-monthly, and the meeting planned for July 2025 was cancelled due to the number of apologies received.			
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. Receive the Triple A Reports from the System Finance and Performance and System Quality 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:

N/A

Appendices

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

Acronyms and Abbreviations explained

N/A

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: System Finance and Performance Committee

Date of meeting: 20 August 2025

Report to: Bradford District and Craven Health and Care Partnership Board

Report completed by: Mike Woodhead, Place Director of Finance for Bradford District and Craven Health and Care Partnership

Key escalation and discussion points from the meeting

Alert:

Regarding ICB organisational change programme:

- The committee noted that the staff consultation on the proposed changes to the ICB had been delayed due to delays in the receipt of further information needed from the government and NHS England. It was noted that the delays could impact on other workstreams.

Advise:

Regarding System Performance:

- The committee considered the July performance report and noted:
 - o Bradford District Care Foundation Trust (BDCFT) – continuing pressures, particularly in adult acute pathways and out of area placements. There were improvements in lengths of stay and admission avoidance.
 - o Bradford Teaching Hospitals Foundation Trust (BTHFT) - good progress in Referral-to-Treatment (RTT) targets and focused work on the audiology pathway. The 62-day cancer performance was in the upper quartile, but improvements were still needed. Urgent care performance was good but there was a challenge with increased attendances.
 - o Airedale NHS Foundation Trust (ANHSFT) - 4-hour performance had been good, the 15 minute ambulance handover target had been met and the Trust were nearly at plan for RTT targets. Diagnostic performance was good, and all cancer targets had been met.
- The committee acknowledged that future performance reports would need to include measures from the new NHS Oversight Framework (NOF).

Regarding NHS Performance Assessment Framework:

- The committee discussed the NOF and noted the initial scores for the three NHS Trusts.
- BDCFT noted:
 - o Mental health trust scores did not take proper account of community metrics which would improve BDCFT scores.
 - o Significant data quality issues to be addressed.
 - o Improvement plans in place in relation to some areas such as sickness absence rates and length of stay.
- BTHFT noted:
 - o Plans in place to improve sickness absence rates.
 - o Challenge back to the national team in relation to the C-Difficile measures.

- The planned deficit score would improve as a result of the revised Trust and ICS plans.
- Challenge back to the national team regarding inclusions and exclusions on cost base used for the implied productivity measure.
- ANHSFT noted:
 - Scores for future periods would improve to reflect improved ED trajectories.
 - Productivity scores which were partially impacted due to RAAC, the new hospital programme and EPR inclusion in the cost base.
 - Work on E-Coli.
 - Measures already in place to improve discharge rates.
- The committee noted that the expected range of metrics would be expanded in quarter 2 of 2025/26 and discussed how organisations could work together on common issues such as sickness absence rates. It was agreed that sickness absence rates would be raised with the ICB assistant director for workforce and discussed with the accountable officer in terms of how this could be reported through the partnership governance arrangements.

Regarding the finance report:

- The committee received the current forecast outturn for each organisation, which was positive however significant risks in the forecast were acknowledged. It was noted that there was a focus in all organisations on derisking financial positions - the ICB had derisked its position by £2m by Month 4.
- ANHSFT – the adverse variance to plan had increased in Month 4 – this was partly due to industrial action and an increased run rate. The most likely scenario was reported as an adverse to plan by £12.4m.
- BDCFT now have a savings target of £18.3m in Month 4 – this is 8% of its turnover with a likely net risk of £3m.
- BTHFT – similar risk to other providers. Quarterly grip and control reviews instigated.
- Bradford Metropolitan District Council - forecasting a small underspend however £127m of exceptional finance support had been received, for which recurrent support would need to be found as soon as possible.

Regarding the 10 Year Health Plan for England:

- The left shift ambition was noted.
- There was a brief discussion on work related to the deconstruction of the block contract with no impact due to be seen in 2025/26 or 2026/27.

Assure:

Regarding the Closing the Gap workstreams:

- The committee received a progress update from the senior responsible officer (SRO) of each workstream.
 - Integrated acute care - over 170 people attended three workshops, where it was agreed that the majority of clinical services should come under a joint / collaborative model. Work was ongoing to develop a target operating model and clinical strategy by October 2025. It would be a 2-3 year journey with consideration for in-year savings in areas, such as bank and agency staff; the use of the independent sector; the improvement of theatre use; ambient AI; and difficult to recruit to posts.

- Integrated corporate support– terms of reference had been agreed and an external advisor appointed to add pace. £3m savings target in the workstream.
- Integrated neighbourhood health and care – initial workshop held in July 2025 and bid submitted to national team to be a pilot site. Recurrent target of at least £3.6m but unlikely to be in-year and organisations were also considering in-year mitigations for the target. The committee discussed the importance of the left shift of funding.
- The committee noted the need, where appropriate, to knit workstreams together, share learning and effects, eg AI.

Regarding the update from the Finance, Performance and Quality Forum:

- The committee were assured that the forum had been established - the first meeting had taken place on 27 June 2025 and was well attended. The membership of the forum had been reviewed and amended and the terms of reference agreed. There were no issues or concerns to escalate to the committee.

Regarding Better Care Fund service update:

- Received and discussed a thorough report on the Better Care Fund (BCF) from colleagues in Bradford Council.
- Agreed to receive the workplan for the BCF in the October meeting and would consider how the committee would review value for money and the prioritisation of resources going forward in the BCF.

Regarding Risk Register:

- Considered the risk report.
- Noted that the main changes in the risk cycle were the merging of risks related to neurodiversity, continuing healthcare and care home sustainability.
- Noted that a number of risks related to the ICB organisational change programme were being developed and would be added to the ICB corporate risk register.
- Noted the increase in scores of strategic risks on the ICB Board Assurance Framework in relation to staffing pressures and system innovation.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven System Quality Committee

Date of SQC meeting: 10th July 2025 (includes further updates from June, July and August 2025)

Report to: Bradford district and Craven Partnership Board

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

Date of Partnership Board: 5th September 2025

Key escalation and discussion points from the meeting

Alert:

Primary Care

- **IT outage**- affected all Primary Care practices/ some hospitals systems and ICB staff in Bradford District and Craven between 28th July 2025 and 4th August 2025. This was caused by a service update at the Calderdale and Huddersfield Data Centres. Some users were able to log on fully whilst others were only able to use contingency mode. Root cause was identified. Enhanced access services were suspended from 6.30pm on Friday 1st August 2025 until 6.30pm Monday 4th August to allow remedial work and testing. All affected patients have been contacted and offered alternatives. Investigations are ongoing and this is largely a localised issue. Intelligence is pointing towards a networking fault as the root cause. This is not considered to be cyber related at this moment in time and therefore patient data remains secure.

Bradford Metropolitan District Council (BMDC)

- **Residential and Nursing Care Provision – North Bradford**
The service currently supports 52 residents, including a significant number requiring nursing care, and remains subject to enhanced monitoring and an embargo on new admissions. It is also involved in a safeguarding OSE with additional intervention by the Care Quality Commission (CQC). There are several serious concerns regarding the quality and safety of care provided. Regular monitoring and resident welfare mee visits are being carried out by the Safeguarding Adults Service, the ICB Quality Team, and the Contract and Quality Team at BMDC.
- **Residential Care Provision – Shipley**
This service currently accommodates 19 residents and is operating under a Serious Concerns embargo. A phased lifting of the embargo is in place, allowing one new admission per month. Some improvements have been observed within the service, and as a result, we are progressing towards an increase in admissions.

Integrated Care Board (Bradford Place):

- **Chestnut Lodge Care Home**, provides residential and nursing care for frail and elderly community members, including those with dementia. Since Jan 2025, the home has been subject to Organisation Safeguarding Enquiry procedures and received support from Local Authority contracting, quality and safeguarding teams,

ICB quality and safety, and All Age continued health care teams. Organisation Safeguarding Enquiry process is continuing; however, the enhanced surveillance has now reduced due to a recruitment of a new management team and evidence that responsiveness and safety risks are being addressed.

- **Airedale NHS Foundation Trust-** complaint received via Health Safety Investigative Bureau (HSIB) from a former patient who had been in receipt of an urgent surgical procedure in Jan 2025. ANHSFT became aware on 29/07/25. ICB informed 01/08/25. WY Police, CQC and NHSE have all been informed. The former patient reported sexual assault during a two-hour period between surgery and ward admission. Despite not making a complaint, the medical team did not note undue distress.
ANHSFT has completed an investigation and are able to fully account for all but 18 minutes of the time. Immediate learning includes documenting accompanying staff members and patient receipt time, the situation remains under police investigation.
- **Continuing Health Care (ICB)-** In view of the recent media attention in relation to fast track rescinds which the CHC team are undertaking. We anticipate that we may continue to receive some negative publicity. This has been discussed with our communication team.

Bradford District Care NHS Foundation Trust (BDCFT)

- Use of **Section 136 suites** as emergency inpatient beds due to lack of immediate bed availability has continued. This practice, while sometimes necessary, was under scrutiny by the CQC.

ICB Quality Team Staffing

- ICB Quality Team reduced staffing through sickness and impacts of vacancy controls across the ICB. Specific issues highlighted in;
 - LeDeR Team – resulting from sickness within the Team and the inability to recruit to the vacant Local Area Contact Role (LAC).
 - Current vacancies within the Continuing Healthcare (CHC) team remain a concern to be able to meet our NHSE KPI's and continue to deliver on our efficiencies. Request to work force panel to extend end dates on 2 posts; one in the WY appeals team hosted by Bradford and Personal Health Budget (PHB) audit for 6 months. A further ECF has been submitted to support acting up positions.

Advise:

Primary Care

- **Hepatitis A outbreak-** Two cases of hepatitis A have been detected in Bradford. Working hypothesis of unvaccinated travel. Siblings of the second case family have now registered at the GP office and are receiving vaccinations, Year 4 students at the school will receive vaccinations on school grounds. UK Health Security Agency (UKHSA) met with the school, school improvement staff visited schools to provide handwashing and infection control advice; Communication has been sent to Parents, Local Authority and GPs.
- **2025 GP Patient Survey results-** The 2024/25 comparison shows improvement in key questions, with ICB and national results showing similar improvements, with the

exception of the question relating to management of long-term conditions. Bradford District and Craven are reporting comparative lower scores than neighbouring places however the gap in performance is lessening. Results continue to be discussed Quality Assurance visits and there is also ongoing work at West Yorkshire regarding consolidating improvement opportunities.

- **Cervical screening.** From 1 July 2025, women aged 25-49 who test negative for human papillomavirus (HPV) – meaning they are at very low risk of developing cervical cancer over the next five years – will be invited for screening at five-year intervals rather than three. This applies to samples taken on or after 1 July 2025 and next test due dates remain the same for any samples taken before this date. This change is backed by clinical evidence and a recommendation by the UK National Screening Committee. Communication sent out to Practice with supporting documentation.
- **Regulation 28 – Significant Events Audit (SEA)** involving GP Assist and a delayed fast-track chest pain referral. Referred to Coroner who issued a Regulation 28- Prevention of future deaths. Changes to be made to the Rapid Access Chest Pain referral information with the streamlining of the options for clinicians and making the task automatically populate, thus removing previous issues identified in the incident and has been communicated to all practices
- **HbA1C Results** - Incorrect HbA1C results issued to practices and confirmation that 498 results have been affected with patients from 39 practices in Bradford & Craven area. It has been reported via Airedale risk reporting and uploaded to Learning from Patient Safety Events (LFPSE). The Local Medical Council (LMC) have also been informed and regional Medical Director. Arrangements made regarding retesting for the affected patients to include an apology/Duty of Candour letter to the patients. An After-action review is underway regionally, with the manufacturer of the analyser in question attending the site.

Integrated Care Board (Bradford Place):

- **Assisted Lives Adult Services in Bradford-** Bradford Local Authority have taken decision to put a suspension in place of all new placements with immediate effect. This was in relation to the death of a service user in the community which is currently under police investigation. The service has been put on enhanced surveillance and the Local Authority will be carrying out monthly enhanced monitoring. BDC CHC staff have started reviewing the packages of care they have with that provider.
- **Alchita Care Ltd-** Recent CQC inspection rated as overall 'inadequate'. There were breaches around the legal regulations in relation to safe care and treatment, need for consent and good governance. CQC has requested Alchita Care Ltd to submit a robust action plan in response to concerns highlighted
- **Morton Close Residential Home** in Keighley reported a respiratory outbreak (covid 19) with 4 residents and 3 staff testing positive. The outbreak has been managed by the care home. Bradford Care Association (BCA) are planning to discuss vaccination uptake with care home managers to encourage staff vaccination uptake.

Bradford Metropolitan District Council (BMDC)

- **Unregulated 16+ provider** – Recent Quality Assurance process undertaken following a number of concerns raised by social care, led to widespread

organisational concerns found financial concerns as well as those related to Housing Standards. Action being taken in response to concerns.

- **Unregulated** – Concerns raised regarding this provision in BD10 and risks experienced by Young Person despite high staff levels. Social Worker & Contract & Quality setting actions and monitoring. Provider challenged by host local authority following complaints by neighbours.
- **Residential Children Home –Provider on regional framework but provision outside Y&H region** – Concerns found relating to non-compliant (training expired) and restraint practice. Action plan agreed. Regional Framework provider so action taken shared with regional colleagues
- **Children Home** – Complaints received via BDCFT/Councillor/ Member of Parliament and Director of Children's Services. Multiple concerns raised from neighbours regarding supervision of young person in placement and impact on community. Regular meetings taking place between provider and social care colleagues.

Bradford Teaching Hospitals NHS Trust (BTHFT)

- **Summary Hospital Level Mortality Indicator (SHMI)** – BTHFT Quality Committee received an update on the increased SHMI score and the work ongoing to ensure the Trust's crude mortality has reduced and that the increased score is a reflection of clinical coding behaviours and other coding issues.
An update will be presented to the BTHFT Quality Committee in September including an update on the work that is underway to ensure that the score is correct.

Public Health

- The review of the local Memorandum of Understanding (MOU) on outbreak response was paused because of the reorganisation of the ICB. At the present, there is currently no formal agreement between Local Authority and ICB to respond to outbreaks at place level. Retainer contracts are in place at West Yorkshire level for High Consequence Infectious Diseases (HCID) and at place for flu/COVID outbreaks. This has been recorded in the WY risk register. Public Health at Place have recruited to a new consultant who will support the development of the ICB health protection role (at WY level).

Bradford District Care NHS Foundation Trust (BDCFT)

- **Out-of-area placements** had totalled 116 bed days in May 2025 and 961 bed days over the past three months. Although mitigations were in place (e.g. contracted independent sector beds), this has remained a significant pressure point.
- While inpatient mental health bed low had improved significantly (from worst to best in West Yorkshire), assurance ratings remained 'limited.' There was a call to revisit these ratings and better align them with current performance and develop a reporting technique that would allow members to clearly see this.
- Two recent CQC enquiries related to staffing concerns and burnout (Airedale and Lynfield sites) had been received. While responses were submitted, the underlying issues may require a broader workforce strategy review.
- Persistent delays in dental treatment requiring general anaesthetic due to lack of anaesthetist availability had continued. This was exacerbated by industrial action and may have worsened.

- Medicine Shortages: Ongoing shortages (e.g. quetiapine, galantamine), placed pressure on clinical and pharmacy teams.

Cygnnet Wyke

- Cygnnet temporarily closed the new ward, causing clinical staff to be redeployed to other services. The hospital director is transferring to Brighouse site, while Brighouse Manager will move to Bradford site. Local site teams are aware of the leadership changes.

Assure:

Shared Care

- All practices expressed that they would accept the new shared care plus/amber drugs contract, which commenced on 1st August 2025. This has stabilised shared care medicines prescribing, and there has been no recent reports of issues via secondary care. For 2025/2026 the “shared care plus” element will deliver system savings by switching Direct Oral Anticoagulants to cost-effective options, and both savings and increased quality by reviewing patients prescribed oral nutritional supplements.

Industrial Action

- All rotas successfully covered with no patient safety incidents due to strike during the period and no need for derogations.
- BTHFT percentage of Resident Doctors taking action lower than previous strikes at between 50-55% in comparison to circa 70% previous occasions.
- No significant issues in Airedale Hospital, although the % was slightly higher (Friday 74%, Saturday 76%, Sunday 80%, Monday 71% and Tuesday 75%). Managed well via several calls throughout the day.
- BDCFT- see above re anaesthetist availability
- Activity cancellations have occurred, but Trusts have tried to minimise these in total over the strike period. Provisional data suggests:
 - BTHFT: Outpatients - 14% of routine activity rescheduled; Outpatient – 3% of cancer or fast track rescheduled; and Electives – 20% of all inpatient, day case and colonoscopies
 - ANHSFT: Elective (27), Outpatient (88), and Diagnostics (14)

Bradford Metropolitan District Council (BMDC)

- Between 1st May 2025 to 23rd June 2025, the following works were undertaken.
 - 12 provider quality assurance reviews taken place, this includes documentation and insurances reviews, responsive works to social care or Ofsted/CQC feedback and whistleblowing/LADO alerts raised.
 - 5 ongoing provider support/ development works planned by the Contract and Quality Team BMDC.
- **16-25 Leaving Care Framework** - Revised monitoring process for new on-framework providers to commence Feb 2026 to track regulatory compliance.

Bradford Teaching Hospitals NHS Trust (BTHFT)

- **Screening Quality Assurance Service Report (SQAS)** – in March 2025, the SQAS conducted an inspection of the Pennine Breast Screening Service. The inspection revealed no immediate concerns, indicating that the breast screening services are overall functioning well and meeting the required standards
- **Nursing and Midwifery Strategy Update** – BTHFT Quality Committee received an update on the current strategy, noting progress against delivery of the strategy and the requirement to align to the 10-year plan and digital initiatives.
- **Maternity and Neonatal Services** – BTHFT Quality Committee received assurance through the Maternity and Neonatal (Perinatal) Service update which reported that during June 2025 there was 2 Stillbirth and 2 Neonatal Deaths and 1 indirect late maternal death.
- **A&E long waits**- BDC System Quality Committee was informed about ongoing work at Bradford Teaching Hospitals NHS Foundation Trust to address the increasing number of people leaving the Emergency Department without treatment due to longer waiting times. Improvements include signposting people to alternative services post triage and safety netting of those leaving before treatment. Safety measures include following up patients and reviewing test results.

Bradford District Care NHS Foundation Trust (BDCFT)

- The Trust have significantly improved inpatient flow and reduced average length of stay.
- Supervision rates have remained above 80%. Immediate life Support training was improving, with targeted plans for newly qualified staff.
- All CQC enquiries had been responded to within timescales.
- A facilitated Learning event involving 60 medical staff (including many consultants) had focused on learning from deaths, including a presentation from a bereaved parent. Plans were in place to expand this to a multidisciplinary audience.
- The Volunteer-to-Career Programme had been recognised by Helpforce and seen as a national exemplar. There was potential to scale this further to support NHS prevention and community engagement agendas.
- Staffing Oversight: governance and mitigation strategies are in place, with improvements in supervision and restraint reduction.

Airedale NHS Foundation Trust (ANHSFT)

- **Maternity**- Maternity and neonatal voices partnerships (MNVP) continue to be rated red and has been escalated to Local maternity and neonatal systems (LMNS), and as a result will not put at risk compliance with Maternity Incentive Scheme (MIS) compliance. A new induction of labour process is being introduced. ANHSFT Quality and Safety Committee have requested a review of the impact of this both in terms of patient safety/experience but also on waits for induction of labour when the data is available.
- **Palliative Care & End of Life** Annual Report- received by ANHSFT Quality Committee, and the work of the team commended.

Primary Care

- **Hollyns Health & Wellbeing** – CQC Inspection 21st March 2025, Report published 12th June 2025; Rated overall as 'Good', was previously rated overall as 'Requires Improvement'.

Integrated Care Board (Bradford District & Craven Place):

- **Quality Accounts-** all Quality Accounts have been signed off and submitted back to providers.

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 from the Finance, Performance and Quality Forum
- An update from the Reducing Inequalities Programme, focussing on Core20plus5

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	10
Meeting date:	5 September 2025
Report title:	Update on the North Yorkshire Health Collaborative
Report presented by:	Richard Webb, Corporate Director, Health and Adult Services, North Yorkshire Council
Report approved by:	As above
Report prepared by:	Victoria Turner, Public Health Consultant and Richard Webb, Corporate Director, Health and Adult Services, North Yorkshire Council

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 presentation provides an update on the North Yorkshire Health Collaborative, which is a new approach to transforming health and care in North Yorkshire through an NHS / North Yorkshire Council Joint Committee and Section 75 agreement. The Joint Committee will have an overview of aligned expenditure on health and care services of up to approximately £590m (not including the Better Care Fund) across North Yorkshire Council and Humber and North Yorkshire Integrated Care Board (HNY ICB) and lead the delivery of the 'Ambitious for Health' programme, a new approach to transforming health and care in North Yorkshire. The arrangements for the North Yorkshire Health Collaborative build on established joint working through the North Yorkshire Place (NYP) Board, which is led by the Council's Chief Executive and includes leaders from Integrated Care Boards, Secondary Care, Primary Care, the Voluntary Sector, and the wider Council. It will provide unified leadership to address key health and social care issues in North Yorkshire through the 'Ambitious for Health' programme. The Section 75 Agreement is between North Yorkshire Council and HNY ICB only and does not include the other ICBs in the North Yorkshire area, however the intention is that key existing NYP Board partners will continue to play an active role in leading the North Yorkshire Health Collaborative as part of the wider health and care system and shall be attendees of the Joint Committee as non-voting members. The work of the Joint Committee will deliver significant elements of the forthcoming national 10-year plan for health on a local level, including the signalled shifts from acute to community services and from treatment to prevention, ultimately supporting our ambition for people in North Yorkshire to live longer, healthier and independent lives. The core components of the			

'Ambitious for Health' programme over the proposed lifetime of the Section 75 Agreement will deliver on areas in the [NHS England » Neighbourhood health guidelines 2025/26](#) including - NHS and social care working together to prevent people spending unnecessary time in hospital or care homes; strengthening primary and community based care to enable more people to be supported closer to home or work; and connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services.

The North Yorkshire Council Executive and HNY ICB agreed to the establish the North Yorkshire Health Collaborative Joint Committee supported by a Section 75 Agreement between the two organisations with an initial 1-year term and 2 options to extend for a further 12 months each (3 years in total) with the new arrangements having taken effect from 10 July 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 Bradford District and Craven Partnership Board is asked to:

1. Note the update on the North Yorkshire Health Collaborative

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

N/A

Appendices

N/A

Acronyms and Abbreviations explained

1. HNY ICB – Humber and North Yorkshire Integrated Care Board
2. NYP – North Yorkshire Place

What are the implications for?

Residents and Communities	-
Quality and Safety	-
Equality, Diversity and Inclusion	-
Finances and Use of Resources	-
Regulation and Legal Requirements	-
Conflicts of Interest	-

Data Protection	-
Transformation and Innovation	-
Environmental and Climate Change	-
Future Decisions and Policy Making	-
Citizen and Stakeholder Engagement	-

**The report should be written in Arial, font size 12, and using 1.15 spacing.
Please use paragraph numbers and do not stray from the following format:**

1. Main Report Detail

1.1

2. Next Steps

2.1

3. Recommendations

1. X
2. X

4. Appendices

North Yorkshire Health Collaborative

Joint Committee and Ambitious for Health programme

Bradford District and Craven Partnership Board

Richard Webb, Corporate Director: Health and Adult Services (North Yorkshire Council)

5th September 2025

Further information can be found in our [report to North Yorkshire Council Executive, 17th June 2025](#)

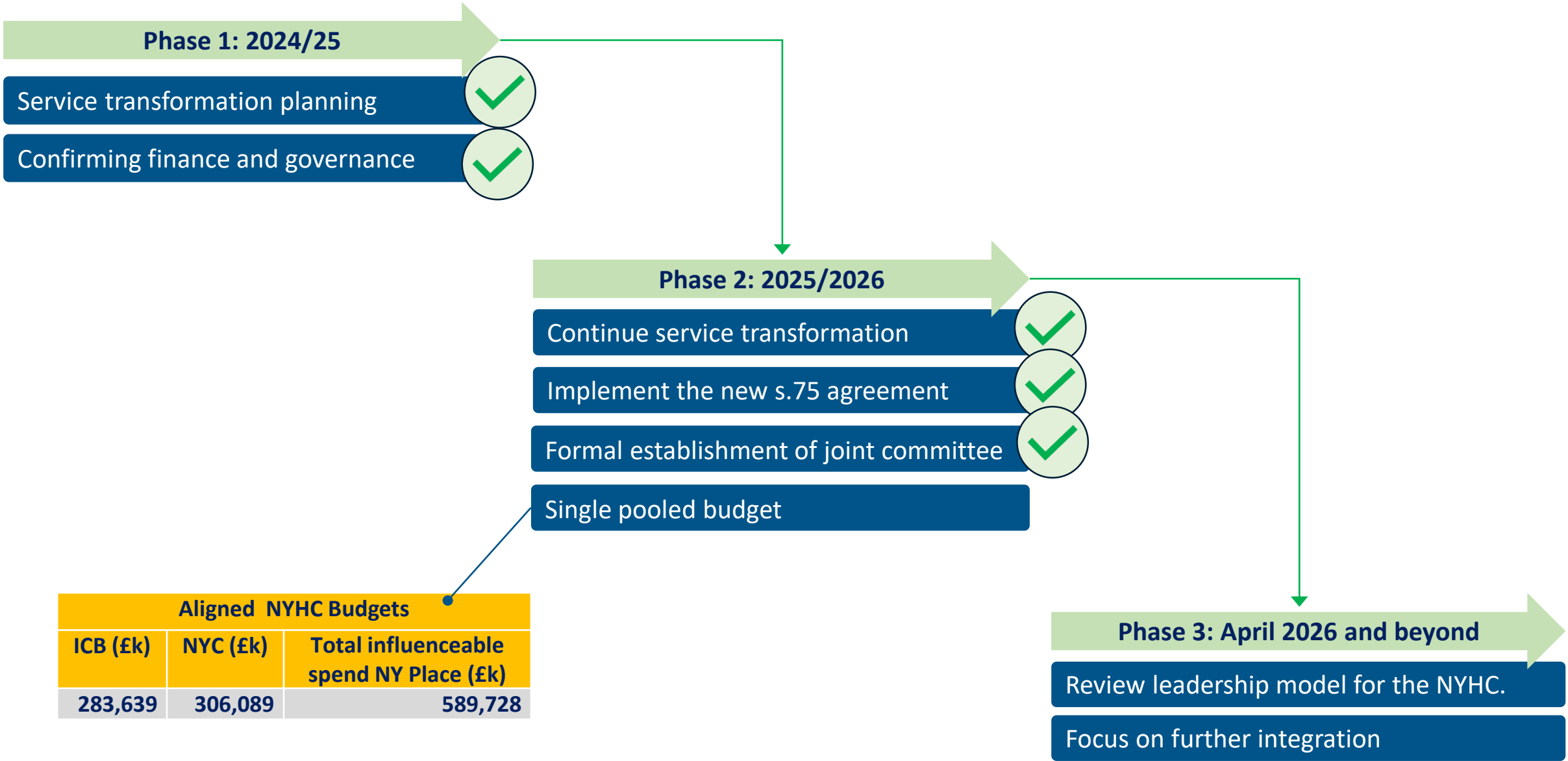
Aim: Meeting population health and care needs by:

- Committing to locality-based integration and neighbourhood health
- Implementing the core offers in a way that is most responsive to local need
- Maximising the impact of shared resources and assets
- Reducing duplication of effort / resources

Component Parts:

- The Joint Committee enables shared governance of meeting health and care needs locally
- Section 75 agreements provide the legal mechanism to pool funding - if required – but enables a move from partnership engagement to a framework for joint planning, joint financial stewardship and joint accountability.

Original High Level Timeline



- Within the legal document, the formal parties of the S.75 are HNY ICB and NYC – The **‘Partners’**
- Formal Joint Committee is convened for decision-making by **‘Partners’**
- Other Joint Committee members from across the system are identified as **‘Attendee Organisations’** within the s.75
- In this agreement, there are no pooled budgets (at this stage) and no decision-making powers delegated.
- But a **key role of the NYHC Joint Committee is to make recommendations for decisions** by Partner organisations within their **normal scheme of delegation**.
- **All members** can contribute to the forming of recommendations through discussion in the meetings.

HNY ICB S.75 Voting Members ('Partners')

- Place Director
- Place Finance Director
- Deputy Place Director

Non-Voting Members ('Attendee Organisations')

- Chief Executive Harrogate and District NHSFT
- Chief Executive Humber NHSFT
- Chief Executive Tees, Esk and Wear Valleys NHSFT
- Chief Executive University Hospitals Tees
- Chief Executive York and Scarborough NHSFT
- Representatives Bradford and Craven Health and Care Partnership (representing West Yorkshire ICB, Airedale NHSFT and Bradford and District Care Trust NHSFT)
- Primary Care
- LCP Representation
- Community First Yorkshire
- Chief Executive Independent Care Group

NYC S.75 Voting Members ('Partners')

- Chief Executive
- Corporate Director Health and Adult Services (Statutory Director of Adult Social Services)
- Director of Public Health

In attendance

- Senior managers and leaders from across the system, determined by content of agendas.
- May include representation from Lancashire and South Cumbria ICB

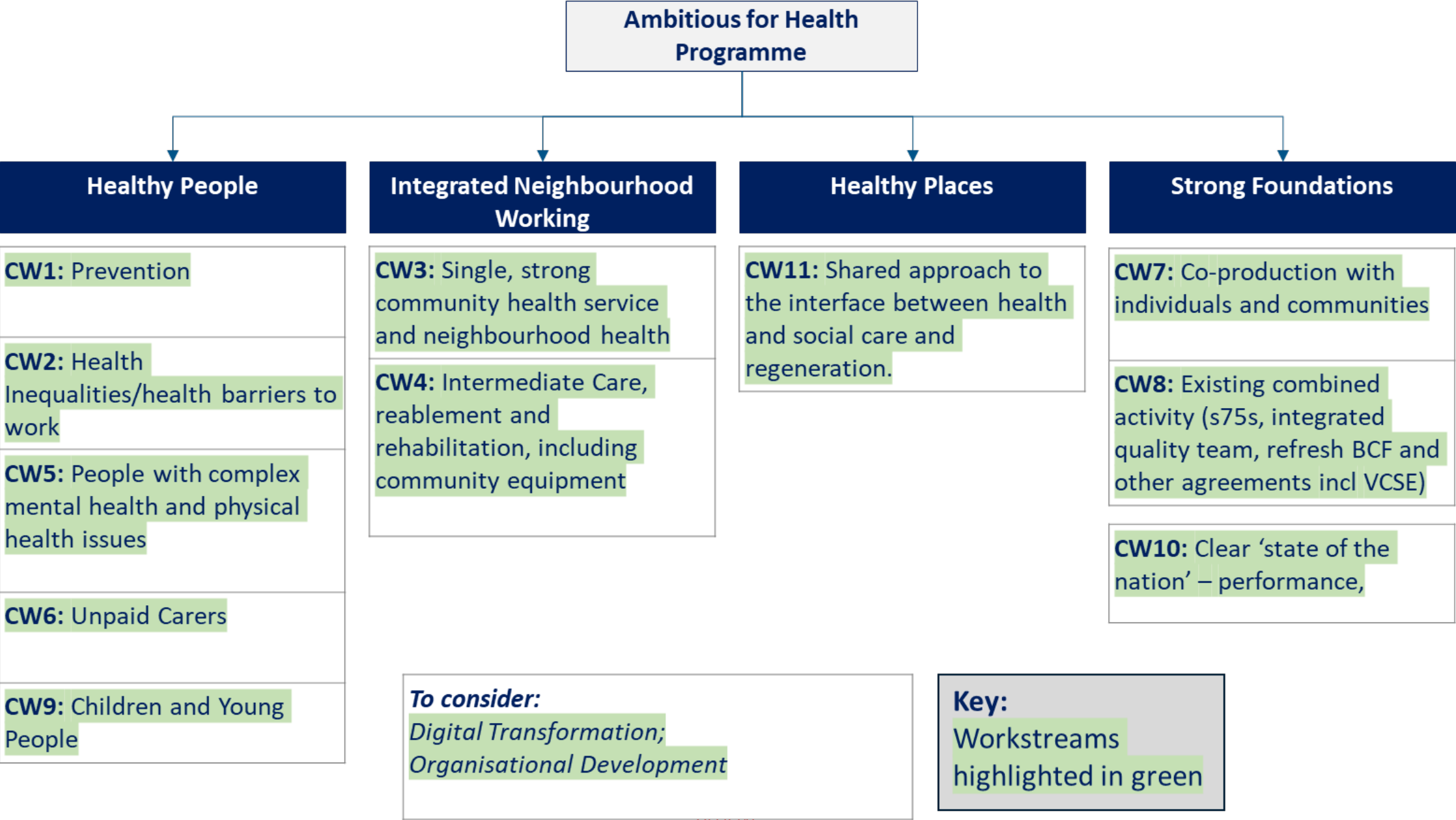
Humber and North Yorkshire
Health and Care Partnership



Aligned budgets (estimates)

	Service / budget / funding	ICB Budget Related to NYHC (£k)	NYC Budget Related to NYHC (£k)	Total influenceable spend NY Place (£k)
1	NHS Community Contracts	51,289		51,289
2	Non NHS Community Health Services	10,055		10,055
3	Community equipment and Wheelchairs	1,237	1,871	3,108
4	Ageing Well	2,364		2,364
5	Virtual Wards	2,329		2,329
6	Demand and Capacity fund	7,576		7,576
7	Prevention funding			0
8	Health Inequalities	548		548
9	Continuing Healthcare and Adult Social Care placements	90,408		90,408
10	S117 aftercare	16,353		16,353
11	Transforming Care Programme	10,282		10,282
12	Primary Care excluding Prescribing	1,391		1,391
13	Local Enhanced Services - Long-acting reversible contraception (LARC).	70		70
14	Local Enhanced Services - Homeless (Scarborough)	173		173
15	Local Enhanced Services - ICB	3,605		3,605
16	ASC Services		267,607	267,607
17	ASC Mental Health		9,522	9,522
18	Mental Health	84,558		84,558
19	LDA SDF - The Provision of a NY Transforming Care Programme Team	120		120
20	MH SDF Community Mental Health Transformation Programme	713		713
21	Healthy Child Service (0-19)		8,243	8,243
22	Sexual Health Service		4,221	4,221
23	Integrated Quality Team		1,206	1,206
24	Public Health Grant		13,419	13,419
25	Acute (Community-based)	56		56
26	Other (premises)	512		512
	Non BCF Place Proposed S75 Aligned Budgets	283,639	306,089	589,728

Ambitious for Health: Programme workstreams



NHS and social care
working together to
prevent people
spending
unnecessary time in
hospital or care
homes

**Strengthening primary and
community-based** care to enable
more people to be supported
closer to home or work.

Connecting people accessing health and care
to wider public services and third sector
support, including social care, public health
and other local government services.

- Implementation of single Hospital at Home / Intermediate Care / Reablement model for North Yorkshire
- Re-design and commissioning of the integrated community equipment service
- Development Care and Support Hubs to provide intermediate care and specialist dementia services

- Working towards collaboration and standardisation of Community Health services and Integrated Neighbourhood Teams
- Continued development of extra care housing schemes and supported accommodation for working age adults
- Integrated NHS Care Hubs – delivery of Catterick Integrated Care Campus, and continued development at other locations

- Action on health inequalities: physical activity, healthy ageing, women's health, smokefree generation
- Developing local models of enhanced prevention services
- Delivery of Get Britain Working Trailblazer (£10m) to address health barriers to work

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	11
Meeting date:	5 September 2025
Report title:	Ploughing through barriers – Healthwatch report on farming (Craven and North Yorkshire)
Report presented by:	Ashley Green, Chief Executive Officer (CEO), Healthwatch North Yorkshire
Report approved by:	N/A
Report prepared by:	Ashley Green, CEO, Healthwatch North Yorkshire

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:			
<u>Introduction</u> Farmers across North Yorkshire (including Craven) face long hours, physically demanding work, and the constant pressure of unpredictable weather and market forces. This means many struggle to find the time or support to prioritise their own health. North Yorkshire is one of the most rural counties in England, with 79% of its land used for farming. This close connection to the land comes with unique health challenges, and too often, farmers delay seeking help, leading to poorer health outcomes. This report by Healthwatch North Yorkshire explores why so many farmers delay or avoid seeking medical support and what can be done to change this. <u>Key highlights</u> We spoke to 220 people in the farming community to understand their experiences. The top three health concerns they face are: 1. 74% experience back, joint, knee, shoulder, or muscle pain. 2. 42% struggle with stress and anxiety. 3. 31% have sleep problems. Many farmers are reluctant to seek help. The report highlights key barriers: • Time constraints – 36% say their farm work stops them from prioritising health. “It is all encompassing because farming isn’t just a job.”			

- **Financial pressures** – Taking time off means lost income, and hiring staff to cover is costly.
- **Difficulties arranging appointments** – 40% say booking and attending appointments is too hard due to the unpredictability of farming work.
- **Rural access issues** – Distance, limited transport, and poor internet make access difficult.
- **Fear and stigma** – 28% feel their issues aren't "serious enough" to get help. "You don't admit weakness, especially if it's mental health weakness."
- **Concerns over gun licences** – Some worry that discussing mental health issues could result in losing their licence.
- **Lack of awareness about services** – "I have no idea what services are about."
- **Health professionals don't always understand farming** – "I just feel like health professionals have no idea about the farming way of life."
- **Some farmers trust their vet more than their GP** – "I haven't time to go to the doctor. It's easier to ask the vet."
- **Health takes a backseat** – "There is nothing wrong until we can't get out of bed in the morning."

Solutions

We want this report to help community and farming support organisations, as well as the NHS and GP practices, understand the key issues and challenges facing the farming community and what could help:

- **Bring services to farmers** – 57% want health drop-in clinics at auction marts. "Farmers won't make the time to go to the doctors, but it would help if the nurses came to them."
- **Provide mobile health units** – 36% said having health services visit rural villages and towns would make a difference. "Mobile services with drop in and mobile blood pressure and blood tests 'get us when we're there.'"
- **Provide ongoing community support** – Establish health workers who can connect farmers with services and reduce stigma.
- **Improve communication and awareness** – Better promotion of services, including in auction marts, community spaces, and pubs.
- **Utilise trusted professionals for signposting** – Train rural professionals like vets to help direct farmers to support.
- **Make healthcare more accessible** – Introduce walk-in clinics at GP practices. "Drop-ins at local GP surgery so you know you can go along without having to make an appointment which can be difficult to get to."
- **Ensure healthcare fits farmers' schedules** – 46% said more flexible appointment times would encourage them to seek help.
- **Improve understanding among healthcare professionals** – 50% believe that better training for GPs and nurses on farming life would make them more likely to seek help.

Outline how this supports our partnership vision and strategy

Whilst the report's findings cover all of North Yorkshire – it is important not to overlook the significance of the farming population in Craven, in what they add to the local economy and how these people, families and workers use and interact with health services, from primary and secondary care across Airedale Hospital and community services.

Across the Craven region there are 908 farm holdings and a total labour force of 1,964 people. Data from <https://www.gov.uk/government/statistical-data-sets/structure-of-the-agricultural-industry-in-england-and-the-uk-at-june>

The report highlights the late presentation of ill health to services due to work pressures and the challenge of rural access. And how the farming community has become a forgotten group of people with growing inequalities around ill health, higher than average suicide rates, poor access to services, and more recently financial concerns with more and more farmers now not making a sustainable profit.

Recommendation(s)

The Bradford District and Craven Partnership Board is asked to:

1. Consider this report
2. Identify any future actions to address the barriers faced by the farming community to accessing health care services.

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. [Ploughing through barriers – understanding the challenges and promoting help-seeking in farming communities](#)

Acronyms and Abbreviations explained

1. CEO – chief executive officer
2. GP – general practitioner

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

Ploughing through barriers:

Understanding the challenges and solutions to support farming communities access healthcare



Background & Aims

- Farmers often reluctant to use services, meaning they present later with these issues resulting in poorer health outcomes for this community.
- Our project aimed to explore what might be stopping the farming community in North Yorkshire (including Craven) from getting help for health and well-being issues and what services could do to make them work better for this community.
- We worked in collaboration with farming support organisations and North Yorkshire Council.



Methodology

- A mixed approach of quantitative and qualitative methods were used to collect data. We heard from 220 people.

Survey

- 149 survey responses.
- Questions were co-designed by Healthwatch North Yorkshire staff, volunteers, NYC and farming support organisations.
- Distributed widely across North Yorkshire, both online and via paper copies.

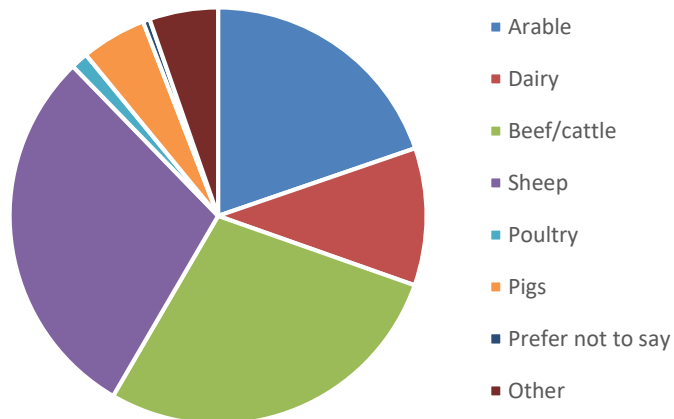
In-person engagement

- Heard from 71 people.
- Attended auction marts and agricultural shows across North Yorkshire
- Conducted a number of phone interviews.

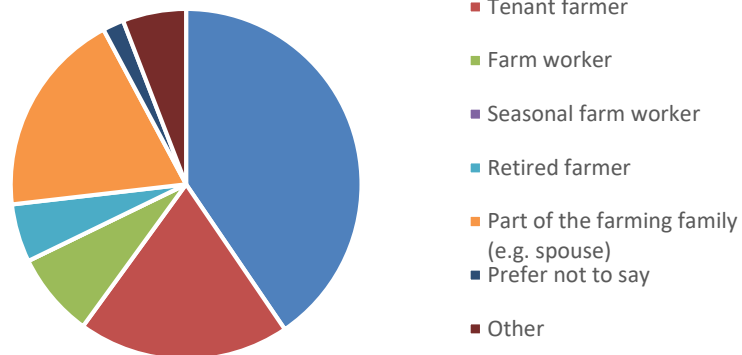


Who we heard from

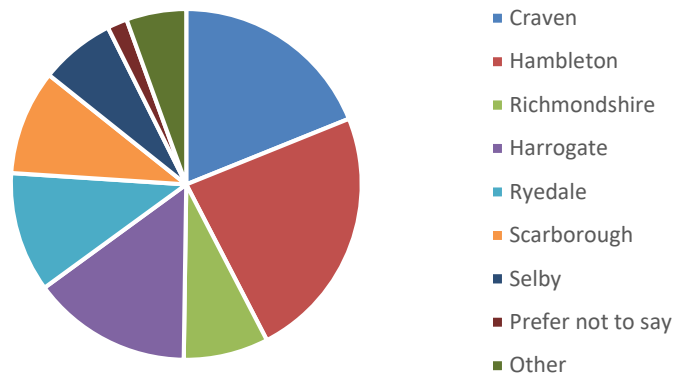
Type of farming



Are you:



Where in North Yorkshire do you farm?



Key findings

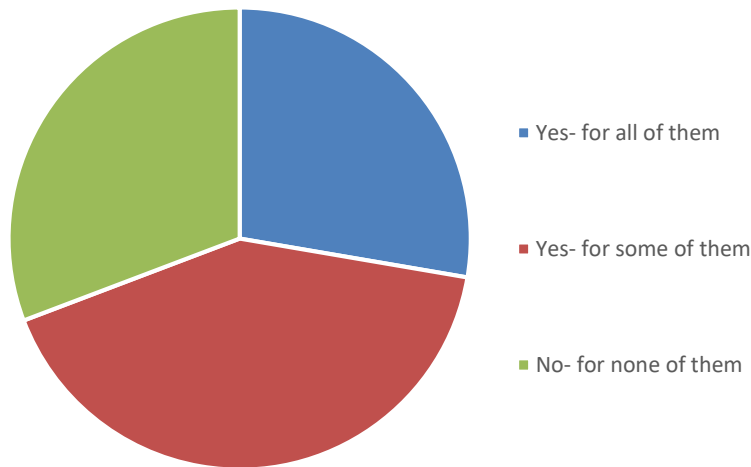
- When asked if they had experienced any health or wellbeing issues in the past year:

74% had experienced back, joint, knee, shoulder or muscle pain

42% had experienced stress & anxiety

31% had experienced sleep problems

Did you seek help in relation to any of these problems?



What stops farmers seeking help when

unwell

40% said it is hard to arrange health appointments around their farming work

36% said they don't have time to attend health appointments due to their farming work

Time off equals **lost income**, and hiring staff to cover is costly

Rural access issues: distance, limited transport, poor internet and phone signal

Worry that sharing mental health issues may lead to their **gun license** being taken away

What stops farmers seeking help when unwell?

Lack of awareness about available services and limited health knowledge

28% said they don't feel that their problems are severe enough to seek help

27% said they don't think that staff in health services understand the farming way of life and its pressures

Health takes a backseat: the farm comes before health

What would help farmers seek help when unwell?

Bringing services to the farming community

57% would like to have drop-in clinics at local farming sites where no appointment is needed (e.g. field nurses at auction marts)

36% said mobile health units in local villages/towns would help

Ongoing support through community-based approaches

In-person health support in rural areas to help encourage farmers to put their health first.

What would help farmers seek help when unwell?

Improving communication and awareness

Better promotion of health services and information at **auction marts, community hubs, pubs**

Reassure farmers that support is **confidential**

Use **farmer friendly language** when speaking with farmers about healthcare

Utilising trusted professionals for signposting

Train rural professionals (such as vets) to signpost farmers to health and wellbeing support

What would help farmers seek help when unwell?

Improving accessibility and trust

42% said they would like to see farmers walk-in clinics at GP practices

46% said more flexible appointment times would help

50% said healthcare professionals who understand the farming way of life and its pressures

Impact so far

- **Selby Living Well Team (NYC)** are trialling attending Selby auction mart to link with the farming community and promote their support service.
- **University Hospitals Tees (cancer & thoracic teams)** are looking to reach the farming community and are going to trial working with local vets to promote their referral pathway and have nurses attend auction marts.
- This autumn we will be delivering protected learning time **training sessions for GP practice staff** to raise awareness of barriers to access for the farming community.
- We have received interest from three PCNs (North Riding, Hambleton N&S, Richmondshire) to trial **farmers walk in clinics**.
- The findings from our report have informed the **NYC Rural Health Needs Assessment**.
- Our report has prompted **questions in Parliament** (via Julian Smith MP) and in October we are meeting Kevin Hollinrake, MP (Chair of the Conservative Party)

Thank you for listening

Any questions?



Meeting name:	Bradford District and Craven (BDC) Partnership Board
Agenda item number:	12
Meeting date:	5 September 2025
Report title:	Risk Register (Cycle 2 2025/26)
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:			
BDC senior managers to discuss the Quality risks – 31 July 2025 BDC executive team meeting – 13 August 2025 BDC Finance and Performance Sub-Committee – 20 August 2025			
Executive summary and points for discussion:			
This report provides details of all risks on the BDC Place Risk Register at the end of the current risk review cycle (Cycle 2, 2025/26). The total number of place risks for consideration, the numbers of risks which are marked for closure, new, increasing or decreasing in score are set out in the report, along with the numbers of Critical and Serious Risks. A comprehensive refresh of the BDC risk register has been undertaken in Cycle 2 and a total of 16 risks has closed, creating four new risk descriptions for workforce, care home sustainability, ADHD and Autism assessments and CHC. The total number of risks remaining are 20 risks. The paper includes the Cycle 2 review of the Board Assurance Framework (BAF) for all five places which is attached at Appendix 3. 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 Partnership Board is asked to review the risks and:			

1. **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in BDC following any recommendation 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 for Cycle 2 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:

The report provides details of all risks on the BDC Place Risk Register and an update of the Board Assurance Framework review. The various ICB Risk Registers support and underpin the BAF, and relevant links will be drawn between risks on each going forward.

Appendices:

Appendix 1: BDC Place Risk Register, Cycle 2 2025/26

Appendix 2: BDC Place Risks on a Page Report, Cycle 2 2025/26

Appendix 3: West Yorkshire ICB Board Assurance Framework, Cycle 2 2025/26

Acronyms and abbreviations explained:

- 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
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1. Purpose of this report

- 1.1 The Bradford District and Craven (BDC) Partnership Board 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.

2. Context and Background information

- 2.1 The WY 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 24 June 2025 which details the risk management process including the risk scoring matrix.
- 2.3 During each risk cycle, risk leads across the ICB review the risks on each place risk register. This supports the identification of place risks scoring 15+ and common risks on the registers. The detailed review and mapping of the risks also enables the flagging of potential anomalies in scoring or wording between different places, supporting the discussions that ensure the continued evolution of the risk register.
- 2.4 All corporate risks, place risks scoring 15 and above and common risks will be presented to the relevant WY ICB committee and to the WY ICB Board on the following dates:
 - West Yorkshire ICB Finance, Investment and Performance Committee – 2 September 2025 (AM)
 - West Yorkshire ICB Quality Committee – 2 September 2025 (PM)
 - West Yorkshire ICB Board – 23 September 2025

- 2.5 The Cycle 1, 2025/26 [Corporate Risk Register](#), the common risk mapping across the five places and the Cycle 1 [Board Assurance Framework](#) was presented to West Yorkshire Integrated Care Board on 24 June 2025.

3. Key Points

- 3.1 This report set out the key changes to the risk profile of the BDC place risks aligned to the BDC Partnership Board during risk Cycle 2 2025/26 which commenced on 25 June 2025 and will end after the WY ICB Board meeting on 23 September 2025.
- 3.2 The extract of the Risk Register (Appendix 1) provides further detail of all risks including the key controls and assurances for each risk. The 'Risk on a Page' report (Appendix 2) provides a summary of the key changes since the last review cycle.

There are 36 risks on the BDC place risk register:

- 18 risks are aligned to the System Quality Sub-Committee
- Six risks are aligned to the Finance and Performance Sub-Committee
- 12 risks are aligned to both the System Quality Sub-Committee and the Finance and Performance Sub-Committee

The following changes have been made in Cycle 2, 2025/26

- 14 high scoring risks (15+ in risk score)
- Five new risks
- One risk reduced in risk score
- Sixteen closed risks

3.3 High level risks

There are 14 high level risks (risk score 15+) aligned to the BDC Partnership Board in cycle 2, 2025/26:

Risk	Sub-Committee Alignment	Cycle 2 2025/26	Update for Cycle 2 2025/26
2527 - 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	Finance and Performance Sub-Committee	20 (I4xL5)	Static – 1 cycle The risk was added in Cycle 1 (2025/26) to reflect the financial position in the new financial year.

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.			
2447 - Renal Services Capacity - Renal Services Capacity There is a risk that as the demand for haemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity that it will not be possible to provide timely dialysis for some patients. Due to increasing demand within the local demographic and an aging and limited footprint, which has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the	Finance and Performance Sub-Committee/ System Quality Sub-Committee	20 (14xL5)	Risk cycle – Static 4 cycles No further updates in Cycle 2, there are discussions taking place whether the service will expand into Sundays and further updates will be provided in Cycle 3.

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.			
2541 - There is a risk of increased waiting lists and financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1m all age cost) due to: Staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for commissioned services; and Increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments) leading to a significant unbudgeted cost to the ICB. This could result in inequitable access to services and delays in treatment for those who do not exercise Right to Choose and further deterioration in the statutory duty service offer for children waiting for assessment,	Finance and Performance Sub-Committee/ System Quality Sub-Committee	16 (I4xL4)	Risk cycle – new risk Three separate neurodiversity risks (IDs 2266, 2227 and 2039) have been merged, and a new risk has been created which covers the quality aspects as well as the financial pressures.

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).			
2538 - There is a risk that initial health assessments for children in care, will not be completed within the statutory time frames. This is due to limited medical resource capacity, increased demand and the complexity of Place-based commissioning arrangements. This could result in health needs assessments of Children in Care being delayed and the health needs of these vulnerable children not being met, which could impact upon long term outcomes.	System Quality Sub-Committee	16 (I4xL4)	Risk cycle – New risk
2433 - 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	Finance and Performance Sub-Committee	16 (I4xL4)	Risk cycle – static 1 cycle This risk was updated in Cycle 1 2025/26.

(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			
2386 - There is a strong and increasing risk to the sustainability of the VCSE sector and the potential collapse of services which will impact on patients having to be transferred to a different pathway/service. This is due to Financial sustainability as system funding comes under increased pressure; Ability to recruit and retain staff (especially due to employment uncertainty and cost of living); and the decision to withdraw the VCSE	Finance and Performance Sub-Committee/ System Quality Committee	16 (I4xL4)	Risk cycle – Static 5 cycles

infrastructure contract due to local authority budget pressures. This could result in a decrease in VCSE capacity to engage with the system and an increase in usage of statutory services and a reduction in proactive preventative work to tackle inequalities.			
2266 - There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	Finance and Performance Sub-Committee	16 (I4xL4)	Risk cycle – Closed. Discussed at BDC executive team meeting and it was agreed to close and to amalgamate risks 2266, 2227 and 2039 (all re: ADHD and Autism). The new risk ID is 2541.

2227- 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.	System Quality Sub-Committee	16 (I4xL4)	Risk cycle – Risk closed Three separate neurodiversity risks (IDs 2266, 2227 and 2039) have been merged, and a new risk has been created which covers the quality aspects as well as the financial pressures under ID 2541.
2173 - BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and	Finance and Performance Sub-Committee	16 (I4xL4)	Risk cycle – Decreasing risk score. Following review by the risk owner and senior manager, the risk score has reduced from 20 to 16. The lifting of the Best Value Notice on Bradford Council, together with a robust 2025/26 budget supported by increased council tax and other sources of income, have led to a decrease in the risk score.

the management of winter pressures.			
2039 - CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.	System Quality Sub-Committee	16 (I4xL4)	Risk cycle – Risk closed Three separate neurodiversity risks (IDs 2266, 2227 and 2039) have been merged, and a new risk has been created which covers the quality aspects as well as the financial pressures under ID 2541.
2519 - 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,	System Quality Sub-Committee	15 (I3xL5)	Risk cycle – Risk closed The four CHC risks have merged (IDs 2519, 2520, 2518 and 2516) to create a new risk under ID 2544.

challenges and appeals, and staff burnout.			
2314 - 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	Finance and Performance Sub-Committee/ System Quality Sub-Committee	15 (I5xL3)	Risk cycle – Static 2 cycles The following updates have been added in Cycle 2: • Protocols are in place for the identification and management of RAAC and associated structural risks including regular inspections, emergency response plans and continuous improvement efforts • Multi-year structural works remediation programme planned. • Multi-disciplinary design team to identify and mitigate risks associated with the programme of works. • Extensive contractor procurement and relationship management approaches in place. • Member of the national RAAC Structure Support Group, national RAAC Research Programme and RAAC EPRR programme sharing learning and best practice to inform the planning of RAAC structural works.

Airedale General Hospital site and a transfer for the continuing provision of services without this facility for months or years. In the event of catastrophic failure of the AGH could result in damage to the partnership's reputation, legal proceedings, claims for compensation and regulatory intervention (implications for AFT and also the NHS WY ICB due to vicarious liability). This links to risk number 2312 (risk that AFT is unsuccessful in securing funding from the new hospitals programme).			
2312 - 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).	Finance and Performance Sub-Committee	15 (I5xL3)	Risk cycle – static 3 cycles The controls have been updated to reflect the inability to fully decant all affected wards, which impacts the pace of structural works, due to limited non-RAAC affected decant space and ongoing inpatient demand. Linked to Risk ID 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.			
2168 - SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	Finance and Performance Sub-Committee	15 (I3xL5)	Risk cycle – static 14 cycles The ICB organisational change process will have an impact on staff capacity to develop programmes and deliver targets. No change to the risk score.

3.4 New risks

There are five new risks aligned to the System Quality Sub-Committee in Cycle 2, 2025/26. Risk IDs 2538 and 2541 is described above as well as the following three new risks;

Risks	Sub-Committee alignment	Risk score	Update for Cycle 2, 2025/26
2544 - There is a risk that the ICB is unable to provide good quality CHC at an affordable cost due to: Increasing demand; CHC workforce capacity; and increasing placement costs This could lead to an inability to deliver all ICB statutory functions, a lack of high quality and cost effective care and an overspend against the ICB budget, individuals presenting with deterioration due to unmet needs and BDC place financial targets not being met.	System Quality Sub-Committee/ Finance and Performance Sub-Committee	12 (I3xL4)	New risk. A new risk has been created to encompass all quality and financial aspect of the risk to CHC. The separate CHC risk IDs 2519, 2520, 2518 and 2516 have been closed.
2543 - WORKFORCE SUSTAINABILITY There is a risk that the future health & care workforce will be insufficient to meet the increasing demands of BDC patients, service users and populations due to: Insufficient resource to deliver workforce transformation pending the refresh of the NHS Long Term Workforce Plan (expected summer 2025); Misalignment between education programmes (both in quantity and nature) and anticipated demand across all clinical professions; Capacity to host clinical placements across all professions is insufficient to train the numbers of healthcare professionals required, particularly outside of acute settings; Gaps in wider	System Quality Sub-Committee	12 (I4xL3)	Risk cycle – New risk The BDC executive team agreed to merge the separate workforce risks under IDs 2422, 2420, 2418, 2419, 2423 and 2421 to create a new workforce risk.

Risks	Sub-Committee alignment	Risk score	Update for Cycle 2, 2025/26
workforce data (primary care, VCSE and social care) inhibit the identification of areas of pressing need, compromising the targeting of partnership level interventions; and 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 could lead to an inability to provide high quality care to all patients and service users and meet the broader objectives of the health and care partnership.			
2542 - CARE HOME MARKET SUSTAINABILITY There is a risk to the sustainability of the current care home market due to: Insufficient social care workforce to deliver safe and quality care services due to a lack of interest/supply from potential domestic workforce; Care sector terms and conditions, pay and progression; and Insufficient funding being available to fund the changes to the national insurance contributions. This could lead to care and nursing home closure, displaced service users, reduced choice for service users, impact on quality of care and delays to patient flow from hospital to	System Quality Sub-Committee/ Finance and Performance Sub-Committee	12 (I4xL3)	New risk The three care home sustainability risks under risk IDs 2434 and 2477 have been merged to create a new risk description.

Risks	Sub-Committee alignment	Risk score	Update for Cycle 2, 2025/26
community settings and create pressures on the wider health and social care system.			

3.5 Increase in risk score

None.

3.6 Decrease in risk score

One risk has decreased in Cycle 2, 2025/26. Risk ID 2173 is highlighted in the section above, under high scoring risks.

3.7 Closed risks

16 risks have closed during cycle 2 2025/26. Risk IDs 2266, 2227, 2039 and 2519 are described above, in addition, the following 12 risks have closed;

Risk ID	Sub-Committee	Risk Description	Reason for closure
2448	System Quality Sub-Committee	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	It has been agreed to close the risk on the BDC risk register and to review the risk again as part of the winter pressures in Cycle 3. There is a vaccine and disease outbreak risk on the corporate risk register (ID 2456) as most action will be taken at WY level.

Risk ID	Sub-Committee	Risk Description	Reason for closure
		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.	
2434	System Quality Sub-Committee	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	The care home sustainability risks (IDs 2477 and 2434) have been merged to create a new risk under ID 2542 (see above).

Risk ID	Sub-Committee	Risk Description	Reason for closure
		in maintaining safe services and delays in hospital discharges.	
2422	System Quality Sub-Committee	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.	The workforce risks have been reviewed by the BDC executive team, and it has been agreed to close workforce risks 2422, 2420, 2418, 2419, 2423 and 2421 and merge the details into one overall workforce risk under ID 2543.
2420	System Quality Sub-Committee	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.	The workforce risks have been reviewed by the BDC executive team, and it has been agreed to close workforce risks 2422, 2420, 2418, 2419, 2423 and 2421 and merge the details into one overall workforce risk under ID 2543.
2419	System Quality Sub-Committee	Due to demand across the health and care sector and limited resource, there is a risk that traditional	The workforce risks have been reviewed by the BDC executive team, and it has been agreed to close workforce risks 2422, 2420, 2418,

Risk ID	Sub-Committee	Risk Description	Reason for closure
		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.	2419, 2423 and 2421 and merge the details into one overall workforce risk under ID 2543.
2418	System Quality Sub-Committee	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	The workforce risks have been reviewed by the BDC executive team, and it has been agreed to close workforce risks 2422, 2420, 2418, 2419, 2423 and 2421 and merge the details into one overall workforce risk under ID 2543.

Risk ID	Sub-Committee	Risk Description	Reason for closure
		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.	
2520	System Quality Sub-Committee	There is a risk that individuals will not be reviewed in a timely manner due to challenging workforce issues in CHC resulting in increased cost to the ICB, the ICB not delivering against its statutory duties, or individuals presenting with unmet needs.	This risk has been merged with four CHC risks (IDs 2519, 2520, 2518 and 2516) to create a new risk under ID 2544 (see above).
2518	System Quality Sub-Committee	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.	This risk has been merged with four CHC risks (IDs 2519, 2520, 2518 and 2516) to create a new risk under ID 2544 (see above).
2516	Finance and Performance Sub-Committee/ System Quality Sub-Committee	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.	This risk has been merged with four CHC risks (IDs 2519, 2520, 2518 and 2516) to create a new risk under ID 2544 (see above).
2477	Finance and Performance Sub-Committee/ System	There is a risk of significant adult social care (statutory care provision) market failure and disruption in Bradford place due to	The care home sustainability risks (IDs 2477 and 2434) have been merged to create a new risk under ID 2542 (see above).

Risk ID	Sub-Committee	Risk Description	Reason for closure
	Quality Sub-Committee	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.	
2423	System Quality Sub-Committee	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.	The workforce risks have been reviewed by the BDC executive team, and it has been agreed to close workforce risks 2422, 2420, 2418, 2419, 2423 and 2421 and merge the details into one overall workforce risk under ID 2543.
2421	System Quality Sub-Committee	There is a risk that capacity to host clinical placements across all professions is	The workforce risks have been reviewed by the BDC executive team, and it has been agreed to close

Risk ID	Sub-Committee	Risk Description	Reason for closure
		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.	workforce risks 2422, 2420, 2418, 2419, 2423 and 2421 and merge the details into one overall workforce risk under ID 2543.

4. Emerging risks

4.1 The following risks are being developed on the WY ICB corporate risk register in relation to the WY ICB organisational change:

- Risk to being able to deliver statutory functions in respect of quality and safety including safeguarding
- Financial risk due to lack of funding for staff redundancy costs and exit packages
- Risk of prolonged distraction, disruption and people starting to disengage impacting on the ICB's core activities
- Risk of increased turnover of staff and wellbeing concerns for staff due to the organisational change programme and the development of the ICB operating model.
- The risk on industrial action will also be reviewed due to recent strike action by resident doctors (previously referred to as Junior Doctors) and the possibility of strike action by nursing colleagues.

5 Board Assurance Framework (BAF) update for Cycle 2 2025/26

5.1 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.

5.2 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**.

5.3 The Board Assurance Framework reviewed in Cycle 2 2025/26 is attached at Appendix 3 and the review for Cycle 2 is highlighted using blue font.

5.4 The table below shows key changes which has been made to the BAF following review by BDC senior managers during Cycle 2, 2025/26;

BAF risk	Cycle 4, 2024/25	Cycle 2 2025/26	Reason for change
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.	12	16	The risk score has increased from 12 to 16 (which is in line with the overall WY ICB position). The risk appetite is currently cautious. Agreed to increase the target risk score from 6 to 8 due to limited tolerance. The workforce challenges in BDC are in line with those across West Yorkshire as a whole. The mitigating actions have been updated to include progress made in supporting the social care workforce with initiatives to recruit staff which will continue. Also, working across the system partners including Higher Education Institutions to develop a pipeline for registered health and care roles.
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.	6	9	The risk score has increased from 6 to 9 due to work needing to be undertaken with regards to digital upgrade for systems and software. The business case has been approved but not implemented to date. The primary care impact is on new approach to shared care protocols/ agreement still to be signed off.

6 Next Steps

- 6.1 The risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 23 September 2025.
- 6.2 Subsequent to that meeting, any closed risks will be archived and open risks carried forward to the next risk review cycle.

7 Recommendations

7.1 The BDC Partnership Board is asked to review the risks aligned to the Board and:

- **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in BDC following any recommendation from the relevant sub-committees.
- **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.
- **RECEIVE** and **NOTE** the Board Assurance Framework for Cycle 2 2025/26

2314	05/06/2023	Both PFC and QC	Improve healthcare outcomes for residents	13	(E)A(3)	6	(E)A(2)	Matt Sandford	Therese Paten	RAAC (reinforced, autoclaved, aerated concrete) AT AREDALE HOSPITAL There is a risk of long term disruption of service provision at Aredale General Hospital due to building component failure, as the majority of the floor, ceilings and walls (B&K of the building) are built of Reinforced Autoclaved Aerated Concrete (RAAC) and indirect infrastructure including flow of supply of electricity and other utilities (shown as display chair) throughout the site OR the emergency plan outlines circumstances which trigger an earlier date from which services at Aredale 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 a subunit or of hospital facilities at the Aredale General Hospital site and a transfer of the continuing provision of services without the 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 leads 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 SMO for Estates including RAAC Chief Operating Officer. Securing the future committee: Security the future Programme Board; and Securing the future delivery group with responsibility for the planning and evaluation 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 £36.6m 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 are also being used to support care to be evacuated. 3. Business continuity plan has been developed which describes the transfer of activity to other trusts in WYN to maintain patient safety and services. - Refined safety plans developed via PDR to transfer activity to other WYAT 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) collects RAAC data for more efficient reporting as of 2023 the following control measures have been added: 9. Operations Director for RAAC (this role also interfaces with new hospital programme) and Director of Estates appointed. 10. Protocols in place for the identification and management of RAAC and associated structural risks including regular inspection, emergency response plans and continuous improvement efforts 11. Multi-year structural works remediation programme planned. Multi-disciplinary design team to identify and mitigate risks associated with the programme of works. 12. Full programme governance mobilised and embedded at both AGH locations and within the Trust's programme. 13. Extensive contractor procurement and relationship management approaches in place. 14. Member of the national RAAC Structure Support Group, national RAAC Research Programme and RAAC EPRR programme sharing learning and best practice to inform the planning of RAAC structural works.	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 WY 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 in the date for that WY plan to be completed has been extended beyond October 2023/24. 5. Situation extends beyond RAAC panels a 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 7. 2023/2024 inability to fully decant all affected wards to increase the pace of structural works within identified areas due to lack of RAAC affected decant space and demand for inpatient care.	- RAAC at AGH (AFT) is registered on the NHS WY ICB risk register and included in the WY BAF - RAAC is routinely reported through WY and BOC HCF governance arrangements. RAAC is a known risk for the WY Association of Health Trusts (WYAHFT). - Emergency planning exercise held on the multi-agency RAAC protocol (6 June 2023). A further exercise is 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 - workshops 1 and another workshop planned - Internal audit review of governance and assurance 2022/23 focused on the organisation and function of the programme's RAAC maintenance and new hospital programme. - Latest national research programme guidance was published in the spring of 2023 and AFT are applying the learning from this guidance. - Investigation in line with previous baseline 2022/22 comparison with 2022/23 5/7% deterioration with 37% of plants with defect. - Internal audit review of governance and assurance 2022/22 focused on the organisation and function of the programme's RAAC maintenance and the new Hospital Programme. - Memorandum of Understanding (MOU) aligned to business cases 2022/2026	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 - 2 (Active)(s)	
2312	05/06/2023	Finance	Improve healthcare outcomes for residents	13	(E)A(3)	10	(E)A(2)	Lekley Tibbott	Matt Sandford	RAAC (reinforced, autoclaved, aerated concrete) AT AREDALE HOSPITAL - Although Aredale NHS Foundation Trust has been successful in securing funding from the new hospitals programme to replace Aredale 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, Aredale 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 remains, or that a significant RAAC incident could occur ahead of this date.	System F&P Committee meets to monthly and planning new undertaken on a system footprint. System performance and recovery dashboard 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 S&P&P Recovery plans being built into S&P&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 2024/25 finalised and signed off at the end of May 2024. Oct 2024 - All 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	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 RAAC 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 BOC HCF governance arrangements. RAAC is a known risk for the WYAHFT. 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. Once RAAC reports 6. ANHSFT BAF links to risk register to provide assurance	Internal Audit review of governance and assurance 2022/23 focused on the organisation and function of the programme's RAAC maintenance and the new Hospital Programme. N/A	Static - 3 (Active)(s)	
2168	17/10/2023	Finance	Improve healthcare outcomes for residents	13	(E)A(3)	4	(E)A(2)	Kerry Weir	Sohail Abbas	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (they constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual IC3 performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	System F&P Committee meets to monthly and planning new undertaken on a system footprint. System performance and recovery dashboard 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 S&P&P Recovery plans being built into S&P&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 2024/25 finalised and signed off at the end of May 2024. Oct 2024 - All 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/NAO programmes.	Provider performance monitoring via Trust performance groups Monitoring of system performance at SFPC Monitoring of provider quality performance at SOC Monitoring of transformation programme work/outcome 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 CIC 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 a 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) The IC3 organisational change process will have an impact on staff capacity to develop programmes and deliver targets	Static - 14 (Active)(s)
2544	15/07/2023	Both PFC and QC	Improve healthcare outcomes for residents	12	(E)A(4)	4	(E)A(2)	Vickie Mihov	Grainne Eloi	There is a risk that the IC3 is unable to provide good quality CHC at an affordable cost due to increasing demand; CHC workforce capacity; and increasing placement costs This could lead to an inability to deliver at ICB statutory function, a lack of high quality and cost effective care and an over-reliance against the IC3 budget. Individuals presenting with deterioration due to unmet needs and BOC place financial targets not being met.	1. Work to ensure the IC3 is able to understand capacity and demand across Place 2. Regular staff supervision and 1:1s in place to address any wellbeing/welfare issues 3. Support of organisation to recruit clinicians into open outside of collaboration with local Council 4. Developing list of individuals not reviewed in a timely manner 5. Market Monitoring and Sustainability activity in place in collaboration with Local Council 6. Direct conversation with Independent Sector Providers relating to gaps in local provision and areas for development 7. Cost setting activity in consideration of National Living Wage, Consumer Price Index as well as increased costs related to needs of someone eligible for NHS CHC 8. Implementation of standardised Commissioning Principles via the Choice and Equity Policy 9. Working alongside local Council to align costs where appropriate.	1. Sickness absence due to work related conditions 2. Inability to recruit into critical posts 3. 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 (potential compensation/legal fees) 4. Financial challenges of increasing the workforce in current operating model, even if the workforce is available. 5. Inability to undertake the review due to gaps in clinical workforce 6. Inability to monitor any changes made to care packages by Local Council for those jointly funded where this results in an unnecessary cost pressure 8. Lack of notification from LA when Provider request further visits in, and LA agree them. 9. Inability to block contract reduce possibility of making cost effective commissioning decisions at Place 10. Spot Purchase costs are often higher than block contract arrangements 11. Gaps in local markets and closures of care homes 12. Out of area placements required for individuals with specialist needs - no ability to influence this market where at a distance from commission 13. Provider will identify alternative methods for income generation (i.e. 1 - 4 costs) 14. Embedding Commissioning Principles is a substantial piece of work and requires a new approach to patient conversations with registered nurses 15. Implementation of Commissioning Principles has a significant impact upon operational processes and can delay commissioning decisions or lead to complaints and challenges. 16. 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. 17. Challenging financial position of Local Councils resulting in increased referrals for A&C consideration 18. Pressure in Acute Hospitals increases rates of individuals being Fast Tracked at full expense of ICB where Fast Track may not be appropriate.	1. Regular monthly budget holder and finance meetings in place to address shifts in position 2. Reduction in leave over the last 12 months. 3. Fast track reviews are completed on time 4. Case management activity ongoing 5. Developing standard specifications for A&C care contracts 6. Regular data checking activity in place to assure financial data 7. Staff aware of responsibilities in regard to Scheme of Delegation 8. Preb Audit and case back processes in place and in operation 9. Packages of care to be delivered via PSH Direct payments are carefully considered in terms of statutory duties of the IC3 to deliver 10. Overdue reviews lead to potential lack of up to date needs and care plan, or costs for care 11. Significant staffing gaps remain, particularly clinical 12. A&C 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 13. Relationships at Place with Local Council can be strained at an operational and strategic level 14. Inability to manage workload with resources in place or configured in current form. 15. Gap in assurance of delivery of services where commissioned externally 16. Inappropriate referrals coming to the team resulting in workforce capacity being further reduced. 17. Requirement for a cost setting tool to support standardised cost setting up against base fees for all care home providers 18. Risk of not accessing a placement for an individual if cost "demands" are not met. 19. Risk of paying more for weekly fee via 1:1 support or other over commissioned package 20. Inflationary upfits do not meet requirements of the sector. 21. Spend on PSH Direct Payment budgets is subject to misuse and mismanagement 22. Potential for inappropriate decisions made on PSH packages of care following historic agreements. 23. Overdue reviews lead to potential lack of up to date needs and care plan, or costs for care 24. Lack of Councils responsible for agreeing upfits and rates for non-eligible individuals, with offering level of assurance/authority to achieve needed of exceptional resulting in increased cost to the IC3 through future funding arrangements. 25. Lack of resources to support rates for individuals and therefore reliance of all fully funded packages and outcomes in a timely manner. 26. Unpredictability of the patient cohort mean significant increases in costs can occur at any time.	New - Open		
2543	15/07/2023	Quality	Improve healthcare outcomes for residents	12	(E)A(3)	6	(E)A(2)	Andrew Miller	Philipp Hubbard	WORKFORCE SUSTAINABILITY There is a risk that the future health & care workforce will be insufficient to meet the increasing demands of BOC patients, service users and populations due to insufficient resources to deliver workforce transformation pending the rollout of the NHS Long Term Workforce Plan (expected summer 2023). Investment in workforce development (both in quantity and nature) and anticipated demand across all clinical professions; Capacity to host clinical placements across all professions is insufficient to train the numbers of healthcare professionals required, particularly outside of acute settings; Gaps in wider workforce data (primary care, VCSE and social care) inhibit the identification of areas of pressing need, compromising the targeting of interventions; and Traditional workforce models and pathways are not sufficiently innovative to create a sustainable workforce profile or efficient pathways to meet the needs of population. This could lead to an inability to provide high quality care to all patients and service users and meet the broader objectives of the health and care system.	1. Development of a data driven approach to identifying areas of most acute risk, meaning resources can be directed accordingly. 2. Utilisation of system workforce for a including People Priority to develop shared approach to international recruitment. 3. Engagement with WYHC and national partners 4. Programme to build placement capacity across BOC system in order to develop pipeline for future registered workforce 5. Place based Learning Needs Analysis process in development 6. Market Monitoring and Sustainability activity in place in collaboration with Local Council 7. Work Yorkshire IC3 Workforce Working Group focusing on innovative workforce development has been formed, with BOC system representation. 8. Establishment of programme within BOC People Priority to focus upon non-medical clinical placements and quality of clinical education. 9. Engagement mechanisms with actors to ensure suitability of graduates for roles within the system, with primary care an area of focus. 10. Re-engaging with BOC Priority Programme to identify areas of pressing need, meaning the targeting of interventions; and Traditional workforce models and pathways are not sufficiently innovative to create a sustainable workforce profile or efficient pathways to meet the needs of population. 11. System approach to review and increase workforce transformation and OD capacity through BOC Quality and Safety and Finance Committee. Along with the system approach to review and increase workforce transformation and OD capacity through BOC Quality and Safety and Finance Committee. 12. 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 13. West Yorkshire IC3 Workforce Working Group focusing on innovative workforce development has been formed, with BOC system representation. Specific streams on innovation and workforce supply will contribute to workforce innovation. 14. Reporting of workforce data via a dashboard to System Finance and Performance Committee, with annual deep dive. 15. Ongoing dialogue with external partners including NHS England, Skills for Care and WYHC on data availability. 16. System approach to issue identification through BOC Workforce Priority 17. Ongoing dialogue with internal partners including social care leads, primary care leads and VCS leads to ascertain qualitative information regarding workforce. 18. Establishment of programme within BOC People Priority to focus upon non-medical clinical placements and quality of clinical education. 19. Establishment and refinement of placements working group with emphasis on priority professions. 20. Agreement of place wide work plan for placement activity.	1. Inaccurate workforce data around social care sector means assessing demand is challenging 2. Detail of implications of three Data Shifts awaited as this will provide some clarity on workforce transformation and development initiatives required 3. Lack of clarity of national funding arrangements for workforce transformation 4. Quantitative information around provision of graduates deemed unsuitable for employment. 5. Whilst improving, system based mechanisms for identification of need remain limited. Funding to support detailed running of workforce transformation schemes and increase of transformation and OD resource not currently possible. 6. Mechanisms for identifying and agreeing capacity to support workforce and service transformation are also limited. 7. Impact of integrated workforce data report to identify areas for prioritisation 8. Interaction with BOC Priority Programme to identify areas of pressing need 9. High level of engagement across sector through BOC Workforce Priority to data. 10. Development and publication of BOC Health and Care Strategy will help identify areas of pressing need. 11. High level of engagement across sector through People Committee and BOC Workforce Priority to data. 12. 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. 13. 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. 14. WY ICB figures for 2024/25 academic year show placement diversity (in terms of setting) greater in BOC than in any other place. 15. WY ICB engaged to ensure place based work is aligned with work undertaken at a West Yorkshire level.	1. Data quality issues mean that ability to identify most acute areas of workforce need remains limited 2. Regular reports from placements programme on level of risk into workforce programme 3. Lack of clarity of national funding arrangements for workforce transformation 4. Reporting at sectoral groups including BOC and WY primary care workforce force. 5. Whilst improving, system based mechanisms for identification of need remain limited. Funding to support detailed running of workforce transformation schemes and increase of transformation and OD resource not currently possible. 6. Mechanisms for identifying and agreeing capacity to support workforce and service transformation are also limited. 7. Impact of integrated workforce data report to identify areas for prioritisation 8. Interaction with BOC Priority Programme to identify areas of pressing need 9. High level of engagement across sector through BOC Workforce Priority to data. 10. Development and publication of BOC Health and Care Strategy will help identify areas of pressing need. 11. 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Availability of data to create consistent narrative and buy in to programme of work across the partnership. 4. Awaiting Governmental detailed response to the Davi report, to enable consideration of workforce implications including detail of refreshed workforce plan	New - Open	
2542	15/07/2023	Both PFC and QC	Improve healthcare outcomes for residents	12	(E)A(3)	4	(E)A(2)	Jane Wood	Iain Macdhaire	CARE HOME MARKET SUSTAINABILITY There is a risk that the sustainability of the current care home market due to insufficient social care workforce to deliver safe and quality services due to a lack of interventions from potential domestic workforce. Care sector terms and conditions, pay and progression, and insufficient funding being available to fund the changes to the national insurance contributions. This could lead to care and nursing home closure, displaced service users, reduced choice for service users, impact on quality of care and delays to patient flow from hospital to community settings, and create pressures on the wider health and social care system.	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. 3. Collaborative approach to the key upfits between the ICA, Council and the NHS 4. Govt has provided new financial place capacity including funding for adult social care 5. Joint working arrangements between the ICB and Council to manage provider closures 6. Strong contract arrangements and contract managers with individual named care homes	1. Data quality for social care sector can be variable, meaning oversight is based on incomplete data and anecdotal evidence including UNV figures. 2. Time lag from data available from Skills for Care A&C WOS prevents a giving real time picture. 3. Inability to significantly improve terms and conditions to attract more domestic workforce. 4. Awareness of NHS funds in the sector around 30% of feasibility	1. Quality assurance are monitored by system quality committee. 2. Joint commissioning arrangements between the council and ICB which means we are monitoring quality for ICB. 3. Collaborative finance forum (ICA, Council, ICB) monthly 4. Departmental management meetings 5. Meetings with financial department (council) 6. Joint planning and commissioning forum (finance working group) 7. Chief executive of Bradford care association is on the executive of Bradford PLE 8. Membership from North Yorkshire Council in the PLE - Head of Quality and Assurance 9. People workforce was cited on recruitment and retention of staff at the care sector	1. Partnership working	1. Further reviews will take place to identify any gaps.	New - Open
2486	24/01/2023	Both PFC and QC	Improve healthcare outcomes for residents	12	(E)A(4)	6	(E)A(3)	Collette Brauns	Helen Farmer	There is a risk of physical and psychological harm and longer waiting times for patients in Bradford and Craven place which require a Tier 1 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 through the Right to Choose patient choice pathway with an increase in expenditure, an increase in referrals to Tier 1 specialist 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. Regular communication to the public to patients understand that access to the new medications will be prioritised to those who need it the most. 4. 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 funding nationally with new medications means that it is a challenging time to design and implement new service models. We have received new national NHS Commissioning guidance which will inform how we start to develop a new service in Primary Care settings 3. Fixed agenda item at the fortnightly Weight Management Steering Group 4. Exploring new delivery models with the other places across the ICB 5. Exploring a new weight management pathway in Primary Care for the roll out of Tirapizole following the NICET TA 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 the end of June 2025, ICA and GP practices will be contacting patients 2. Raised the issue at PLE in March 2024 and again in September 2024 and December 2024 to ensure that strategic leaders are aligned 3. Lack of ability to mitigate any referrals to Right To Choose providers 4. Exploring new delivery models with the other places across the ICB 5. Exploring a new weight management pathway in Primary Care for the roll out of Tirapizole following the NICET TA	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. We have received new national NHS Commissioning guidance which will inform how we start to develop a new service in Primary Care settings 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. 5. National changes to ICB budgets and staffing means that there are challenges in provision of external capital funding yet to be confirmed - expected August 2025.	Static - 2 (Active)(s)
2482	14/01/2023	Quality	Improve healthcare outcomes for residents	12	(E)A(4)	6	(E)A(2)	Leanne Cooper	Justin Taggerty	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 Midhewave use across the majority of acute services Aredale NHS Foundation Trust. This could lead to potential delays to referrals being actioned, a delay in the receipt and sharing of key discharge information from Aredale NHS 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 by October 2025 Capacity of shared domain due other partners requirements (C&H and EMT). Confirmed in detail plan no later than June 2025. Ability to secure data and expertise on site in the timescale available. Confirmed in detail plan no later than September 2025.	1st line (Programme) Clinical risk management process National Governance & PMO infrastructure Delivery partner key stakeholders in T&S from July 2025. 2nd line (Organisation Oversight) EPR Transformation Assurance Group Monthly reporting into the PFPC Quarterly reporting to Trust Board via Delivery Partner commencing in July 2025. 3rd line (external / regulator) independent external review by PwC commissioned and completed Enterprises to be provided by NHSE at appropriate time intervals Oracle Health Gateway process NHS Digital assurance process	See above section	Provision of external capital funding yet to be confirmed - expected August 2025.	Static - 2 (Active)(s)
2448	25/07/2024	Quality	Improve healthcare outcomes for residents	12	(E)A(3)	6	(E)A(2)	Berge Zapella	Rosa Dunlop	There is a risk of major outbreaks of infectious diseases like measles, flu and COVID-19 requiring rapid escalation of a multi-agency response beyond business as usual. This 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 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 rates and pressures on services. The risk is greater in areas where there are other vulnerabilities e.g. poor housing conditions.	Multi-agency plans to increase uptake of vaccines at place level Operational Group chartered by the NHS Immunisation and Screening Public Health Improvement Plan (PHIP) developed by the PHIP in NHSE • BOC Multi-Agency Influenza and Covid-19 Plan • Bradford COVID-19 vaccine inequalities plan Memorandum of Understanding (MOU) between LA, NHSE/ICB, UHSA to respond to PH emergencies and incidents - currently under review (2022/26), to clarify roles and responsibilities for initial response to disrupting activities, including funding and commissioning of response. WY ICB is exploring options for commissioning one or more providers to deliver the healthcare components of an outbreak response.	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 funding nationally with new medications means that it is a challenging time to design and implement new service models. We have received new national NHS Commissioning guidance which will inform how we start to develop a new service in Primary Care settings 3. Fixed agenda item at the fortnightly Weight Management Steering Group 4. Exploring new delivery models with the other places across the ICB 5. Exploring a new weight management pathway in Primary Care for the roll out of Tirapizole following the NICET TA 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 the end of June 2025, ICA and GP practices will be contacting patients 2. Raised the issue at PLE in March 2024 and again in September 2024 and December 2024 to ensure that strategic leaders are aligned 3. Lack of ability to mitigate any referrals to Right To Choose providers 4. Exploring new delivery models with the other places across the ICB 5. Exploring a new weight management pathway in Primary Care for the roll out of Tirapizole following the NICET TA	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. We have received new national NHS Commissioning guidance which will inform how we start to develop a new service in Primary Care settings 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. 5. National changes to ICB budgets and staffing means that there are challenges in provision of external capital funding yet to be confirmed - expected August 2025.	Static - 2 (Active)(s)

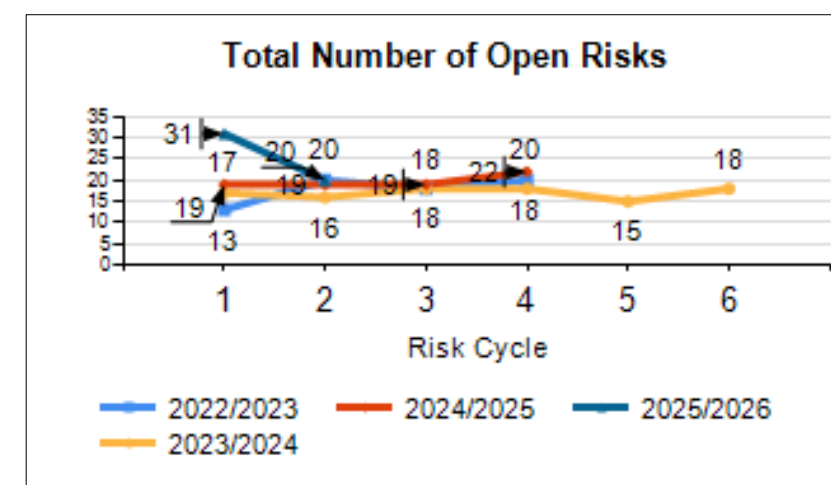
2422	27/03/2024	Quality	Improve healthcare outcomes for residents	12	(194L3)	9	(134L3)	Andrew Milner	Faem Lai	There is a risk that in the long term Bradford place are unable to deliver high quality health and care services to the People and Populations we serve. To date, the NHS Long Term Workforce plan has failed to deliver a sustainable domestic supply for the health and care workforce. Funding linked to LTPW 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 data including People Priority to develop shared approach to international recruitment. Engagement with WYCS and national partners. Programme to build placement capacity across BOC 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, completed with performance against plan monitored through system finance and performance committee. West Yorkshire ICB Workforce Working Group focusing on innovative workforce development has been formed, with BOC system representation.	Accurate workforce data around social care sector means assessing demand is challenging Detail of implications of three Darsi Shifts awaited as this will provide some clarity on workforce transformation and development intentions required Lack of clarity of national funding arrangements for workforce transformation	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 BOC and WY primary care workforce fora. Qualitative feedback from system leads (including Darsi and lead AHP) on issues within specific professions Ongoing dialogue between education providers and employing bodies to resolve any issues arising	Operational workforce plans for BOC system submitted in Q1 2025 ensuring alignment between workforce, financial and operational activity planning	Data quality issues mean that ability to identify most acute areas of workforce need remains limited.	Closed - Reviewed by BOC exec team, agreed to close workforce risks 2422, 2420, 2418, 2423 and 2421 and merge the detail into one overall workforce risk.
2420	27/03/2024	Quality	Improve healthcare outcomes for residents	12	(134L4)	6	(134L2)	Andrew Milner	Philipp Hubbard	There is a risk that current educational programmes are unable to meet current and future demand for registered staff across all clinical professions/degree 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 BOC patients, service users and populations.	Establishment of programme within BOC People Priority to focus upon non-medical clinical placements and quality of clinical education. 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 updates to Programme Board and escalation route via PLT and PLE Reporting at sectoral groups including BOC and WY primary care workforce fora. Qualitative feedback from system leads (including Darsi and lead AHP) on issues within specific professions Ongoing dialogue between education providers and employing bodies to resolve any issues arising	Programme established and engagement from across partnership including social care, primary care, VCL, FE and HEI sectors has been excellent. Programme priorities agreed with full workshop established. WYCB 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	Placement lead secondment due to end July 2025 necessitating cessation of programme.	Closed - Reviewed by BOC exec team, agreed to close workforce risks 2422, 2420, 2418, 2423 and 2421 and merge the detail into one overall workforce risk.	
2419	27/03/2024	Quality	Improve healthcare outcomes for residents	12	(194L3)	9	(134L3)	Andrew Milner	Jo Harrison	Due to demand across the health and care sector and limited resources, there is a risk that traditional workforce pipelines and pathways are not sufficiently innovative to create a sustainable workforce pipeline or efficient pathway 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 BOC Partnership (including through priority programmes, PLE and broader governance structures) to identify areas of pressing need to available resource can be directed accordingly. System approach to review and increase workforce transformation and OD capacity through BOC 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	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 workforces 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 priority areas Interaction with BOC 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 developed and reflected in identified transformation priorities of integrated back office functions, integrated acute care and integrated neighbourhood care with strategic delivery boards established for each 3. Workforce planned for late April to identify system wide priorities based upon submitted plans. 4. High level of engagement across sector through BOC Workforce Priority to date. 5. Development and publication of BOC 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 Darsi report, to enable consideration of workforce implications including detail of refreshed workforce plan	Closed - Reviewed by BOC exec team, agreed to close workforce risks 2422, 2420, 2418, 2423 and 2421 and merge the detail into one overall workforce risk.
2418	27/03/2024	Quality	Improve healthcare outcomes for residents	12	(134L4)	6	(134L2)	Andrew Milner	Faem Lai	There is a risk that the partnership is unable to optimise its role in social and economic development of BOC, 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 BOC. 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 reasons there is a system based approach to addressing the issues, with the programme containing representation from across the partnership. RCPCHP partnership	To be reviewed	1. Regular deep dives at Partnership Board. 2. System wide review of impact of BMDU on CTE Health and Care Careers and Technical Education Board. 3. Review at BOCCHP Workforce Programme Board.	1. Programme 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 NHS. This is actively being addressed.	Closed - A new workforce risk has been opened.
2221	26/01/2023	Quality	Tackle inequalities in access, experience, outcome	12	(194L3)	8	(194L2)	Duncan Cooper	Sohail Abbas	There is a risk of future social health inequalities of the population in BOC by coordinated action at scale across organisations and programmes in Bradford District and Cavenham partnership. Due to lack of IT engagement and buy-in from key system partners (21 recognised performance and financial drivers to reduce inequalities (1) action at scale to address issues health inequalities (4) transition of local intelligence, research and evaluation into new models of care and transformation. This could result in widening of health inequalities.	Reducing inequalities Alliance established under a programme 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 Agreement of BOC partnership priority board key metrics (identified by inequalities and linked to specific actions/priorities) this remains a challenge. Updates Cycle 1 2023/24. 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).	Strong working relationships between the Wellbeing collaborative & NHS 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 Forward Plan to form the health inequalities section of the district plan to which the wellbeing collaborative will contribute. Agreement of BOC partnership priority board key metrics (identified by inequalities and linked to specific actions/priorities) this remains a challenge. Updates Cycle 1 2023/24. 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).	ConDPLUSS place based programme reporting WY ICS Core2022 group, and into RIA steering group. Reducing inequalities team membership and support for BOC partnership priority boards (and with Public Health Leadership team, WYCB Board). RIA associated director working within place closing the gap programme. A range of guidance documents summarising key actions and interventions for the NHS and for partners to reduce inequalities has been published and promoted.	Current RIA core team in new BOC partnership operating model to support system wide action to reduce inequalities. Assurance under a Reducing Inequalities Alliance 4 programme (present work below). 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 Q4 (with separate powerpoint briefing for WY board partnership events). ConDPLUSS health inequalities funding paper local commissioning of 62 interventions across 13 Community Partnership community for clinical priorities and "place" groups). Developed community health model taking NHS Health Check to community venues. Developed maximising social value and reducing inequalities via procurement guide (shared with WY colleagues for standard WYCS template). Leading the Work and Health Accelerator for Bradford Place with an inequalities focus, involving community organisations. 4. Creating opportunities to evaluate and share learning. Evaluated RSC services moved to business as usual or de-commissioned. Work and Health Accelerator (Bradford District and Cavenham) funded national accelerator pilot in BOC to reduce health related economic inactivity (starts April 1st 2025) with strong WYCS 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 reform system review.	Inequalities and community budgets have made efficiencies due to financial challenges. The RIA core team (within BOC partnership) has lost 2 posts reducing ability to influence the system wide approach to reducing inequalities (and further risk due to March announcement of SDRs cuts to CDS). SIL work to be done on producing key performance indicators and metrics that measure, prevent and assure on inequalities. Being discussed at BOC Board March 2025 Discussion (April 2025) with WY ICS population health team on areas of future working (given SDRs cut x3).	Static - 12 Active(s)
2215	13/01/2023	Both PPC and QC	Tackle inequalities in access, experience, outcome	12	(194L3)	2	(124L1)	Shane Emberton	Mike Woodhead	UNIFIED 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 use of area not used and experience impact on staff wellbeing, recruitment and retention and on the organisation's reputation. This is due to the deteriorating and falling physical condition of Unified Mount Hospital building with EBN looking maintenance as well being an estate requiring redevelopment (last out of date estate has insufficient therapeutic space, low ward size 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 Case updated. Expression of interest for EBN 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 AGM and EHTF (but not approved in the latest round and no foreseeable change in that position). Contract with Capital to deliver the EBN NHP scheme. Additional staffing and CCTV in place to mitigate impacts upon quality, privacy and dignity impacted upon by the environment. Additional cleaning and maintenance staffing resource. Limited enabling works on the car park have commenced on the main site, (now completed 31/12/23). Offer of a £150m capital received from DfC and accepted on 29/08/23. OHC being updated for "plan B" (£49.5m). Design team appointed. Engagement ongoing with NHS and DfC re approval gateway, procurement strategy, profile of spend, early draw-down of cash, etc. Outline Business Case completed and submitted 01/12/23, approved 13/02/25 (with conditions) - allowing commencement of activities to progress Full Business Case (FBC) development. BOC Project Board established with Governance Programme and key delivery team appointments made. Enabling works completed (£1.275m drawdown for early works from NHS) - initial spend profile being established for subsequent years. Planning submission (reserved matters) has been made to Bradford Council. Approval expected August 2025. Early modular/MCM contractor engagement with a PCSA resulted in a higher cost than forecast of up to £15m. Detailed design (M&E AS & value engineering completed and architectural layout sign off including dependencies have been agreed at Project Board. Progress reported through Project Board monthly and Finance & Performance Committee. Procurement process to begin in August 2025 to inform the FBC. Case Leads and Workstream Leads established for completion of FBC - submission expected November 2025.	Approved FBC. Detailed agreement on approval gateway etc., (gateway review) but this is expected to be agreed before end of October 2025. (initially closed following cabinet controls "assured" status i.e. OHC approved). Cabinet Controls have been confirmed as still "assured" in July 2025. Project expected to exceed EBN outcome cost. Support of ICB required to assist with funding gaps to be managed locally in WY. ICB approached for £15m support - approved in June 2025. Total achieve envelope now £65m. Seeking further advice from NHS on re-evaluation of approval gateway. Treasury approvals now being required, potential to add 26 weeks to programme. Final business Case FBC in development noting change in value. Governance & engagement strategy in development.	Hard to board quality assurance and oversight structures in place to identify, manage and act on 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 leads. ODs are framework and reports up into Quality Safety Committee and Board. Maintenance work funded through revenue and capital budgets. Overnight 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 Ambulink from 25 to 21 to mitigate ward size and impacts upon quality, safety and recruitment and retention agreed and enacted. Capital work undertaken to create co-horting space to support IPC on 3 wards. Inpatient Clinical Risk Formulation Training and Inpatient Risk Training delivered within real time clinical setting with staff teams. Content includes impacts that environment has upon 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 patient flow. - Unified Mount Redevelopment - full project governance structure and project delivery team in place. Reporting into LHM Project Board through to Finance & Performance Committee and Trust Board. Detailed Project Plan in place.	Work and Health Accelerator (Bradford District and Cavenham) funded national accelerator pilot in BOC to reduce health related economic inactivity (starts April 1st 2025) with strong WYCS 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 reform system review.	Ongoing increase in demand to access services, causing additional pressure that are unsustainable on workforce & assurance measures.	Static - 12 Active(s)
2520	08/04/2025	Quality	Improve healthcare outcomes for residents	12	(124L5)	6	(124L3)	Vickie Milner	Grainne Ebi	There is a risk that individuals will not be reviewed in a timely manner due to challenging workforce issues or CHC 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 collection & new clearance 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 - risk of notification from LA when Provider request further uplifts year on year, and LA agree them.	Reviews undertaken monitored on a monthly basis - Data on overdue and pending reviews is now up to date and cleaned - 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.	Closed - Discussed at BOC exec team meeting and agreed to close CHC risks 2518, 2520, 2518 and 2516 and merge them into one new CHC risk.
2518	08/04/2025	Quality	Improve healthcare outcomes for residents	9	(134L3)	4	(124L2)	Vickie Milner	Grainne Ebi	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 its gap in cost for care and affordable budgets resulting in higher costs for the ICB as 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 in consideration of National Living Wage, Consumer Price index as well as increased costs related to needs of someone eligible for NHS CHC. - 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 'demand' are not met. - risk of paying more for weekly fees as a support or other over commissioned package if inflationary uplifts do not meet requirements of the sector.	Closed - Discussed at BOC exec team meeting and agreed to close CHC risks 2518, 2520, 2518 and 2516 and merge them into one new CHC risk.	
2516	08/04/2025	Both PPC and QC	Enhance productivity and value for money	9	(134L3)	4	(124L2)	Vickie Milner	Grainne Ebi	There is a risk of over-spending 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 Allocation processes in place aligned to Standard 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.	- Regular data cleaning 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 - Making in eligibility and commissioning decisions are fully aware of Commissioning Principles and how to implement - PHM Audit and "Check-back" processes in place and in operation. - Packages of care to be delivered via PHM Direct Payment are carefully considered in terms of statutory duties of the ICB to deliver.	- Spend on PHM Direct Payment budgets is subject to misuse and mis-management - Potential for inappropriate decisions made on PHM 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 increases in costs can occur at any time.	Closed - Discussed at BOC exec team meeting and agreed to close CHC risks 2518, 2520, 2518 and 2516 and merge them into one new CHC risk.	
2477	14/01/2025	Both PPC and QC	Improve healthcare outcomes for residents	9	(134L3)	4	(124L2)	Jane Wood	Joan Macleath	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 delivery of discharge, displaced service users, reduced choice for service users, impact on quality of care and pressure 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	Partnership working	None identified at present, further reviews will take place at senior managers meeting.	Closed - Risk has been reviewed by the BOC exec team, agreed to close recommendation to close this risk, alongside risks 2427 and 2477 and to create a new care home market
2423	27/03/2024	Quality	Improve healthcare outcomes for residents	9	(134L3)	6	(134L2)	Andrew Milner	Kerry War	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 targeting 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 WYCB on data availability. System approach to issue identification through BOC Workforce Priority. Ongoing dialogue with internal partners including social care leads, primary care leads and VCS leads to ascertain qualitative information regarding workforce.	Data centric approach will be incomplete due to variable data quality Qualitative data is a 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) - BOC 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. Regularly 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	Refined programme and use of data centric approach early in development and therefore progress to date is limited. High level of engagement across sector through People Committee and BOC 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 linked to NHS Trust/primary care data. Request for temporary staffing usage/expenditure to be included made in December 2024.	n/a	Closed - Reviewed by BOC exec team, agreed to close workforce risks 2422, 2420, 2418, 2423 and 2421 and merge the detail into one overall workforce risk.
2421	27/03/2024	Quality	Improve healthcare outcomes for residents	9	(134L3)	6	(134L2)	Andrew Milner	Philipp Hubbard	There is a risk that capacity to meet 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 BOC 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. Ongoing refinement of plans.	System wide placement programme under review following completion of secondment for placements lead and inability to extend post. This means there is insufficient capacity to run BOC wide programme focused on expanding diversity and number of clinical placements.	Regular reports from placements programme on level of risk into workforce programme board (with escalation to PLT/PLE Partnership Board).	WY ICS figures for BOC 2024/25 academic year show placement diversity (in terms of setting) greater in BOC than in any other place. WY ICB engaged to ensure place based work is aligned with work undertaken at a West Yorkshire level.	N/A	Closed - Reviewed by BOC exec team, agreed to close workforce risks 2422, 2420, 2418, 2423 and 2421 and merge the detail into one overall workforce risk.
2528	10/04/2025	Both PPC and QC	Tackle inequalities in access, experience, outcome	12	(134L2)	2	(124L1)	Jo Howes	Sohail Abbas	There is an increased risk of data breach by some of our smaller VCS providers (21 Core2045 project providers with funding of £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 VCS sector	1. Working with VCSs enhance BOC and WH maximising the power of community team 2. Liaising with VCSs contracting dept 3. Liaising with WY ICS Information Governance lead 4. West Yorkshire wide work around contracting and procurement with the VCS 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 Health Communities Team Meeting Reducing Inequalities Alliance Meeting Extended Management Team Meeting	1. Approve SDR of providers are compliant 2. VCSs are aware and are working on a solution	To add when identified	Static - 1 Active(s)

2047	12/07/2022	Both FPC and QC	Tackle inequalities in access, experience, outcome	154(L1)	1 (134L1)	Vickie Mihov	Grainne Ebi	DOLS in PCO FUNDED CASES There is a risk of legal challenge against the MCP and potential harm to patients due to unauthorised Deprivation of Liberty (DoL) in PCO funded community cases resulting in reputational and financial damage. Where people are deprived of their liberty in their own homes as a result of PCO 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 MCPs across the country are taking a risk management approach to prioritise only the most contained cases. The planned Liberty Protection Safeguards (LPS) aim to provide a statutory process for CCGs to authorise CHC funded cases, without the need for court proceedings, this activity has now been paused.	The PCO 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 PCO has a clinical lead in post and established systems for identifying potential DoL in CHC cases. Case numbers are monitored by the PCO. 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 MCPs and LAs.	UPS 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 MACA/CCP 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 WGA 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 20/11/2022 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 25/12/2023 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 leading 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. 24/05/2023 Looking at training for nurses to undertake BIA assessor course to increase the resource within the team. 12/07/2022 PCP's ability to report remains unchanged whilst the team continue to transfer data across to its new reporting system (dolan) 14/09/2022 PCO are still progressing the data input into the new information system, reporting capability on this caseload remains unchanged and limited as prevent. 20/11/2022 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 - 10 Active(s)
2040	11/07/2022	Quality	Tackle inequalities in access, experience, outcome	124(L2)	3 (134L1)	Najma Javid	Helen Farmer	O-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. CBMOC Public Health services were subject to a WSOA in the Ofsted/QOC 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 BDMC MCP. CBMOC Start for Life Family Hub has brought partners together to deliver an integrated offer for families focusing in the first 1000 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 ownership via the pillars of the CPIMB Programme Board and the SEND Strategic Partnership Board. Better Start Bradford and BDOFT Community Children's Services have worked together to ensure the legacy and continuation of the MIECHV 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, ELSFC, MNTP, triangulation of data, taking Bradford, ready to make etc... all of which supports the 0-19 work. Health visiting review is taking place (2025,26)	CBMOC Public Health services were subject to a WSOA in the Ofsted/QOC 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 BDMC MCP. CBMOC Start for Life Family Hub has brought partners together to deliver an integrated offer for families focusing in the first 1000 days. 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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, ELSFC, MNTP, triangulation of data, taking Bradford, ready to make etc... all of which supports the 0-19 work. Health visiting review is taking place (2025,26)	There was a possibility that despite additional funding BDOFT 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. Najma Javid is part of the review Board for the 0-19 services, currently being chaired by Jan Macbeth.	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 CPIMB 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 reviewed and strengthened. A Complex Support Needs Panel has been developed to include representation from Healthy Childrens and Families, Healthy mind 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 BDOFT 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 - 6 Active(s)

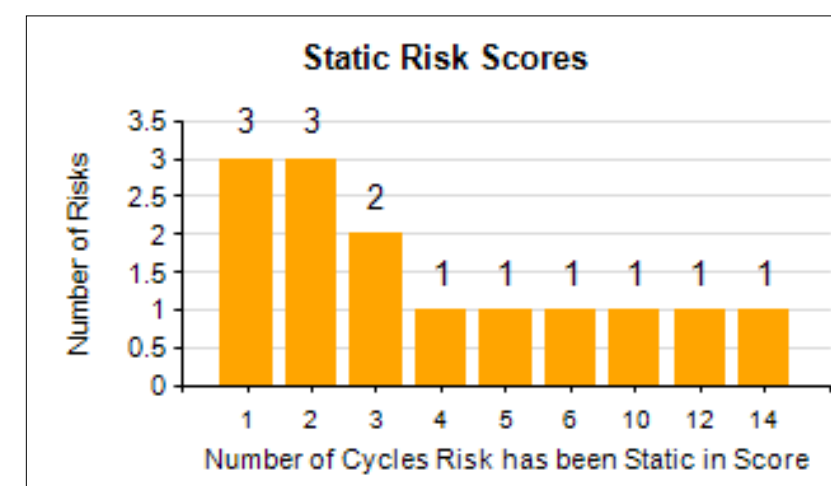
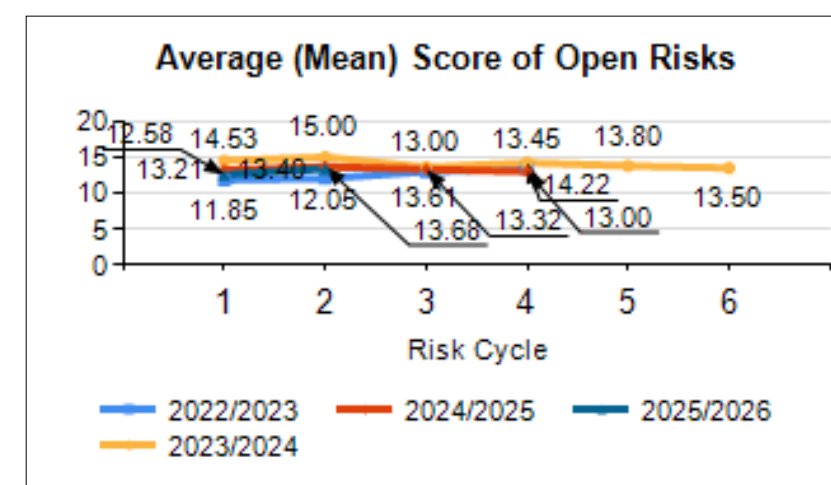
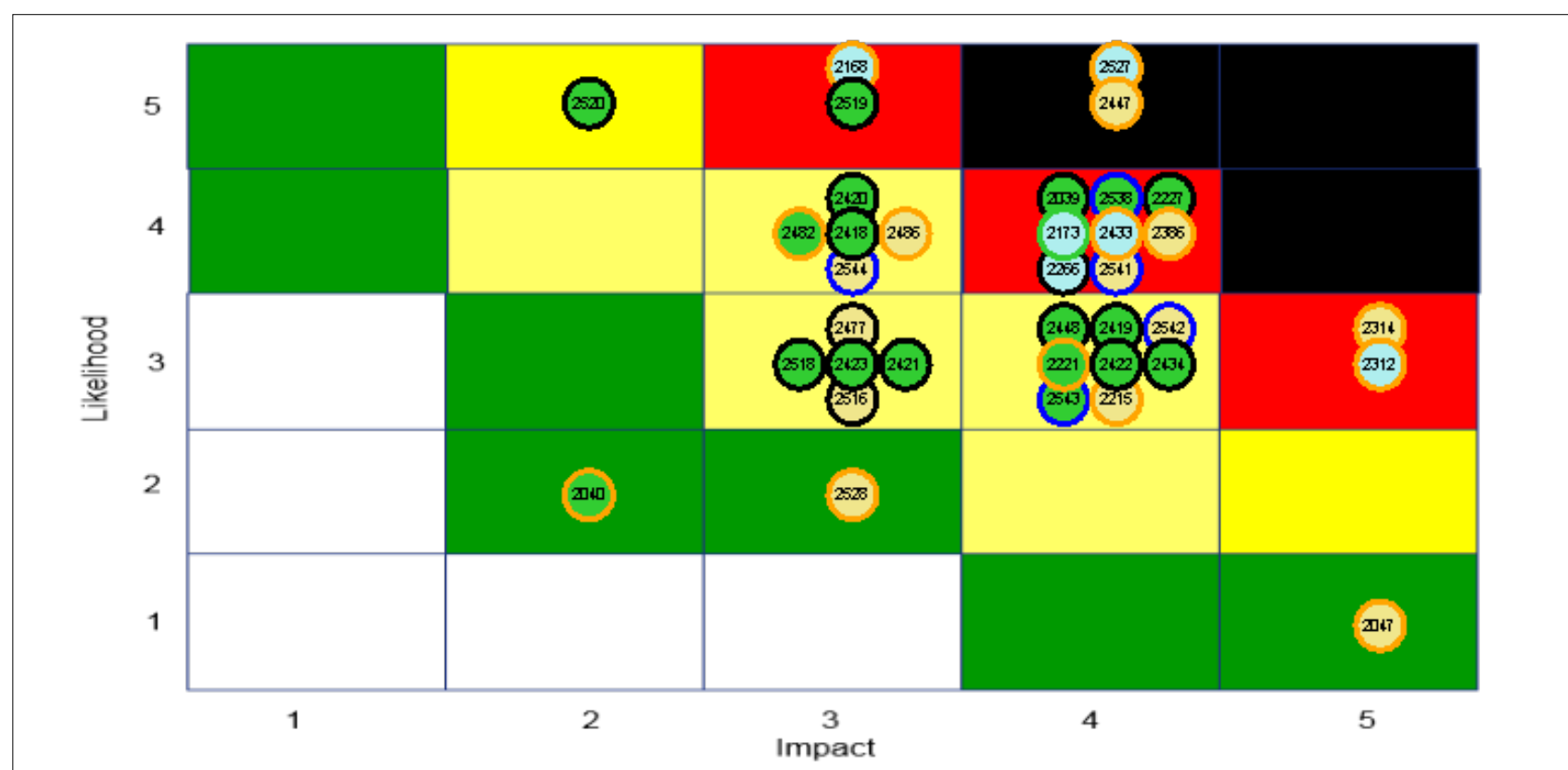
Bradford District and Craven place, Risk on a Page Report Cycle 2, 2025/26

Total Place Risks	36
Finance & Performance	6
Quality	18
Finance and Quality	12

Movement of Risks		Risk Score Increasing	0
New	5	Risk Score Decreasing	1
Marked for Closure	16	Risk Score Static	14



Risk Overview (BDC place)



Key

- Quality
- Finance
- Both FPC and QC

Key

- 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

The following information is taken from the WYICB's *Risk Management Policy and Framework (v1.0)* to provide guidance to those completing the Board Assurance Framework (BAF) on behalf of the ICB and place partnerships. The full document can be accessed here:

https://www.wypartnership.co.uk/application/files/7017/5395/3821/Risk_Management_Framework_v4.0.pdf

The ICB operates the principle of subsidiarity. As the statutory body, the ICB is accountable for delivery of its priorities, but delegates responsibility for delivery to the five places (Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield). Risks associated with delivery at Place will be managed at Place unless it is agreed to manage centrally.

Currently, fifteen strategic risks, linked with the mission of the ICB, have been identified following a series of development sessions held during summer 2022. These were ratified at the meeting of the ICB Board held on 20 September 2022.

The **Board Assurance Framework** summarises how the Board knows that the controls it has in place are effectively managing the principal (strategic) risks, together with references to documentary evidence/assurances and current mitigation action plans. The ICB and the Place Partnership Committee of each of the five places will maintain an Assurance Framework and Corporate Risk Register through which risk management activities are prioritised and managed.

Risk appetite refers to the level of risk that an organisation is willing to tolerate or expose itself to when controlling risks as they arise or when embarking on new projects. An organisation may accept different levels of risk appetite for different types of risk, or in relation to different projects. The organisation's risk appetite ensures that risks are considered in terms of both opportunities and threats. Risk appetite (*which is a description, not a score*) informs the risk tolerance levels, which are considered for individual risks. Based on the risk appetite, a target risk score is set for individual risks. This is the level to which the risk is to be managed.

PLEASE NOTE: The worksheets titled 'Summary' and 'Heat map' will be completed by the ICB governance team. The worksheets 1.1 to 4.3 inclusive should be completed by the ICB lead director / board lead (blue section) and all the worksheets except 3.4 and 4.3 should be completed by the Place leads (or their nominees) as follows: Bradford District and Craven (peach section); Calderdale (orange section); Kirklees (green section); Leeds (purple section); Wakefield (pink section). Please do not change any formatting within this document.

Controls describe the available systems and processes (*the specific things we are doing*) which help to minimise and/or manage the risk.

Assurance is the (*source*) information used to ascertain whether the controls are effective.

Mitigating actions describe what else we are doing to control the risk and/or provide additional assurance.

ICB and Place leads are asked to describe three key controls - each requiring linked assurance(s) - relevant to the strategic risk.

A risk score is obtained, using a 5 x 5 matrix, (impact x likelihood), which determines whether the risk is ranked as low, moderate, high, serious or critical. The following tables are provided to inform the target and current risk scores.

Definitions of impact:

Risk impact	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Purpose					
Achievement of the ICB mission	A decision affecting contracts finance, collaborations, quality or governance has no impact on the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance does not support the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance impedes or significantly delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance majorly impedes and/or delays the achievement of the ICB mission.
Health outcomes and life expectancy	Marginal reduction to health outcomes and life expectancy	Minor reduction to health outcomes and life expectancy	Moderate reduction in health outcomes and life expectancy	Significant reduction in health outcomes and life expectancy	Major reduction to health outcomes and life expectancy

Health outcomes and life expectancy	outcomes and/or life expectancy for >5% of a given population.	outcomes and/or life expectancy for >15% of a given population.	outcomes and/or life expectancy for >30% of a given population.	outcomes and/or life expectancy for > 50% of a given population.	Major reduction in health outcomes and/or life expectancy for >75% of a given population.
Health inequalities	Marginal increase in the health inequality gap in up to all six of most deprived Local Care/Community Partnerships (PCNs)	Minor increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a minor increase in the number of deprived Local Care/Community Partnerships (PCNs)	Moderate increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a moderate increase in the number of deprived Local Care/Community Partnerships (PCNs)	Significant increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a significant increase in the number of deprived Local Care/Community Partnerships (PCNs)	Major increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a major increase in the number of deprived Local Care/Community Partnerships (PCNs)
Service quality and performance (includes patient experience, safety and clinical effectiveness)	Informal complaint	Formal complaint	Investigation by Health Service Ombudsman	Multiple complaints	Litigation certain
		Local resolution	Minor out-of-court settlement	Judicial review Litigation expected Civil action – no defence	Criminal prosecution
	Negligible effect on quality of clinical care	Noticeable effect on quality of care Single failure to meet internal standards Minor implications for patient safety if unresolved	Significant effect on quality of care / significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications of findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
	Commissioned local or national targets not achievable – single episode	Commissioned local or national targets not achievable – 1-3 episodes	Repeated failure to meet commissioned local or national targets > 3 episodes	Commissioned national targets not achieved resulting in involvement of external bodies / regulator	Commissioned national targets not achieved resulting in special measures
Financial efficiency	Small loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
Capability					
Compliance (includes H&S and other legal or governance factors such as procurement, information governance etc.)	Negligible injury or ill health requiring no absence from work. Negligible damage to equipment or property. No or minimal impact or breach of guidance / statutory duty.	Minor injury or ill health requiring up to 2 days absence from work. Minor damage to equipment or property. Breach of statutory legislation Reduced performance rating if unresolved	Moderate injury or illness resulting in the submission of a RIDDOR report. Moderate damage to equipment or property. Single breach in statutory duty Challenging external recommendations / improvement notice	Single fatality. HSE improvement notice received. Major damage to property Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple fatalities HSE or police investigation resulting in imprisonment of Chief Executive or other implicated staff Multiple breaches in statutory duty Prosecution Complete system s change required Zero performance rating Severely critical report

Descriptors for risk likelihood:

Level	Descriptor	Description / suggested frequency
1	Rare	The event may occur only in exceptional circumstances
2	Unlikely	The event could occur at some time
3	Possible	The event may occur at some time
4	Likely	The event will probably occur in most circumstances
5	Almost certain	The event is expected to occur

Overall risk matrix scoring (= impact x likelihood):

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

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 11	Date: Sept 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	Lou Auger	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	Lou Auger	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	Lou Auger / 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

[illegible]

WYICB - Board Assurance Framework - ICB and places						Version: 11	22 April 2025	
Mission 1	Failure to manage strategic risk could result in a failure to REDUCE INEQUALITIES					Lead director(s) / board lead	Ian Holmes	
Strategic risk 1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.					Lead committee / board	ICB Board (linked to place committees)	
ICB risk appetite	ICB risk scores					Rationale for current ICB score		
	Target (ICB)			Current (ICB)			Inequalities have widened in recent years due to broader social and economic factors. Our health and care partnership will make a positive contribution on these issues, there are a range of factors outside of our control that are likely to make narrowing inequalities more challenging.	
	Likelihood	4	16	Likelihood	5	20		
Impact	4		Impact	4				
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at ICB level?)		
1	ICS Five Year Strategy, including the 10 Big Ambitions, focusing on health inequalities and wider economic, social and political factors.					(1) Development of granularity of data to have full insight across different inequalities and impact across different populations. This is aimed for completion by the end of 2025/26.		
2	Health Inequalities Steering Group oversees spend of funding on specific initiatives to address inequalities.							
3	An MOU with WYCA setting out shared priorities, working and governance arrangements.							
4	Team working across health inequalities, with an in-house ICB team together with shared posts with WYCA.							
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)		
1	Integrated Care Partnership Board - agenda items, discussions, evidenced by minutes					2120 - reduction/loss of VCSE services; 2437 - GP collective action; 2402 - access GP services; 2267 - maternity services; 2106 - Cancer health inequalities;		
2	ICB Board - four deep dives into health inequalities during 2024/25 - agenda and minutes							
3	ICB Board - six monthly performance dashboard metrics against 10 Big Ambitions - agenda and minutes							
4	System Oversight and Assurance Group - rolling programme of metrics reported - agenda and minutes							
5	WYCA / ICB Quarterly Leadership Team meeting to oversee MOU							
6	Internal Audit review of Health Inequalities Partnering Arrangements - Significant Assurance (June 2024)					Positive Assurance - see separate log		
Bradford District and Craven (BD&C)						Place lead: Therese Patten		
ICB risk appetite	Place risk scores					Rationale for current place score		
	Target (BD&C)			Current (BD&C)				We agree with WYICB assessment and score the same for the BDC HCP with the following rationale: Inequalities occur due to health and wider determinants. We are working closely with health and social partners within BDC HCP. There are a range of factors where we have more limited control with regards to narrowing inequalities, e.g. around poverty, housing, skills. With the financial deficit in the ICB there is a risk of losing funding streams aimed at reducing health inequalities for example Core20Plus5.
	Likelihood	4	16	Likelihood	4	20		
Impact	4		Impact	5				
Key controls (What helps us mitigate the risk?)						Mitigating actions(What more are we/should we be doing at place by when?)		
1	BDC HCP (place) Population Health Management structure implemented and Business Intelligence team aligned to transformation priorities, enablers, Community Partnerships / Primary Care Networks					1. Health and Wellbeing Board Strategy - work is ongoing to finalise the district plan for 2025/2035 with a clear focus on improving economic activity and reducing wider inequalities. 2. EDI work and anti-racism strategy development in Bradford District and Craven (2025 ongoing). 3. The economic accelerator programme has started from April 2025, work ongoing (2025/26) 4. Core20Plus5 intial evaluation is complete, we are now working on the economic evaluation of the programme (2025/26) 5. BDC Health and Care Strategy is in development and underpinned by the work of Population Health Management and reducing inequalities teams on assessing our population health and care needs (2025/26) 6. Bradford District Council growth plans (including city of culture 2025) are in development and will have an impact on the overall healthcare of our population.		
2	Wellbeing Board (Bradford District) and Health and Wellbeing Board (North Yorkshire)							
3	Health and Wellbeing Board Strategy							
4	Reducing Inequalities in Communities (RIC) work plan for the Reducing Inequalities Alliance sets out work on local priorities to address wider determinants; local Core20PLUS5 implementation group; Reducing Inequalities Alliance (cross partnership membership).							
5	The alliance has a work plan to deliver the Core20PLUS5 programme locally (with hyper local commissioning at community partnership level, and for CYP interventions to reduce inequalities).							
6	We are ensuring that our work to reduce inequalities runs as a golden thread through all that we do in the Act as One partnership and have published our Call to Action to reduce inequalities locally (and launched the Inequalities campaign and events with our workforce)							
7	The Core20Plus5 and health inequalities premium dashboards are established							
8	We are supporting West Yorkshire Health Equity fellowship scheme and mentoring local fellows across a range of work areas. Our Reducing Inequalities in Communities programme has 20 different projects covering health, wider determinants of health and community settings and we have extended many of these initiatives and embedded into business as usual where appropriate.							
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register		
1	Reducing inequalities alliance - regular meetings - Papers and Mins					2317, 2386, 2477, 2418, 2221		
2	Health and Wellbeing Board - Papers and Mins							
3	The Core20Plus5 and health inequalities premium dashboards							
4	Outcomes focused performance report for HCP Board capturing health inequalities							
Calderdale						Place lead: Robin Tuddenham		
Calderdale						Nominated lead for this risk: Neil Smurthwaite (17.07.2025)		
ICB risk appetite	Place risk scores					Rationale for current place score		
	Target (Calderdale)			Current (Calderdale)			As WYICB outlines above. The CCPB focuses regularly on health inequalities. Presentation due in September 2025 Committee on latest intelligence and how we will using linked data sets to provide greater insight into the Integrated Neighbourhood Health work.	
	Likelihood	4	16	Likelihood	5	20		
Impact	4		Impact	4				
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)		
1	We have a shared set of priorities set by Calderdale Health and Wellbeing Board - local plan feeds into ICB / ICP 5-year strategy forward plan					1. Calderdale council run a cost of living programme (2022 - ongoing) 2. Public have produced population data packes for each PCN and Integrated Neighbourhood health team.		
2	Reducing inequalities is a key ambition of the partnership							
3	Council Director of Public Health is lead for health inequalities work across Calderdale							
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register;		
1	Progress against the ICB metrics on inequalities is reviewed regular by HWBB and CCPB					2224, 2476, 2149, 1998, 1493, 62, 2469, 2484,		
2	Local JSNA							
3	Council Director of Public Health- attends Partnership Board							
Kirklees						Place lead: Vicky Dutchburn		
Kirklees						Nominated lead for this risk: Steve Brennan (27.06.2025)		
ICB risk appetite	Place risk scores					Rationale for current place score		
	Target (Kirklees)			Current (Kirklees)			Recognise that addressing inequalities will take time and there are factors beyond our	

BOLD	Likelihood	4	16	Likelihood	5	20	control, however the partners are committed to addressing this through the work that they do.
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions
1 Kirklees Health and Wellbeing strategy							1. Progressing on the work of the inclusive community framework (one of top tier partnership strategy) Power of one, power of many, working other for equity and fairness linked to the inclusive communities framework (2025/26) 2. The Kirklees ICB committee committed to continue with their work and actions were agreed as part of this work (November 2025) 3. Focus on addressing inequalities is key to how we deliver the Kirklees Healthy Working Life programme (for example the VCSE sector has a prominent role in helping to deliver this) 2025/26
2 Health and Wellbeing Plan							
3 Kirklees Economic, Environment and Inclusive Communities Strategies.							
Sources of assurance (Where is the evidence that the controls work?)							Links to place risk register: 2475, 2240, 2445
1 Regular reports to Health and Wellbeing Board							
2 Regular reports to Partnership Forum / ICB committee/ and other place governance							
3 Project reports							
Leeds Place lead: Tim Rley							Nominated lead for this risk: Nick Earl 27.06.25
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			Inequalities continue to widen in Leeds due to wider social and economic factors. LHCP has a strong and continued focus to address these disparities through our operating framework. Risk score remains the same.
BOLD	Likelihood	4	16	Likelihood	5	20	
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Partnership Leadership Team and Health and Wellbeing Board meetings in Leeds - allow influence of wider							1. Continued participation and support for Leeds City Council's Marmot City ambition 2. Leveraging ICB's role at place as a (small) anchor institution, and influence over other (larger) anchor institutions (NB this may not take place during vacancy freeze/restructure)
2 The Delivery and Inequalities Sub-Committee - highlighting impact of wider factors							
3 Marmot City Programme - provides joint working mechanism to address wider determinants							
4 Ongoing contracting with the third sector - provide additional resource flow into local economy and areas of need							
							Links to place risk register: 2415, 2354, 2301, 2018
Sources of assurance (Where is the evidence that the controls work?)							
1 Minutes from PLT / HWB meetings, particularly sessions with a wider strategic focus							
2 Minutes from Delivery and Inequalities Sub-Committee							
3 Programme reports from the Marmot city programme							
4 Financial accounts recording proportion of spend in this area							
Wakefield Place lead: Mel Brown							Nominated lead for this risk: Ruth Unwin, Amrit Reyat (14.07.25)
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			Local position reflects the WYICB position. Current likelihood is high due to significant pressures in the system.
BOLD	Likelihood	4	16	Likelihood	5	20	
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Healthy Standard of Living for All is one of the four priorities in the Health and Wellbeing Strategy							1. A further community of practice event has been planned for November 2025 2. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26) 3. Wakefield is working with funding from Health Determinants Research Collaborative (HDRC) to establish research capacity around health inequalities (2025/26) 4. The development of our integrated neighbourhood health model (2025/26)
2 Economic Strategy is in place led by the local authority. Elements that impact on health inequalities are reported to Health and Wellbeing Board							
3 Joint post working across health and the Local Authority addressing inequalities is in place							
4 Joint Steering Group established							
5 We are now established as a enabler programme in our transformation and delivery collaborative							
6 Community of Practice event being took place in May 2025							
7 Some of our uncommitted core spend for 2025/26 will be focusing on COPD							
8 The economic accelerator programme is now established.							
9 Development of a district plan							
Sources of assurance (Where is the evidence that the controls work?)							
1 Regular reports such as Bi-monthly public health profiles addressing inequalities are presented to the Health and Wellbeing Board and to the Wakefield District Health and Care Partnership							
2 Wakefield Joint Strategic Needs Assessment							Link to Place Risk Register
4 Report to WDHCP Committee in November 2024 on the evaluation and principles of allocation of resource for CORE20PLUS							2481

WYICB - Board Assurance Framework - ICB and places							Version 11	Date: 12 June 2025
Mission 1	Failure to manage strategic risk could result in a failure to REDUCE INEQUALITIES						Lead director(s) / board lead	Ian Holmes / Jonathan Webb
Strategic risk 1.2	There is a risk that operational pressures and priorities impact our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.						Lead committee / board	Finance, Investment and Performance Committee
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Significant financial and operational pressure continues to impact on our ability to deliver wider ambitions. The organisational change process and capacity will impact on the operational pressure.	
OPEN	Likelihood	3	9	Likelihood	4	16		
	Impact	3		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1	Clear, agreed plans that deploys £10.75m Health Inequalities funding across all Core 20PLUS5 priorities - specific workstream headed by Improving Population Health (IPH) Board with remit to recommend allocation of specific funding across the ICS						1. EQIA process on any proposed service change and commissioning policy change (2025/26).	
2	The first 3 ambitions in our Strategic Plan relate to inequalities. Plans for these are set out in the Joint Forward Plan which provides the foundation to prioritisation by the ICB Board. The Plan has a refreshed set of metrics to ensure that a difference can be made and measured.							
3	Measurement of inequalities relating to key operational priorities - such as elective recovery and ambulance waiting times.							
4	Board approved WY ICS Finance Strategy confirms importance of health inequalities as key element of how deploy resources.							
5	Committee overview of commissioning policies and quality impact by the Transformation Committee and Quality Committee respectively.							
6	Inclusion Health Unit, whose focus is on the sustainability of inclusion health services, supporting the system to improve the health of population groups.							
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1	Partnership Board focus on 10 big ambitions						Risk 2309 - demand for CYP mental health services; 2451 - Delays in gender identity specialist services; 2400 - delays in health assessments of CiC; 2479 - children's hospice care; Positive Assurance: see log	
2	ICB Board - performance dashboard and deep dives into health inequalities							
3	SOAG updates against 10 big ambitions							
4	ICB Annual Report summarises work on improving outcomes and reducing inequalities							
5	Internal Audit 'Health Inequalities Partnership Working' review - Significant Assurance - June 2024							
Bradford District and Craven (BD&C) Place lead: Therese Patten							Nominated lead for this risk: Sohail Abbas (26.06.25)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			There are higher levels of inequality in BDC as compared to other places. The organisational changes and wider environments makes it difficult to reduce inequalities. The risk score remains the same for this cycle.	
OPEN	Likelihood	3	9	Likelihood	3	12		
	Impact	3		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	QEIA assessments in routine use						1. Work is ongoing on population needs assessment and using population health management principles to identify population cohorts for targetting interventions (2025/26) 2. We are in the process of developing our health and care strategies in place together with our partners which will meet our ambitions around improving outcome and reducing inequalities. This work is being led by the Director of partnership and place (2025/26) 3. Alongside the strategy development we are developing our intent around neighbourhood health and have events in the diary both with practices but also as part of our Listen In engagement schedule across our communities to ensure we are developing services in partnership (2025/26) 4. QEIA assessments in routine use (process being refined and reviewed 2025) to ensure that the impact of proposed decisions does not move resource away from critical areas of health inequality (2025/26) 5. Economic evaluation of our health inequalities programme is undergoing which will help us deliver financial case for reducing inequalities (2025/26)	
2	Prioritising action plans to address the main causes of death, inequalities and poor health across BDC HCP (place) within the new Closing the Gap programme. Leadership group has been set up for implementing Core20PLUS5 for the ICS and BDC HCP (place). Targeting reduction of health inequalities by working closely with PCNs and Community Partnerships (and with Local Authority Area teams)							
3	Closing the gap programme has segmented the population and examines trends on health needs against expenditure, and high impact evidence based interventions to reduce inequalities and address pressure points locally.							
4	Inequalities toolkits have been used by our 13 Community Partnerships to guide commissioning (with guidance and separate intelligence packs itemising outliers). Primary care practice priorities have been aligned to Core20 priorities via the health inequality practice premium.							
5	Priority boards maintain a key focus on inequalities through their programmes of work							
6	Developing a System approach to reducing inequalities via improved collaboration between Inequalities, EDI, Research and Prevention programmes (included board readiness toolkit & development sessions to embed work to reduce inequalities through the governance structure).							
Sources of assurance (Where is the evidence that the controls work?)								
1	BDC Partnership Board and Exec receive full papers and briefings on progress within the Priorities and Enablers alongside system based committees which provide oversight and assurance on our outcomes.						Links to Place Risk Register	
2	Inequalities are embedded into our transformation work with Population Health Management (PHM) data identifying key areas of focus for priority. Priority Boards providing ownership of transforming services across all place based partners							
3	Outcomes focused performance report for HCP Board capturing health inequalities							
							2386, 2227, 2039, 2221	
Calderdale Place lead: Robin Tuddenham							Nominated lead for this risk: Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Risk score reflects operational performance on NHS targets. There are pressures in the system but it's not impacting on our ability to deliver Core 20+5. There is a significant risk on future finances and the overall change programme announced in March 25 could result in inequalities being impacted. Score will be continually monitored. Reviewed target score and reduced this from 9 to 6, due to a OPEN risk appetite.	
OPEN	Likelihood	2	6	Likelihood	3	9		
	Impact	3		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	Clear plan for place share of £12m led by DPH, reports to HWBB.						1. The data model is being developed to help analyse the use of urgent care to help address and ensure that out-of-hospital services do not create health inequalities - Population health tool is being developed - local drop in sessions will take place with discussion at Board level in 2025-26. 2. Financial pressures continue to be monitored and savings identified recurrently to ensure underlying position does not deteriorate. 3. Change programme and new ICB operating model will impact on this risk and will be monitored.	
2	Tackling inequalities is a core requirement of all papers to comment upon, particularly contract awards / service improvement.							
3	Measurement of health inequalities for elective recovery has been key component for CHFT and its delivery of its waiting lists.							
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register: 2224, 1338, 2476, 2149, 1998, 1493, 62, 2092	
1	Regular report to HWBB (as above) and CCPB.							
2	Joint Forward Plan will include health inequalities.							
3	Transformation delivery plan signed off by Board on 5 September 2024, one of the key ambitions in reduction in health inequalities							
Kirklees Place lead: Vicky Dutchburn							Nominated lead for this risk: Vickv Dutchburn (25.06.2025)	

ICB risk appetite		Place risk scores				Rationale for current place score		
		Target (Kirklees)		Current (Kirklees)				
OPEN	Likelihood	2	6	Likelihood	3	12	Outcomes Framework, indicators and proxy indicators, establish network, align core 20 plus 5 , strengthen reporting through PMO and align approaches to VCSE investment and Inclusive communities framework. The elective performances is included in the bi-monthly performance committee. There have been deep dive reports and discussions with our health and care partnership board specifically on child and adult mental health and neurodiversity assessment, there is an action plan. The core 20+5 schemes have been reviewed and built in as business as usual as an outcome of that review. The rigour of internal processes with regards to prioritisation and reviews of all contracts which are due to expire March 2026 - the governance timeline complete until the end of October 2025.	
	Impact	3		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>		
1	Health and Wellbeing Strategy						1. Agreed that Kirklees place will develop an action plan on children and young people's neurodiversity to sign off by April 2025 - action plan has been completed and submitted as part of the SEND review - June 2025. 2. Expecting final SEND report end of August 2025 and implementing review actions from Q3, 2025/26 3. Establishment of transformation dashboard as per annual review recommendation (Q2, 2025/26)	
2	Health and Wellbeing Plan							
3	Outcomes Framework							
4	Deep dive reports on high risk areas e.g. child & adult mental health, neurodiversity assessments.							
5	Completed review of the children and young people's mental health model (Kirklees Keeping In Mind) implementation commenced April 2025.							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						<u>Links to place risk register:</u> 2240		
1	Regular reporting into Health and Wellbeing Board							
2	Regular reporting into place governance such as the Kirklees Quality Committee							
3	PMO reports on projects							
4	Reports and action plans to Transformation Committee							
Leeds				Place lead:	Tim Ryley		Nominated lead for <u>this risk</u> : Nick Earl 27.06.2025	
ICB risk appetite		Place risk scores				Rationale for current place score		
		Target (Leeds)		Current (Leeds)				
OPEN	Likelihood	3	9	Likelihood	4	16	Current reduction in ICB resources and associated restructure will be presenting notable challenges to driving work in this area (alongside existing operational pressures - particularly during Winter). Reviewed target risk score in light of a open risk appetite (willing to take reasonable risks and is tolerant to some uncertainty), agreed to reduce the target risk score from 12 to 9.	
	Impact	3		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>		
1	Local strategy with a focus on health inequalities (Healthy Leeds Plan), with key data cut by IMD and other relevant HI metrics.						1. Partnership focus in 25/26 on programme benefits quantification should support greater assessment of potential HI impact 2. Review approach to incentives in line with strategic commissioning role towards the end of this financial year 3. Provide both challenge and support to emerging HealthCare Inequalities Oversight Group, which has a partnership focus across providers	
2	Local governance structures with a focus on inequalities - Delivery and Inequalities sub-committee, Health Inequalities Oversight Group and specific sessions at Partnership Leadership Team							
3	Leeds financial planning process includes mechanisms to minimise impact on inequalities as well as QEIA assessments in routine use (and published)							
4	All delivery plans have a clear focus on addressing inequalities within existing resources.							
5	Inequalities / Core20+5 / transformation funding as part of general practice incentive scheme (GPOP)							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						<u>Links to place risk register:</u> 2354, 2301, 2480		
1	HLP document and access to PowerBI reporting							
2	Minutes and terms of reference for Delivery Sub-Committee, HIOG and PLT							
3	Online QEIA resource							
4	Business reporting to Leeds Director Team							
5	GPOP scheme documents							
Wakefield				Place lead:	Mel Brown		Nominated lead for this risk: Ruth Unwin, Amrit Reyat (14.07.25)	
ICB risk appetite		Place risk scores				Rationale for current place score		
		Target (Wakefield)		Current (Wakefield)				
OPEN	Likelihood	3	9	Likelihood	4	16	Reflects the Integrated Care Board position. Local places have limited powers to reduce likelihood.	
	Impact	3		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>		
1	Allocation of CORE20plus5 monies						1. Working with the data team to do more deeper evaluation of our CORE20plus funded programmes (2025/26) 2. Working through the investment panel process to secure funding (2025/26)	
2	Healthy Sustainable Communities Oversight Group established for CORE20plus5 and reports through the governance structure							
3	Place Outcomes Framework currently in development							
4	Tackling inequalities is a priority of the Health and Wellbeing Board and associated work programmes							
5	Established CORE20plus5 strategic group which oversees the evaluation of funded programmes. Developed a evaluation framework which will support targeted interventions							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						<u>Link to Place Risk Register</u> 2128		
1	Health and Wellbeing Board Outcomes Framework - reports to the Health & Wellbeing Board - annually							
2	Performance Report to Integrated Assurance Committee - bi-monthly							
3	Performance Report to Wakefield District Health and Care Partnership - quarterly							

WYICB - Board Assurance Framework - ICB and places							Version: 11	22 April 2025
Mission 1	Failure to manage strategic risk could result in a failure to REDUCE INEQUALITIES						Lead director(s) / board lead	Ian Holmes
Strategic risk 1.3 (previously 1.4)	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.						Lead committee / board	ICB Board <i>(linked to place committees)</i>
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for all places. We have made good progress in some areas, but progress has been variable and there is still significant work to be done.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at ICB level?)</i>	
1	ICS and HWB strategies, together with the Joint Forward Plan set out a clear and aligned vision and plans for integrating services in communities, in line with the Fuller recommendations and the medium term strategy.						1. Place Partnership Review (led by Anthony Kealy) will support further development of Place model including provider collaboratives and integration in Places. The ICB's response to the running cost reduction will need to consider the findings of this review in the context of significantly reduced capacity. 2. National focus on integrated neighbourhood health as part of the new Government's objectives will create greater focus. This will influence ICB planning for 2025/26. The ICB has identified integrated neighbourhood health as a key priority lead by Places.	
2	ICB medium term financial plan supports a differential investment towards primary and community care.							
3	Working with stakeholders through the Power of Communities programme on 4 key priority areas for specific focus over the next 5 years to ensure reduction in inequalities and to add value and maximise impact including: Acute & Specialist Provision; Community & Neighbourhoods; Access, inclusion and working with diverse communities and workforce.							
4	Quality Committee and ICB Board receive Integrated Performance Dashboard which reflects progress made towards integrating services and neighbourhoods.							
5	Development of a Blueprint for delivering neighbourhood-based care, driven by integration, to deliver outcomes important to people and tackle inequalities. This is being overseen by the Transformation Committee.							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to ICB risk register (Reference numbers/brief description)	
1	Published ICS health and wellbeing strategy and Joint Forward Plan						2120 - risk of a widening of health inequalities and poorer health outcomes due to the reduction or loss of VCSE services and aggregated impact of disinvestment in the VCSE	
2	Delivery of the Fuller Board work plan (minutes and actions)							
3	Metrics within the Integrated Performance Dashboard, discussion evidenced through minutes of Quality Committee and ICB Board							
4	Internal Audit review - Primary Medical Services Commissioning (significant assurance)						See the separate Positive Assurance Log	
Bradford District and Craven (BD&C)				Place lead: Therese Patten			Nominated lead for <u>this</u> risk: Sohail Abbas (26.06.25)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Key priority with significant work required across our PCNs, CPs and localities. Challenges are capacity to deliver and maturity of multi-sector provider collaboration. We are prioritising based on areas PHM data is highlighting.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1	Development of our Primary Care Networks and Community Partnerships (CPs) that together support integrated neighbourhood health service models - and which can be flexible to the specific needs of local communities across BDC.						1. Continuing to expand use population health management data and analysis to drive our commissioning intentions and decisions on service transformation and provision - and empower service change at the neighbourhood level (2025/26) 2. Reducing Inequalities Alliance are working with our Community Partnerships (CPs) in relation to on-going roll out of Core20+5 initiatives. CPs are grouped by LA wards, have linked PCNs and also have strong input from the VCSE, to further facilitate opportunities for neighbourhood co-production on integrating care and tackling inequalities (2025/26) 3. BDC health and care strategy and national 10 Year Plan will inform continued evolution of local integrated neighbourhood health models (2025/26) 4. Long term conditions and multi-morbidity needs assessment and development of a holistic model of care, with focus on those at high/rising risk and high intensity users of health services (2025/26) 5. Work underway to develop our integrated neighbourhood team model (2025/26)	
2	Reduce Inequalities Alliance (RIA) built around 4 themes: to set the strategic vision; support best practice; build leadership capacity; and facilitate and share learning. This is also enabling embedding of Core20Plus5 approaches at the neighbourhood level.							
3	Strategic commissioning intent and development of our health and care strategy is underway.							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to Place Risk Register	
1	Place priorities for system transformation, including integrated neighbourhood health services development, report to Partnership Leadership Executive and to the BDC HCP Partnership Board						2221, 2486	
2	Reducing Inequalities Alliance reporting to Exec and BDC HCP Partnership Board							
3	Development of our health and care strategy; co-production with Bradford LA on the district plan (delivery oversight by the Health and Wellbeing Board); ongoing work with NY LA via our localities							
Calderdale				Place lead: Robin Tuddenham			Nominated lead for <u>this</u> risk: Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for Calderdale.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1	Calderdale Cares Community Programme Board is in place for integrating services and community.						1. Looking to utilise data over coming year to ensure efficiency and effectiveness of services to ensure out of hospital care reduces inequalities, there is a programme of work ongoing (Quality group) 2025/26 2 Place Partnership Review (led by Anthony Kealy) and ICB letter March 25 regarding Provider Collaboration will support further development of Place model including provider collaboratives and integration in Places. The ICB's response to the running cost reduction will need to consider the findings of this review in the context of significantly reduced capacity. 3. National focus on integrated neighbourhood health as part of the new Government's 10 year plan create greater focus. This will influence ICB planning for 2025/26 and beyond. The ICB has identified integrated neighbourhood health as a key priority lead by Places. 4. Consideration made for national programme for Integrated Neighbourhood Health, however due to uncertain times first phase application not proceeded with. Further strengthening of data and resource needed for future waves Links to Place risk register: 2476, 2163, 1493, 62, 1977, 2469, 2484, 2092	
2	Tranformation deliver plan has integrated neighbourhood team as key objective for the partnership board							
3	Calderdale Community Collaborative Programme board in placed led by PCN Directors.							
4	Senior leadership meeting in July 2024, discussion on integrated neighbourhood teams							
5	There are variety of governor forums and enabler groups that bring partners across the health and care partnership together to address issues relating to issues in a joined up way							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>								
1	A year end report will be presented to the partnership board on the tranformation delivery plan for which integrated neighbourhood is the key priority							
2	Joint Forward Plan being developed.							
3	Calderdale Community Collaborative Programme board in place led by PCN Directors. Terms of Reference and mins.							
Kirklees				Place lead: Vicky Dutchburn			Nominated lead for <u>this</u> risk: Catherine Wormstone (30.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			While a strategy is in place, there is a need to focus on the delivery of transformation and improvements across all nine integrated neighbourhood teams and to ensure adequate capacity is freed up by system partners. Risk score remains the same.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1	Core20+5 is being lead by the Public Health team on behalf of the Partnership						1. Programme plan in place to fully implement integrated neighbourhood teams and improve integrated neighbourhood health in line with 2025/26 planning guidance	

2		Addressing inequalities is and will continue to be written into the scope and terms of reference for all place based work areas, to ensure that the focus on inequalities is a common theme to all our work					2. Business case developed for accessing West Yorkshire SDF funds (non-recurrent) to assist with accelerating pace of implementation	
3		INT data packs developed and data sharing agreements in place					3. Identified accelerator site to commence first INT on 2 July 2025, system partners are ready to facilitate engagement and support for accelerator site.	
4		A number of services including VCSE already aligned around communities					4. Regular fortnightly call in place with SROs for 6 core components of integrated neighbourhood health	
		Sources of assurance (Where is the evidence that the controls work?)					5. Workshop held on 27 June 2025 to co-design OD support for system leaders and integrated neighbourhood teams. Next steps will be to share draft programme with stakeholders (2025/26)	
1		Published Health and Wellbeing Strategy					6.Planned refresh of the objective within the health and care plan (2025/26)	
2		The local Health and Care Plan follows directly on from the Health and Wellbeing Strategy					7. Neighbourhood level data being extracted from primary care and supported by linked data sets to facilitate a population health management approach. Next steps to share with accelerator site and other INTs (2025/26)	
3		Extensive engagement (lead by Healthwatch) with local people to inform strategy and plans to ensure they meet the needs of the local population						
4		ICB Committee meetings - notes						
5		Delivery collaborative - notes						
6		PCN meetings - notes						
7		Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground.					Links to place risk register	
8		WY INH Board in place					2475	
Leeds		Place lead:		Tim Ryley			Nominated lead for this risk: Helen Lewis (23.06.25)	
ICB risk appetite		Place risk scores					Rationale for current place score	
		Target (Leeds)			Current (Leeds)			Strong work plans already within the Leeds Health and Care Partnership, within LCP areas and in key areas such as frailty, mental health and transfer of care. More to do, and the impacts of getting it wrong for individuals remain high but good progress.
OPEN	Likelihood	2	8	Likelihood	3	12		
		Impact	4		Impact	4		
		Key controls (What helps us mitigate the risk?)					Mitigating actions (What more are we/should we be doing at place?)	
1		Strong LCPs and PCNs.					1. Developing (integrated neighbourhood clinics are in place and considering further developments) (2025/26)	
2		All relevant data displayed by IMD and other key variables linked to inequalities.					2. LCH and GP confederation looking at neighbourhood integration opportunities as part of the system neighbourhood health model (2025/26)	
3		Population and care delivery board structures in place, with increasing access to data that enables analysis of issues at very local levels, add neighbourhood health is one of the partnership leadership priorities and programme is reviewed regularly and overseen by partnership leadership team					3. LCH and Leeds City Council rolling out their active recovery offer to improve integration (2025/26)	
		Sources of assurance (Where is the evidence that the controls work?)					4. Community mental health programme engaging all relevant partners to improve service integration and focus on those people most at risk (new contract with VCSE 2025/26)	
1		Access to Leeds data model/power BI platforms, and RAIDR to review data sets.					Positive Assurance	
2		Notes of LCP/PCN meetings.					Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground.	
3		All LHCP programmes pay due attention to joining up services, demonstrated via minutes.					Link to place Risk Register	
							2415	
Wakefield		Place lead:		Mel Brown			Nominated lead for this risk: Ruth Unwin, Amrit Reyat (14.07.25)	
ICB risk appetite		Place risk scores					Rationale for current place score	
		Target (Wakefield)			Current (Wakefield)			There is limited opportunity for place to influence the impact of inequalities but reducing inequalities is a priority for the Health and Wellbeing Board and the Wakefield District Health and Care Partnership.
OPEN	Likelihood	2	8	Likelihood	3	12		
		Impact	4		Impact	4		
		Key controls (What helps us mitigate the risk?)					Mitigating actions (What more are we/should we be doing at place?)	
1		Wakefield Transformation and Delivery Collaborative established supported by a network of Provider Alliances with responsibility for joining up services and addressing inequalities					1. The development of a neighbourhood model enables a targeted and more planned approach to care (2025/26)	
2		Core Senior Leadership team established across Wakefield place with distributed leadership responsibilities					2. The reducing healthcare inequalities steering group is connected into the VCSE collaborative which is taking forward the development of the VCSE strategy for the district (2025/26)	
3		Action plan to address the gaps following the publication of the Fuller report					3. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26)	
4		This work is connected to the work to develop a neighbourhood model						
		Sources of assurance (Where is the evidence that the controls work?)					Positive Assurance	
1		Transformation and Delivery Collaborative Chair's report to Wakefield District Health and Care Partnership highlights key discussions - bi monthly					An update report was provided to the health and wellbeing board on the 30 January 2025 regarding the development of the VCSE strategy.	
2		Provider Alliance deep dive regarding progress against priorities reported to Transformation and Delivery Collaborative - monthly					Links to Place Risk Register	
3		Medical Director for Integrated Community Services attends Fuller Board					2397, 2429	

WYICB - Board Assurance Framework - ICB and places							Version: 11		Date: 8 April 2025	
Mission 2		Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE					Lead director(s) / board lead		Kate Sims	
Strategic risk 2.1		There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.					Lead committee / board		Transformation Committee	
ICB risk appetite		ICB risk scores					Rationale for current ICB score			
		Target (ICB)			Current (ICB)			Workforce recruitment and retention remains a challenge across the system. The current workforce reduction programmes within both the ICB and provider Trusts will impact on the ability to attract and retain staff across the workforce. In addition, the system awaits further detail in relation to any potential growth as part of the NHS long term workforce plan and Adult Social Care workforce strategy. Risk score- increased impact from 3 to 4 for this quarter - increased from 12 to 16.		
Likelihood	4	8	Likelihood	4	16					
OPEN	Impact	2		Impact	4					
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at ICB level?)</i>			
1		WY People Board (multi-sector) oversight of priority programmes, The ICB EMT organisational change programme board - a system wide overview of the responses to the workforce challenges under the West Yorkshire People Plan					(1) WY People Strategy is being refreshed during 2025.			
2		WY Mental Health and Well Being Hub - a system wide offer to all staff across the WY partnership to ensure that access to Mental Health Wellbeing is available to all - with regular reporting into People Board					(2) The ICB received detail from each NHS provider of their current workforce planning and control mechanisms. These will be used to help monitor each Trusts workforce position against its operating planning submission (2025/26)			
3		WY Strategic Workforce Transformation Forum established (system wide) to have strategic overview to ensure readiness against long term workforce plan and adult social care workforce strategy					(3) Workforce Strategy and Planning Team - primary agenda is aligned with Strategic Workforce Transformation Forum, and as this develops they will provide a level of workforce transformation capacity.			
4		Workforce Place Leads and place-based plans (for further details, see Place BAF below)					(4) One of the agreed terms of reference for the Strategic Workforce Transformation Forum centres on influencing regionally and nationally. The Forum has now agreed its core 4 priorities with delivery groups established to respond to each - 2025/26			
5		Creating Global partnerships for the supply of International recruits into challenged areas - to ensure ethical and sustainable international recruitment, education pathway and to offer system support. Dedicated global team working directly with NHS England.					(5) The ICB has commenced a review of its operating model (Apr 2025) in response to the further targetted reduction of 50% of costs. There will be a large scale organisational change programme to deliver the required response to this announcement.			
6		Active leadership on workforce part of annual operating plan cycle, with ongoing assurance through Finance Investment and Performance Committee, Transformation Committee and ICB Board.					(6) NHS providers across West Yorkshire are also required to review their growth in corporate service costs since 2019/2020 and reduce these by 50%. This is in addition to the workforce reductions indicated within the operating planning submission.			
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to ICB risk register <i>(Reference numbers/brief description)</i>			
1		Transformation Committee; Strategic Workforce Forum; People Board - agenda, papers and minutes					2296 - YAS workforce; 2108 - cancer workforce; 2324 - ICB workforce; 2402 - general practice workforce; 2512 - ICB workforce			
2		Place leads meet with local NHS providers to ensure progress is monitored across WY against the operating planning submission. WY People Team actively attend Place workforce committees. Director of People is a member of Yorkshire and Humber Workforce Steering Group for adult social care.								
3		NHS sickness absence and turnover is reported to ICB Board via Integrated Performance Report.								
2		Active data flow across wider People agenda, which is presented to the People Board and Strategic Workforce Transformation Forum.								
3		(NHS specific) Staff Survey annual results					See the separate Positive Assurance Log			
Bradford District and Craven (BD&C)		Place lead:		Therese Patten			Nominated lead for <u>this</u> risk:		Andrew Milner 27.06.2025	
ICB risk appetite		Place risk scores					Rationale for current place score			
		Target (BD&C)			Current (BD&C)			The workforce challenges remain across both health and social care within the public and independent sector. Additionally, there are similar challenges within the voluntary, community and social enterprise sector where issues around living wage and competition from larger employers is cited as a particular challenge. Within health, retention remains a significant challenge. Current financial and organisational circumstances mean recruitment across healthcare organisations is extremely limited. Risk score increased from 12 to 16. Discussed target score as the appetite is currently cautious, agreed to increase the target risk score from 6 to 8 due to limited tolerance.		
Likelihood	4	8	Likelihood	4	16					
CAUTIOUS	Impact	2		Impact	4					
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>			
1		BDC HCP System Finance and Performance Committee (System FPC) – led by an independent NED chair who champions the agenda at the BDC Partnership Board. Broad based senior participation including care sector and primary care. Quarterly review of the detailed workforce dashboard with a view to identifying workforce risks and issues.					1 We have made progress in supporting the social care workforce with initiatives to help retain staff. As a part of the health and work accelerator programme multiple interventions including the provision of mental health and physiotherapy support are being commissioned to support the social care workforce. This builds upon learning from successful employee assistance programmes operating within our NHS provider organisations. We are building on this by working with the Bradford Care Association. 2. Delivery of the workforce priority programme at place with emphasis on building recruitment pipelines for health and social care staff specifically through the development of a consolidated entry level recruitment programme run via Skills House within Bradford Metropolitan District Council (Ongoing 2025/26) 3. Working across the system within partners including Higher Education Institutions to develop a pipeline for registered health and care roles (Ongoing 2025/26)			
2		BDC HCP People Plan has been refined to ensure alignment with the priorities of partner organisations and the partnership more broadly. As a part of this, particular focus has been placed upon capacity and ability to deliver.								
3		'People' is one of five strategic priorities for BDC HCP which means that additional focus and resource applied to delivery of the People Plan. Reported on at Partnership Leadership Executive and Partnership Board. With CEO lead Foluke Ajayi in place.								
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to Place Risk Register			
1		Triple A report from SFPC to Partnership Board					2386, 2227, 2477, 2434, 2422, 2420, 2418, 2417, 2215, 2421,			
2		Highlight reports from the People Programme through a Programme Board								
3										
Calderdale		Place lead:		Robin Tuddenham			Nominated lead for <u>this</u> risk:		Neil Smurthwaite (17.07.2025)	
ICB risk appetite		Place risk scores					Rationale for current place score			
		Target (Calderdale)			Current (Calderdale)			The workforce challenges remain across social care both within the public and independent sector, together with the voluntary, community and social enterprise sector, with challenges of living wage and competition from larger employers cited as a particular challenge. Within health, retention of staff is seen as a priority alongside recruitment.		
Likelihood	4	8	Likelihood	4	12					
CAUTIOUS	Impact	2		Impact	3					
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>			
1		West Yorkshire plans reflected at place.					1. Provider workforce plans led by Acute and Primary Care leads 2025/26 2. Local group looks at recruitment and development 2025/26			
2		Operating model is in place								
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to Place Risk Register:			
1		Update to the partnership board					2224, 1338, 2149, 1493, 62, 1977, 2092			
Kirklees		Place lead:		Vicky Dutchburn			Nominated lead for <u>this</u> risk:		Steve Brennan (25.06.2025)	
ICB risk appetite		Place risk scores					Rationale for current place score			
		Target (Kirklees)			Current (Kirklees)			Whilst workforce data shows that generally the workforce is increasing at a modest rate, it is not		
Likelihood			Likelihood							
	Impact			Impact						

CAUTIONS	Likelihood	4	8	Likelihood	4	16	in line with growth targets and therefore workforce challenges still remain across all sectors of Health and Social Care. The workforce controls around the 2025/26 planning round makes this challenging. Some of the challenges are structural [such as rates of pay within social care and potential changes for international staff particularly in the independent care sector and recent NI changes] and therefore are difficult to address in the short term. Current ongoing changes to where the responsibility for strategic workforce planning sits within the NHS make this more challenging. The workforce challenges with Kirklees are in line with those across West Yorkshire as a whole, and therefore our risk scores are in line with those for the wider West Yorkshire ICB. Risk score increased from 12 to 16 in line with WY ICB.
	Impact	2		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1	Kirklees actively engaged in West Yorkshire arrangements.						1 We have made progress in supporting the social care workforce with initiatives to help recruit staff. We are building on this by working with the Kirklees and Calderdale Care Association, for example, to support staff wellbeing within care homes roadshow which took place in May 2025. Compassionate cultures conference took place in June 2025, supporting staff with health and wellbeing. However, this is an area where we continue on supporting staff health and wellbeing. 2 We want to develop approaches to building training capacity in non-acute settings, but this will take time. Working as part of the WY placement expansion work with a focus on placements in care home settings (2025/26) 3 We also want to build more on the opportunities created by working with the University of Huddersfield, particularly around the new Health Innovation Campus, Health and Wellbeing Academy, and Leadership Development. Recently established a partnership board to oversee this work (2025/26) for example the development of new Radiography course.
2	Workforce arrangements well established within Kirklees for working with health and care providers and sectors including the VCSE and social care. We have an agreed integrated workforce approach with Calderdale which focuses on 3 pillars (1. Looking after our people, 2. Recruiting and retaining our people, and 3. Developing our people together). We have a system Senior Responsible Officer in place and a joint Workforce Steering Group which is supported by a Working Group for each of the 3 pillars.						
3	Placement work on pharmacy is now complete, the placement arrangements and systems will continue 2025/26						
Sources of assurance (Where is the evidence that the controls work?)							
1	Evidence on the impact of projects and initiatives is monitored within the appropriate Working Group for each of the pillars.						Link to place risk register: 2498
2	Each of the 3 Working Groups reports into our Joint Workforce Steering Group to present evidence of impact of their projects and initiatives.						
3	Regular updates on the Joint Workforce Programme are reported into the Kirklees Partnership Forum, which is part of our overall place governance arrangements. Updates are also presented to other governance forums when required such as the Kirklees Transformation sub-committee.						
Leeds Place lead: Tim Rley Nominated lead for this risk: Kate O'Connell (02/07/2025)							
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
CAUTIONS	Likelihood	3	9	Likelihood	4	12	The current risk score reflects the scale of unfilled vacancies across the vast majority of employers in the context of a tight labour market. Although targeted activity has reduced some vacancies, the financial pressures have created recruitment controls and so notable risk remains. There has been a shift in focus from recruitment to retention. Current pressures on services and the cost of living increase creates significant risk of retention, particularly for the lowest paid staff, many of whom are in the third sector. Existing mitigations are unlikely to resolve the scale and nature of these challenges in the short term.
	Impact	3		Impact	3		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1	The Leeds One Workforce Strategy has been refreshed, continuing to providing a cohesive, prioritised approach for the city's health and care partners and a clearly defined programme of work.						1. Continue to identify and secure diverse funding which supports collaborative recruitment and retention. The Leeds Health and Care Academy leads this on behalf of the city and income is assessed annually. The last review took place on April 2025. The next review will take place in April 2026. 2. Continue to increase and diversify student placement opportunities and experience, and support transition from education to employment. This is a priority strategic project in the Leeds One Workforce Programme due for review in November 2025. 3. Health and growth accelerator programme providing additional support to retain staff in work (2025/26)
2	Leeds City Resourcing Group (LCRG) guide and monitor the collective impact of workforce recruitment and retention activity across Leeds Health and Care Partnership.						
3	Leeds H&W Community of Practice (CoP) collaborates on city-wide funding and services for H&SC staff.						
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: None.
1	Minutes from Leeds One Workforce Strategic Board (LOWSB), LCRG and Leeds H&W CoP						
2	Academy Steering Group quarterly reports						
3	Leeds One Workforce City Risk profile						
Wakefield Place lead: Mel Brown Nominated lead for this risk: Dominic Blaydon/ Philip Marshall 01.07.25							
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
CAUTIONS	Likelihood	4	8	Likelihood	4	12	The current likelihood and impact scores recognise the work underway as part of the implementation and delivery of The Wakefield People Plan. The Plan consists of 6 Pillars, all aligned to supporting staff health and wellbeing, retention and recruitment included in Pillar 1 'Looking after our People' and Pillar 5 'Growing and Developing Our Workforce. These programmes will support partnership and collaborative initiatives. It also includes commitment to the Memorandum of Understanding (MoU) and Operational Template to support the deployment of staff between organisations. This MoU will mitigate any future impact of operational and process challenges with recruitment and retention of staff at an organisational level. Currently there is a significant risk to the workforce as a result of the 50% reduction in ICB funding however, in Wakefield we are to some extent protected from this because of the way the PMO is currently funded. There is still residual risks to the social care workforce associated with a lack of the national strategy and funding arrangements.
	Impact	2		Impact	3		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1	Wakefield People Alliance oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the Wakefield People Plan						The Wakefield People Alliance's Pillar 5 Programme adopts a comprehensive approach to tackling workforce risks through strategic recruitment initiatives. These initiatives mitigate workforce risks associated with recruitment and retention of staff across the health and care system. Initiatives include: (timescale - 2025/26) 1. Hyperlocal Recruitment Programme, which focuses on attracting talent from within the local community. By partnering with local organisations and offering tailored recruitment opportunities, this programme supports the development of a diverse workforce that is connected to local communities. 2. School Engagement Programme, which fosters early career awareness by engaging students and raising the profile of the full range of careers available in our sector. This initiative not only encourages the pursuit of healthcare careers but also strengthens the pipeline of future professionals. 3. The Student Placement Framework further enhances workforce sustainability by providing students with hands-on experience within the Wakefield health and care sectors, helping to
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.						
3	The Wakefield People Plan has 6 Pillars within it, each with two Pillar Leads, supported by a Programme Manager to plan, lead the delivery of each Programme						
4	Wakefield Workforce Project Management Office established across the Wakefield system						
Sources of assurance (Where is the evidence that the controls work?)							
1	Access and analysis of workforce sector data to inform the development of a Workforce Plan dashboard to be reported through to Integrated Assurance Committee.						3. The Student Placement Framework further enhances workforce sustainability by providing students with hands-on experience within the Wakefield health and care sectors, helping to
2	Wakefield has been supported via system-wide funding/workstreams including staff training and support, coaching and mentoring, money buddies, physical health checks.						

	Positive Assurance The current Programme within the Wakefield People Plan focuses on the following priorities: - Community Career Events co-designed by the Community delivered by all health and social care providers across Place and hosted in Community Anchors. Hyper local recruitment in place with job interviews on the day and roles offered to community members. This is an evolving programme which will be delivered across all localities. - System approach to the pooling of the apprenticeship levy and developing resources specifically for young people to increase the number of apprenticeships in the system and grow our own from the future generation - Working with the social care independent sector to support their key challenges identified and co-design solutions, which include system offers on training, well-being and local recruitment. - Strong place-based governance arrangements are in place to support the delivery of the programmes, including a well-developed People Alliance, dedicated System Workforce Programme Management Office and Wakefield Health and District Partnership People Hub. - Recently launched economic accelerator programme that supports people in the current workforce who are at risk of becoming economically inactive. Commissioned a range of services to support this cohort.	bridge the gap between academic learning and real-world application. The Wakefield People Alliance addresses retention through its Pillars 1-3 Programmes. Initiatives include: (timescale - 2025/26) 1. The Wakefield Health and Care Learning Portal supports continuous development by offering accessible training and development resources for current staff, promoting career growth within the sector. 2. The Compassionate Leadership Programme cultivates empathetic leadership to create supportive working environments, while The Leading Wakefield Together training builds collaborative leadership skills across the workforce. 3. Coaching and Mentoring Hubs provide personalised support to staff, helping them navigate career challenges and fostering long-term engagement. Continues for 2025/26.
		Links to Place Risk Register
		2129

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 19 March 2025
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE						Lead director(s) / board lead	James Thomas
Strategic risk 2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.						Lead committee / board	Quality Committee
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			More formal assurance is needed through Transformation Committee and Partnership Board. Significant work has taken place over the last 12 months. Digital is a risk in terms of separation with the new leadership arrangements however this is being focused on, this will continue in 2025/26. Uncertainty around the implications of current changes with ICBs and the impact on the WY ICB research function, risk scores may change by the end of Cycle 1 2025/26.	
	Likelihood	2	6	Likelihood	2	8		
OPEN	Impact	3		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1 Clear governance around Quality with NHSE, providers and places working collaboratively to share learning and report via System Quality Group and ICB Quality Committee							1. Develop assurance mechanisms to Transformation Committee and Partnership Board.	
2 Research via Applied Research Collaborative (ARC)							2. Annual review to bring additional rigour with lens on innovation.	
3 West Yorkshire Innovation Leadership Collaborative – joint chaired by Medical Director with Health Innovation Network Clinical lead								
4 West Yorkshire Health and Care Partnership Research Leadership Working Group (RLWG), chaired by Medical Director								
5 HIVE network brings together research and innovation networks								
6 Collaboration with Digital								
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1 Agenda and minutes of meetings listed as controls							WY Corporate Risk Register - reference - 2108	
2 SOAG oversight of innovation and research networks								
3 Clinical and Care Professional Forum							See the separate Positive Assurance Log	
Bradford District and Craven (BD&C)			Place lead:	Therese Patten			Nominated lead for this risk:	Phillipa Hubbard (30.06.2025)
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Recognise the requirement to implement the BDC HCP strategy and 'inverting the power to act' at locality level - this is ongoing through Healthy Communities and Living Well Programmes. Risk score increased from 6 to 9 due to work needing to be undertaken with regards to digital upgrade for systems and software. Business case approved but not implemented to date. Primary care impact is on new approach to shared care protocols/ agreement still to be signed off.	
	Likelihood	2	4	Likelihood	3	9		
OPEN	Impact	2		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	Committee structure in place including BDC HCP System Quality Committee which oversees the process of mutual assurance of quality of care delivered by local providers, which identifies issues, and supports improvement. In addition we have Priority and Enabler Programme Boards that provide ownership to transforming services across all place based partners. The system quality insight and assurance group meets monthly to triangulate themes, intelligence and learning which then reports into the System and Quality Committee. The SQC reports quarterly into place partnership board and WY Quality Committee and Quality Group.						1.The Quality Team input into BDC priorities and transformation programmes and patient safety/ quality is taken into account when responding to financial pressures (Work ongoing 2024/25-2026)	
2	The Innovation Hub working alongside the development of improves as one portal and accompanying process identifies proven best practice and supports local teams to adopt and adapt across the BDC HCP						2. Development of the dashboard to include patient outcomes to be used as a source of assurance operational is ongoing (2024/25 - 2026)	
3	Model of Distributive leadership in place in Bd&C with HCP for Chief Nurse which provides opportunities to provide assurance and oversight, share best practice, learning and improvement opportunities between partner organisations						3. Work is progressing on the BDC clinical strategy to support and streamlining of clinical pathways which supports the work of the place based clinical forum. (September 2025) Governance system structures and alignment to support the wider collaborative have been revised including workstreams for integrated neighbourhood health.	
4	Prioritisation framework and WY ICB wide QEIA process has been implemented alongside strategic principles that have been produced by the BDC System Strategy working group to try and narrow the gap						Links to Bradford place risk register:	
5	Quality requirements are represented with all providers and monitored through the contract management process						2419	
Sources of assurance (Where is the evidence that the controls work?)								
1	Assurance through Internal Audit of our transformation programmes and via ongoing reporting and challenge through individual Programme Boards, Partnership Board, Clinical Forum and SQC/SQG and ICB governance structures - through AAA updates from assurance and governance committees (combined F&PC SQC and meet monthly) and priority and enabler programmes.							
2	Redeveloped model/way of working for the Place (Bd&C) System Quality Committee (SQC) including the provision of governance and assurance and sharing of best practice through the work of sub-groups and the reporting structure. Terms of Reference and Minutes.							
3	The Innovation Hub networked to all other parts of our BDC governance structure, including whole system enabling strategy groups for population health management, workforce, digital, estates, and communication & engagement. Supported by shared system committees for Finance and Performance, Quality and Safety, and our Clinical Forum. The Hub maintains strong links with Bradford Institute of Health Research (BIHR), Yorkshire & Humber AHSN, Yorkshire and Humber Improvement Academy (IA) and the University of Bradford (UoB). Terms of Reference and Meeting Minutes.							
4	Recommendations on investment / dis-investment take into account EQIAs/QEIAs, output from the prioritisation tool and demonstrate strategic fit.Equity, Quality Impact Assessment (EQIA) / Quality, Equality Impact Assessment (QEIA) embedded.							
Calderdale			Place lead:	Robin Tuddenham			Nominated lead for this risk:	Neil Smurthwaite (17.07.2025)
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Governance arrangements are continually reviewed locally. Development time dedicated at Partnership Board to discuss key issues as a system. Clear weakness in WY data/analytics for system overview. No significant resource locally to compare with other resource. Recognise work ongoing to produce consistent WY data.	
	Likelihood	2	4	Likelihood	2	6		
OPEN	Impact	2		Impact	3			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Place-based Quality Group established to ensure we continue to share lessons and good practice.							1. Calderdale lead on a number of WY elective recovery programmes, ensuring greater consistency in single contracts, to help avoid variation. Consistent Independent Sector waiting times recently agreed across WY.	
2 Clinical and Professional Forum currently being reviewed with a aim to link the output of the forum to our transformation priorities and financial position								
3 Primary Care Strategy Group meets quarterly and reports to the partnership board.								

4 Urgent care model has been developed that will help UECB and Community programmes joined up impactful initiatives.								
Sources of assurance (Where is the evidence that the controls work?)							Links to Place risk register:	
1 Regular reporting to Calderdale Care Partnership Board.							1338, 2476, 2163, 2149, 1493, 62, 1977, 2092	
Kirklees Place lead: Vicky Dutchburn							Nominated lead for this risk: Vicky Dutchburn (25.06.2025)	
ICB risk appetite		Place risk scores					Rationale for current place score	
		Target (Kirklees)			Current (Kirklees)		Kirklees place reflects the current WYICB wide score.	
OPEN		Likelihood	2	4	Likelihood	2	8	
		Impact	2		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Kirklees ICB Transformation Sub-Committee, supported by the Kirklees Delivery Collaborative as mechanism to enable shared learning across providers							1. Increase visibility and understanding of the West Yorkshire Innovation Leadership Collaborative and the interface between this network and place (Review 2025/26)	
2 Working across places and with WY programmes to share learning and experience, identify variation, and opportunities for improvement							2. Establish clearer connections between the WY ICB and the West Yorkshire Innovation Leadership Collaborative (Review 2025/26)	
3 Clear governance around Quality oversight in place with providers, working collaboratively to share learning and report via System Quality Group and ICB Quality Sub-Committee							3. Chief Digital and Information Officer attending Kirklees Board Development Session to share learning, next steps (Q2, 2025/26)	
4 Active participation in WY networks and programmes with evidence of having shared learning from Kirklees, and adopted it from elsewhere.								
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register:	
1 Evidence of early adoption and innovation in place e.g. UCR, Lung Health Checks, approach to neighbourhood working.							2445	
2 Reports to Kirklees Sub-Committees demonstrating provider collaboration, examples of innovation and shared learning. Papers and Mins.								
3 System Quality Group and ICB Quality Sub-Committee. Papers and Mins.								
Leeds Place lead: Tim Rley							Nominated lead for this risk: Jason Broch (26.06.2025)	
ICB risk appetite		Place risk scores					Rationale for current place score	
		Target (Leeds)			Current (Leeds)		Earlier in the year the Leeds governance arrangements were established with a wide range of stakeholders, these were relatively new and establishing a rhythm and recognition of function. Throughout the last Quarter of 2024/25 and into 2025/26 there is a continual improvement approach to the Leeds governance and prioritisation. Our partnership governance arrangements have become more mature and we have identified some priority areas to collectively focus on as part of the Healthy Leeds plan. The biggest barriers to progress in these programmes tend to be digital and this is complex across competing providers with different needs as well as the Leeds digital infrastructure being a challenge when compared with the WY strategic approach.	
OPEN		Likelihood	2	4	Likelihood	3	12	
		Impact	2		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Clear governance arrangements in place to provide assurance to the Leeds Committee of the ICB. Place partners working collaboratively through the Assurance Sub-Committees (Quality & People's Experience and Finance & Best Value).							1. There has been a lot of progress amongst senior clinical leaders to understand the wide range of interface issues in the city and a programme has been established to try and manage some of these better (2025/26)	
2 Regular contribution and representation at the ICB Quality Committee and System Quality Group							2. Leeds partnership has appointed a Lead Chief digital information officer (CDIO) from one of the partners to oversee partnership development work and facilitate integration. New governance around this is being developed to be in place by 2025/26. Although these governance arrangements are starting to become clearer they are also highlighting some of the competing ambitions between different partners. They are not yet in a clearer enough form for senior leaders to prioritise. There is a piece of work to look at developing provider collaborative in line with the direction the government is taking the NHS and in line with the ICB blue print which will hopefully address some of the digital issues.	
3 Regular contribution and representation at the WY ICB Safeguarding Oversight and Assurance Partnership							3. All Leeds partnership across Leeds health and social care were working collaboratively with the University of Leeds to develop a research project (SEISMIC) to bring academic rigour to system improvements and integration for people with long term conditions and mental illness, facilitating the use of innovative technology. Unfortunately Leeds was unsuccessful in the bid but there is ongoing conversation to see how the partnership can capitalise on the work so far anyway.	
4 Leeds Academic Health Partnership membership with representation at Board and implementation levels.								
5 As a partner with Leeds Academic health partnership identifying opportunities from health professionals,								
6 The Clinical Professional Executive Group (CPEG) meet monthly and has been reviewing a system approach to risk and learnings from escalated cases to make sure there is a Leeds based approach to those learnings and that partners can better manage system risk collectively							Link to place risk register:	
							2480, 2487	
Sources of assurance (Where is the evidence that the controls work?)								
1 Regular arrangements to evaluate the effectiveness of the Sub-Committees.								
2 Emerging system-wide networking between Quality Improvement leaders across the partnership.								
3 WY ICB Safeguarding Oversight and Assurance Partnership. Papers and Mins								
4 ICB Quality Committee and System Quality Group. Papers and Mins								
5 West Yorkshire clinical and professional forum (monthly) - representation from Leeds								
6 The Clinical Professional Executive Group (CPEG) meet monthly								
Wakefield Place lead: Mel Brown							Nominated lead for this risk: Penny McSorley (30.06.25)	
ICB risk appetite		Place risk scores					Rationale for current place score	
		Target (Wakefield)			Current (Wakefield)		WDHCP governance arrangements are now well established and relationships strengthened. Examples of sharing and learning across key forums in the ICB and wider partners. Governance is in place with connection to West Yorkshire System Quality Group and WY Quality Committee. Risk score remains the same until the release of the 10 year plan.	
OPEN		Likelihood	2	4	Likelihood	3	12	
		Impact	2		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Clear governance around quality, safety and patient experience with regular reports through to Integrated Assurance Committee, Wakefield District Health and Care Partnership and People Panel							Timescale 2025/26:	
2 Experience of Care Network - sharing good practice following feedback from service users							1. District plan has been agreed	
3 Transformation and delivery committee established to which shares good practice and focus on improving services							2. Clinical and professional engagement takes place and is collated and monitored.	
4 Patient safety priorities, development of place quality priorities, and alignment with West Yorkshire quality priority areas in place							3. Wakefield and district health and care partnership have commenced a neighbourhood health programme of work focusing on the 6 key elements of neighbourhood health in preparation for the 10 year plan (2025/26)	
5 Shared quality frameworks in place								
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register	
1 Reports provided of quality across the WDHCP of areas of transformation and improvement							None.	
2 Minutes of meetings from multiple governance forums								
3 Recommendations and action plans from Care Quality Commission inspections and quality visits								
4 Local performance dashboards and improvement plans								

WYICB - Board Assurance Framework - ICB and places						Version: 11	Date: 12 March 2025
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE					Lead director(s) / board lead	Lou Auger
Strategic risk 2.3	There is a risk that we cannot measure and assess performance across the system in a timely and meaningful way, which impacts our ability to respond quickly as issues arise.					Lead committee / board	Finance, Investment and Performance Committee
ICB risk appetite	ICB risk scores					Rationale for current ICB score	
	Target (ICB)			Current (ICB)			The current likelihood is possible , given the limited business intelligence capacity in the ICB, limited access to near real-time performance data and lack of a comprehensive, shared performance dashboard. Failure to control this risk will lead to moderate impact on system performance. We could see a failure to meet national standards, a failure to address unwarranted variation, an inability to provide mutual aid in a timely way and regulatory breaches.
OPEN	Likelihood	2	6	Likelihood	3	9	
	Impact	3		Impact	3		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at ICB level?)</i>	
1 A comprehensive performance dashboard and exception report shared by the Board and its committees						1. Development of Business intelligence (BI) capacity across the ICB (Q3, 2025/26) .	
2 A system co-ordination centre is live to consolidate information and action on UEC pressures. The SCC meets the revised national specification.						☐	
3 Securing access to, and review of, comprehensive, up-to-date management data						☐	
4 System-wide meetings to share intelligence, review risk and agree mitigating actions						☐	
5 UEC-Raidr app is active and continues to be developed						☐	
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Links to ICB risk register <i>(Reference numbers/brief description)</i>	
1 Minutes of Board and committee meetings						None identified	
2 Minutes and action logs of System Oversight and Assurance Group (SOAG) and other system groups							
3 Evidence of access by system leaders to UEC app and national data sources							
4 3 x daily SCC reports to NHSE Regional Team and shared with senior leaders						See the separate Positive Assurance Log	
Bradford District and Craven (BD&C)						Nominated lead for <u>this risk</u> : Sohail Abbas and Kerry Weir (26.06.25)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Good processes and systems in place to monitor performance and capacity across providers and BD&C place . Performance dashboards which are regularly taken to System committees and transformation programmes. Ability to pull out performance data quickly on an ad-hoc basis when required.
OPEN	Likelihood	1	2	Likelihood	2	4	
	Impact	2		Impact	2		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 BDC HCP (place) governance assurance through sub-committees System Finance and Performance Committee to the Partnership Board						Partnership Board level outcomes report has been developed and includes health and inequalities metrics (control)	
2 BDC HCP (place) governance assurance through sub-committees System Quality Committee to the Partnership Board						1. Reviewed governance arrangements, which will help to triangulate performance across the range of areas (2025/26)	
3 HCP programme boards						#	
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Control	
1 Performance dashboard at System Finance and Performance Committee and robust processes in place to review performance (range of dashboards, reports to SF&P and HCP board)						Finance, performance and quality forum (inbetween the FIPC and QC quaterly meetings)	
2 Sub Committee of Quality committee receives performance dashboard focussing on patient experience and outcomes and statutory requirements, issues discussed at Quality Committee						performance reported monthly to the extended leadership team (ELT)	
3 Regular update on performance provided to WYICB to support development of SOAG report							
4 3 times weekly system resilience dashboard circulated across HCP partners							
5 Regular Performance reports to HCP programme boards and ICB executive meeting							
6 Core 20+5 and health inequality premium performance reporting							
7 Triple A reports from finance and quality committees to Health and Care Partnership Board							
8 Core 20+5 and health inequality premium performance reporting (assurance)						Links to Place Risk Register	
						2168, 2423	
Calderdale						Nominated lead for <u>this risk</u> : Neil Smurthwaite (17.07.25)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Established performance monitoring process across commissioners and providers. Recognise we have potential BI capacity issues but we are currently performing as expected.
OPEN	Likelihood	1	2	Likelihood	2	6	
	Impact	2		Impact	3		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 Oversight framework used as base of performance monitoring at CCPB.						(See WY response above regarding BI)	
2 Working with partners to provide singular view at WY and place level.						1. Calderdale has good oversight on the key national performance metrics and outperforms in a number of areas.	
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						2. Joint UECB across CHFT footprint monitoring urgent care performance, including winter, discharge and ambulance performance.	
1 Performance monitoring at CCPB. Papers and Minutes.							
						Links to Place Risk Register:	
						2476, 2149, 62	
Kirklees						Nominated lead for <u>this risk</u> : Vicky Dutchburn (25.06.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			Kirklees has processes in place that monitor the current performance with main providers and as a Kirklees position. This is reported to the Kirklees Finance and Performance Sub-Committee. A local framework for daily escalations and service capacity is in place and monitored through our CHFT/ MYTT silver escalations.
OPEN	Likelihood	1	2	Likelihood	2	8	
	Impact	2		Impact	4		
Key controls <i>(What helps us mitigate the risk?)</i>						Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 Detailed performance reports presented to Kirklees Finance and Performance Sub-Committee and ICB						1. The local dashboard and indicators will transition into the new national RAIDR KPIs when signed off (2025/26)	
2 Partnership processes for sharing timely data across the system partners						2. Data sharing agreement across primary and secondary care with regards to integrated neighbourhood team development (100% by Q2, 2025/26)	
3 Speciality level reports at Elective Care and Urgent Care Boards							
4 A Urgent and Emergency Care Board (UECB) has a system dashboard							
5 Community service and primary care performance indicators now in place in a local dashboard (reviewed daily)							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>						Link to place risk register:	
1 Minutes of Finance and Performance Sub-Committee and Kirklees Health and Care Partnership Board						None.	
2 Action logs and performance slide packs from Elective Boards							
3 Minutes from system silver escalation calls							
4 Review the UECB dashboard and agree actions							
5 Data sharing agreement by the end of Q1, data flow is 80% and by the end of Q2, 100%							
Leeds						Nominated lead for <u>this risk</u> : Richard Irvine (23.06.2025)	
Place lead: Tim Ryley							

ICB risk appetite		Place risk scores					Rationale for current place score
		Target (Leeds)			Current (Leeds)		
OPEN	Likelihood	1	2	Likelihood	2	6	Reasonable oversight already of activity, capacity and performance via excellent place based relationships and working arrangements. Continues to be timely, automated and wide availability of data. Risk score remains.
	Impact	2		Impact	3		
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>
1 System Resilience Operational and Coordination groups in place, and daily pressures meeting.							1. There is a wider set of dashboards, metrics and indicators that have been developed and are used to track both operational and transformational activity across Leeds. All data that feed the various dashboards in Leeds have been automated and all dashboards are accessible to individuals across a range of organisations as per access controls. Individuals and organisations (including the Population and Care Delivery Boards) use these data to manage strategic risk of unwarranted variation of care. 2. During Q1 2025/26, the Opel dashboard has been improved and General Practice data flows are being included (2025/26). The audience has widened and this dashboard provides timely awareness of pressures right across Leeds. The dashboard has high use with almost 100 managers and service leaders across Leeds accessing this on a daily basis.
2 Daily data shared via Opel System gives good oversight of volumes of attendances and pressures across sectors.							
3 Regular feedback from Trust Boards about performance risks and issues feeding local dashboards and delivery groups.							
4 The system visibility tool/ dashboard to support daily oversight of capacity and demand around system flow is in place and is mature							
5 The Opel dashboard is also available across the Leeds system, harnessing data from UEC-RAIDR and supplementing it with data from Leeds City Council/ Adult Social Care. Across the Leeds system all partners have access to this data and alerts our providers where thresholds are exceeded							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Link to place risk register:
1 Minutes of meetings.							None
2 Partner Board reports demonstrate tight tracking on behalf of the system via their IQPRs.							
3 The use of data and insight (as evidence) is fast becoming central to a number of governance boards. For example, the Population and Care Delivery Boards have a compelling score card that describes performance for each population segment.							
Wakefield							Nominated lead for <u>this</u> risk: Natalie Tolson (14.07.25)
ICB risk appetite		Place risk scores					Rationale for current place score
		Target (Wakefield)			Current (Wakefield)		
OPEN	Likelihood	1	2	Likelihood	2	6	Good processes and systems in place. Performance dashboards which are regularly taken to Integrated Assurance Committee. Responsive narrative on a monthly basis to central core team. Ability to pull out performance data quickly on an ad-hoc basis when required. Risk score remains the same in Cycle 2.
	Impact	2		Impact	3		
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>
1 Wakefield District and Health Care Partnership Committee, Integrated assurance committee and Transformation and Delivery Collaborative receives activity and performance report at each of its meetings							1 Currently working on the flow of community data to extend the OPEL framework to incorporate community services (2025/26) 2 Continue to strengthen collaborative / joint working between ICB BI and MYTT BI to support the efficient sharing of performance information, single version of the truth, access to live data and removal of duplication. MYTT will migrate to PowerBI across 2025 which will improve the accessibility of live information across the system - supporting the ability to make rapid decision making based on live data and intelligence (by March 2026) 3. Mid Yorkshire Teaching Hospital are actively engaging with the national federated data platform, adopting a number of applications that support performance delivery and access to timely data to support daily decision making (OPTICA, shared Patient Treatment List) Ongoing development 2025/26
2 System Outcomes Framework in place and is being re-evaluated as part of a new District Plan.							
3 Each transformation programme has it's own performance dashboard or a dashboard is in development which tracks performance, progress and supports evaluation							
4 MYTT share daily sit-rep data (DSIT) with the ICB BI team so we are sighted on current performance							
5 Investment in Business Intelligence, including the shared PowerBI tenancy with MYTT allows colleagues with easy access to performance information and 'live' performance information from within the Trust							
6 Recently appointed Data & Analytic Business Partners to support collaborative performance reporting / analytics across the Wakefield system / MYTT							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							
1	Minutes and papers from the Wakefield District and Health Care Partnership Committee, Integrated assurance committee and Transformation and Delivery Collaborative						
2	Tracking of key consitutional and local priority metrics through dashboards and reports - presented to Integrated Assurance Committee, Transformation Delivery Collaborative, Transformation programmes and Wakefield District Health and Care Partnership.						
3	The system visibility of tools/reports to support daily oversight of capacity and demand around system flow is in place and is mature (one suite of reports shared across ICB/MYTT)						
4	Use of RAIDR UEC Dahboard, OPEL information and feedback from System Meetings (to support on call and system command)						Link to Place Risk Register
5	Through collaborative working / shared BI roles across ICB/MYTT, the ICB is kept informed of any upcoming or changes to risks to performance and reporting.						None

WYICB - Board Assurance Framework - ICB and places						Version: 11	Date: 10 June 2025
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE					Lead director(s) / board lead	Jonathan Webb / Shaukat Ali Khan
Strategic risk 2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.					Lead committee / board	Finance, Investment and Performance. Transformation Committee - for Digital.
ICB risk appetite	ICB risk scores					Rationale for current ICB score	
	Target (ICB)			Current (ICB)			This risk relates to two specific areas; - the backlog of maintenance stood at £750m with operational capacity lower at £158m in the current financial year. - the risk that ICB / organisational IT have insufficient capacity to implement ICB and regional solutions due to increasing demands for solutions and the prioritisation of local vs regional projects, resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement ICB / regional solutions at scale.
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at ICB level?)	
1	Development and approval of ISC infrastucture strategy.					1.Consider approaches to 'carve out' an element of operational capital to support schemes more strategic in nature. 2. Digital investments to be increased within ICB and place budgets to strategise and to enable increased capacity and expectations, with the dedicated time allocated to regional and national programmes (2025/26 - 2026/27) 3. (Digital) - evaluating the current operating model to leverage the maximum benefit on resources and technical skills (2025/26)	
2	Regular oversight and assurance from ICS infrastructure strategy oversight groups.						
3	Digital Strategy Board - oversight of digital strategies and risks						
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)	
1	Minutes from - ICS Capital Infrastructure Oversight Group; ICS Finance Forum; Digital Strategy Board					2118 - Not able to spend all capital 2165 - There is a risk that place IT teams have insufficient capacity to implement regional solutions due to increasing demands for digital solutions and the prioritisation of local vs regional projects 2121 - There is a risk of the VCSE sector being left behind digitally due to lack of capacity, resource and understanding at statutory level as to what is needed by VCSE	
2	ICB / Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.						
3	Initial feedback from NHSE national digital maturity assessment has shown considerable improvement from the previous year.					See the separate Positive Assurance Log	
Bradford District and Craven (BD&C)				Place lead:	Therese Patten		Nominated lead for this risk: Robert Maden (01.07.2025)
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (BD&C)			Current (BD&C)			For digital, investment in AFT, BDCT will move us to a higher level of digital maturity over the next 18 months 2025/26. However, we have investment challenges in Primary Care persisting due to limited primary care capital. For estates, even allowing for investment in the Airedale Hospital development and Lynfield Mount, significant backlog maintenance remains an issue, both for the acute estate and the primary and community estate. Significant affordability issues remain in relation to primary care developments. The utilisation and modernisation fund for primary care has the potential to mitigate some of these issues, but funding for year 2 onwards remains to be confirmed, risk score will remain the same in this cycle.
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1	Programme Boards established to take forward the business cases for the new hospital at AFT and for the redevelopment of Lynfield Mount.					1. The existing WY digital strategy is undergoing review across the ICS. Each organisation will review and update its own digital strategy and plan alongside (2025/26) 2. Place health and wellbeing strategy has been developed which will shape the development of the new hospital at Airedale to support the shift of services into the community and deliver an affordable solution. This will also support the development of neighbourhood health services for BDC localities. 3. Initial Place Based Capital Infrastructure Strategy completed and will continue to be developed to ensure that our estate planning across health and care reflects changing service delivery models and supports safe and innovate service provision that is targeted at the areas of highest population need. Implementation will be overseen by the Strategic Estates Group on an ongoing basis. Ongoing. More emphasis on the better use of our existing estate as opposed to looking at new build solutions, unless there is no alternative option (2025/26) 5. Access to the utilisation and modernisation fund for primary care has outlined in the planning guidance for 2025/26. This provides a specific funding for addressing primary care capacity issues.	
2	Estates is an enabler in BDC HCP (place) operating model and is key to supporting the shift of services into the community.						
3	BDC HCP continues to be supported by the BDC Digital Programme Board and meets bi-monthly. It reports into BDC executive. Digital programme of work in place with formal workstreams identified, inclusive of partnership representation (Cyber Security, Work as One, Shared Care Records, workforce, Digital Inclusion). Additional subgroups focus on infrastructure and services, research and business intelligence linked to priority programmes.						
Sources of assurance (Where is the evidence that the controls work?)						Links to Place Risk Register	
1	Programme Board minutes for the Airedale and Lynfield Mount developments and regular updates to PLE.					2314, 2312, 2482, 2215	
2	Place Based Estates strategy being developed in support of the health and wellbeing strategy and regular updates to PLE.						
3	Minutes of the BDC Digital Programme Board.						
Calderdale				Place lead:	Robin Tuddenham		Nominated lead for this risk: Neil Smurthwaite (17.07.2025)
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Our main mitigation is CHFT reconfiguration. Detailed work undertaken in primary care but biggest risk is capacity to bring partner plans together as a system.
OPEN	Likelihood	3	9	Likelihood	4	16	
	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1	Regular round-table on financing of CHFT reconfiguration.					1. Need to be able to identify capacity and capability to support further estates and digital transformation - Operating Model clearly identified risks around estates and digital capacity gaps due to affordability. This hasn't been addressed fully. Local support purchased to enable invovlement in WY Infrastructure Strategy for primary care (2025/26) 2. Work still ongoing to identify local capacity for estates going forward (2025/26) 3. Digital need to be addressed by new Digital Director (2025/26) 4. Recruitment for CKW GP estates post hampered due to cost control (2025/26) and business case approved to use external company to support bids for national capital pot.	
2	Calderdale is a member of: ICS Capital Infrastructure Board; Finance Forum; Digital Strategy Board						
3	General practice PCN estate strategies in plan with support procured from external organisation for national bids.						
Sources of assurance (Where is the evidence that the controls work?)						Link to place risk register	
1	Reports to Committee					None	
Kirklees				Place lead:	Vicky Dutchburn		Nominated lead for this risk: Alison Needham (02.07.2025)
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			Place is refreshing Estates and IT strategies to understand the infrastructure needs of the wider system. Currently, constraints in both funding and resources have resulted in lower investment into
	Likelihood	3	9	Likelihood	4	16	

OPEN	Impact	3		Impact	4		the Kirklees Estates, which will create unwarranted variation of services for the Kirklees place.
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Estates Strategy							1. Estates lead continues to focus on key developments in estates within the place and wider ICB. However, potential estates operational support is currently provided by independant consultant. This contract has ended June 2025. Paper has gone to panel to extend this support (2025/26)
2 IT Strategy							2. Support Primary Care to understand the need to develop and support services from an IT and an Estates perspective. Explore creative solutions with other public sector partners, particularly to develop primary care estate 2025/26.
3 Estates and IT leads							3. Ensure funding available flows into the Kirklees place.
4 Kirklees - one public estates forum now established							4. Work with partners and stakeholders to access capital resources to support development in primary care (2025/26)
5							5. On going round table meeting of senior leaders to support the ongoing development of the CHFT reconfiguration
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: None.
1 Estates Forums							
2 IT and Digital Groups							
3 Reports to Committee							
4 Kirklees Estates Forum (partnership with providers) monthly							
5 Meeting with senior leaders to discuss CHFT reconfiguration							
Leeds				Place lead: Tim Ryley		Nominated lead for this risk: Tim Ryley 26.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			The new hospitals scheme for Leeds General Infirmary rebuild is critical to the transformations in the Leeds Health and Care system. Currently we have only limited assurance that, despite all the processes completed to secure NHSE approval to proceed, the scheme will be allowed to finally proceed. Primary Care expansion of roles and the ambition for a neighbourhood health model is placing greater strain on estates in Primary Care with little access to capital. Risk score increased from 12 to 16 due to delayed funding for LTHT scheme.
	Likelihood	3	9	Likelihood	4	16	
OPEN	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Leeds City Strategic Estates Board and its Specific Programme Boards meet							1. LTHT working through medium term alternatives to the Leeds Way due to national delays until 2030 and beyond, this includes working with Leeds City Council to consider alternatives to the innovation hub.
2 City Wide Digital Resources are combined across Health and Social Care jointly							2. Exploring innovative joint ventures/schemes and strenghten a one city estates strategy across NHS and Local Authority and cutting-edge digital solutions with detailed plans in place by March 2026
3 Providers have strong infrastructure to manage capital planning and building.							3. City Wide Digital and Estates Strategies linked to our wider H&WB plans (2025/26)
							Link to place risk register: 2530
Sources of assurance (Where is the evidence that the controls work?)							
1 Providers have strong infrastructure to manage capital planning and building.							
2 Minutes of Strategic Estates and Programme Boards.							
Wakefield				Place lead: Mel Brown		Nominated lead for this risk: Colin Speers (02.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score
				Current (Wakefield)			There is currently no process or forum for bringing together a total estates strategy across Wakefield Place. There is no identified capital resources for any estates across the sectors. The Digital Strategy is in delivery phase for place. The major programme of works is MYTT EPR procurement which is nationally and regionally assured, therefore there is no change to the risk score in Cycle 2.
	Likelihood	3	9	Likelihood	3	12	
OPEN	Impact	3		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Wakefield Place Digital Strategy in place and now being aligned across partners							1. Place digital forum brings together all sector and it delivers on the place digital strategy (2025/26)
2 Wakefield Place Finance Working Group linking into the West Yorkshire Integrated							Both business as usual replacement and innovation investment.
3 Leads at Place that are fully involved in the Integrated Care Board strategy meetings							
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: 2481, 2440
1 Minutes from Digital Programme Board							
2 Place nominated lead on West Yorkshire groups							
3 Digital maturity assessments (annually) - national programme							

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 11	Date: 12 March 2025
Mission 2	Failure to manage the strategic risk could result in a failure to MANAGE UNWARRANTED VARIATION IN CARE						Lead director(s) / board lead	Lou Auger
Strategic risk 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.						Lead committee / board	ICB Board
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			The likelihood of a future pandemic is certain; the scale, severity and impact is unknown. This risk is based on the potential impact of a serious pandemic, based on learning from Covid. The scoring mirrors the regional NHS England score of 16 (4Lx4I).	
AVERSE	Likelihood	4	16	Likelihood	4	16		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1	Surveillance systems						1. Awaiting findings of the national Covid inquiry to incorporate learning into plans. Specific recommendations around the NHS are due by June 2025.	
2	Pandemic Plan							
3	Exercises							
4	Business Continuity Plans							
5								
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1	EPRR Core Standards and assurance process provide evidence that plans are in place and tested - this is reported to the ICB Board annually						2456 - Health protection	
2	Local Health Resilience Partnership meets quarterly to review learning from incidents and							
3	Local Resilience Forum (multi agency) meets quarterly						Positive Assurance (see log)	

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 12 June 2025		
Mission 3	Failure to manage the strategic risk could result in a failure to USE OUR COLLECTIVE RESOURCES WISELY						Lead director(s) / board lead	Jonathan Webb		
Strategic risk 3.1	There is a risk that we do not invest resources in a way which prioritises community, primary & prevention programmes and so doesn't maximise value for money.						Lead committee / board	Finance, Investment and Performance Committee		
ICB risk appetite	ICB risk scores						Rationale for current ICB score			
	Target (ICB)			Current (ICB)			There has been a disproportionate increase of resource in recent years into acute hospital services in West Yorkshire and no clear plan to remedy this.			
OPEN	Likelihood	2	6	Likelihood	4	12				
	Impact	3		Impact	3					
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)			
1 Board approved Finance Strategy which sets out intentions.							(1) ICB Board could issue clear intent to all Places that there should be increased positive investment in community and primary care services, as part of planning during December 2024 / January 2025 after publication of planning guidance. (2) Place Committees to develop plans in line with this intent.			
2 ICS Financial Plan										
3 ICB Medium Term Financial Plan and Annual Plan										
4 Local plans implemented through Health and Wellbeing Strategy, Health and Wellbeing Boards and Place Committees										
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)			
1 Internal Audit Plan, Head of Internal Audit Opinion and individual internal audit reviews							None			
2 External Audit VFM opinion										
3 Performance Report alongside Finance Report into Finance Investment and Performance Committee and ICB Board										
4 Mental Health Investment Standard independent review							See the separate Positive Assurance Log			
Bradford District and Craven (BD&C)							Place lead:	Therese Patten	Nominated lead for this risk:	Karen Parkin (30.06.2025)
ICB risk appetite	Place risk scores						Rationale for current place score			
	Target (BD&C)			Current (BD&C)			Agree with the WYICB scores and these are relevant for place too. Financial position of Bradford and Craven Health and Care partners may mean we are unable to mitigate impact on community services.			
OPEN	Likelihood	2	4	Likelihood	4	12				
	Impact	2		Impact	3					
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)			
1	Section 75 and Better Care Fund arrangements in place reporting to planning and commissioning forum which is embedded within our governance arrangements between NHS and Local Authority for Bradford district						1. Development of Better Care Fund benchmarking across West Yorkshire during 2025/26 subject to capacity. 2. Implemmentation of a integrated neighbourhood health West Yorkshire Board to oversee the distribution of £5m funding in order to accelerate integrated neighbourhood health teams. 3. Bradford District Care Trust are part of the community services review which is being led by an external partner. This wil enable better collection of activity information and a comparison across West Yorkshire and nationally. 4. There is now a new governance framework across BDC with three priority programmes, one is Airedale Bradford Collaboration of Acute Services (ABCAS), second is implementation of integrated neighbourhood health and the third is corporate services review and progressing with closing the gap. All of these have efficiency saving targets to meet.			
2	A new established governance framework which includes relevant committees and business meetings. This has a clear reporting structure.									
3	All VCSE sector awarded 25/26 uplift factor to help with sustainability. In addition, hospice sector allocated an extra £2m funding.									
Sources of assurance (Where is the evidence that the controls work?)							Link to Place risk register: 2447, 2386, 2227, 2486, 2040			
1	Better Care Fund submission 2025/26 and monitoring overseen by the Planning and Commissioning Forum									
2	Much tighter monitoring arrangements for efficiency savings, closing the gap and difficult decisions. All Bradford and Craven NHS organisations have robust monitoring frameworks in place.									
3	New priority programmes established and regular reports to those business meetings.									
Calderdale							Place lead:	Robin Tuddenham	Nominated lead for this risk:	Neil Smurthwaite (17.07.2025)
ICB risk appetite	Place risk scores						Rationale for current place score			
	Target (Calderdale)			Current (Calderdale)			Significantly pressured financial environment with acute hospital in deficit. This means lack of resources to move funds to invest in other areas or services. Current allocations suggest we are utilising more financial resource than we should, therefore not able to invest new money in additional areas to integrate services. Development of Provider collaboration in its infancy and with 10 year plan we should be able to develop strategies for more proportionate distribution of funding.			
OPEN	Likelihood	2	4	Likelihood	4	12				
	Impact	2		Impact	3					
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)			
1 Partnership Board in place has membership from all place organisations.							1. Financial strategy in development (2025/26) 2. Need to understand the place-based allocation process to clearly identify where we are using more resource than currently indicated (2025/26)			
2 Joint Forward Plan has been signed off - which includes health, social care and fourth sector priorities.										
3 Ongoing review around sustainability of fourth sector and voluntary sector.										
4 New strategic finance group has been set up with an aim to develop a Calderdale financial strategy (2025/26) and medium to long term financial strategy.										
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register:			
1 Finance and performance a key component of partnership board meetings. Papers and Minutes.							2163, 2469			
2										
3										
Kirklees							Place lead:	Vicky Dutchburn	Nominated lead for this risk:	Alison Needham (02.07.2025)
ICB risk appetite	Place risk scores						Rationale for current place score			
	Target (Kirklees)			Current (Kirklees)			The planning guidance and funding allocations does not allow for significant investment within primary care and the community. As stated in the WY narrative, funding is heavily weighted to the acute sector. Kirklees place whilst working collaboratively across the system, due to these challenges and the contractual form does not allow funding to flow around the system to allow services to align and increase investment in those areas. Review of target score against risk appetite, agreed to reduce the target risk score from 8 to 4 as the place is willing to take reasonable risks and tolerant of a certain amount of uncertainty.			
OPEN	Likelihood	2	4	Likelihood	3	12				
	Impact	2		Impact	4					
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)			
1 Place committees, which comprise of partner organisations to discuss utilisation of resources							1.Continue the development of the provider collaborative and the Wells agenda to allow the discussions to support more joined-up working - 2025/26 2. Priority setting across Kirklees partnership in relation to maximising the utilisation of resources (2025/26) 3. Using the financial strategy to break down the boundaries currently in place and allow the system to work to maximise resources of staff and funds.			
2 Financial Strategy has been developed to support how resources are utilised within the place, which links to the overarching West Yorkshire Strategy										
3 Development of PMO function to enable investment are review in order to ensure value for money and consideration of specific service impact.										
Sources of assurance (Where is the evidence that the controls work?)										
1 Kirklees Finance Sub-Committee and Transformation Sub-Committee to agree on utilisation of resources. Papers and Minutes.							Link to place risk register: None.			
2 All investments reviewed via a priority matrix										
3 PMO reports and financial review against Value for Money criteria										
Leeds							Place lead:	Tim Ryley	Nominated lead for this risk:	Nick Earl 27.06.2025 Cycle 3 review will be undertaken by Alex Crickmar

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			Despite progress for a more integrated approach to financial planning across LHCP there remain challenges based on organisational boundaries and ongoing financial pressures. Additional challenges in Q3 and Q4 anticipated given reduction in ICB resources and associated restructure.
OPEN	Likelihood	2	4	Likelihood	3	9	
	Impact	2		Impact	3		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Integrated finance reports through LHCP governance - Leeds Finance and Best Value Committee oversees Leeds System Financial and Commissioning positions.							1. A programme of work is underway to continue to develop our joint approach to financial planning and decision-making to allow us to make the most value-driven decisions on resource allocation across the LHCP. To be actioned within the medium term financial plans (2025/26) 2. Increasing focus on quantifying impact for and transformational change for larger partnership programmes and release of benefits (alongside their quantification)
2 Analysis of spend through lens of populations and sub-groups as well as service lines.							
3 Strategic Finance Executive Group and Joint Planning Process across the partnership							
4 Finance sub-committee oversees financial planning and decisions.							
5 Regular attendance of DOFs at LHCP Partnership Exec Group and guiding priority programme ambition							
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register 2414
1 Finance sub-committee receives financial planning and decisions. Papers and Minutes							
2 DOFs at LHCP Partnership Exec Group. Papers and Minutes							
3 Benefits realisation assessments for priority programmes							
Wakefield Place lead: Mel Brown							Nominated lead for this risk: Jenny Davies (26.06.25)
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			Continued development of the Wakefield Place working together, investment in services, greater understanding required of service join-up within Place in order to invest more wisely. Greater involvement of system partners in decision making, for example - voluntary sector. A requirement for more robust return on investment modelling within place. Risk score increased from 9 to 12 in line with WY ICB.
OPEN	Likelihood	2	4	Likelihood	4	12	
	Impact	2		Impact	3		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Partnership Committee comprises of partner organisations and Integrated Assurance Committee looks in more detail at financial decision making							1. Within Wakefield place, there is Transforming Development Collaborative (TDC) whereby they engage with all parties to ensure there is investment in the right areas and in 2025/26 planning there will be a commitment to increase investment within primary care. A balanced financial plan was submitted, monitoring continues on a monthly basis (2025/26).
2 The Wakefield Place Finance Leaders meeting is now established, forming a wider financial strategy, including the voluntary sector and local authority.							
3 Each place finance lead closely connected with director of finance for Integrated Care Board therefore strategies aligned.							
4 Shared posts across partner organisations - link services together to make more informed decisions around							
5 A framework for investment decisions agreed and implemented							
6 Financial Plan in place							
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register None.
1 Minutes from meetings (TDS and Wakefield management meetings)							
2 Honorary contracts in place							
3 Regular reporting mechanisms for quality, performance and finance in place							
4 Monthly review at Wakefield Senior Leadership Team meeting							

WYICB - Board Assurance Framework - ICB and places						Version: 11	Date: 12 June 2025
Mission 3	Failure to manage the strategic risk could result in a failure to USE OUR COLLECTIVE RESOURCES WISELY					Lead director(s) / board lead	Jonathan Webb
Strategic risk 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.					Lead committee / board	Finance, Investment and Performance Committee
ICB risk appetite	ICB risk scores					Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Despite a number of years of strong performance as an ICS, the 2024/25 position and 2025/26 plan were only balanced after receipt of significant non-recurrent financial support from NHS England, and as such there is a challenging plan to deliver this year and risks are materialising.
	Likelihood	3	9	Likelihood	4	20	
Impact	3		Impact	5			
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at ICB level?)	
1 Financial Framework document agreed by FIPC						(1) ICB Board sponsored across all places and organisations to improve financial underlining positions. (2) Development of a robust and credible medium term financial plan.	
2 All Plans are signed off by the organisational Boards							
3 Escalation and joint approach with NHS England for Trusts in NOF3							
4 Finance Forum, SOAG, FIPC, EMT and Board all have oversight							
5 Place Committees and their finance sub-committees have oversight and provide assurance upwards							
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)	
1 Quarterly review meetings with NHS England and outcome letters						2431 - managing within capital limits; 2430 - financial breakeven	
2 Agendas, reports and minutes of all meetings above							
3 Internal Audit and External Audit							
4 External review commissioned into Finance by WYAAT (July 2024) and across the ICS (November 2024).						Positive Assurance Log - see separate	
Bradford District and Craven (BD&C) Place lead: Therese Patten						Nominated lead for this risk: Karen Parkin (30.06.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Due to the current financial pressures there is a significant risk that Bradford and Craven will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Likelihood	3	9	Likelihood	4	20	
Impact	3		Impact	5			
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1 System Finance & Performance Committee oversight of Place financial position						1. Implementation of closing the gap programme now included within the corporate services priority programme. 2. Difficult decisions list established and being prioritised 3. Robust and regular monitoring of all Bradford and Craven NHS organisations by the ICB and by NHSE. All frameworks and monitoring processes have been strengthened and implemented. Actions to de-risk efficiency saving plans are being developed. 4. Development of plans for the further stretch of £12m is underway with the establishment of the new priority programmes as part of the new governance structure.	
2 BDC follows the West Yorkshire established principles and process.							
3 Regular detailed review of in-year financial performance by Place DoFs with full transparency of cost pressures and sources of mitigation.							
3 Ongoing closing the gap programme reports to Place Leadership and Partnership Board							
4 Overarching programme board which oversees the three priority programmes							
5 Organisations under regulatory scrutiny meet monthly by ICB/ NHSE							
Sources of assurance (Where is the evidence that the controls work?)						Alignment to place risk register:	
1 SF&PC minutes. Place financial performance reported to System F&P on a regular basis and key messages reported to BDC Health and Care Partnership Board.						2433, 2337, 2314, 2039, 2047	
2 Strategic Partnering Agreement updated January 2025.							
3 Programme Board minutes							
4 NHSE letters of assurance following scrutiny visits.							
5 BDC system F&P committee approved financial and operating plans in April 2025. Regular monthly monitoring of financial and operating plans.							
Calderdale Place lead: Robin Tuddenham						Nominated lead for this risk: Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			As a place we are in deficit due to acute pressures. Whilst we are assessing the risk at place level a lot of this is controlled via WY working at DoF level and little influence on this via ICB place team. Its monitored and understood but difficult to influence for the BAF. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Likelihood	3	9	Likelihood	4	20	
Impact	3		Impact	5			
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1 Strategic finance group established with a aim to develop a Calderdale financial strategy.						1. As WYICB above. However we are also undertaking work in strategic finance group to understand where our acute and commissioning budgets are overspending compared to best practice and allocation tool to be clear where we need to target to bring down costs (meet monthly, then quarterly) 2025/26	
2 Financial Framework document agreed by FIPC, monitored by partnership board.							
3 Robust budget setting in open book approach so all places understand allocations and basis							
Sources of assurance (Where is the evidence that the controls work?)						Link to place risk register:	
1 Financial Framework as agreed by FIPC.						2163, 2469	
2 Bi-monthly monitoring at CCPB, evidenced in minutes. Detailed board reports.							
Kirklees Place lead: Vicky Dutchburn						Nominated lead for this risk: Alison Needham (02.07.2025)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			Due to the current financial pressures there is a real risk that Kirklees Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Likelihood	3	9	Likelihood	4	20	
Impact	3		Impact	5			
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1 Financial Strategy						1. Engage in WY-wide work to drive transformation and efficiency, including leading efficiency programmes undertaken on a WY footprint (2025/26) 2. Develop priority setting of resources within Kirklees place (2025/26) 3. We have developed a long list of difficult decisions around contracts and services that could be paused/ stopped/ slowed down across the Kirklees place. Ensuring decisions made align with West Yorkshire principles, and consider the prioritisation and disinvestment / decommissioning framework across the place (2025/26) 4. We have developed a working group across Kirklees place and neighbouring partners to review all services and spend that can improve the financial position of the Kirklees system (2025/26) 5. Review of all contracts commissioned by the ICB as to whether they can be stopped	
2 Review of Financial position and plans by Kirklees Finance Sub-Committee and ICB Committee, both locally and at a West Yorkshire level.							
3 Kirklees & Calderdale Recovery group							
4 Collaborative meetings to discuss how services can be undertaken differently to maximise resources							
5 Utilisation of the cross- partner Finance Forum to strengthen ownership of place based solutions.							
Sources of assurance (Where is the evidence that the controls work?)							
1 Financial plan will be signed off by the ICB Committee and risks identified							
2 PMO function to support financial recovery for the ICB and its wider system							

3	Aligned to West Yorkshire ICB approach to planning and final plan signed off by WY Committees	or reduced (2025/26) 6. We have developed a PMO process to develop recurrent efficiency schemes to improve the financial sustainability within the current year and future (2025/26) Link to place risk register: 2533
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Leeds		Place lead:		Tim Rley		Nominated lead for this risk: Alex Crickmar (reviewed 23.06.25)	
ICB risk appetite	Place risk scores					Rationale for current place score	
	Target (Leeds)			Current (Leeds)			Due to the current financial pressures there is a significant risk that Leeds Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
CAUTIOUS	Likelihood	3	9	Likelihood	4	20	
	Impact	3		Impact	5		
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at place?)	
1	Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.					(1) Development of a number of key transformation business cases for change aimed at changing suboptimal care pathways with potential for significant savings longer term (timing: ongoing and part of planning for 25/26)	
2	Strategic Finance Executive Group					(2) Review of potential opportunities and mitigating financial actions within each organisation and across Place, including delaying/stopping spend, focus on efficiencies and productivity	
3	Financial Framework and controls within each organisation at Place					(3) Integrated Commissioning Executive share plans between LCC and NHS and present jointly to Adults and Health Scrutiny (ongoing).	
4	Robust Budget setting and financial planning						
5	Leeds Health and Care Partnership Committee oversight of City wide statutory duties on behalf of the WY ICB.						
Sources of assurance (Where is the evidence that the controls work?)							
1	Agendas, reports and minutes of all meetings above						
2	External Review of system finances (PwC report)						
3	Internal and External Audit						
4	Fortnightly meetings between DoFs to review position						
5	Budgets/Financial plans set						
6	PMO functions within each org					Links to Place Risk Register	
						2530	

Wakefield		Place lead: Mel Brown			Nominated lead for <u>this</u> risk: Jenny Davies (26.06.25)		
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			Due to the current financial pressures there is a real risk that Wakefield Place will fail to operate within current resource envelopes. Target risk score increased from 6 to 9 due to cautious risk appetite.
	Likelihood	3	9	Likelihood	4	20	
Impact	3		Impact	5			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1	Monthly monitoring of Integrated Care Board delegated financial position to assurance committee including efficiency savings						1. Review of difficult decisions/choices across organisations/place (timing: ongoing first draft was submitted February 2025)
2	Monthly monitoring of Wakefield partners financial position to assurance and partnership committees						2. Set financial plans in line with planning guidance (2025/26)
3	Robust budget setting with place programmes						3. Agree Quality, Improvement and Performance Productivity (QIPP) to identify savings and reduce pressures whilst improving patient quality (2025/26)
4	Regular sharing of information and agreements via the Integrated Care System Finance Forum						4. Work with all system partners to increase efficiency and effectiveness (2025/26)
5	Consistency Checks within Wakefield against other places.						
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register
1	Minutes from Wakefield District Health and Care Partnership and Integrated Assurance Committee meetings						
2	Financial plans or any amendments to financial plans presented and discussed at partnership committee.						
3	Principles already established at Wakefield District Health and Care Partnership Committee						2329

WYICB - Board Assurance Framework - ICB and places							Version: 11	Date: 10 March 2025
Mission 3	Failure to manage the strategic risk could result in a failure to USE OUR COLLECTIVE RESOURCES WISELY						Lead director(s) / board lead	Rob Webster
Strategic risk 3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.						Lead committee / board	ICB Board
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			We have developed the new operating model which clarifies roles and responsibilities and ensures capacity in the right areas. Ongoing demands following new Government ambitions coupled with reductions in staffing means difficult choices continue to be made. There is recognition of additional uncertainty through NHSE reduction in staff and the ICB organisational change programme which may impact on the ICB's ability to deliver.	
OPEN	Likelihood	3	9	Likelihood	3	12		
	Impact	3		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1 An agreed operating model, approved through the Board and set out in the constitution and handbook							1. Place Partnership Delivery (led by Anthony Kealy) to support the development of Place model and infrastructure will be implemented by September 2025. 2. Ongoing organisational development work across Executives to support level of agility required in current context.	
2 Agreed objectives for all directors, including places, cascaded throughout the ICB								
3 Business planning processes that align capacity to our plans								
4 Place partnership review concluded in March 2025.								
5 MAUs with provider collaboratives specifying their responsibilities for delivery								
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1 Annual business plan approved by the Executive and ICB Board							2165 - insufficient IT team capacity to deliver digital priorities	
2 CEO and director appraisals, with outcome reported to Remuneration and Nominations Committee								
3 Annual review of governance and statement of internal control, reported through Audit to Board							See the separate Positive Assurance Log	
Bradford District and Craven (BD&C) Place lead: Therese Patten							Nominated lead for this risk: Matt Sandford (26.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			The move to a new Operating Model, where BDC significantly reduced its capacity is still embedding, along with current vacancy controls due to the financial challenges, means that, similar to other Places, Bradford place is carrying a number of vacancies. A further impact will be felt following the organisational change by Q3. Bradford is utilising partnership relationships to help boost that capacity by building on current joint roles, to identify opportunities for further targeted shared and aligned resources across our Place so they can continue to deliver against both local and national standards and priorities.	
OPEN	Likelihood	1	4	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	The Partnership Leadership Executive oversee the deployment of resources (including ICB capacity) in pursuit of the BDC HCP strategy agreed by the Partnership Board						1. Utilise strength of our Health and Care Partnership, building on current joint roles, to identify opportunities for further targeted shared and aligned resources across Place (February – September 2025) 2. Annual business planning process to align resources to required activity/ priorities (April/ May 2025) 3. Priority Programme and Programme Board oversight of key system transformation plans (including workforce) and related activity, to review resource requirements against transformation delivery plans (February – September 2025) 4. Place level 'difficult decisions' programme to target resources at activity that delivers strategic and financial priorities (February – Apr 2026) 5. Adoption of WY Vacancy Control measures into Place level governance to ensure grip and control, alongside overarching understanding of Place resource requirements (already in place - ongoing) 6. Developed Health, Care and Wellbeing strategy (clinical strategy) at Place in full co-production with partners including citizens and our workforce. The strategy focuses on clear alignment of services, pathways and models of care driven by population health needs. This strategy will enable us to target and deploy resources in the most effective way. Three strategy delivery boards are being established focused on integrated acute services, integrated neighbourhood services and integrated corporate services, these are our core priorities for delivery and resource management 7. Specific Integrated Neighbourhood Team (INT) development work is underway across the BDC system is ongoing (2025/26) 8. Work has begun locally on the development of a BDC provider collaborative approach to be implemented by September 2025 (2025/26). 9. Developed Healthcare and Wellbeing strategy (clinical strategy) at place in full co-production with partners such as citizens and our workforce. The strategy focuses on clear alignment of services, pathways and models of care driven by population health needs. This strategy will enable us to target and deploy resources in the most effective way. Three strategy delivery boards are being established focused on integrated acute services, integrated neighbourhood services and integrated corporate services, these are our core priorities for delivery and resource management <u>Link to place risk register</u> 2447	
2	System transformation priorities and enablers established through our operating model using a distributed leadership approach							
3	Place based lead influence deployment of ICB resource for BDC HCP							
4	Closing the Gap programme – already established – with widened scope to incorporate Investment/ Business Case review							
5	Difficult Decisions programme has commenced and incorporates all partners across the system. This provides targeted focus on delivery of our efficiency programme whilst identifying risks associated with capacity.							
6	Place Clinical Strategy; and Place Financial Recovery Plan – providing greater oversight of resource							
7	3 x Strategic Delivery Group meetings (Integrated Acute Care; Integrated Neighbourhood Health & Care; Integrated Corporate Support & Closing the Gap will bring together all partners across the system to provide greater oversight on delivery of the core priorities we have set out in our health, care and wellbeing strategy.							
Sources of assurance (Where is the evidence that the controls work?)								
1	An agreed BDC HCP operating model approved by the PLE and the PB within the BDC HCP governance handbook							
2	Priority Programmes in place including: access; healthy communities; healthy minds; workforce and children and young people improvement. Enablers in place including: reducing inequalities alliance; digital, data, intelligence and insight; living well; and Estates. All priorities and enablers report into PLE							
3	ICB SORD sets out place role within both the WY ICB SORD (WY Governance Handbook) and BDC HCP Strategic Partnering Agreement and Governance Handbook set our the way we work, including our operating model, SORD and Terms of Reference.							
4	Closing the Gap programme – Partnership led and supported – Reviewed via System Finance and Performance Committee, PLE and Partnership Board.							
Calderdale Place lead: Robin Tuddenham							Nominated lead for this risk: Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Capacity and capability within Calderdale Place team is severely limited for both finance and transformation resource. This impacts on our ability to address all ICB and place priorities. Whilst Operating Model work enabled no real impact on Calderdale financial the place team is still small and not resilient. Consolidated teams will impact on local resource and will work with colleagues to manage impact.	
OPEN	Likelihood	1	4	Likelihood	4	16		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1 Work undergoing with neighbouring places to ensure resilient finance function.							1. Transformation delivery plans list seven key priorities and discussions are ongoing at operational and senior leadership meetings (2025/26) 2. Senior Leadership team continue to monitor risks relating to resource, intensified given NHS changes and 50% cuts. 3. Working collaboration with KW partners on sharing resource in difficult situation of zero recruitment and future reduced resource.	
2 Partnership board regularly conducts deep dives for tranformational priorities.								
3 Prioritisation takes place on a weekly basis to assess place workload and ability to respond to asks.								
Sources of assurance (Where is the evidence that the controls work?)								
1 Tranformation delivery plan approved by Calderdale Care Partnership Board.							<u>Link to place risk register:</u> 1998, 2484	
2 Prioritisation process as part of annual planning round.								
Kirklees Place lead: Vicky Dutchburn							Nominated lead for this risk: Vicky Dutchburn (25.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			There are specific challenges in Kirklees place related to leadership changes in several	

OPEN	Likelihood	1	4	Likelihood	3	12	parts of the health and care partnership and the transition period could lead to uncertainty. Time will have to dedicated to establish new working relationships when leadership changes take effect. The impact of the operating model changes are still being felt and challenges remain in some functions.
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Weekly SLT meetings to discuss current priorities and ensure capacity is dedicated to the right areas							1. Organisational change review ongoing will include a Kirklees integrator function to be consulted on (Q3, 2025/26) 2. Ongoing development prioritisation and review within and across Teams in Kirklees (2025/26) 3. Specific Integrated Neighbourhood Team (INT) development work across Kirklees system (2025/26) 4. Ongoing local development of the Kirklees provider collaborative approach by September 2025.
2 Health & Care Executive to support cross sector prioritisation within the Health & Care Partnership							
3 Business planning processes to support confirmation of priorities							
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: None
1	Clear examples of where capacity is being used to best effect by sharing teams with other places, in particular Calderdale (where there is a history of shared teams) and increasingly with Wakefield. Examples of capacity from across the partnership (not just the ICB) supporting our work e.g. Place Director of Finance role. Other examples of programme leadership from beyond the ICB team in place.						
	2 Staff survey results relating to the ability of individuals to undertake their role within their designated hours, clarity of objective setting and additional hours worked.The action plan agreed to respond to findings of staff survey.						
	3 Agreement from the Kirklees ICB Committee as to our shared priorities, supported by teams within partner organisations dedicating capacity to these priorities (e.g. Discharge, community services transformation)						
Leeds							Nominated lead for this risk: Sabrina Armstrong (30.06.2025)
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	1	4	Likelihood	4	16	The move to a new Operating Model in April 2024, where Leeds reduced its capacity by 20% was still bedding in when the national announcement was made for reduction in ICB staff by 50%. Leeds was holding a number of vacancies whilst it settled and due to vacancy control they can no longer be filled. The latest organisational change programme is likely to exacerbate this issue. Failure to address these issues is likely and this could lead to a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions. Risk score remains the same.
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Agreed Operating Model with WY ICB and Leeds Health & Care Partnership							1. The ICB in Leeds has agreed a number of city priorities with partners in the Leeds Health and Care Partnership (LHCP). The ICB in Leeds needs to ensure that the majority of its capacity is working on these priority areas. Apr - Mar 2026 2. Refreshed OD priorities in place to support staff within the ICB in Leeds to deliver the capabilities needed to deliver the above priorities. However the OD plan has been extended to provide support and resilience training to staff during the organisational change (2025/26) 3. ICB in Leeds Business Plan for 25/26 in place, outlining the BU actions to deliver the LHCP priority programmes and work has been prioritised to take account of diminishing capacity due to both people leaving and people working on the organisational change 4. Action plan on staff survey results most pertinent to Leeds, 2025/26 5. Leeds Directors will continue to review capacity and reprioritise as necessary (2025/26)
2 Capacity aligned to Healthy Leeds Plan and LHCP objectives							
3 Director accountabilities finalised and objectives set by end of April							
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: None
1 Healthy Leeds Plan and Business Plan reviewed monthly in line with LHCP priority work							
2 Ongoing appraisal throughout year with all directors in place							
3 Staff Survey results							
Wakefield							Nominated lead for this risk: Mel Brown 27.06.2025
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	1	4	Likelihood	3	12	The current likelihood is possible, given the movement to a new operating model for the NHS and the Integrated Care Board. Failure to control this risk will lead to major impact on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions. Wakefield place are working with other places and the strategic commissioning functions between June and September 2025 to mobilise a new operating model to go live in April 2026.
	Impact	4		Impact	4		
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)
1 Agreed operating model in place aligned to Integrated Care Board structures and went live in April 2024, some reviews have been underway due to leadership changes							1. Continue to review gaps in strategic capacity across the leadership team at Wakefield and confirm these objectives through PDR processes in the summer of 2025 2. Working with partner organisations across Wakefield district to maximise capacity to and to deliver objectives in 2025/26 3. Reviewing everyones PDR objectives to ensure any areas that need capacity are appropriately addressed such as EDI leadership (End of Summer 2025) 4. Contributing to the organisational change programme in place across WY ICB to shape the integrator teams
2 Agreed objectives for all directors							
3 Wakefield place plan agreement in May 2025, signed off objectives and plans for Wakefield district							
4 Business planning processes that aligns both to the WY ICB 10 ambitions and the Wakefield district plan (annual review)							
5 Developed a new business planning process that aligns with our Integrated Care System strategy and place delivery plan in line with national guidance							
6 Some Directors have previously undertaken leadership roles with partner organisations, these directors are now working full time for the ICB, such as Director of Nursing and Director of Strategy.							
Sources of assurance (Where is the evidence that the controls work?)							Links to Place Risk Register
1 Delivery plan approved including Outcomes Framework.							
2 The Mutual Accountability meetings chaired by Rob Webster, quarterly meetings, these provide assurance of the progress against the functions in Wakefield place.							
3 Director appraisals conducted and regular one to ones are mobilised across the Wakefield district, this ensures flexibility in responding to new work that emerges from WY ICB.							None.
4 Contribute to the annual governance review.							
5 Regular one to ones between Accountable officer and Cheif Executive WY ICB							

WYICB - Board Assurance Framework - ICB and places							Version: 11	22 April 2025
Mission 4	Failure to manage the strategic risk could result in a failure to SECURE BENEFITS OF INVESTING IN HEALTH AND CARE						Lead director(s) / board lead	Ian Holmes
Strategic risk 4.1	There is a risk that partnership working on wider societal issues is deprioritised to meet current operational pressures.						Lead committee / board	ICB Board
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.	
OPEN	Likelihood	2	8	Likelihood	2	8		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)	
1	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually via an outcomes framework and associated integrated dashboard.						1. Economic Inactivity Accelerator work to be delivered throughout 2025/26 ensuring dedicated capacity and the establishment of a programme board with WY Combined Authority to oversee it.	
2	We have established dedicated capacity working on these issues at WY level, together with appropriate programme boards, working with the Combined Authority - focusing on issues such as poverty, climate change, violence reduction, housing and employment							
3	Business planning process describes how we use our capacity to support delivery of all ambitions.							
4	Memorandum of Understanding with WY Combined Authority which describes shared priorities, capacity and ways of working.							
5	Consultant in Population Health appointment ensures focus on wider societal issues.							
5	Director objectives, subsequently cascaded to teams, reflect partnership working.							
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)	
1	Progress against the strategy and 10 big ambitions is overseen by the Partnership Board, together with deep dives - evidenced in agenda and minutes						None identified	
2	ICB Board receives six monthly updates on 10 big ambitions - agenda / minutes							
3	SOAG - minutes evidence review of progress against 10 big ambitions						See the separate Positive Assurance Log	
Bradford District and Craven (BD&C) Place lead: Therese Patten							Nominated lead for this risk: Helen Farmer, 23.06.2025	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Challenging financial circumstances for all partner organisations may increase likelihood of retrenchment into siloed, short term approaches, emphasising direct operational delivery over longer term outcome focused system thinking, which evidence shows will have a bigger impact on the determinants of health and wellbeing outcomes.	
OPEN	Likelihood	2	8	Likelihood	2	8		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	Our BDC health and care strategy localises the WY strategy and clearly establishes the focus on the wider contribution of the health and care system to the determinants of health, and encourages stewardship for the future as well as short term delivery focus.						1. All district partners (including those outside health and care) will sign up to a new district strategy to improve the wellbeing, both health and economically in Bradford district (2025 - 2028) 2. Our reducing inequalities alliance continues to lead the way in identifying our wider determinants and mitigating the impact, including leading on our economic accelerator programme 3.,The BD&C HC&P has now finalised the healthcare and wellbeing strategy and we are moving to implementation through our new governance arrangements. This jointly agrees the safe and sustainable service models and pathways across all partners, driven by the health and care needs of our population, ensuring a holistic approach to delivery (2025/26)	
2	The Wellbeing Board (HWB for Bradford District) is comprised of the leaders of all local strategic partnerships and all local anchor organisations. Its focus is firmly on the ‘wider determinants’. The BDC Partnership Board and its Committees have broad based participation across VCSE, Local Government and Care sectors. Our approach is to engage with communities through locality based Listen In visits and to take our Partnership Board meetings into communities, to understand the strengths and challenges of communities and what will help - which includes focus on the 'wider determinants' - e.g. development session on sustainability, Partnership Board papers on anti poverty actions etc.							
3	Our closing the gap business case appraisal process takes into account impact on wider health and care and public sector and population including health inequalities, social value etc (ongoing)							
4	People priority include focus on inclusive community recruitment.							
5	Our partnership work is focused on five Strategic Priorities and four key Enablers. This includes a prevention focus through Living Well, Reducing Inequalities, an asset based approach to Healthy Communities, and a focus on net zero and local economic development through our partnership Estates work.							
Sources of assurance (Where is the evidence that the controls work?)							Link to place risk register: 2317, 2386, 2221	
1	See strategy and closing the gap process on partnership website https://bdcpartnership.co.uk/							
2	Wellbeing Board (Bradford district) on the BMDC wellbeing web page https://bdp.bradford.gov.uk/about-us/health-and-wellbeing-board/ See partnership governance structure, TORs, meeting papers including Listen In reports - on website							
3	See priorities and enablers scoping documents on partnership website https://bdcpartnership.co.uk/our-strategic-priorities-re-set-programme/							
Calderdale Place lead: Robin Tuddenham							Nominated lead for this risk: Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. Risk score reduced from 12 to 8.	
OPEN	Likelihood	2	8	Likelihood	2	8		
	Impact	4		Impact	4			
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at place?)	
1	Joint membership of HWBB and CCPB by each chair to ensure societal issues continue across.						1. The Transformation delivery plans list seven key priorities, these aim to address wider societal challenges in Calderdale, there is ongoing work at senior leadership level to ensure governance arrangements align with the transformational priorities (2025/26) Link to place risk register: None	
2	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually. We also have Health and Wellbeing Strategy, monitored via HWBB.							
3	Business planning process will describe how we use our capacity to support delivery of all ambitions.							
4	The senior leadership group terms of reference refers to operational delivery as a "must do" so that our transformational plans are able to flourish							
Sources of assurance (Where is the evidence that the controls work?)								
1	Progress against health and wellbeing priorities is undertaken at every meeting. Evidenced by papers and minutes.							
2	We also have an inclusive economy strategy led by the local authority.							
3								
Kirklees Place lead: Vicky Dutchburn							Nominated lead for this risk: Steve Brennan (25.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			As Kirklees place we have signed up to 4 top tier strategies that cover areas of joint working beyond just health and care, including the wider societal issues. These are: 1. Health and Wellbeing Strategy 2. Inclusive Communities Framework 3. Inclusive Economy Strategy 4. Environment Strategy. However, whilst we have agreed this strategic approach, there are still challenges of delivery to be navigated. Operational pressures are significant, alongside significant financial challenges across the partnership. This means that our ability to deliver on these in the short term is challenged. Due to capacity constraints realising the full benefits of the Economic Inactivity Accelerator and related programmes will be challenging, but progress is being made. Uncertainty around ongoing ICB organisational change and what this will mean for local partnership working in Kirklees and the ICBs ongoing role in this as we potentially move to a CKW footprint. Risk score to remain the same.	
OPEN	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			

Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>						
1 4 top tier strategies for Kirklees that go beyond just health and care and cover wider societal issues.							1. Commitment to the 4 top tier strategies reiterated at the Kirklees partnership executive. There is a programme of work agreed for 2025/26 overseeing by the partnership executive.						
2 Ownership of these 4 strategies assigned to partnership boards or forums.													
3 Partnership Executive in place which includes business, education in addition to health, care and LA.													
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Link to place risk register:						
1 Reporting to the relevant board/partnership forum on progress against each of the 4 strategies.							None						
2 Use of other partnership forums to support this e.g. Partnership Forum, ICB committee.													
Leeds							Place lead: Tim Rley						
							Nominated lead for this risk: Tim Rley (26.06.2025)						
ICB risk appetite		Place risk scores						Rationale for current place score					
		Target (Leeds)			Current (Leeds)			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.					
OPEN	Likelihood	2	8	Likelihood	3	12							
	Impact	4		Impact	4								
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>						
1 Health & Wellbeing Board Strategy							1. Creation of a joint neighbourhood model between NHS and Local Authority (2025/26) 2. Monitor and report on anchor institution work to test impact for the city (ongoing piece of work) 3. Continue to drive digital and medical technology innovation through the Integrated digital service, Leeds Academic Health Partnership and the Leeds Health & Care Hub. 4. Implement action plan arising from Marmot city programme led through public health (2025 - 2027) 5. Leeds Health and Care Partnership have signed off four priority programmes all with a strong health inequality focus including links to wider social determinants (2025/26)						
2 Active participation and alignment to Marmot City agenda													
3 Shared goals across Leeds Health & Care Partnership reflecting 10 big ambitions and requiring addressing													
4 Continuing monitoring of metrics by ethnicity and deprivation as routine													
Sources of assurance <i>(Where is the evidence that the controls work?)</i>													
1 Progress against 10 big ambitions in Leeds							Link to Place Risk Register						
2 Reporting on key Healthy Leeds Plan metrics by deprivation													
3 Health & Wellbeing Board monitoring of HWB strategy													
4 Director of public health annual reports													
							None						
Wakefield							Place lead: Mel Brown						
							Nominated lead for this risk: Ruth Unwin, Becky Barwick (02.07.2025)						
ICB risk appetite		Place risk scores						Rationale for current place score					
		Target (Wakefield)			Current (Wakefield)			Impact score is high as there is strong evidence that failure to address social determinants leads to poor population health and increased demand on care services. Risk score remains the same this cycle.					
OPEN	Likelihood	2	8	Likelihood	2	8							
	Impact	4		Impact	4								
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>						
1 Wakefield District Health and Wellbeing strategy provides a framework for tackling wider determinants of health							1. A district plan is being developed under the joint leadership Wakefield Together (statutory, voluntary and commercial sectors), which includes plans to improve population health by addressing wider determinants. Plan will be in place by Autumn 2025. 2. The bid to the local vestment panel supported protection for the previous Core 20 plus 5 funding but not protecting all of the uncommitted resource.						
2 Wakefield Forward Plan includes work to deliver Health and Wellbeing Board priorities													
3 Core20plus5 funding directed to addressing social determinants, to be confirmed via the investment panel for 2025/26.													
Sources of assurance <i>(Where is the evidence that the controls work?)</i>													
1 Regular reports to Health and Wellbeing Board & Wakefield District Health and Care Partnership Committee on work to address priorities							Link to Place Risk Register						
2 Outcomes framework has been developed for both the Health and Wellbeing Board and Wakefield District Health and Care Partnership Committee and being reported through both committees													
3 Impact of investment in Core20plus5 programmes was reported to Wakefield District Health and Care Partnership Committee November 2023													
							None.						

WYICB - Board Assurance Framework - ICB and places							Version: 11	22 April 2025
Mission 4	Failure to manage the strategic risk could result in a failure to SECURE BENEFITS OF INVESTING IN HEALTH AND CARE						Lead director(s) / board lead	Ian Holmes
Strategic risk 4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.						Lead committee / board	Quality Committee
ICB risk appetite	ICB risk scores						Rationale for current ICB score	
	Target (ICB)			Current (ICB)			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.	
BOLD	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at ICB level?)</i>	
1 Five Year Integrated Care Strategy - Ambition 8							(1) Equity and Fairness Strategy was approved Partnership Board in January 2025. This will be overseen by the Partnership Board including a number of objectives for delivery by the Partnership Board. Transformation Committee will oversee ICB actions in relation to the strategy. (2) The Race Equality Review undertaken in 2020 will be reviewed by Donna Kinnair during 2025/26. The findings reported to the Partnership Board in January 2025 and actions identified were included in the Equity and Fairness Strategy.	
2 Race Equality Review Action Plan overseen by the Partnership Board								
3 EDI Oversight Group maintains oversight of statutory requirements and objectives								
4 ICB People Plan, with a strong focus on inclusivity								
EQIA process embedded to inform decision-making								
5								
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Links to ICB risk register <i>(Reference numbers/brief description)</i>	
1 Internal Audit Review 2023/24							None identified	
2 People Plan had ICB Board sign off in September 2024								
3 Staff survey data								
4 WRES data								
5 EMT discussion and oversight of priorities and responses to audit actions								
6 Agenda and minutes of EDI Oversight Group								
7 Examples of reports and minutes showing consideration of EQIAs during decision-making								
8 Transformation Committee discussion and oversight of strategy action plan.							See the separate Positive Assurance Log	
Bradford District and Craven (BD&C) Place lead: Therese Patten							Nominated lead for <u>this risk</u> : Kez Hayat (30.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (BD&C)			Current (BD&C)			Concerted work on all aspects on EDI is required to meet the needs of our population and ensure our colleagues experience at work enables them all to flourish. Our data and qualitative information tells us that much remains to be done, building on the strong commitment shown already EDI leads have identified that 'If we are unable to improve outcomes for our population and workforce by advancing our collective approach to EDI then our population and workforce will continue to experience inequality of outcome, unfair treatment and discrimination'. Risk reviewed and the risk score remains the same for Cycle 2.	
BOLD	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1	Place wide (broader than health and care - all sectors) EDI group, chaired by Prof Udi Archibong. Good engagement from EDI leads Acting As One. ICB input through Act As One partnership EDI lead Kez Hayat. 6-8 weekly Systems Equalities Group meeting to ensure collective plan for EDI stays on track.						Continue with three priorities which align with the WY ICB strategic equality objectives for 2025/26; 1. Continue with our focus and efforts on reducing health inequalities across the district with particular focus on 'Access, Experience and Outcomes' for our diverse communities and wider communities of interest. This will foster collaborative processes that actively listen to patients and service users and act on their feedback to shape access, experiences, and outcomes. 2. To work with place level partners in influencing the development of an anti-racist approach/strategy for Bradford and Craven district with focus on targeted engagement and involvement with communities and wider workforce. REN currently taking the lead with system partners onboard with focus on co-producing an anti-racist approach for Bradford and Craven 3. Improve and advance our role and position in ensuring we have diverse senior leaders at band (8b) and above across our place with particular focus on positive action approaches for diverse staff across place. This links with the WY Race review that Professor Dame Donna Kinnair chaired. <u>Link to place risk register:</u> None	
2	EDI reporting is carried out by each large organisation in line with national requirements e.g. WRES, WDES, EDS2, PSED and use of EQIAs/QEIAs for NHS Trusts/FTs. Also Public Sector Equality Duty annual reporting by all statutory bodies, includes 'place partnership view' fed into WY ICB report.							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>								
1	Minutes of the systems EDI group							
2	BDC People Board							
3	Assurance provided via Executive Leadership Executive, minutes.							
4	BDC Extended Leadership Team meeting, minutes.							
5	NHSE website for WRES and WDES data. WYICB PSED report on website							
Calderdale Place lead: Robin Tuddenham							Nominated lead for <u>this risk</u> : Neil Smurthwaite (17.07.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Calderdale)			Current (Calderdale)			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.	
BOLD	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 Race equality standard compliance is monitored at place level.							1. Suporting the EDI strategy in West Yorkshire (2025/26) <u>Link to place risk register:</u> None	
Sources of assurance <i>(Where is the evidence that the controls work?)</i>								
1 Outcomes of staff survey is discussed at Calderdale senior leadership team meetings								
Kirklees Place lead: Vicky Dutchburn							Nominated lead for <u>this risk</u> : Steve Brennan (25.06.2025)	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Kirklees)			Current (Kirklees)			Place have history of tackling issues related to inclusion, but recognise the need to go further given the diversity of our population, experiences of care and access to services and how our colleagues improve practice.	
BOLD	Likelihood	2	8	Likelihood	3	12		
	Impact	4		Impact	4			
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>	
1 Inclusive Communities Framework adopted by Place Committee							1. EDI Strategy is being developed for approval at ICB Board in January 2025 (assurance). This will be overseen by the Partnership Board including a number of objectives which have been developed for delivery by the WY Partnership Board. The Kirklees objectives of the EDI strategy have been developed and agreed and work is progressing (2025/26)	
2 EQIAs embedded as part of PMO functions								
3 Community champions / Community voices								
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							<u>Link to place risk register:</u> None	
1 ICB (Kirklees) self-assessment against the ICF during 2025/26 (last completed 2023)								
2 Examples of EQIAs and subsequent action / mitigation								
3 Examples of voice and influence from diverse population in planning and transformation								
Leeds Place lead: Tim Rley							Nominated lead for <u>this risk</u> : Nick Earl 27.06.2025 Cycle 3 review will be undertaken by Sharon Moore	
ICB risk appetite	Place risk scores						Rationale for current place score	
	Target (Leeds)			Current (Leeds)			ICB in Leeds works proactively in relation to EDI in respect of our workforce.	

BOLD	Likelihood	2	6	Likelihood	3	9	organisational development and commissioning responsibilities. The controls currently in place should limit any breaches in statutory duty. Although the risk appetite is set at BOLD, the target risk score was reviewed and the impact increased from 2 to 3, even though we can influence the likelihood, the impact will remain moderate, target risk is therefore 6 rather than 4. .
	Impact	3		Impact	3		
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>
1 Compliance with the requirements of the Equality Act 2010 Public Sector Duties in relation to our workforce and commissioning responsibilities.							1. Supporting the EDI strategy in West Yorkshire (2025/26) and leading on the development of Leeds EDI priorities 2. Increased focus on personal wellbeing within objective setting which will include EDI components (2025/26) 3. On going improvement and development in relation to the integration of Equality Impact Assessments within the business process cycle and all decision making processes
2 NHS Equality Delivery System 2 (EDS) and transition to EDS 2022; Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); Gender Pay Gap (GPG) report and subsequent action plans.							
3 Integration of our Equality Impact Assessment and Quality and Equality Impact Assessment within all decision making processes							
4 Ongoing interaction/partnership working in relation to our insights, communication and involvement team and equality, diversity, and inclusion.							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Link to place risk register:
1 Development of ICB in Leeds equality, diversity, and inclusion (EDI) priorities; annual contribution to WYICB Public Sector Equality Duty Report; equality impact assessments completed for commissioning programmes/projects and in relation to decisions .							None.
2 Ongoing partnership working across Leeds Health and Care partnership and the wider WYICB partnership in relation to the EDS transition and development of key priorities. WYICB WRES; WDES; GPG actions plans.							
3 Continuation of ICB in Leeds REN; continued implementation of the REN recruitment and selection procedure/ guidelines.							
Wakefield Place lead: Mel Brown							Nominated lead for this risk: Ruth Unwin, Dasa Farmer (07.07.25)
ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
BOLD	Likelihood	2	8	Likelihood	3	12	Impact assessed as high due to evidence that people with different protected characteristics have poorer health outcomes. Likelihood assessed as high due to Wakefield District Health and Care Partnership having limited ability to change deeply ingrained attitudes.
	Impact	4		Impact	4		
Key controls <i>(What helps us mitigate the risk?)</i>							Mitigating actions <i>(What more are we/should we be doing at place?)</i>
1 Equality, Diversity and Inclusion network established for place							1. A proactive approach to monitoring population health and uptake of services by groups with protected characteristics. Linked data model implementation for children and young people and other cohorts continuing (2025/26) 2. Supporting delivery of WY wide equality and fairness strategy through localised objectives. The delivery will be monitored via the People Panel. 3. Workforce alliance has a dedicated pillar of work in addressing equality, diversity and inclusion in all aspects of workforce, recruitment, development and training (2025/26)
2 Local equality objectives in place							
3 Work programme to ensure compliance with Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Public Sector Equality Duty (PSED)							
4 Local, multi-agency health inequalities alliance developed.							
5 The workforce alliance has a specific workstream for belonging to ensure equality of opportunity in recruitment and career progression							
6 Communication, Involvement and EDI at place							
Sources of assurance <i>(Where is the evidence that the controls work?)</i>							Link to place risk register:
1 People panel (partnership committee) receives and scrutinises delivery of equality agenda							None.
2 Formal reports - WRES,DES, PSED, Equality Delivery System to People Panel							
3 Equality and fairness strategy has been presented to the People Panel, to place management team and Healthcare Inequalities Steering Group							

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)						Version: 11		Date: 3 April 2025			
Mission 4		Failure to manage the strategic risk could result in a failure to SECURE BENEFITS OF INVESTING IN HEALTH AND CARE				Lead director(s) / board lead		Shaukat Ali Khan/ Lou Auger			
Strategic risk 4.3		There is a risk that threatens 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.				Lead committee / board		ICB Board/Transformation Committee			
ICB risk appetite		ICB risk scores				Rationale for current ICB score					
		Target (ICB)		Current (ICB)		This risk relates to the ability of the ICB to work with partners to mitigate the impact of a significant incident on the delivery of healthcare services. Our current score has been assessed against the operation of the controls during recent EPRR events and incidents . We have evidenced significant system ability to respond to an emergency, however there are limited controls the ICB can put in place for the largest scale event such as a future pandemic.					
AVERSE		Likelihood	3	9	Likelihood					3	12
		Impact	3		Impact					4	
Key controls (What helps us mitigate the risk?)						Mitigating actions (What more are we/should we be doing at ICB level?)					
1 Engagement with all partners and direct alignment to WY Resilience Forum						1. Directorates and Places to complete Business Impact Assessments by June 2025 to support further development of business continuity plans. 2. Scheduled cyber security summit in June 2025 - a workshop to build awareness on cyber security. The second half of the day will feature a role play exercise to stress test our approach to real life scenarios. (2025) 3. Data Security Protection Toolkit is in progress and audit has commenced in April 2025. There remains substantial work to be done to complete the evidence and associated statements (2025/26) 4. Cyber Security Discovery exercise: we have undertaken a cyber security discovery to identify risks and mitigation to improve cyber security resilience. An action plan will be developed to begin implementation by June 2025.					
2 Training at senior level - Principles of Health Command Training - Strategic Health Commander											
3 WY CIO Forum inc Place CIOs											
4 System Winter Plan with mitigating actions for surge and escalation inc Strategic Coordination Centre											
5 EPRR Compliance and Action Plans for each NHS organisation											
6 WY ICB has established arrangements for 1st and 2nd on-call.											
7 Business continuity plans are in place in the event of a prolonged IT system issue.											
8 WY ICB attends or facilitates a range of WY EPRR exercises during the course of each financial year.											
9 EPRR Team have completed testing and exercising of business continuity plans in March 2025											
Sources of assurance (Where is the evidence that the controls work?)						Links to ICB risk register (Reference numbers/brief description)					
1 Reporting of EPRR Compliance to Board						2194 - industrial action 2036 - Airedale Hospital structural RAAC 2166 - Risk of a successful cyber attack, hack and data breach on ICB. 2234 - Risk of cyber attack on commissioned services 2295 - Business continuity arrangements					
2 Minutes of Audit Committee and Internal Audit Meetings											
3 WY EPRR exercises - outputs, from papers and Mins.											
4 Significant learning from incidents											
5 Regular reporting on progress with DSPT annual self-assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission											
6 There is a newly established directorate called Digital, Data and Technology (DDaT) - output from papers.						Positive Assurance - see separate log					

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 11		22 April 2025		
Mission 4		Failure to manage the strategic risk could result in a failure to SECURE BENEFITS OF INVESTING IN HEALTH AND CARE					Lead director(s) / board lead		Ian Holmes		
Strategic risk 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.					Lead committee / board		Transformation Committee		
ICB risk appetite		ICB risk scores					Rationale for current ICB score				
		Target (ICB)			Current (ICB)			Climate change is already affecting us in West Yorkshire. International, national, regional and local strategies and actions are insufficient at present to avert the worst effects. In West Yorkshire, we are most likely to be directly affected by flooding, heatwaves, wind and wildfire, but specialist (medical) and general (food, office supplies) supply chains will be disrupted. There is a real risk of disruption to power, internet and gas grids at a regional level. We need to reduce our environmental impact (mitigation) and change what we do to make us ready for the new normal (adaptation).			
OPEN	Likelihood	4	12	Likelihood	4	16					
	Impact	3		Impact	4						
Key controls (What helps us mitigate the risk?)							Mitigating actions (What more are we/should we be doing at ICB level?)				
1		Climate Change strategy approved by Partnership Board December 2023					No specific actions at this point, however consideration is being given to developing actions focused on adaptation.				
2		Regular meetings and data submission to national Greener NHS team									
3		Transformation Committee will take oversight of ICB organisational response.									
4		Board Level Net Zero Leads network and the Operational Leads Network.									
5		Regional Greener NHS steering group.									
Sources of assurance (Where is the evidence that the controls work?)							Links to ICB risk register (Reference numbers/brief description)				
1		Minutes of Partnership Board focus on Big Ambition number 9 (climate change)					None identified.				
2		Dashboard received by ICB Board on 10 big ambitions									
3		Quarterly data submission to the National Greener NHS team									
4		Minutes of the Transformation Committee					Positive Assurance - see separate log				