Bradford District and Craven Partnership Board

10:35 - 13:00
13 February 2026
Belle Vue Suite, Belle Vue Square, Broughton Road, Skipton, BD23 1FJ

AGENDA

Item	Lead	Purpose	Time	Page no.	Links to Board Assurance Framework risks
1. Welcome, introductions, apologies and quoracy	Chair	Information	10:35		N/A
2. Declarations of interest – a register of Board members can be found at (mydeclarations.co.uk)	Chair	Assurance	10:45		N/A
3. a. Minutes of the meeting held on 14 November 2025 b. Action log / matters arising c. Previous BD&C Partnership Board Triple A report	Chair	Approve / to note	10:45	4	N/A
4. Public questions	Chair	Information	10:50		N/A
5. Changes to ICB governance arrangements for 2026/25 and year end arrangements for 2025/26	Sue Baxter	Agree / support	10:55	23	N/A
6. Listen in report	Victoria Simmons	Discussion	11:10	44	Topics link to multiple BAF risks
7. Place Lead's update	Therese Patten	Information	11:40	63	Topics link to multiple BAF risks
Break 12:00 – 12:10					
8. Reports from committees and fora	Committee and Forum Chairs	Information / assurance	12:10	70	1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 2.4, 3.1, 3.2, 3.3, 4.1
9. Update on financial position / planning	Mike Woodhead / Kerry Weir	Information / assurance	12:25	78	1.2, 2.3, 3.1, 3.2, 3.3

Item	Lead	Purpose	Time	Page no.	Links to Board Assurance Framework strategic risks
10. Partnership high level risk report / Board Assurance Framework	Asma Sacha	Assurance	12:40	94	Includes oversight of all BAF risks
11. Any other business	All	Information	12:55		N/A
12. Reports/escalations to WY ICB Board and review of meeting	Chair	Information	12:58		N/A

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

Board Assurance Framework, Cycle 4 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map				Version 13												Dec-25	
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield			
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)		
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20		
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	16	9	12	6	9	6	12	9	16	9	16		
	1.3	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12		
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Open	8	16	8	16	8	12	8	16	9	12	8	12		
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	6	8	4	9	4	6	4	8	4	12	4	12		
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	9	2	4	2	6	2	8	2	6	2	6		
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	16	9	16	9	16	9	16	9	12		
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required		
Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	6	12	4	12	4	12	4	9	4	12		
	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	9	20	9	20	9	20	9	20	9	20		
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	9	12	4	12	4	16	4	12	4	16	4	12		
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	8	8	8	8	8	12	8	12	8	8		
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	6	9	8	12		
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required		
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required		

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	3
Meeting date:	13 February 2026
Report title:	Bradford District and Craven (BD&C) Partnership Board Meeting Business Items
Report presented by:	Elaine Appelbee, Independent Chair of the BD&C Partnership Board
Report approved by:	Elaine Appelbee, Independent Chair of the BD&C Partnership Board
Report prepared by:	Catherine Smith, Governance Manager, NHS WY ICB

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

Previous considerations and any resulting action:

WY ICB Board: 16 December 2025 – BD&C (Bradford District and Craven) Partnership Board Triple A Report

Executive summary and points for discussion:

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

- Minutes of the BD&C Partnership Board formal public meeting held on 14 November 2025
- BD&C Partnership Board action log
- BD&C Partnership Board Triple A report submitted to the WY ICB Board meeting on 16 December 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. **APPROVE** the draft minutes from the meeting held on 14 November 2025
2. **DISCUSS** any open actions on the action log
3. **RECEIVE** the previous Triple A report for information

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
N/A
Appendices
1. Minutes of the BD&C Partnership Board meeting held in public on 14 November 2025 2. BD&C Partnership Board action log 3. BD&C Partnership Board Triple A report submitted for the WY ICB Board meeting on 16 December 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
ACTasONE
Proud to be part of the West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Draft minutes of the Bradford District and Craven Health and Care Partnership Board
10:30-13:00, Friday 14 November 2025
G7/G8, Scorex House, 1 Bolton Road, Bradford, BD1 4AS

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)
Foluke Ajayi	**FA**	Chief Executive, Airedale NHS Foundation Trust
Richard Crane	**RC**	Assistant Director for Schools and Learning, BMDC (minute 29-35)
Dena Dalton	**DD**	Head of Health Collaboration, Community First Yorkshire
Ashley Green	**AG**	Chief Executive, Healthwatch North Yorkshire
Danielle Hann	**DH**	Deputy Chair, Bradford and Airedale Branch of YORLMC
Louise Bestwick	**LB**	Chief Executive, Bradford Care Association (minute 35-42)
Iain MacBeath	**IM**	Strategic Director, Adult Social Care, Health and Housing, Bradford Metropolitan District Council (BMDC)
Sarah Jones	**SJ**	Chair, Bradford Teaching Hospitals NHS FT
Sam Keighley	**SK**	VCSE System Lead
John Lawlor	**JoL**	Chair, ANHSFT
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
Helen Rushworth	**HR**	Chief Executive, Healthwatch Bradford District
Matt Sandford	**MS**	Deputy Accountable Officer / Director of Partnership and Place, NHS WY ICB (BD&C)
Victoria Turner	**VT**	Public Health Consultant, North Yorkshire Council
Andy Withers	**AW**	Non-Executive Chair of the Quality Committee of the BD&C H&CP

In attendance	Initials	Role
Sue Baxter	**SB**	Head of Partnership Governance, NHS WY ICB
Saeed Khan	**SK**	Insight and Involvement Manager, NHS WY ICB (BD&C) (minute 29-38)
Karen Parkin	**KP**	Director of Operational Finance, NHS WY ICB (BD&C)
Catherine Smith	**CS**	Governance Manager, NHS WY ICB (minutes)
Lesley Tillotson	**LT**	Associate Director, Partnership Delivery, NHS WY ICB (BD&C)
Kerry Weir	**KW**	Associate Director Planning, Performance & Business Intelligence, NHS WY ICB (BD&C H&CP) minute 29-36)
Mike Woodhead	**MW**	Lead Finance Director, BD&C H&CP / Director of Finance, Contracting and Estates, Bradford District Care NHS Foundation Trust (minute 29-35)
Apologies		
Craig Blundred	**CB**	Director of Public Health, BMDC
Richard Haddad	**RH**	Chair of the Clinical Advisory Board
Phillipa Hubbard	**PH**	Director of Nursing and Quality, BD&C H&CP
Julie Lawreniuk	**JuL**	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
Rebecca Randell	**RR**	Professor of Digital Innovations in Healthcare, University of Bradford
Victoria Simmons	**VS**	Senior Head of Communications and Involvement, NHS WY ICB (BD&C)
Louise Wallace	**LW**	Director of Public Health, North Yorkshire Council
Richard Webb	**RW**	Corporate Director, Health and Adult Services, North Yorkshire Council

Members of the public - 5

29 WELCOME, INTRODUCTIONS AND APOLOGIES

Elaine Appelbee (EA), 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 quorate.

30 DECLARATIONS OF INTEREST

Minute 35 – Lynfield Mount Hospital redevelopment: support for Full Business Case –Therese Patten (TP), Linda Patterson (LP) and Mike Woodhead (MW) declared an interest as employees of Bradford District Care Foundation Trust (BDCFT). It was agreed that they would be present at the table and able to answer any questions but unable to participate in the discussion – MW was leading the item. TP and LP were unable to vote.

Minute 39 – Section 75 variation – all members of organisations that provided a service under Section 75 had an interest therefore the decision was taken under mutual accountability, and all members could take part in the discussion and vote.

31 MEETING BUSINESS

a) Minutes of the meeting held on 5 September 2025

The Board approved the minutes of the meeting held in public on 5 September 2025 as a correct record.

b) Action log / matters arising

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

- 2024/05 – the communication and engagement team to explore a kindness campaign, in reference to Airedale NHS FT's campaign. It was agreed that the action would remain open.

No further matters arising were raised.

c) Previous BD&C Partnership Board Triple A report

The Bradford District and Craven Partnership Board **APPROVED** the draft minutes from the meeting held on 5 September 2025, **NOTED** the open action on the action log and **RECEIVE**D the previous Triple A report for information.

32 PUBLIC QUESTIONS

The following questions had been received ahead of the meeting. The Chair noted that the questions would be answered in full following the meeting.

- Is the Board aware that providing section 117 aftercare is a legal requirement in order to prevent a relapse in a person's mental health; and that currently as I know all too well guidance given by the ombudsman is not being followed in Bradford? Can the board undertake to ensure procedures are put in place so no other family has to go

through the hell we have in the last three years?

- The partnership advocates for a community-centred approach to service design and delivery, ensuring that local voices shape outcomes. Could you please clarify your working definition of “community” in this context? Additionally, how are communities meaningfully involved in the co-production of services to ensure these services are responsive to their specific needs and priorities?

33 PLACE LEAD’S UPDATE

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

TP provided an update on West Yorkshire Integrated Care Board’s (WY ICB) organisational change programme, explaining that in March 2025 the Government announced a reset of the NHS. As part of this, NHS England would merge with the Department of Health and Social Care, reducing its workforce by 50%, and the remit of ICBs would shift to focus on strategic commissioning, accompanied by a 50% reduction in their workforce by October 2025.

The Board was reminded of the expectation that ICBs would operate within a new financial envelope equivalent to £19 per head of population from April 2026. Despite some uncertainty at a national level around the funding for any redundancies earlier in the year, it was reported that WY ICB would open a voluntary redundancy scheme for staff on 26 November 2025 with the intention of opening a formal staff consultation on the new structure on 14 January 2026. A recruitment and selection process for the new structure would form part of that consultation documentation. The difficult and challenging position for local ICB staff was acknowledged and a request was made to support ICB colleagues and recognise the challenges and pressures due to reducing capacity in the ICB. Matt Sandford (MS) referred to an ask from ICB colleagues that this is disseminated through organisations by senior leaders.

Ashley Green (AG) referred to the need for a strong back office to support the front line of the NHS and the need for an understanding on the potential impact on services following the reduction in both the workforce of NHS England and West Yorkshire ICB.

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

34 FINANCE / PLANNING GUIDANCE UPDATES

Kerry Weir (KW) presented a paper which summarised the expectations for the 2026/27 NHS planning cycle following publication of NHS England’s ‘Planning Framework for the NHS in England’ and the ‘Medium Term Planning Framework – delivering change together

2026/27 to 2028/29' which both set out the national expectations to enable delivery of the NHS 10 Year Health Plan. The 'Planning Framework for the NHS in England' was a five-year plan to support transformational change and set out roles, responsibilities, core activities and assurance expectations. The 'Medium Term Planning Framework' described the changes required over the next three years and included approaches to quality and data-led monitoring; a redesign of the current financial regime; improving productivity; reducing unwarranted variation; and an expectation on delivering national targets.

KW detailed how the first submission would include the draft three-year plan alongside a Board assurance statement confirming oversight of the process, followed by the full plan submission in early 2026 which would include updated plans, a five-year plan narrative and a Board assurance statement confirming oversight and endorsement of the totality of the plans. A meeting was taking place on 27 November 2025 to agree the assumptions and principles supporting the planning process for 2026/27 as a system. The deadline for initial draft plans was 18 December 2025 with separate plans to be submitted by providers and the ICB, however there was a need to triangulate the plans.

The Medium Term Planning Framework built on the NHS 10 Year Health plan and set out how the NHS could deliver the three shifts and the new way of working. The shifts would be supported by a new financial regime distributing funding more fairly and ensuring payment schemes supported new models of care. There would be a new payment model for urgent and emergency care, which would be developed to incentivise the shift of care out of hospitals and into community settings. A review of the wider funding formula would seek to return system allocations to their corresponding fair share of resources. In terms of the financial priorities there was a requirement for a break-even or surplus financial position without deficit support funding and to meet a 2% annual productivity ambition through a number of key areas of focus.

The Bradford District and Craven Partnership Board **NOTED** the update on the latest NHS planning guidance.

Louise Bestwick joined the meeting

35 LYNFIELD MOUNT HOSPITAL REDEVELOPMENT: SUPPORT FOR FULL BUSINESS CASE

TP, LP and MW declared an interest as employees of BDCFT. It was agreed that they would be present at the table and able to answer any questions but unable to participate in the discussion – MW was leading the item. TP and LP were unable to vote.

MW highlighted that the Partnership Board had given support for the Outline Business Case (OBC) for the Lynfield Mount Hospital redevelopment scheme in October 2024. The OBC was then formally approved by the Department of Health and Social Care in February 2025, which led to the development for the Full Business Case (FBC) for submission in November 2025.

The Partnership Board were asked to reconfirm their support for the scheme.

MW summarised the strategic case for change highlighting Lynfield Mount Hospital as the main mental health inpatient building for BDCFT. It had been built to a 1950s design and had a number of significant issues including a lack of recreational space, no ensuite facilities and ongoing issues with the building infrastructure. The issues with the building contributed to increased length of stays for patients, high backlog maintenance costs, increased capital costs and difficulties recruiting and retaining staff. The building had been noted as substandard in CQC reports however a good quality of care had been reported despite the poor facilities.

MW summarised the economic case noting that the costs of the 'Preferred Option' in the Full Business Case (FBC) had increased from £50m to £65m since the OBC and the timescales revised from March 2028 to November 2028. The Benefit: Cost Ratio at OBC stage was 5.11:1 and at FBC stage 4.6:1. The economic case concluded that the redevelopment of £65m was economically sound and delivered a Benefit: Cost Ratio in excess of the minimum national requirement of 4:1.

In terms of the commercial case MW highlighted that a procurement exercise had taken place and a preferred supplier had been chosen. The tender evaluation considered both cost and quality to ensure that the project delivered best value and not just lowest cost. The tender had been signed off by the BDCFT Board and would be included in the FBC.

The financial case noted the change in costs between the OBC and FBC including a reduction in total funding cover costs (support to non-recurrently use MHIS funding needed from commissioners) from £3.8m to £2.4m mainly due to a reduction in the timescale for refurbishment and a favourable renegotiation of prices for beds with independent providers. There was an increase in capital charges due to an increase in capital costs and a change in asset life to 54.1 years from 60 years in the OBC, however it was expected that additional funding would cover most of the depreciation element of this increase (noted that this additional funding is not currently factored into the FBC pending release of national technical guidance).

MW highlighted the change in benefits between OBC and FBC with some changes in the revenue benefits and noted that the in-year benefits would outweigh the in-year costs by 2028/29. MW concluded by explaining that the redevelopment involved two aspects – there would be a new two-story modular ward block and a refurbishment of legacy wards to provide ensuite facilities alongside the redevelopment of communal spaces, outside spaces and therapy areas.

Andy Withers (AW) queried the quality and safety benefits of the redevelopment. MW explained that the redevelopment would improve dignity and privacy for patients; wider corridors would decrease incidents of violence and aggression; there would be increased daylight in rooms; improved infrastructure including less issues with drains and the heating system; reduced noise; and improved therapeutic space and green spaces. He noted that

evidence-based studies had shown that all of these aspects impacted on length of stay and patient experience, and that the quality benefits aligned with the finance benefits of the redevelopment as well as supporting the recruitment and retention of staff.

Mel Pickup (MP) expressed support for the redevelopment and referred to support from the Health and Care Partnership to prioritise Lynfield Mount Hospital and the new hospital at the Airedale general hospital site and hoped that there would be similar support for Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) in the future, recognising old estate in Bradford Royal Infirmary and St Luke's Hospital and associated risks and issues. JoL expressed full support for the scheme and welcomed the information on the financial case.

The Bradford District and Craven Partnership Board **CONSIDERED** the report and, in particular, the developments since OBC approval and **RECONFIRMED** Place support for the redevelopment of Lynfield Mount Hospital and **RECOMMENDED** that NHS West Yorkshire ICB confirm their full support to NHSE and DHSC.

Richard Crane and Mike Woodhead left the meeting

36 REPORTS FROM COMMITTES AND FORA

The Chair explained that each committee and fora completed a Triple A Report following their recent meetings to provide assurance to the Partnership Board and enable committee chairs to alert the Board to any significant risks or asks.

AW raised recurring issues with primary care IT which were having a significant impact on GP practices and the rest of the system. He noted the need for a robust IT system to support the shifts from analogue to digital and hospital to community, as described in the NHS 10 Year Plan. Danielle Hann (DH) added that a 'lessons learnt' exercise had taken place, but the recurring issues were putting significant pressure on general practice and noted that compliance with the GP contract relied on robust digital and IT infrastructure and support services. DH also referred to the impact on the workforce from the ongoing issues. Sohail Abbas (SA) acknowledged the impact on GP practices and patient experience and the need for additional Government funding for GP IT. He added that there would be work with GP practices on the implications following changes in the GP contract and support to comply with the contract.

SA referred to a discussion in the Clinical and Professional Forum on 12 November 2025 where the role of the Forum in the context of the ICB changes was discussed. Members recognised the role of the Forum and requested that the Partnership Oversight Executive considered its role in the new governance structure of the Place Provider Partnership.

The Bradford District and Craven Partnership Board **RECEIVED** the Triple A Reports from the recent meetings of the Clinical and Professional Forum and System Quality

Committee.

37 LISTEN IN REPORT

Saeed Khan (SK) presented a report which described the recent cycle of Listen in activity which focused on hearing from white British working-class men across Bradford district and Craven. It was highlighted that the group experienced some of the poorest health outcomes but were least likely to engage in formal consultation or co-design. Themes from the report were summarised as frustration with access to primary care services and inflexible appointment systems that do not fit around shift-based or insecure work; men not accessing services until health problems became urgent; a loss of social connection; stigma around mental health; and work as core to men's identity. The Board was asked to reflect on how the Partnership could respond to the insights.

SA suggested promotion of the extended access service, which provided primary care appointments outside of core hours, and digital access. It was noted that some men had issues making appointments as well as attending in working hours. LP suggested consideration for providing preventative services in a different way, such as blood pressure and other health checks in workplaces and community settings to make them more accessible. SA highlighted the success of community health checks in the Core20PLUS5 and 'reducing inequalities in communities' programmes. SK referred to good examples of preventative work in the VCSE, such as immunisations and health checks, and suggested consideration for how they could be scaled up across Bradford district and Craven. SK suggested reviewing the extended access service in response to the report.
Action – SK and SA to review the extended access service to see how it could be made more responsive in response to the themes highlighted in the Listen in report

The Bradford District and Craven Partnership Board **CONSIDERED** the ideas and insights from the Listen in cycle.

38 FOCUS ON CRAVEN – HEALTHWATCH REPORT – PLOUGHING THROUGH BARRIERS

AG presented a report called 'ploughing through barriers – understanding the challenges and solutions to support farming communities access healthcare' which had been produced by Healthwatch Yorkshire and explored the unique health challenges and barriers to accessing healthcare experienced by the farming communities in North Yorkshire. AG explained that the research to inform the report had been undertaken collaboratively with North Yorkshire Council and farming support organisations and was based on engagement with 220 people in the local farming community.

The top three health concerns raised by members of the farming community were related to pain, stress and anxiety, and sleep problems. The barriers to seeking help were summarised as a lack of time to book or attend appointments, an impact on income by

attending appointments, concern over losing a gun licence if mental health issues were raised, rural access issues and health not being prioritised. The report suggested a number of solutions including taking services to the farming community and improving accessibility, such as drop-in clinics at auction marts and mobile health units; ongoing support through community-based approaches; using trusted professionals for signposting; and improving communication and awareness. The findings from the report had informed the North Yorkshire Council Rural Health Needs Assessment and led to the trialling of farmer walk-in clinics and services attending auction marts to promote their work and to provide health checks.

Victoria Turner (VT) thanked AG and Healthwatch for their work and explained that it supported the collation of other insights on farming communities and would be built on through the Rural Health Needs Assessment. LP referred to the importance of the work feeding into the commissioning frameworks in terms of prevention. MS added that both the findings of the report and the themes from the Listen in programme would feed into the work of the delivery plan for the Health, Care and Wellbeing Strategy. Helen Rushworth (HR) referred to the loss of engagement capacity in the Partnership due to the changes in the ICB and the future abolition of Healthwatch. SK added that there was work on patient voice activity in Bradford Metropolitan District Council (BMDC) in terms of how it was co-ordinated and utilised to the best effect.

The Bradford District and Craven Partnership Board **CONSIDERED** the report and any future actions to address the barriers faced by the farming community to accessing health care services.

39 SECTION 75 VARIATION

Iain MacBeath (IM) presented the section 75 agreement which had been updated to reflect changes in the joint commissioning arrangements between BMDC and NHS West Yorkshire ICB: Bradford District and Craven. It was noted the ICB constitution changes supporting greater delegation had been approved by NHS England so the updated section 75 agreement and accompanying variation agreement could be signed by the Place Lead rather than the Chief Executive of the ICB. The Planning and Commissioning Forum would continue to oversee the section 75 agreement and review the services in the agreement. It was noted that the agreement only related to Bradford and there was a separate agreement between the ICB and North Yorkshire Council which included Craven.

The Bradford District and Craven Partnership Board **APPROVED** the proposed variation to the section 75 agreement.

40 PARTNERSHIP HIGH LEVEL RISK REPORT

Sue Baxter (SB) presented a report which detailed the risks on the Partnership risk register and the review of the Board Assurance Framework (BAF) during cycle three of

2025/26. There were 20 open risks on the risk register – nine of which were high-level risks. Two risks had decreased in risk score. The risk related to the financial position of BMDC (2173) had decreased in score from 16 to 12 due to an improving position and a reduced risk of an impact on the rest of the system. The risk related to the provision of good quality continuing healthcare at an affordable cost (2544) had decreased from 12 to 6 due to a review of existing care packages and commissioning care using the WY equality and choice policy which had supported reducing the risk of high-cost care being commissioned.

There were a number of risks which were being developed ahead of inclusion to the risk register during cycle four:

- There was a risk that children and young people diagnosed with autism and ADHD would suffer harm due to the lack of access to ADHD medication and treatment, an increase in demand from independent providers, capacity issues and right to choose assessments and previous medication shortage. TP noted that a group was focusing on these areas.
- There was a risk that WY ICB would not meet its safeguarding statutory requirements and safeguarding responsibilities at Bradford Place due to the impact of sickness within the safeguarding team on capacity. MS noted that there had been long-term absences in the safeguarding team however the Associate Director of Nursing and Quality in Kirklees was supporting Bradford District and Craven particularly in safeguarding and SEND for an interim period.
- There was a risk of patient harm to the population of Bradford district and Craven and Leeds due to the operational challenges linked to the major Laboratory Information Management System (LIMS) transition in December 2024 and the physical relocation of the laboratory from Leeds General Infirmary to St James's University Hospital. SA referred to the impact on GP practices, including additional work in managing late, wrong or duplicated test results. A stakeholder group had been established by Leeds which included quality leads and GPs from PCNs in Bradford district and Craven to examine whether there had been potential for patient harm.

The Bradford District and Craven Partnership Board **RECEIVED** and **NOTED** the high-scoring risk report as a true reflection of the risk position in the ICB in BD&C. It was **ASSURED** in respect of the effective management of the risks, controls and assurances in place. It **RECEIVED** and **NOTED** the Board Assurance Framework for cycle three of 2025/26.

41 ANY OTHER BUSINESS

EA highlighted that an easy read version of the Bradford District and Craven Health, Care and Wellbeing Strategy was available and encouraged members and attendees to promote it through their organisations.

EA noted that it was the LP's last Board meeting as her tenure as Chair of BDCFT ended in December 2025. On behalf of the Board EA thanked LP for her wisdom, expertise and support and wished her well for the future.

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

It was agreed that key messages to be included in the triple A report to the WY ICB Board would be drafted following the meeting.

The meeting closed at 12:50.

DATE AND TIME OF NEXT MEETING

10:00 – 13:00
Friday 13 February 2026
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. 05/09/25: Agreed to keep the action open.
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 (Ambitious for Health) to be added to the Partnership Board workplan.	Louise Wallace/Catherine Smith	05-Sep-25	Closed	Agenda item in meeting on 5 Sept 2025
2025/01	14-Nov-25	37 - Listen in report	Sam Keighley and Sohail Abbas to review the extended access service to see how it could be made more responsive in response to the themes highlighted in the Listen in report	Sam Keighley / Sohail Abbas	13-Feb-26	Open	

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

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

Date of meeting: 14 November 2025

Report to: NHS West Yorkshire ICB Board on 16 December 2025

Report completed by: Catherine Smith on behalf of Elaine Appelbee (independent chair) and Therese Patten (Bradford District and Craven place lead)

Date: 17 November 2025

Key escalation and discussion points from the meeting
Alert:
• **DECISION:** The Partnership Board reconfirmed Place support for the **redevelopment of Lynfield Mount Hospital** and recommended approval of the Full Business Case to the NHS WY ICB Board. The BD&C Partnership Board had supported the Outline Business Case (OBC) in October 2024. Key changes made since the support for the OBC were highlighted and included noting that the capital costs had increased from £50m to £65m with the additional funding secured. (BAF 2.4 and RR 2215) • **DECISION:** The Board approved a **variation to the Section 75 agreement** between Bradford Metropolitan District Council and NHS WY ICB – Bradford District and Craven (BD&C) Place which had been updated to reflect changes in the joint commissioning arrangements, which included: expansion of schedules to cover additional services; updates to terms within the overarching agreement and approval of the Better Care Fund. It was noted that recent amendments to the ICB's Constitution had been approved by NHS England so the updated agreement could be signed by the Place Lead rather than the Chief Executive of the ICB. It was also noted that there was a separate agreement between North Yorkshire Council and the ICB for Craven. (BAF 1.1, 1.2, 1.3, 3.1 and RR 2543, 2433)
Advise:
• The Board received an updated timeline for the **ICB's organisational change programme** following confirmation from HM Treasury that a proportion of the funding for redundancies in ICBs and NHS England would be made available in 2025/26. The challenging and difficult position for local ICB staff was acknowledged and a request was made for an awareness of this position and reducing capacity in the ICB across the Bradford district and Craven system. (BAF 2.1, 3.3 and RR 2543) • The Board were made aware of **recurring IT outages** affecting practices in Bradford district and Craven. The impact on practices and the subsequent effects on the rest of the system during outages was highlighted. It was noted that 'lessons learnt' exercises had taken place but as outages continued, robust IT systems (and the

necessary investment) were needed to fully support the shifts from hospital to community and analogue to digital.

- It was noted that there was a risk in development related to the potential impact on patient safety due to operational challenges following the **Laboratory Information Management System (LIMS)** transition in December 2024 and the physical relocation of the laboratory from Leeds General Infirmary to St James's University Hospital in June 2025. There was work underway to understand the scale of the issue, identify potential patient harm and the management of the risk at Place alongside oversight at a West Yorkshire level through the establishment of a stakeholder group.

Assure:

- The Board received an update on the expectations for the **2026/27 NHS planning cycle** following publication of NHS England's 'Planning Framework for the NHS in England' and the 'Medium Term Planning Framework – delivering change together 2026/27 to 2028/29' which both set out the national expectations to enable delivery of the NHS 10-year plan. The Board noted that organisations were expected to submit a draft 3-year plan in December 2025 with Board assurance confirming oversight of the process and then revision of the plans in early 2026 alongside a 5-year plan narrative and Board assurance statements confirming oversight and endorsement of the totality of the plans. A workshop was taking place on 27 November 2025 for colleagues across BD&C to agree the assumptions and principles supporting the planning process. (BAF 1.2, 2.3, 3.2 and RR 2168)
- The **Listen in** report was received as part of the focus on reaching into communities of interest, with the report focused on hearing from white British working-class men from Bradford district and Craven noting the group as experiencing some of the poorest outcomes and the least likely to engage in formal consultations or co-design. Themes from the report were considered including how to promote and increase accessibility to services, including primary care and prevention. (BAF 1,1, 1.2, 1.3, 3.1 and RR 2221).
- The Board also received a report from Healthwatch North Yorkshire on barriers, challenges and proposed solutions to accessing healthcare for farming communities in North Yorkshire: '**Ploughing through Barriers: understanding the challenges and promoting help-seeking in farming communities**'. Similar themes between the report and the **Listen in** report were highlighted and it was noted that the findings from these reports would inform the development of the delivery plan for the Bradford District and Craven Health, Care and Wellbeing Strategy. (BAF 1,1, 1.2, 1.3, 3.1 and RR 2221).

Partnership Board 14 November 2025

Question

Is the board aware that providing section 117 aftercare is a legal requirement in order to prevent a relapse in a person's mental health; and that currently as I know all too well guidance given by the ombudsman is not being followed in Bradford? Can the board undertake to ensure procedures are put in place so no other family has to go through the hell we have in the last three years?

Response

As a partnership all providers are aware of their responsibility under Section 117 of the Mental Health Act 1983, Integrated Care Boards (ICBs) share a statutory duty with local authorities to provide or arrange free aftercare services for individuals who have been detained under certain sections of the Act (specifically sections 3, 37, 45A, 47, or 48) once they leave hospital care. The Hospitals who have cared for individuals whilst they have been detained under the Mental Health Act will arrange a discharge care programme approach (CPA) which includes the community mental health teams, Bradford Metropolitan District Council (BMDC) and the individual. As appropriate, there is recommendation for Section 117 funding via the joint funding forum, which includes both BMDC and the ICB. This is on a case by cases basis, and not all individuals admitted under a section 3, 37,45A, 47 or 48 will be referred, as many needs are already met by commissioned services as part of discharge planning. Partners across Bradford District and Craven continue to work together to ensure that all statutory responsibilities are appropriately undertaken.

Partnership Board 14 November 2025

Question from the Steeton Health Centre Action Group

The partnership advocates for a community-centred approach to service design and delivery, ensuring that local voices shape outcomes. Could you please clarify your working definition of “community” in this context? Additionally, how are communities meaningfully involved in the co-production of services to ensure these services are responsive to their specific needs and priorities.

Response

Thank you for your question from the Steeton Health Centre Action Group. We share the principle that health and care services are strongest when they are shaped with, and informed by, the people who use them, drawing on local knowledge, lived experience and community relationships.

There is no single definition of “community”, as it is understood and experienced differently by different people. In our work, community can include the place people live, the networks they belong to, and the relationships that shape their day to day lives. From a health and care perspective, services need to recognise and respond to these different dimensions of community, while also working at a scale that enables sustainability, equity of access and effective use of workforce and resources.

Nationally, NHS England uses the term “neighbourhood” to describe populations of approximately 30,000–50,000 people. These are intended to reflect recognisable local areas where general practice, community services, local authorities and voluntary and community sector organisations can work together in a coordinated way around shared priorities. Within Bradford District and Craven, this neighbourhood level is a key part of how integrated health and care is developing.

Alongside this, some teams and services work across wider geographical areas where this enables more consistent provision, access to specialist skills or better coordination across services. These arrangements have developed over time and are not identical across all organisations within the Health and Care Partnership. While we are not proposing short-term reorganisation of these footprints, there is a clear focus on improving how teams working at different levels connect with one another, so that people experience care as joined up rather than fragmented. This reflects a “team of teams” approach, where the emphasis is on how services work together, rather than on a single fixed structure.

To provide clarity rather than prescription, services and teams currently tend to operate across a small number of broad levels, depending on their role and purpose:

- hyper-local, for example at ward level or a registered GP practice population, or a segment of that population

- neighbourhood, typically around 30,000–50,000 people (in Bradford District and Craven this is will be aligned to our 14 Community Partnerships)
- locality, typically around 100,000–200,000 people
- place, covering the full Bradford District and Craven population

In terms of community involvement and co-production, over recent years we have worked with communities across the district to understand what matters most to people in shaping future neighbourhood health and care. This has included both targeted work with specific groups and broader place based engagement. Importantly, this insight is used to inform priorities, test assumptions and shape how services work together, rather than being treated as a one off consultation exercise. You can read reports from our Listen In programme and see how it has influenced our strategy here: Listen in | Engage Bradford District & Craven

We recognise the important role that local groups play in sharing lived experience and helping to shape how neighbourhood health works in practice. For Steeton, the Wharfedale and Silsden Community Partnership provides the primary local space where this dialogue feeds into the development of integrated neighbourhood teams, bringing together partners across health, care and the voluntary sector. We would encourage the Action Group to connect with this forum, alongside wider engagement activity, as neighbourhood approaches continue to evolve. https://www.facebook.com/WharfedaleAndSilsdenCommunityPartnership/ .

Meeting name:	Bradford District and Craven Health and Care Partnership Board
Agenda item no.	5
Meeting date:	13 February 2026
Report title:	Changes to NHS West Yorkshire ICB Governance Arrangements for 2026/27 (transitional year) and Committee Year End Arrangements for 2025/26
Report presented by:	Sue Baxter (Head of Partnership Governance), WY ICB
Report approved by:	Matt Sandford, Director of Partnership and Place / Deputy Accountable Officer, BDC ICB
Report prepared by:	Sue Baxter, Head of Partnership Governance, WY ICB

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

Previous considerations:

NHS West Yorkshire ICB Board – October 2025 development session; and

NHS West Yorkshire ICB Board meeting 16 December 2026 – part of ICB Constitution changes item 23

Executive summary and points for discussion:

The current operating context is informed by three areas: firstly, on the 1 April 2025, Working together in 2025/26 to lay the foundations for reform letter from Sir James Mackey (CEO, NHS England) outlined the requirement placed on ICB's to reduce costs by 50% with ICBs primary focus becoming strategic commissioners. Secondly, through 2026/27 transitional year emerging place provider partnerships will prepare to sign an NHS contract with the ICB for the provision of in-scope services. Thirdly, the Partnership has developed the Partnership's Health, Care and Wellbeing Strategy in September 2025 and implementation is underway. The SPA refresh sets out arrangements established to enable delivery of this Strategy. Taking account of the operating context, a refreshed version of the Strategic Partnering Agreement (SPA) and governance handbook will support arrangements through this transitional year (2026/27).

During 2026/27 the transitional year delegation from NHS West Yorkshire ICB Board to Bradford district and Craven place will remain via the Bradford District and Craven Health and Care

Partnerships Board (a Committee of the ICB). Changes to the ICB governance arrangements in Bradford District and Craven (place):

- Bradford District and Craven Health and Care Partnership Board, composition (chair & membership) and focus of responsibilities will be reduced to ensure that this committee of the ICB Board only undertakes decisions that it is required to discharge to enable the smooth transition;
- Bradford District and Craven Health and Care Partnership Board will continue to meet on a quarterly basis and will cease to meet once the emergent Place Provider Partnership have agreed and signed an NHS Contract with NHS West Yorkshire ICB for in-scope services. The expectation by no later than 31 March 2027;
- The Bradford District and Craven Health and Care Partnership Board will no longer meet for development sessions; and
- Sub-committees of the Bradford District and Craven Health and Care Partnership Board to cease by 31 March 2026, including:
    - System Quality Committee,
    - System Finance & Performance Committee, and
    - All other sub-committees/groups with accountability to the Partnership Board that do not form part of the Bradford District and Craven Place Provider Partnership Governance arrangements.

Bradford District and Craven Health and Care Partnership recognises the contributions and important work of the System Quality Committee and the System Finance and Performance Committee over the last four years:

- the System Quality Committee have provided important oversight, assurance and contributions to the partnership regarding the quality, safety and effectiveness of services and the contribution services make to improving health outcomes for local people; and
- the System Finance and Performance Committee provided a collective focus on financial and performance outcomes with oversight and assurance, including the development and delivery of a viable and sustainable place financial plan and management of risks affecting delivery of the financial plan; approval of business cases; and oversight of system performance and operational delivery.

Year End Arrangements for 2025/26

The Partnership Board's terms of reference require it to produce an annual report, to be submitted to the West Yorkshire ICB Board. Alongside this, the Board would normally review its terms of reference at year end and recommend any changes to the ICB Board, alongside a work plan for the ensuing year.

Given the transitional arrangements outlined above, and the need for documents to be submitted to the ICB Board for 24 March 2026, the following streamlined arrangements are proposed for the 2025/26 year-end processes:

- To inform the content of the committee's annual report, members will be asked to consider the following questions via email:
    - What has the committee achieved this year?
    - What challenges did the committee face this year and how were they overcome?
    - What key learning has resulted from this year?
- The annual report will then be drafted by the committee's Governance Lead in consultation with the Chair and Place Lead/Deputy Accountable Officer, and the approval of the final version will be delegated to the Chair and Place Lead;
- The draft terms of reference for the reconstituted Bradford District and Craven Partnership Board are attached for discussion/comment prior to being submitted to the ICB Board for approval; and

An indicative draft work plan for 2026/27 is attached for discussion/comment prior to being submitted to the ICB Board.

Outline how this supports our partnership vision and strategy

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

Which purpose(s) of an Integrated Care System does this report align with?

☒ 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:

1. **NOTE** the actions to change the Bradford District and Craven Health and Care Partnership's governance arrangements by 31 March 2026, in preparation for the 2026/27 transitional year.
2. **COMMENT** on the draft terms of reference and indicative draft work plan for the reconstituted committee; and
3. **DELEGATE** the approval of the final version of the Bradford District and Craven Partnership Board Annual Report 2025/26 to the Chair and Place Lead.

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:

None specifically.

Appendices

1. Draft terms of reference for the reconstituted Bradford District and Craven Partnership Board. 2. Indicative draft work plan for 2026/27.
Acronyms and Abbreviations explained
1. ICB – NHS West Yorkshire Integrated Care Board 2. SPA – Strategic Partnering Agreement

What are the implications for

Residents and Communities	Delegation arrangements support our commitment to meet the health needs of our residents and communities and are changing to support the transition to enable emergent Place Provider Partnerships
Quality and Safety	There are potential risks to the monitoring & escalation of quality and safety issues resulting from the stopping of the System Quality Committee at Place ahead of hand over to an alternative provision. This will need to be accounted for and any risks mitigated.
Equality, Diversity and Inclusion	The Board and Committees are required to consider the equality, diversity and inclusion implications of all decisions. No specific implications have been identified from this report.
Finances and Use of Resources	There are no specific financial implications arising from this report.
Regulation and Legal Requirements	Arrangements are designed to comply with regulation and legal requirements
Conflicts of Interest	The approach to conflicts of interest set out within the ICB Conflicts of Interest Policy, Standards of Business Conduct Policy, and within the Conflicts of Interest schedules appended to each partnership agreement.
Data Protection	There are no specific data protection implications arising from this report
Transformation and Innovation	There are no specific transformation or innovation implications arising from this report
Environmental and Climate Change	None identified

Future Decisions and Policy Making	Partnership agreements are designed to support agile decision making
Citizen and Stakeholder Engagement	Approach set in the ICB involvement framework and our act-as one Listen-In approach

Bradford District and Craven Health and Care Partnership

ACTasONE

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

Version control

Version:	3.1
Approved by:	NHS West Yorkshire Integrated Care Board (ICB)
Date Approved:	tbc
Responsible Officer:	~~Matt Sandford, Director of Partnership and Place, NHS WY ICB (BD&C)~~ Director of Integration (BD&C)
Date Issued:	1 July 2022
Date to be reviewed:	January 2027

Change history

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

Version number	Changes applied	By	Date
1.3	Changes to secretariat support and publication of approved minutes	Carrie Haywood	ICB Board to approve on the 25 June 2024
2.0	Annual review following end of year effectiveness self-assessment	Approved by Board	25.06.2024
2.1	Annual review following end of year effectiveness self-assessment and review of membership to reflect current membership	Catherine Smith / Lesley Tillotson / Matt Sandford	Reviewed by the BD&C Partnership Board on 23.05.2025 – recommended approval to the NHS WY ICB Board on 24.06.25
3.0	Annual review	Approved by the NHS WY ICB Board	24.06.2025
3.1	Reviewed ahead of 2026/27 transitional year	Sue Baxter	February 2026

Partnership Board Terms of Reference

1. Introduction

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

2. General

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

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

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

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

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

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

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

3. Remit and responsibilities

NHS West Yorkshire ICB's operating model and governance framework has changed to reflect the requirements of all ICB's to become Strategic Commissioners. Through 2026/27 transitional year decision making will continue to be discharged through ICB delegation and therefore Place Committees will continue to meet on a quarterly basis. They will run alongside evolving place provider collaborative governance.

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

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

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

Its responsibilities are to:

i. establish governance arrangements to support collective accountability between partner organisations for Bradford District and Craven Health and Care Partnership (Partnership) delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations
ii. agree a plan to meet the health, wellbeing and care needs of the population within Bradford District and Craven, having regard to the partnership's integrated care strategy and health and wellbeing strategies across Bradford District and Craven
iii. allocate resources to deliver the plan in Bradford District and Craven, determining what resources should be available to meet population need and underpinned by the partnership's financial and risk management principles (SPA schedule 5), for how they should be allocated across services and providers (both revenue and capital)
iv. arrange for the provision of health and care services in Bradford District and Craven in line with the resources allocated across the Integrated Care System (ICS), through a range of activities including:
    a) putting contracts and agreements in place to secure delivery of its plan by providers

b) convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes
c) support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships, including through investment in PCN management support, data and digital capabilities, workforce development and estates
d) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care

v. approve decisions on the review, planning and procurement of primary medical care services
vi. approve the operating structure for the Bradford District and Craven Health and Care Partnership
vii. agree implementation of the people priorities across the Partnership
viii. agree place action on digital, data, intelligence and insight: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care
ix. agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money in place and support wider goals of development and sustainability
x. develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within NHS West Yorkshire ICB and the Bradford District and Craven Health and Care Partnership plan
xi. develop arrangements for risk sharing and /or risk pooling with other organisations (for example pooled budget arrangements under section 75 of the NHS Act 2006), for approval by the NHS West Yorkshire ICB Board and the Councils
xii. Approve arrangements for senior / executive staff appointments (for PB and sub-PB level posts)
xiii. Agree clinical pathways, clinical thresholds, service specifications and service standards for matters that do not meet one or more of the '3 tests' for working at scale
xiv. Approve partnership-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.
~~xv. make arrangements to implement in place NHS West Yorkshire ICB and Partnership risk management arrangements~~
xvi. agree implementation in place of the arrangements for complying with the NHS Provider Selection Regime and
xvii. Approve place tenders and contracts
~~xviii. Review all strategic risks on the Place Board Assurance Framework and provide to the NHS WY Integrated Care Board on the management of these risks.~~

4. Membership

The Members of the Partnership Board are the:

- ~~independent chair of the BD&C Partnership Board~~
- ~~non-executive chair of the Finance and Performance Committee of the BD&C H&C Partnership~~
- ~~non-executive chair of the Quality Committee of the BD&C H&C Partnership~~
- ~~chair of the BD&C H&CP Clinical Forum~~
- ~~chair of the BD&C H&CP Citizens Forum~~
- ~~BD&C H&CP Partnership place lead (note this role is currently held by the chief executive of Bradford District Care NHS FT and is not an additional member of the Board for quoracy purposes)~~
- ~~Deputy accountable officer / Director of Partnership and Place of NHS West Yorkshire ICB (BD&C)~~
- West Yorkshire ICB Non-Executive Member - Chair
- ICB Director of Integration (BD&C)
- ICB finance lead
- ICB quality lead
- chair of the Clinical Advisory Board (PCNs)
- chair of the Local Medical Council
- chair of Airedale NHS FT
- chief executive of Airedale NHS FT
- chair of Bradford District Care NHS FT
- chief executive of Bradford District Care NHS FT
- chair of Bradford Teaching Hospitals NHS FT
- chief executive of Bradford Teaching Hospitals NHS FT
- chief executive of Healthwatch Bradford District
- chief executive of Healthwatch North Yorkshire
- chief executive of the City of Bradford Metropolitan District Council
- strategic director adult social care and health of the City of Bradford Metropolitan District Council
- strategic director children of the City of Bradford Metropolitan District Council
- director of public health of the City of Bradford Metropolitan District Council
- corporate director health and adult services of North Yorkshire Council
- director of public health of North Yorkshire Council
- chief executive of Bradford Care Association
- the chief executive officer of North Yorkshire Independent Care Group

- The VCSE sector lead for the Bradford District and Craven Health and Care Partnership
- senior representative of the VCSE sector in Craven
- Bradford University representative

5. Required attendees

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

- ICB Governance Manager
- ~~lead finance director of the BD&C Health & Care Partnership~~
- ~~director of quality and nursing of the NHS WY ICB (BD&C) (also holds the role of director of nursing at Bradford District Care NHS Foundation Trust)~~
- ~~strategic communications and stakeholder engagement lead of the BD&C Health & Care Partnership~~
- ~~associate director of partnership delivery of the NHS West Yorkshire ICB (BD&C)~~
- ~~head of partnership governance of the NHS West Yorkshire ICB (BD&C)~~

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

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

6. Deputies

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

7. Chair

[See **4. Membership** for selection of the Chair]
The meetings will be run by the chair. In the event of the chair of the Partnership Board being unable to attend all or part of the meeting, another WY Non-Executive Member ~~member of the Partnership Board~~ shall chair the meeting.

8. Quoracy

No business shall be transacted unless at least 50% of the membership (which equates to 13 individuals) and including the following are present - 1 WY non-executive member/ chair; at least 1 further ICB member; and at least 3 partner members.

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

For the sake of clarity:

a) no person can act in more than one capacity when determining the quorum
b) an individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum

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

9. Conduct of meetings

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

a. all members of the Partnership Board who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the committee are set out at section 4; attendees and observers do not have voting rights.)
b. absent members may not vote by proxy. Absence is defined as not being present at the time of the vote
c. a resolution will be passed if more votes are cast for the resolution than against it
d. if an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the deputy chair presiding over the meeting) will have a second and casting vote and

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

10. Frequency of meetings

The Partnership Board will meet quarterly. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to members of the Partnership Board.

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

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

11. Urgent decisions

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

a) powers which are delegated to the Partnership Board, may for an urgent decision be exercised by the Chair of the Partnership Board and the Director of Integration (BD&C) ~~Place Lead for Bradford District and Craven Health and Care Partnership~~ and
b) exercise of such powers shall be reported to the next formal meeting of the Partnership Board for formal ratification, where the Chair will explain the reason for the action taken, and the NHS West Yorkshire ICB's Audit Committee will be notified, for oversight.

~~12. Admissions of the press and public~~

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

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

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

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

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

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

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

13. Declarations of interest

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

14. Support to the Partnership Board

The Partnership Board's lead manager is the Director of Integration (BD&C) ~~Director of Partnership and Place / Deputy Accountable Officer~~ of the NHS West Yorkshire ICB ~~(BD&C).~~ Administrative support will be provided to the Partnership Board by officers of NHS West Yorkshire ICB. This will include:

- agreement of the agenda with the Chair in consultation with the Lead Manager, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward
- maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions
- agenda setting meetings to be scheduled between governance support / chair of meeting / lead director for meeting at least three weeks in advance of meeting
- Draft agenda to be issued to committee/board members and report authors two weeks before the deadline for papers
- sending out agendas and supporting papers to members five working days before the meeting
- drafting minutes for approval by the Chair and ICB Lead Manager within ten working days of the meeting
- chair/Lead Director to review and respond with any amendments within the next 5 working days
- draft minutes distributed to all attendees of the meeting following this – within one calendar month of the meeting (this applies to bi-monthly/quarterly meetings)
- minutes to be formally approved at the subsequent Committee/Board meeting
- an annual work plan to be updated and maintained on a quarterly basis

15. Authority

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

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

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

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

16. Reporting

- The Partnership Board shall submit its ratified minutes to each formal NHS West Yorkshire ICB Board meeting
- report within two weeks of the Partnership Board meeting to the NHS West Yorkshire ICB Board using the committee assurance report framework 'Triple A' (alert, advise and assure summarising key items at the meeting)
- provide the NHS West Yorkshire ICB Board meeting with a copy of the Partnership Board meeting forward plan annually
- the Chair shall draw to the attention of the NHS West Yorkshire ICB Board any significant issues or risks relevant to the ICB
- the Partnership Board's minutes will be published on the NHS West Yorkshire ICB website once ratified
- the Partnership Board shall submit an annual report to the NHS West Yorkshire ICB Audit Committee and the NHS West Yorkshire ICB Board and
- ~~the Partnership Board will receive for information the Triple A reports (alert, advise, assure) of other meetings which are captured in the Partnership Board workplan e.g. sub-committees.~~

17. Conduct of the Partnership Board

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

- any resulting changes to the terms of reference shall be submitted for approval by the NHS West Yorkshire ICB Board.

18. Amendments

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

19. Review Date

After 1 year.

Bradford District and Craven Health and Care Partnership

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NHS West Yorkshire Integrated Care Board

Bradford District and Craven Health and Care Partnership Board
2026/27 Work Plan

Item	Frequency	Purpose	Lead	Source	May 2026	Aug 2026	Nov 2025	Feb 2027
Opening Items:								
Welcome, introductions, apologies and quoracy	Each meeting	To note	Chair, WY NEM	Verbal	X	X	X	X
Declarations of interest		Update	Chair, WY NEM	Verbal and Link to register	X	X	X	X
• Draft minutes of the previous meeting for approval • Action log / matters arising • Previous Partnership Board triple A report		Approval	Chair, WY NEM	Paper	X	X	X	X
• Approve minutes of Bradford District and Craven Provider Partnership monthly meetings		Ratification	Director of Integration (BD&C)	Paper	X	X	X	X
Public questions		Information	Chair, WY NEM	Verbal	X	X	X	X
Focus items								
Financial and operational planning round 2026/27					X			
Financial and operational planning round 2027/28								X
Place-based Provider Partnership Self - Assessment Framework review of readiness for formal contracting arrangement							X	

Item	Frequency	Purpose	Lead	Source	May 2026	Aug 2026	Nov 2025	Feb 2027
WY ICB and Bradford District and Craven Place-Based Provider Partnership Contract Agreement for in-scope services, and governance arrangements							X	
Lynfield Mount Redevelopment (tbc)	Ad hoc	Recommend for support	Mike Woodhead, Chief Finance Officer, BDCFT	Paper				
Airedale New Hospital Programme (tbc)	Ad hoc	Recommend for support	Stuart Shaw, Director of Strategy, Planning and Partnerships, ANHSFT	Paper				
Any other recommendations for decision taking on service changes that may need to be considered	Ad hoc	Recommendations for approval using ICB Delegation	Director of Integration (BD&C)					
Governance and Assurance:								
Strategic Partnering Agreement	Annual	Assurance / approval	Sue Baxter, Head of Partnership Governance	Paper	X			
Governance handbook including Place-Based Provider Partnership ToR	Annual	Assurance / approval	Sue Baxter, Head of Partnership Governance	Paper	X			
Bradford District and Craven Health and Care Partnership Board Annual Report 2025/26 and 2026/27	Annual	Assurance / approval	Sue Baxter, Head of Partnership Governance	Paper	X			X
Approval of Annual Reports • System Finance and Performance Committee • System Quality Committee	Annual	Assurance / approval	Sue Baxter, Head of Partnership Governance	Paper	X			

Item	Frequency	Purpose	Lead	Source	May 2026	Aug 2026	Nov 2025	Feb 2027
Bradford District and Craven Risk Register and ICB Board Assurance Framework: Place close down report	One	Assurance / approval	Asma Sacha	Paper	X			
Closing Items:								
Any other business	Each meeting	Discussion	Chair, WY NEM	Verbal	X	X	X	X
Triple A Report to NHS West Yorkshire ICB Board		Discussion	Chair, WY NEM	Verbal	X	X	X	X
Date and Time of the Next Meeting		Information	Chair, WY NEM	Verbal	X	X	X	

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	6
Meeting date:	13 February 2026
Report title:	Listen in report
Report presented by:	Victoria Simmons, Senior head of communications and involvement, NHS WY ICB
Report approved by:	Matt Sandford, Director of Partnership and Place, NHS WY ICB
Report prepared by:	Victoria Simmons, Senior head of communications and involvement, NHS WY ICB

Purpose and Action

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

Previous considerations:

- Listen in – how what we are hearing is shaping our strategy, Presented at Partnership Board meeting May 2025
- What are we hearing from racially minoritised communities? Presented at Partnership Board meeting September 2025
- What are we hearing from White British working-class men? Presented at Partnership Board meeting November 2025

Executive summary and points for discussion:

Listen in is an ongoing approach to involvement across Bradford District and Craven, focused on listening to what matters to people in their own words and understanding how health and care is experienced in everyday life, rather than responding to predefined questions or proposals.

Over the past three years, Listen in has developed into a sustained programme of work, combining locality-based listening, focused conversations about access to care, deliberative approaches to difficult system decisions, and deeper engagement with communities of interest. Together, this work has supported a richer understanding of people's experiences across a diverse geography and population, and has helped shape how the partnership listens, learns and acts.

Across this period, a consistent set of themes has emerged. Access to care remains the most persistent concern, often experienced as systems that do not fit around people's lives. People also describe difficulty navigating a fragmented system, frustration with repeated retelling of their story, and the importance of being listened to and treated with dignity. Alongside these

challenges, Listen in continues to highlight the strength of informal networks, community organisations and trusted local spaces.

Listening across different places and communities has also made visible important variation. While some challenges are widely shared, others are shaped by geography, transport, local services, identity, stigma and trust. This reinforces the need for both universal improvement and targeted, relational approaches.

The report sets out how Listen in insight is being used alongside other evidence to inform decisions and action, including shaping access to primary care, informing service redesign and capital planning, supporting deliberative conversations about financial challenge, and grounding strategy through the use of population personas.

As this marks the final meeting of the Partnership Board in its current form, the report provides an opportunity to reflect on what has been built through sustained listening, and how these ways of working can be carried forward within slimmer governance arrangements. Looking ahead to integrated neighbourhood teams and the place provider partnership, it also invites reflection on how the Listen in approach could support organisational and workforce development, recognising the close connection between staff experience and population experience.

Board members are invited to:

- note the key themes emerging through Listen in over time
- reflect on how lived experience has shaped priorities, decisions and ways of working
- consider how the strengths of the Listen in approach can be carried forward as governance and structures evolve

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 the review of the Listen in programme

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

n/a

Appendices

1. Listen in, so what? Insights and impacts from three years of listening

Acronyms and Abbreviations explained
LGBTQ+ is an inclusive acronym that stands for Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), with the '+' representing other diverse sexual orientations, gender identities, and expressions. We use the term *racially minoritised communities* to emphasise that marginalisation is the result of social and systemic processes, rather than an inherent characteristic of the people or communities themselves. We purposefully avoid the acronym BAME (*Black, Asian, and Minority Ethnic)* because it groups together very diverse communities and experiences under one broad label, which can obscure important differences in culture, history, and health inequalities.

What are the implications for?

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

Bradford District and Craven
Health and Care Partnership

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Listen in So what?

Insights and impacts from three years of listening

January 2026

Contents

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

30 January 2026

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

1. About this report

This paper brings together learning from the Listen in approach to listening with communities across Bradford District and Craven, with a particular focus on what we continue to hear from people and how that insight is being used alongside other evidence to shape decisions, priorities and action across the health and care system.

Listen in was established as a different way of listening. Rather than asking people to respond to predefined questions or proposals, the approach focuses on being present in communities, listening to what matters to people in their own words, and understanding how health and care is experienced in everyday life. This way of working continues to generate live insight as the system changes and new pressures emerge.

Some board members will be familiar with individual Listen in reports or cycles. This paper does not repeat those in full. Instead, it:

- summarises the themes that continue to come through consistently
- highlights how issues show up differently across communities and places
- sets out examples of how listening is translating into tangible change for people, as well as shaping system thinking and planning

Throughout the report there are quotes from colleagues across the system, reflecting on how Listen in has shaped their work.

Over the past three years, the Listen in approach has evolved while remaining grounded in the same core principles. The method has stayed consistent – meeting people where they are, listening without a predefined agenda, and valuing lived experience alongside other forms of evidence. What has shifted over time is the focus of the work. Early cycles built a place-based understanding across localities; this was followed by deeper exploration of access to care, particularly general practice; and more recently by a focus on communities of interest and system-wide issues such as financial decision-making.

Together, these phases show how sustained listening can move from understanding experience, to shaping priorities, to influencing how decisions are made.

2. What we consistently hear

Across localities, communities of interest and deliberative conversations, Listen in continues to surface a remarkably consistent set of themes about how people experience health and care.

Access remains the most persistent issue people raise. This is rarely described simply as a lack of appointments. Instead, people talk about access systems that do not fit around their lives, work patterns, caring responsibilities, health conditions or confidence navigating services. From this perspective, access problems are often experienced as design failures rather than a lack of effort or demand.

People consistently describe difficulty navigating a fragmented system. They are often unclear where to go, who to contact, or how different services fit together. Repeated retelling of their story, inconsistent information and unclear responsibility contribute to frustration and disengagement.

Relationships matter more than process. People value being listened to, believed and treated as individuals. This applies both to interactions with services and to how the system shows up in communities. Trust is fragile, but can be rebuilt through presence, honesty and continuity.

Workforce experience and public experience are closely linked. Staff are often members of the same communities they serve, and pressures on staff show up directly in people's experience of care. There is significant untapped potential in listening more systematically to the workforce as part of understanding population need.

People want to be involved earlier, not informed later. There is a strong appetite for genuine involvement in shaping solutions, particularly where issues affect daily life.

Alongside challenges, Listen in also continues to highlight strengths within communities. People rely heavily on informal networks, trusted voluntary and community organisations, faith groups and local spaces. These assets are often central to wellbeing, prevention and resilience, even when statutory services are under pressure.

> *"People are genuinely happy to see and talk to us – people would often express their gratitude for their voice been heard – especially that senior leaders and staff members were coming out to listen to them and that we had no set questions or agenda other than hearing about their experiences."*

3. Insights from across the Listen in approach

Locality cycles

The locality cycles provide an ongoing, place-based understanding of how health and care is experienced across a large and diverse geography, from rural communities in Craven to inner-city neighbourhoods in Bradford.

Looking across the Listen in locality cycles, the themes people raise are often consistent, but they are not experienced evenly across Bradford District and Craven. The table below shows where themes were most prominent across different localities, highlighting both shared system-wide challenges and important geographical differences.

Some issues, such as difficulty accessing services, navigating a fragmented system, and the importance of human relationships, appear strongly across almost all localities, reinforcing their significance at system level. Other themes show greater variation, shaped by factors such as transport, rurality, deprivation, local service configuration and the strength of voluntary and community sector infrastructure.

Read together, these patterns underline why place matters. They help explain why people's experiences of health and care differ across Bradford District and Craven, and why neighbourhood-based and locality-sensitive approaches are essential alongside system-wide improvement.

Each detailed locality report is published online Listen in | Engage Bradford District & Craven

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

Ticks indicate themes that were prominent in each Listen in cycle; darker ticks are stronger themes; absence of a tick does not mean the issue was not present.

Thinking together about access to general practice

Across the first six locality cycles, access to general practice emerged as the most dominant and shared issue affecting people's experience of care. Rather than moving straight to service redesign, the programme deliberately paused to create space for a large-scale deliberative conversation focused on GP access.

The event brought together around 120 people, including local residents, frontline staff and senior leaders from across the partnership. Participants worked together as equals, with a conscious effort to set aside organisational roles and job titles. People were recruited through a mix of community groups met during Listen in visits, an external recruitment agency, and the local workforce, ensuring a broad mix of lived experience and perspectives.

The structure of the day was designed to move beyond complaint or consultation. Participants spent time understanding the pressures facing general practice, sharing lived experience, working together on the challenges, and developing and prioritising ideas for change. Importantly, the focus was not on asking people to endorse predetermined solutions, but on thinking together about what might make the biggest difference.

Feedback from the event showed strong experiential impact. Participants consistently reported that the process helped them understand the issue differently, moving away from blame and frustration towards shared problem-solving.

> *Before attending the event, 47% of people said they felt hopeful about the future of general practice: after the event, 72% said they felt hopeful.*

Communities of interest

Following the locality cycles, the Listen in approach shifted to focus on communities of interest. This reflected a concern that returning to the same places without visible change risked undermining trust, and that some voices were still less likely to be heard through place-based work alone.

Across all communities of interest, people described many of the same system challenges identified through the locality cycles, particularly around access, navigation, trust and continuity. However, listening in this way made visible how these issues show up differently in people's lives, and how identity, stigma and experience shape whether and how people engage with services.

Children and young people

Children and young people spoke most strongly about **mental health and emotional wellbeing**, with many describing long waits for support and a sense that services often respond too late, once difficulties have escalated. School was frequently described as both a source of support and pressure.

Young people also talked about **not being taken seriously**, particularly when concerns were dismissed as "just a phase" or when transitions between services felt abrupt and poorly explained. Digital access was often seen as positive, but only when it felt responsive and human rather than transactional.

Alongside challenges, young people highlighted the importance of **trusted adults, peer support and safe spaces**. Where relationships were strong, engagement and confidence were noticeably higher.

Inclusion health groups

People within inclusion health groups, particularly those with experience of the criminal justice system, described facing **multiple, overlapping barriers** to accessing health and care. Challenges included difficulty navigating fragmented services, inconsistent support during transitions (such as release from prison), and experiences of stigma or judgement when seeking help. Mental health needs were frequently intertwined with substance use, trauma, and unstable housing, with delays in access often leading to crisis-point use of services such as A&E. Trusting relationships, **trauma-informed practice**, and continuity of support were consistently highlighted as critical enablers of engagement, alongside the vital role of peer support, navigator services, and community-based organisations in helping people to access and stay connected to care.

Disabled people

Disabled people described a system that often feels **fragmented and exhausting to navigate**, with repeated assessments, inconsistent adjustments and a lack of coordination between services. Many spoke about having to continually explain their needs and advocate for themselves, which was emotionally and practically draining.

Access issues were not limited to physical environments, but included communication, appointment systems and assumptions about capability. People described the impact of services being designed around “average” users, rather than a range of needs.

At the same time, disabled people emphasised their **expertise in their own lives** and the value of being listened to early, rather than only when things go wrong. Trusted relationships with individual staff or organisations made a significant difference to experience.

LGBTQ+ communities

LGBTQ+ participants spoke about **fear of judgement and discrimination** shaping how and when they seek help. Many described actively weighing up whether it felt safe to disclose aspects of their identity, and the emotional labour involved in explaining themselves repeatedly.

Mental health support was a recurring theme, alongside frustration at services that felt fragmented or poorly equipped to understand LGBTQ+ experiences. Participants also described gaps in knowledge and confidence among professionals, which could undermine trust even when intentions were positive.

Community organisations and peer networks were consistently identified as **critical sources of support**, often providing safety, understanding and continuity that statutory services struggled to offer.

Women (women’s health movement insight)

Listening through the women’s health movement highlighted gaps across the life course, particularly in **perinatal, reproductive and menopause support**. Many women described not knowing what support was available, or only accessing help once difficulties had become severe.

Loneliness, isolation and cost of living pressures featured strongly, especially for new mothers and carers. Language, literacy and cultural barriers further shaped access for some women, compounding existing inequalities.

Alongside challenges, women spoke about the strength of **informal networks, community spaces and peer support**. Where services worked with these assets, engagement and trust were noticeably stronger.

Racially minoritised communities

Participants from racially minoritised communities described **structural and cultural barriers** to accessing care, including language barriers, lack of culturally appropriate support and experiences of not being listened to or believed.

Stigma around certain conditions, particularly mental health, influenced help-seeking behaviour. People often relied on family or community networks first, approaching services only when issues had escalated.

Trust was shaped by both individual interactions and wider system behaviour. Where relationships with community organisations were strong, these acted as vital bridges between people and services.

White British working-class men

White British working-class men often described **disengagement from services until crisis point**, with help-seeking framed as a last resort. Many spoke about services not feeling relevant, welcoming or designed with them in mind.

Traditional masculine norms influenced how health concerns were managed, particularly around mental health. Informal settings, such as workplaces, community venues or social spaces, were often seen as more comfortable places to talk.

Participants valued being approached **without an agenda**, and many commented on the novelty of being listened to in this way. This cycle highlighted the risk of missing significant need when engagement relies on the same groups and settings repeatedly.

Common challenges, shaped by identity

Across all communities of interest, people described many of the same underlying challenges: difficulty accessing services that fit around their lives, navigating a fragmented system, and feeling unheard or judged. What differed most sharply was how these challenges were experienced, shaped by identity, stigma, life circumstances and trust in services.

Listening in this way made visible needs and barriers that are less apparent through place-based work alone, reinforcing why a single approach cannot reach everyone and why different forms of listening are essential to understanding population experience.

Each detailed community of interest report is published online Listen in | Engage Bradford District & Craven

What are we hearing from …?	Children & young people	Inclusion health groups	Disabled people	LGBTQ+ people	Women	Racially minoritised people	White British working-class men
Healthcare access– systems not designed around people	✓	✓	✓	✓	✓	✓	✓
Cost and difficulty of transport as barrier to healthcare	✓	✓	✓		✓	✓	✓
Challenges of navigating a fragmented system		✓		✓	✓	✓	
Mental health and emotional wellbeing	✓	✓	✓	✓		✓	✓
Stigma shapes health-seeking behaviour		✓		✓	✓	✓	✓
Not feeling heard or taken seriously	✓	✓			✓		✓
Fear of judgement or discrimination	✓	✓		✓		✓	
Late presentation or crisis-point access		✓		✓		✓	✓
Disengagement or distrust of statutory services	✓	✓				✓	✓
Importance of human relationships in healthcare	✓	✓	✓	✓	✓	✓	✓
Reliance on informal sources of support		✓		✓		✓	✓
Gendered or identity-based expectations	✓			✓	✓		✓
Community strengths and peer support		✓	✓			✓	

Ticks indicate themes that were prominent in each Listen In cycle; darker ticks are stronger themes; absence of a tick does not mean the issue was not present.

Closing the Gap: difficult financial decisions

Alongside the Listen in cycles, the partnership has used deliberative approaches through the Closing the Gap work to support open and honest conversations with residents and the workforce about the scale of financial challenge facing the local health and care system and the difficult decisions this creates.

This work shows that when people are trusted with complexity and uncertainty, they are willing to engage constructively with questions about prioritisation, sustainability and trade-offs. Participants consistently emphasised the importance of transparency, clear principles and protecting core services, while also recognising the need for prevention, early intervention and care closer to home.

The use of Listen in personas within these conversations helped anchor abstract financial discussions in real lives, reinforcing the importance of keeping people's lived experience visible when making system-level choices.

Bringing data to life

Bringing together qualitative insight with population health data has supported a more rounded and timely understanding of need across Bradford District and Craven through the development of population personas, which draw directly on what people have told us through Listen in. The personas are now used across the system to test thinking and support decision-making.

> *"The personas have resonated strongly with people. They keep 'real' people at the front of our minds."*

Our personas are published on our partnership website alongside our strategy: Our strategy - Bradford District and Craven Health and Care Partnership

4. How listening is translating into change

Listen in is designed to support action as well as understanding. Our published report 'How we Act on What We Hear' from 2024 set out detailed examples of impact: Listen in | Engage Bradford District & Craven

The recent examples below illustrate how listening is continuing to inform tangible changes for people, alongside shaping system thinking and planning.

These examples do not imply that changes were made solely because of Listen in. In most cases, insight reinforced existing concerns, added confidence to decisions, or helped shape how issues were framed and addressed.

Focus on people's experience of accessing GP services
Across locality cycles and deliberative work, Listen in continues to surface access to general practice as a central issue. This insight informed the decision to align the Innovation Hub programme with primary care, creating space to test practical changes that respond to what people have said matters most.

The Innovation Hub programme has been independently evaluated by University of Bradford, and its report cites the importance of the evidence base generated through Listen in as a key success factor.

> "Listen in identified a clear system priority […] the Innovation Hub selected this as an area in which to innovate […] Engagement in the Hub initiatives was high and the view of those participating was that it was of value and would improve experiences for staff and patients longer term. The interventions chosen for innovation were addressing live and direct challenges and issues for staff, and so they could see the benefit of taking action to try and improve things. This was an important outcome for progress, sustainability and spread."

As well as supporting specific interventions, the Innovation Hub's focus on primary care led to the creation of a community of practice for 'primary care through a community lens'. This is a collaborative space where professionals learn and connect to make improvements in their practices and PCNs. Insights and learnings from Listen in have continued to feed in directly to the community of practice, providing ongoing opportunities for teams to reflect and test ideas:

> "Many spoke of how it led them to look at things differently and even to change practice:
>
> *'I won't speak for anyone else, but I'm a doctor. There's a tendency to think that you're doing it the right way and to be quite kind of married to that view. And I think this sort of work opens up possibilities that there is another way that may also be right or may be best. May even be better.'*

> *'As a GP, you know, […] it's so hard. And actually being in a group like that and being connected to the outside world, that perspective is incredible. And you'll hear stories about patients. Well, I've never had that.'*

Read more in blogs from the Community of Practice: Primary Care through a community lens Archives - Bradford District and Craven Health and Care Partnership

Testing and improving access in primary care (Five Parks PCN)
Five Parks PCN were active partners in the Innovation Hub programme, with the team getting alongside practices to develop and test three interventions to respond directly to the issues surfaced through the Listen in deliberative work:

- joint GP and social prescriber appointments
- work to improve flow and navigation at the point of contact
- support to move towards a total triage model.

As assumptions were tested, approaches were adapted in response to observation and feedback, leading to clearer routes to care, reduced confusion for patients and better use of the wider practice team.

Cancer screening and diagnostics closer to home
Listening reinforced what people told us about practical barriers such as travel, cost and accessibility. This insight is reflected in mobile lung health check provision, relocation of breast screening services, reasonable adjustments for people with learning disabilities and autism, and pilots addressing transport and screening processes.

> *"Knowing we needed to reduce travel barriers made us revisit what we could deliver locally."*

Shaping the Airedale New Hospital Programme
Listen in insight is actively informing the Securing the Future programme and planning for the new Airedale hospital. Reviewing Listen in themes alongside the programme's own engagement helped test assumptions and ensured planning reflects the needs of a diverse population.

> *"There are so many real examples of where Listen in insight has helped shape thinking, decisions or action. […] It got to the voices we often exclude. […] It's hard and time-consuming to do this properly."*

Concrete impacts include decisions about extended outpatient and diagnostic hours, planning of a Keighley hub to reduce travel barriers, increased use of mobile delivery models, inclusive digital design with alternatives for those who are digitally excluded, and hospital environments designed with accessibility and sensory needs in mind. Insight about hospital-to-home transitions, mental health crisis support and staff wellbeing is also shaping both hospital design and out-of-hospital pathways, with some improvements expected to be felt before the new hospital opens.

Using Listen in insight at Bradford Teaching Hospitals

Bradford Teaching Hospitals is using Listen in insight to strengthen both strategic planning and the early development of capital proposals. Rather than repeating engagement or asking communities the same questions in different ways, the Trust has drawn on existing Listen in learning to inform its thinking.

For example, in the early exploration of a potential *Health on the High Street* facility in Bradford, Listen in feedback was used to understand what services people would value in a high street location, and how a city-centre offer might help address some of the access barriers people have described.

Listen in reports – particularly the summary of what people have told us they want from acute care – are also informing the Trust's five-year Integrated Delivery Plan, supporting planning that reflects lived experience alongside other evidence.

Perinatal support through Maternity Circles
Listen in events with new parents highlighted loneliness, cost of living pressures, maternal mental health and barriers to accessing support. In response, Maternity Circles were developed in accessible community locations, targeted using both lived experience and data, and delivered with voluntary and community sector partners. This translated listening into practical support that reduces isolation and improves access for families least likely to engage with traditional services.

Inclusion health and criminal justice experience
Listen in cycles with inclusion groups, including people with experience of the criminal justice system, informed the district's inclusion health needs assessment. Listening confirmed gaps in engagement, stigma-related non-disclosure and the wider impact on families. This insight is reflected throughout the needs assessment, strengthening understanding of how services can better reach people who are often missed.

> *"There was very little to no engagement with this group before. These needs don't systematically get flagged or disclosed due to fear or stigma. Listen in helped us see the wider picture, including the impact on families."*

Shaping strategy and decision-making culture
Across the system, Listen in insight continues to be used alongside quantitative data to shape strategic planning. Personas developed through Listen in are now used routinely to test strategy, inform scrutiny discussions and support transformation planning, helping shift conversations from abstract service debates towards the lived experience of people and communities.

> *"When writing our plan I am careful to always come back to our population and our people. This was aided by all the Listen in reports and the development of the personas. It was commented on by the WY ICB Chair how focused on people it was."*

5. Listen in – what next?

Over three years, Listen in has shown the value of investing in a sustained listening programme, building understanding, trust and insight across the system. Its strength lies not only in what has been heard, but in how the listening has been done – through time, presence and skilled facilitation. As the system reflects on the next phase of this work, there is an opportunity both to recognise what has been achieved and to consider what is needed to maintain the depth and quality of listening that has made the approach effective.

Listen in consistently reaches people who are least likely to engage through formal consultations or standing forums and brings senior leaders into direct contact with lived experience.

As the system enters a period of significant organisational and financial change, there is a choice to be made about whether this way of listening continues to be resourced, adapts to new partnership arrangements, or is allowed to fall away.

As integrated neighbourhood teams and the place provider partnership take shape, the system will require significant organisational and workforce development. New ways of working will depend not only on structures and plans, but on trust, shared purpose and the everyday experience of staff across organisations.

To date, Listen in has focused primarily on hearing from our population. The partnership has previously expressed interest in a Listen in cycle focused on hearing directly from our workforce. While organisational change and capacity constraints have limited the ability to take this forward, the case for listening in this way is becoming stronger rather than weaker.

There is an opportunity to consider how the principles and methods of Listen in could support the organisational and workforce development needed in the next phase of system change – creating space to listen to teams, understand pressures and opportunities on the ground, and support change that feels owned, credible and sustainable. Investing in listening to our workforce, alongside continued listening to our communities, may be an important enabler of the culture, relationships and ways of working that future models of care will depend on.

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Health and Care Partnership Board
Agenda item no:	7
Meeting date:	13 February 2026
Report title:	Place Lead's Update
Report presented by:	Therese Patten, Place Lead for Bradford District and Craven (BD&C)
Report approved by:	Matt Sandford, Director of Partnership and Place / Deputy Accountable Officer, WY ICB (BD&C)
Report prepared by:	Victoria Simmons, Senior Head of Communications and Involvement, WY ICB (BD&C)

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. BD&C Bradford District and Craven
2. DHSC Department of Health and Social Care
3. NHSE NHS England
4. ICB integrated care board
5. NNHIP National Neighbourhood Health Implementation Programme
6. ABCAS Airedale and Bradford collaboration of acute services
7. CQC Care Quality Commission
8. MNVP Maternity and Neonatal Voices Partnership
9. CQC Care Quality Commission
10. ILACS Inspecting Local Authority Children's Services

National context and policy development

Industrial action

Recent national developments indicate that resident doctors (formerly junior doctors) in England have overwhelmingly voted to extend their mandate for industrial action for a further six months as part of ongoing negotiations with the government on pay and roles, with a strong “yes” vote in the re-ballot. This renewed mandate gives the British Medical Association continued authority to call strike action during this period, though it does not itself confirm specific planned strikes.

Negotiations between national representatives and government continue, with both sides indicating a willingness to find a resolution and avoid further service disruption. Local systems will continue to monitor the national position, engage with staff where appropriate, and plan operational mitigations should industrial action be announced.

National organisational change updates

The Department of Health and Social Care (DHSC) and NHS England (NHSE) merger timetable has now been published. A new target operating model is being developed and is expected to be published by the end of May 2026. The DHSC plans to launch a 45-day consultation from October on the detailed design proposals for the new DHSC and on any potential future downsizing. This operating model will be aligned with both the Model Integrated Care Board (ICB) and Regional Blueprints, both of which have changed over time, as new information has come to light or decisions on changes reversed.

Both DHSC and NHSE have already started to manage their own resizing separately, reflecting the aim of reducing the collective workforce by around 50 per cent. It has been confirmed that the process is not a merger but creating a new DHSC. It looks likely that this will become a reality some time in 2027/2028.

West Yorkshire ICB

Leadership update

In December, Rob Webster CBE, Chief Executive of NHS West Yorkshire Integrated Care Board and Lead Chief Executive of the West Yorkshire Health and Care Partnership, informed colleagues of his decision to step down from his role during 2026. After more than 35 years in health and care leadership, including over a decade leading the West Yorkshire partnership, Rob indicated that this decision reflects the organisation’s transition into a new operating model and his intention to take a break from NHS leadership.

Following the departure of Cathy Elliott, Professor Nadira Mirza has been serving as Acting Chair. Interviews for the substantive ICB Chair have now been completed,

and the ICB is working with NHS England on the next steps in the appointment process. This includes approval through the NHS England Regional Leadership Group, endorsement by the NHS England Chair, and final approval by the Secretary of State for Health and Social Care. Confirmation of the appointment is expected to take several weeks, and an update will be provided once the process is complete. The ICB will also shortly begin recruitment for three Non-Executive Member roles, as a number of current terms come to an end. This is to ensure continuity, with new appointments expected to commence from 1 April 2026. The recruitment process will seek candidates from a wide range of backgrounds to support a diverse and effective Board.

ICB organisational change update

The first cohort of colleagues leaving under the voluntary redundancy (VR) scheme will begin to exit the organisation shortly. The final leaving date for staff approved in round one of the scheme is 30 April 2026, with the majority of departures expected to take place by the end of March 2026. More than 250 applications were approved in the first round of the scheme.

A formal consultation with staff commenced on 14 January 2026. This consultation covers the proposed organisational structures, including job descriptions, the appointments to post process, the implications for office bases, and changes to first and second on-call arrangements. The consultation period will run for 45 days and conclude on Friday 27 February 2026.

Subject to the outcome of the consultation, final structures are expected to be confirmed in mid to late March 2026, with the appointments to post process commencing in April. The appointments process is currently expected to continue into the summer.

Place Accountable Officers have arranged a series of briefings with system partners to provide an overview of the consultation proposals and emerging structures. These discussions are intended to support shared understanding as work progresses to establish place provider partnerships and clarify the future allocation of responsibilities and functions.

The ICB Executive Management Team met this week to consider transitional arrangements as the organisation moves towards its future operating model. In light of colleagues leaving through voluntary redundancy and a number of resignations since March 2025, some teams and functions are experiencing increased capacity pressures.

As a result, interim arrangements will be required in some areas. This may include functions working in a more consolidated way earlier than originally planned,

balancing place-based and West Yorkshire-wide priorities, while also laying the groundwork for the future operating model.

Bradford District & Craven Partnership

Trust Chair changes

In order to support the wider system, Sarah Jones has been appointed to the Chair role at Airedale NHS Foundation Trust from 1 February 2026 and from 1 March as Interim Chair in Common with Bradford District Care NHS Foundation Trust. As a result, she will step away from day-to-day involvement with Bradford Teaching Hospitals NHS Foundation Trust and Karen Walker, Deputy Chair for Bradford Teaching Hospitals NHS Foundation Trust, will take over the role of acting chair.

Place Provider Partnership development

Partners across Bradford District and Craven have agreed to form a formal Place Provider Partnership, marking a significant step forward in strengthening how organisations work together to deliver joined-up care. Chief executives and sector leaders are now actively working together to design the partnership, with a shared ambition to improve outcomes for local people, tackle inequalities, and make better use of collective resources. This work builds on existing collaboration but moves it into a more formal, accountable arrangement.

Good progress has been made in shaping how the partnership will operate in practice. Six core workstreams are under way, covering leadership, governance, finance, resourcing, clinical leadership, and delivery capacity, with the aim of establishing a shadow provider committee by April 2026. This shadow year will allow partners to test decision-making arrangements, strengthen relationships, and prepare for formal operation from April 2027, while continuing to work closely with the ICB during the transition.

Key next steps focus on moving from design to delivery. This includes agreeing which services and budgets will transfer into the partnership, finalising governance arrangements, completing a readiness self-assessment, and setting out clear decision-making routes. This work is essential to ensure the partnership is ready to take on greater responsibility as the ICB’s role evolves, and to support the delivery of neighbourhood health and other shared priorities in a more coordinated and sustainable way.

Strategy Delivery Groups

The three Strategy Delivery Groups continue to make steady progress in shaping and delivering shared priorities across the partnership, reporting to Place Oversight Executive through regular highlight reports.

Integrated Neighbourhood Health
Work is progressing to put the right structures in place to support integrated neighbourhood health across Bradford District and Craven. Most neighbourhood teams now have agreed boundaries (86%), with the remaining areas on track to be confirmed by February, and teams in the National Neighbourhood Health Implementation Programme **(**NNHIP) areas are already delivering practical support for defined population groups. While some activity has been slowed by ICB capacity pressures, partners are actively exploring how additional support can be provided, and engagement remains strong, with well-attended workshops, positive feedback from across health and care, growing national interest in the work, and new joint arrangements in place to support future neighbourhood estates development. Minal Bakhai, NHS England Director for Primary Care and Community Transformation and the NNHIP, is visiting Bradford in March 2026 to see how our NNHIP work is progressing.

Corporate Services and Closing the Gap
A well-attended visioning session on 7 January brought together partners for open and constructive discussion, resulting in a shared understanding of the programme's purpose and the need to strengthen financial sustainability, resilience and collaboration across corporate services. Participants reflected on lessons from previous shared services initiatives and agreed that any future approach must be benefit-led, carefully managed, and focused on standardisation, automation and modernisation to improve quality and efficiency. The session also established early design principles, including protecting locally valuable roles while pooling more transactional services, and set clear expectations for continued open engagement and learning from other systems.

Integrated Acute (ABCAS)
Good progress is being made across the programme, with project prioritisation completed for 18 specialties and detailed plans now being developed for the first phase. Additional capacity has been secured through KPMG to maintain momentum and align delivery with national timescales, and a quality and equality impact assessment has been drafted and is due for sign-off later this month. Alongside this, agreement has been reached on next steps for collaborative working in stroke, midwifery and radiology/MSK, and demand and capacity modelling is under way in ENT, max fax and ophthalmology to improve use of theatres and outpatient clinics.

CQC rates Bradford maternity services as 'Good'
Bradford Royal Infirmary's maternity services have achieved a 'Good' rating from the Care Quality Commission (CQC) following an unannounced full inspection carried out in September 2025.

The CQC found the services were well-led, were responding to the needs of the communities they serve and demonstrated evidence of a commitment to continuous

improvement. The report highlighted how people working in the services are working hard to learn from the experiences of families accessing maternity care.

The report has highlighted most mothers and babies received good care and had complimentary feedback to give on their birth experiences. This included support provided in a timely manner and the use of an electronic interpreting tool available in different languages to ensure any information given to women and their families was accessible. Inspectors also recognised the focused efforts being made to improve outcomes for women, especially considering deprivation level and ethnic background which can often impact negatively on birthing experiences.

Update on the National Maternity and Neonatal Investigation
Baroness Amos and her team visited perinatal services at Bradford Teaching Hospitals NHS Foundation Trust on 1 and 2 December 2025. The team met with families, co-ordinated by the Maternity and Neonatal Voices Partnership (MNVP) Lead, received a presentation from the senior leadership team and executive colleagues, toured the clinical areas, and held staff forums. There was no service-related feedback which was as expected, and no immediate safety concerns were escalated as part of the visit. The service has responded to data requests providing evidence, that was submitted on 15 January 2026, following the initial site visit. The Trust expects the outcome of the national review to report back its findings in spring 2026.

Lynfield Mount redevelopment
Plans to redevelop Lynfield Mount Hospital have been approved, enabling significant investment to modernise mental health inpatient facilities in Bradford. The redevelopment will improve the quality, safety and dignity of care for patients, including better therapeutic spaces and upgraded wards, while supporting staff to deliver care more effectively. This marks an important step in strengthening local mental health services and responding to long-standing estate and capacity challenges. Lynfield Mount Hospital given green light for redevelopment - Bradford District Care NHS Foundation Trust

Local Authority Children's Services (ILACS) inspection
The Ofsted Inspection of Local Authority Children's Services or ILACS took place in the Bradford district from 12th January 2026. The focus is on the effectiveness of local authority services, leadership and arrangements. Colleagues from across health services supported the process. The final report should be received later in February. Information about ILACS: Inspecting local authority children's services - GOV.UK A joint CQC/Ofsted reinspection of SEND services is anticipated for Bradford District soon.

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	8
Meeting date:	13 February 2026
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, West Yorkshire ICB

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

Previous considerations:

N/A

Executive summary and points for discussion:

The Clinical and Professional Forum 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. They are presented to the Partnership Board for assurance purposes and to allow committee chairs to alert the Board to any significant risks and asks. There will be a verbal update from the System Finance and Performance Committee.

Outline how this supports our partnership vision and strategy

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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 recent meetings of the Clinical and Professional Forum and System Quality Committee, and a verbal update from the System Finance and Performance Committee.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
N/A
Appendices
1. Clinical and Professional Forum 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: Bradford district and Craven Clinical Forum

Dates of meetings: 12th November 2025 and 14th January 2026

Report to: Bradford district and Craven Partnership Board

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

Date of Partnership Board: 13 February 2026

Key escalation and discussion points from the meeting
Alert:
N/A
Advise:
Future Role of Clinical & Professional Forum – a development session took place on 12th November 2025. The session explored the future role of a Clinical and Professional Forum within a changing governance system. There was agreement that a focused, system wide clinical forum is still needed to provide strategic insight, challenge and assurance, beyond individual clinical representation on other boards. Its value lies in thinking boldly about whole system models of care, influencing major transformation programmes and providing clear clinical challenge within agreed system parameters. Further discussions were held on 14th January 2026 with a view to potential options for the forum moving forward after April 2026. **Local Enhanced Service**- the Forum received an update on the current position regarding Local enhanced services as at 14th Jan 2026. This provided an opportunity for discussion and comment on the proposed scheme. **Clinical Pathway Reference Group**- the Forum discussed an establishment of a clinical pathway reference group to provide system wide governance and assurance over the prioritisation, development, approval, implementation and review of clinical pathways. The group will support consistent, evidence based pathways that improve patient outcomes, reduce unwarranted variation and avoidable demand on health and care services, strengthen prevention and shift appropriate care into community and primary care settings.
Assure:
N/A

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven System Quality Committee

Date of SQC meeting: 8th January 2026

Report to: Bradford district and Craven Partnership Board

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

Date of Partnership Board: 13th February 2026

Key escalation and discussion points from the meeting
Alert:

Primary Care

- **Patient Welfare Checks -System significant event -** Recent incidents highlight inconsistent support from police and Yorkshire Ambulance Service (YAS) for patient welfare checks, creating significant gaps in safeguarding vulnerable patients and increasing risk across primary and secondary care. YAS will work towards a system wide coordinated approach.
- **Leeds Teaching Hospitals NHS Foundation Trust (LTHFT) Pathology Service-** ongoing issues within the LTHFT pathology service driven by Laboratory Information Management System (LIMS) rollout and service relocation is generating uncertainty around result reliability and communication with practice. Clearer assurance, structure incident reporting and improved coordination between LTHFT, ICB and affected practices are needed. Reducing concerns relating to the service. It is unclear of the volume of results affected to date; however, GP's have been escalating concerns to the Trust as requested via LTHFT with follow up from the Quality team at B&C ICB. Corrective actions are being coordinated through weekly meetings chaired by LTHFT and attended by ICB Primary care colleagues.

Bradford Teaching Hospitals NHS Trust (BTHFT)

- **Summary Hospital-level Mortality Indicator (SHMI)** - has decreased but specific issues have been identified that are impacting the accuracy of the data, such as 'hidden' activity going unrecognised, erroneous recording, and ward attenders admitted as inpatient activity. A clinical coding transformation plan has been developed to address the issues and improve data integrity, operational efficiency and benchmarking.

Bradford Metropolitan District Council (CBMDC)

- **Large Residential/Nursing Home - Bradford North-** Weekly visits by ICB and CBMDC continue. The latest enhanced monitoring visit identified significant issues, prompting a joint plan with the ICB for ongoing visits through to year-end. The next visit will focus on medication management, followed by a review of handover systems, both high-risk areas. Since this update the service is

demonstrating improvements. Ongoing system quality oversight continues but sustained positive progress evident.

- **Supported Living LD/Home support provider-** All services are now under embargo, and enhanced monitoring is being carried out twice monthly. The provider has begun implementing governance improvements, and monitoring visits will continue to ensure sustained progress. The ICB have provided clinical LD support.
- **ASC Overall-** system partners continue to work together to respond when concerns arise to ensure the safety of residents. The sector continues to require a significant amount of system resource.

Airedale NHS Foundation Trust

- **Maternity-** the Trust did not meet the 90% threshold for compliance for Saving Babies Lives; however, evidence has been submitted this month which will provide compliance going forward. Oversight is provided through the WY Local Maternity Neonatal Services (LMNS) and Place Perinatal Quality Surveillance Group

Advise:

Primary Care

- **IT System performance issues –** Following the Windows 11 Upgrade, widespread IT performance issues have disrupted clinical workflows and drawn public and press attention, highlighting vulnerabilities in system resilience. Strengthened governance of IT changes, improved contingency planning, and transparent communications are essential to maintain service continuity and patient confidence. Reports highlighting issues and risks continue to be discussed to ensure future work and planning includes identified learning.

Public Health

- **Flu update-** An early start for the season with a different strain. Hospitals and GPs particularly Airedale are seeing high numbers of cases reflecting both increase in demand and delayed discharge. The main public health recommendations are to vaccinate all eligible and stay home if flu symptoms and unwell. Low vaccine uptake and high hospital attendance are consistent with trends from previous years. Concerns that the strain would lead to a significantly different flu season behaviour have not materialised. Catch up vaccination sessions are being offered in January in Undercliff and Horton Park Health Centres
- **Local measles outbreak**- An outbreak linked to unvaccinated children is still ongoing. There are 11 confirmed cases so far, 9 linked to a same primary school (BD6) where MMR catch up sessions were already offered. Cases include one baby who was hospitalised. Affected families maintain vaccine hesitancy despite vaccine offer.
- **Community acquired infections-** ongoing issues regarding community acquired infections and uncertainty about who leads on community Infection Prevention Control reviews at Place level following organisational changed. No nominated lead since BDC Health and Care Partnership Director of Systems Transformation left, which has resulted in a gap in health protection governance.

Since SQC met the Associate Director of Nursing and Quality has met with LA colleagues to discuss delivery of system IPC functions, barriers to the achievement of these, explore options for improvement and ensure robust understanding and management of risks and impact.

Bradford Teaching Hospitals NHS Trust (BTHFT)

- **Care Quality Commission-** Unannounced inspections have taken place for AED, Community Hospitals (Westwood Park, Westbourne Green) during September 2025 and October 2025. Well Led assessment has taken place November. Reports are awaited.

Bradford District Care NHS Foundation Trust (BDCFT)

- **Staffing and Service Challenges:** Children's services are undergoing management reorganisation, with mitigations in place for team-specific challenges. Friends and Family Test scores remain high (95.79%), though targeted work which was underway to address areas of lower engagement and improve patient experience through digital innovation.

System Quality Insight, Assurance, Improvement Group (SQIAIG)

- **Manorlands Hospice-** System partners have recently been notified of the introduction of active bed management due to inpatient nursing and medical during December 2025 and January 2026. The interim period of active bed management leads into a short closure of the inpatient unit from 19 January 2026 until 1 February 2026 due to mandated fire-safety works. Since SQC received this update, no impacts have become apparent with the situation closely monitored at weekly system Surge and Escalation meetings
- **Concerns re Dental Practice-** The ICB dental team and place quality team are working with system partners including CQC and Public Health following concerns relating to a single-handed dental practice. ICB safeguarding colleagues are involved. The site is currently closed with dental cover being provided elsewhere. Scoping of any potential risk to patients has occurred and it has been agreed that there is currently no indication for patient recall. Since SQC met ongoing visits and support continued including WY Dental Clinical Advisor with improvement evident and the provider remained engaged. CQC were active positive system partners and conducted a follow up announced visit. The report is awaited however CQC felt the practice was now safe and well led. System partners agreed that the practice could re-open with some modifications and close ongoing support, oversight and monitoring planned. This was a positive outcome, and all partners were keen to support improvements due to the health inequalities impacting on the need of the population the practice served.
- **Fire in a nursing home**- On December 20, 2025, a fire at a nursing home in Craven led to the urgent relocation of over 40 residents to six other facilities within Bradford District & Craven, one resident is hospitalized, potentially for unrelated health issues. North Yorkshire County Council (NYCC) is coordinating regular updates and reviews regarding the residents and incident responses with independent providers and system partners. Potential impacts affecting system partners such as Primary Care, Local Authorities, Emergency Services, and Quality and Commissioning in Local Authorities and ICBs. The situation continues to be managed with all residents safe and well and a System Learning Lessons is planned.

- **Cygnet-**Recent changes in management arrangements across Cygnet services (Wyke, Bierley, Brighouse) have been implemented to support workforce wellbeing and service continuity. Despite some short-term leadership movement, services across the footprint remain stable, with appropriate interim cover in place where required. The WY Consolidated Host Commissioner and Place Quality Leads maintain supportive oversight.

Assure:

Primary Care

- **CQC report for Valley View Surgery-** have been rated as 'Requires Improvement' Overall. Report Published 25.10.25. Ongoing support offered and has been arranged by ICB BDC Primary Care and Quality Team.
- **Primary Care IT Outage Investigation Report**- outcomes from the review of systems and processes were presented to BDC System Quality Committee (SQC) in January 2026 by colleagues from WY Central Emergency Preparedness Resilience and Response (EPRR) and IT, including corrective and preventive actions and lessons learnt.

Bradford Teaching Hospitals NHS Trust (BTHFT)

- **CQC report (published November 2025) -** has rated **maternity services** at BTHFT from 'requires improvement' to 'good' following an unannounced full inspection in September 2025. The service had made improvements and was no longer in breach of regulations previously identified.
- **CQC report (published Jan 2026)** has rated **Community Hospitals** at BTHFT as overall 'good'
- **Medical Care** at St Luke's Hospital, has been rated overall as 'good' following an unannounced focused inspection.

Bradford District Care NHS Foundation Trust (BDCFT)

- **The Care Quality Commission (CQC) quarterly report: engagement and activity:** Recent activity including two unannounced visits to Step Forward and Low Secure Unit.
- **Neurodevelopmental Waiting Lists**: A system-wide approach was being implemented to address excessive waiting times. A detailed paper outlining this collaborative work will be presented at BDCFT Quality and Safety Committee.

System Quality Insight, Assurance, Improvement Group (SQIAIG)

- **NHSE Principles for patient care in corridors-** Updated guidance was published on 11 December 2025. System partners will continue to work together to reduce patient care delivery in these spaces and gain assurance on the quality of care people receive against these principles.(NHS England » Principles for providing patient care in corridors). SQC heard that the ICB providers are underway with reviewing and benchmarking themselves against the guidance and will share outputs which is stated as an ICB responsibility. The ICB have arranged a 'fresh eyes' supportive quality assurance visit to BTHFT and are working with AHNSFT to progress the same.

- The **West Yorkshire Impact Assessment Quality Oversight group** established in January 25 now meets bi-monthly with representation from all WY place quality teams. The group aims, amongst other things to ensure a proportionate approach to QIA is consistently applied and provide consistent expert support, scrutiny and oversight to completed WY transformation programme QIA's.
  A West Yorkshire Quality Impact Assessment (QIA) oversight tracker is updated by all places bi-monthly with any completed quality impact assessments for the 5 WY places, or for West Yorkshire.
  In line with the principles of integration and collective system oversight it has been agreed that going into the new year a request will be made to Place provider colleagues to seek assurances on internal mechanisms and processes in place for the assessment of impact on quality of any Cost Improvement Plan proposals, whether there are currently any schemes which have been rated as high risk, or any schemes where impacts may arise in another system partner.
  The group are keen to understand what the need for, and process of quality impact assessment will be as part of the development of the ICB's proposed future operating model functions.
  The WY consolidated quality team will progress this work and provide future updates into SQC.

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	9
Meeting date:	13th February 2026
Report title:	Operational planning 2026-2029
Report presented by:	Kerry Weir, Associate Director Planning, Performance & Business Intelligence, NHS WY ICB (BD&C)
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, NHS WY ICB (BD&C)

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

Previous considerations:

An update on the expectations of the 2026-29 operational planning guidance was provided at the November meeting.

Executive summary and points for discussion:

NHS Trusts and West Yorkshire ICB (WYICB) submitted draft plans in December 2025. Final plans are due for submission on February 12th 2026. As in previous years, the WYICB plan is an aggregate of the plans for the 5 places (Bradford District & Craven (BDC), Leeds, Kirklees, Wakefield and Calderdale). Unlike previous years, Trusts are expected to submit their plans directly to NHE England (NHSE).

Appendix 1 provides an update on the plans submitted (as of 9th February) for BDC against the national requirements set out by NHSE in the 2026-29 planning guidance. This may therefore not be our final position, and the Board will be updated verbally on any changes made prior to the February 12th submissions to NHSE. Key points to note are:

- The BDC acute activity plans and elective recovery are aligned with Airedale NHS Foundation Trust (ANHSFT) and Bradford Teaching Hospital Trust (BTHFT) plans. However, whilst activity/performance plans have been built bottom up, the BDC finance plans have been developed at WY level and allocated to places. The finance and activity/performance plans for BDC do not therefore currently triangulate;
- Elective recovery plans do not meet the national 18-week referral to treatment (RTT) expectations as the BTHFT plan is constrained by the Trust's financial plan and the implementation of the new electronic patient record (EPR) system at ANHSFT is likely to also have an impact in 2026/27;
- Our diagnostic plan meets the national requirements but not the WYICB stretch target allocated by NHSE;
- Both Trust plans and the WYICB plans meet the national requirements for cancer performance recovery;
- ICB level plans are not required for urgent care performance. The ANHSFT plan does not meet the 82% 4-hour A&E performance level by March 2027, although it does recover in 2027/28 and delivers 85% by March 2029. Neither Trust has plans to eliminate 45-minute

ambulance waits by March 2027;

- Virtual Ward bed occupancy is currently constrained by BTHFT performance. However, plans recover to the 80% national requirement by March 2027;
- BDC Mental Health (MH) plans in most cases align with Bradford District Care NHS Foundation Trust (BDCFT) forecast activity/growth. The exception to this is children and young peoples' (CYP) access to NHS MH services, where circa 38% of activity is provided by a range of Voluntary, Community and Social Enterprise (VCSE) organisations. Plans align with BDCFT planned growth but with no additional VCSE growth anticipated;
- All MH and Learning Disability (LD) plans meet national expectations with the exception of: Increasing access to Talking Therapies where, although growth is planned in line with BDCFT financial allocations, this does not meet our fair share of WYICB's national allocation; and Mental Health Support Teams in schools/colleges as funding for additional teams is not yet confirmed and teams are already holding caseloads higher than guidelines;
- We have been delivering a high number of GP appointments in BDC for a significant time, and whilst we still deliver a high rate, we are now encouraging increased quality over quantity and our primary care team is working with practices to improve appointment mapping and data quality. Plans therefore show a 1% growth for 2026/27, with no further growth in subsequent years. There is also no planned growth in the current primary care workforce numbers;
- WYICB plans show an increase in dental access and a reduction in people with LD and autism in inpatient beds;
- BDC plans show a reduction to zero 52+ week waits for both adult and CYP community services waiting times and an improvement in the % of people waiting less than 18-weeks in line with planned improvements by BDCFT; and
- There are a number of risks to delivering plans including the current financial context and deliverability of challenging waste reduction/cost savings targets, recruitment challenges to delivering some plans and lack of quantification regarding the impact of our three BDC programmes of work.

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 final BDC planning submission.

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. Operational Planning 2026-29 Final Submission
Acronyms and Abbreviations explained
1. ANHSFT - Airedale NHS Foundation Trust 2. BDCFT - Bradford District Care NHS Foundation Trust 3. BDC – Bradford District & Craven 4. BTHFT - Bradford Teaching Hospital Trust 5. CYP - Children and young peoples 6. EPR - Electronic Patient Record 7. LD - Learning Disability 8. MH - Mental Health 9. NHSE – NHS England 10. RTT - Referral to treatment 11. VCSE - Voluntary, Community and Social Enterprise 12. WYICB – West Yorkshire Integrated Care Board

What are the implications for?

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

Bradford District and Craven
Health and Care Partnership

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Operational Planning 2026-29 Final Submission

Headline targets (1)

Bradford District and Craven Health and Care Partnership

	Success measure	2026/27 target	2028/29 target
Elective, cancer, diagnostics	Improve the % of patients waiting no longer than 18 weeks for treatment	Minimum 7% improvement or a minimum of 65%, whichever is greater (national performance target of 70%)	At least 92% of patients are waiting 18 weeks or less for treatment
	Improve performance against cancer constitutional standards	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%	
		94% performance for 31-day and 80% performance for 62-day standards	Maintain performance against the 31-day standard at 96% and 62-day standard at 85% from March 2029
	Improve performance against the DM01 diagnostics 6-week wait standard	Minimum 3% improvement in performance or performance of 20% or better, whichever is greater (national performance of no more than 14% of patients waiting over 6 weeks)	No more than 1% of patients are waiting over 6 weeks for a test
Urgent and emergency care	4-hour A&E performance	Maintain/improve to 82% by March 2027, with no lower than 80% as an average across the year	National target of 85% as the average for the year
	12-hour A&E performance	Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26	Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours
	Category-2 response times	Improve upon 2025/26 standard to reach an average response time of 25 minutes	Further improvement so that by the end of 2028/29 the average response time is 18 minutes, with 90% of calls responded to within 40 minutes
Primary Care	Same day appointments for all clinically urgent patients (face to face, phone or online)	90% (NHSE will consult with the profession on this new ambition)	
	Improved patient experience of access to general practice	Year-on-year improvement	
	Deliver 700k additional urgent dental appointments against the July 2023 – June 2024 baseline period	Each ICB to deliver their share of the urgent dental appointment target every year (2026/27 – 2028/29)	

Headline targets (2)

Bradford District and Craven Health and Care Partnership

	Success measure	2026/27 target	2028/29 target
Community Health Services	Address long waiting times for community health services	At least 78% of CHS activity occurring within 18 weeks	At least 80% of CHS activity occurring within 18 weeks
Mental Health	Expand coverage of Mental Health Support Teams in schools and colleges	77% coverage of operational MHSTs and teams in training	94% coverage of operational MHSTs and teams in training, reaching 100% by 2029
	Meet the existing commitments to expand NHS Talking Therapies and IPS	63,500 accessing IPS by the end of 26/27 805,000 courses of Talking Therapies by the end of 26/27 with 51% reliable recovery rate and 69% reliable improvement rate	73,500 accessing IPS by the end of 28/29 915,000 courses of Talking Therapies by the end of 28/29 with 53% reliable recovery rate and 71% reliable improvement rate
	Eliminating inappropriate out of area placements	Reducing the number of OAPs	Reducing or maintaining at zero the number of inappropriate out of area placements
Learning Disability and Autism	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people	Deliver a minimum 10% reduction year-on-year	
Workforce	Reduce use of bank and agency staffing	Trusts to reduce agency and bank use in-line with individual trust limits as set out in planning templates, working towards zero spend on agency by 29/30 Annual limits will be set for trusts individually based on a national target of 30% reduction agency in 26/27, and 10% year on year reduction in spend on bank staffing	

Elective Recovery

Bradford District and Craven Health and Care Partnership

Activity

- The Bradford District & Craven (BDC) plan is aligned with Airedale NHS Foundation Trust (ANHSFT) and Bradford Teaching Hospital Trust (BTHFT) plans.
- In general, no growth assumed for other West Yorkshire (WY) NHS providers (it's assumed that this will be reflected in other place plans).
- Some independent sector (IS) positions have over run in the first half 2025/26 so forecast outturn (FOT) may be over inflated. Plans have been adjusted to reflect this.
- However, whilst activity/performance plans have been built bottom up, the finance plans have been developed at WY level and allocated to places. The finance and activity/performance plans for BDC do not therefore currently triangulate.

			Growth		
			2026/27 Plan	2027/28 Plan	2028/29 Plan
Outpatients	E.M.8	Consultant-led first outpatient attendances (Spec acute)	102%	102%	100%
	E.M.9	Consultant-led follow-up outpatient attendances (Spec acute)	92%	100%	99%
Elective	E.M.10	Total number of specific acute elective spells in the period	111%	103%	101%
	E.M.18	The number of completed admitted RTT pathways in the reporting period	102%	110%	100%
	E.M.19	The number of completed non-admitted RTT pathways in the reporting period	108%	102%	102%
	E.M.20	The number of new RTT pathways in the reporting period	104%	103%	103%
Diagnostics	E.B.26x	The number of diagnostic tests or procedures carried out in the period	105%	101%	104%

Elective recovery

Bradford District and Craven Health and Care Partnership

Referral to Treatment (RTT)

The West Yorkshire ICB (WYICB) expectation is for an ICB level compliant plan for RTT measures.

- Planned activity growth will result in reducing the current RTT waiting list, improving 18-week performance and reducing 52+ week waits.
- However, plans do not meet the national expectation to achieve a minimum of 78.2% RTT performance by March 2027, 84.9% by March 2028 and 92% by March 2029, as the BTHFT plan is constrained by the Trust's financial plan and the implementation of the new electronic patient record (EPR) system at ANHSFT is likely to also have an impact in 2026/27.

Diagnostics

- Whilst our diagnostic plan meets the national requirement to ensure no more than 1% of patients are waiting over 6 weeks for a test, WYICB has been given a stretch target by NHS England of 3.9% by March 2027 and 1% by March 2028. As our plan is aligned to Trust plans, it does not deliver this requirement.

			BDC				Improvement		
			Nov-25	2026/27 Plan	2027/28 Plan	2028/29 Plan	2026/27 Plan	2027/28 Plan	2028/29 Plan
Elective RTT	E.B.18	The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 52 weeks or more	425	47	12	12	-89%	-74%	0%
	E.B.40	RTT waiting list 18 weeks and under	36,028	36,963	37,285	40,739	3%	1%	9%
	E.B.3a	RTT waiting list – total	53,802	50,288	48,075	45,656	-7%	-4%	-5%
	E.B.49	RTT % within 18 weeks	67.0%	73.5%	77.6%	89.2%	10%	6%	15%
Diagnostics	E.B.28x	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	**14.3%**	**5.5%**	**2.2%**	**0.5%**	-61%	-60%	-76%

Cancer

Bradford District and Craven
Health and Care Partnership

- **Faster diagnosis (FDS):** Both Trusts are on track to deliver the 80% FDS performance requirement by March 2025 with performance of 77.9% at ANHSFT and 75.5% at BTHFT in November. BDC performance was 76.4%. Trust plans maintain the 80% performance requirement across the 3 years.
- **31 days:** Current performance is 100%, 93.9% and 96.4% for ANHSFT, BTHFT and BDC respectively. Trust plans deliver the 94% requirement by March 2027 and the improvement to 96% by March 2029.
- **62-days:** The national expectation is to improve performance to 80% in 2026/27 and 85% by March 2029. Delivering this target remains more challenging with current performance at 75.1%, 74.4% and 74.3% for ANHSFT, BTHFT and BDC respectively, impacted by complex diagnostic pathways, late inter provider transfers, backlogs and operational issues in some specialties and patients requiring multiple investigations and/or Multi Disciplinary Team discussions, alongside patient compliance issues. However, Trust plans deliver the national targets.
- WYICB plans have been developed by the Cancer Alliance. All 3 plans meet the national requirements.

Urgent care

Bradford District and Craven Health and Care Partnership

ICB level plans are not required for urgent care performance. However, there are 3 key Trust specific requirements that plans must deliver.

- **4-hour A&E waiting time:** Trusts should maintain/improve to 82% by March 2027, with no lower than 80% as an average across the year and meet a national target of 85% as the average for the year in 2028/29. Despite daily attendances currently being above planned levels, BTHFT's performance continues to benchmark well, with the Trust consistently seeing over 80% of people within 4-hours compared to a national average of circa 70%. The BTHFT plan therefore delivers the national requirements.
- Although ANHSFT's 4-hour performance has improved compared with previous years, it continues to fall short of this years national 78% expectation, with December performance at 66.7% (against a plan of 67%). The Trust enacted its winter plan in the second week of December to help mitigate the impact of seasonal pressures and has an improvement plan that focusses on improving discharge pathways, improved emergency care pathways and real-time monitoring of patient flow. Whilst the Trust's plan does not meet the 82% performance level by March 2027, it does recover in 2027/28 and delivers 85% by March 2029.
- **12-hour waits:** Both Trusts have plans for year-on-year reductions in the number of attendances in A&E of over 12-hours in line with the planning guidance.
- **45-minute ambulance handover times:** Trusts are expected to plan to reduce these to zero by the end of 2026/27. Both Trusts are working collaboratively with regional partners and Yorkshire Ambulance Service (YAS) colleagues to deliver the 45-minute transfer of care handover initiative and the average ambulance handover times have reduced as a result. However, zero 45-minute waits is felt to be un-realistic and therefore not reflected in plans, with ongoing discussions with YAS, WYICB and across the West Yorkshire Association of Acute Trusts (WYAAT) as to what is achievable.

Patient Flow

Bradford District and Craven
Health and Care Partnership

- **Urgent Community Response (UCR) referrals:** Our UCR services is provided by our two acute Trusts and Bradford District Care NHS Foundation Trust (BDCFT). UCR referrals have been increasing since August with 510 in November, bringing our year-to-date position to 3,245 against a plan of 3,064. There are no plans currently to expand UCR capacity, so the BDC trajectory maintains current forecast outturn activity levels with some minimal growth forecast by BDCFT.
- **Virtual ward (VW) bed occupancy:** We currently have 129 VW beds (49 at ANHSFT and 80 at BTHFT). BDC WV occupancy was 69.2% in December with BTHFT occupancy levels continuing to fall. A feasibility review is underway to identify suitable patient cohorts for discharge and both Trust have agreed to review the current models to understand the differences with a view to recovering to the 80% national requirement by March 2027.
- **Intermediate Care (IMC) bed occupancy:** A new requirement for this planning round is to provide trajectories for the % of commissioned IMC beds which are occupied by people with no criteria to reside. This currently equates to 19.7% across our NHS IMC beds. As part of our BDC IMC blueprint, work is progressing to standardise approaches across all of our 125 intermediate care beds (both NHS and Local Authority managed) and plans therefore show year on year improvement.

Mental Health (MH) & Learning Disability (LD) Plans

Bradford District and Craven Health and Care Partnership

BDC plans align, and in most cases, are based on BDCFT activity/growth.

- **Inappropriate Out of Area (OOA) placements:** BDCFT's inappropriate OOA placements increased to 15 at the end of December. This was primarily due to a planned reduction in block beds and increased demand in the Christmas/New Year period. Numbers were down to 8 towards the end of January and the Trust plans to be back on track for zero by the end of March at the latest. Plans maintain this position across the 3 years.
- **Talking Therapies:** Performance in November was 65.7% and 48.5% against the national targets for reliable improvement and recovery of 67% and 48%. Plans meet the requirements to achieve 51% reliable recovery and 69% reliable improvement by March 2027 and improve to 53% and 71% by March 2029. WYICB are expected to increase the number of completed Talking Therapy courses year on year and have an ICB allocation of national activity. Whilst BDCFT planned activity meets the growth requirement, activity has only been uplifted in line with increased funding allocations and does not therefore meet the fair share allocation level for 26/27 of 9,168 (this would need a significant increase in completions above funded levels).
- **MH (adult/PICU and Older adult) bed average LoS:** This is a new requirement for 2026/27 for both Trusts and ICBs. BDC plans are based on total BDC MH bed activity with a reduction in line with BDCFT plans.
- **Individual Placement Support (IPS):** In the 12 months to the end of November, 405 people have accessed BDCFT's IPS service to help them get back into employment against a plan of 252, a 23% increase against the November 2024 position. Plans show an increase to 837 in 2028/29.
- **Perinatal MH:** In the 12-month period to the end of November, 505 women have accessed perinatal MH services against a plan of 350, a 49% increase against the November 2024 position. However, BDCFT continues to support this underfunded service and therefore, whilst activity levels are maintained in line with national requirements, no further growth is planned.

MH & LD Plans

Bradford District and Craven Health and Care Partnership

- **Children & Young peoples (CYP) Access to MH Services:** 12,155 CYP have accessed NHS mental health services across BDC in the 12-month period to the end of November, an increase of 7% from November 2024 and above our planned position. Circa 62% of activity is delivered by BDCFT, with the remainder provided by a range of Voluntary, Community and Social Enterprise (VCSE) organisations. Plans align with BDCFT planned growth but with no additional VCSE growth anticipated, with an increase to 12,870 by 2028/29.
- **CYP 104-week waits:** This is a new metric with plans required at both Trust and ICB level. Current national data for November shows 4,710 and 4,050 104-week waits for BDC and BDCFT respectively. The BDC plan aligns with BDCFT's expectation that 104-week waits will reduce to zero by March 2027. Current numbers reported nationally are predominantly as a result of data quality issues, as the correct SNOMED outcome codes have not been available on SystmOne. The correct codes are being added to SystmOne which should see numbers reduce.
- **Mental Health Support Teams (MHST):** A new ICB requirement to provide plans for the number of schools /colleges and subsequent pupils/learners covered by an MHST and the number of pupils accessing MHST services. BDCFT has 2 teams fully trained for 2026/27 and, as of August 2025, 6,930 pupils had accessed MHST support in 2025/26. However, funding for additional teams is not yet confirmed and teams are already holding caseloads higher than guidelines, so BDCFT has no growth planned over the 2026/27 position of 57% of schools covered (80.7% of pupils) across BDC. There is however a planned increase to 10,250 pupils accessing support by 2028/29.
- **LD Annual Health Checks (AHCs):** This is also a new metric which now focusses on AHCs having health action plans in place. Published annual data for 2024/25 shows BDC performance of 80.1%, slightly above WYICB performance of 79.3%. Plans maintain current performance for the 3 years as it is difficult to commit to improvement in 27/28 and 28/29 without agreeing a clear work plan across BDC.
- **LD inpatients:** ICBs are expected to deliver a minimum 10% reduction in 2026/27 in the number of people with a learning disability or autism in MH inpatient beds. WYICB plans deliver this requirement.

Community and Primary Care

Bradford District and Craven Health and Care Partnership

- **GP appointments:** There have been 3,335,566 GP appointments year to date at the end of November 2025. This is 5% below our planned delivery for 2025/26. 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 and our primary care team is working with practices to improve appointment mapping and data quality. Plans show a 1% growth for 2026/27, with no further growth in subsequent years.
- **Primary care workforce:** As of September 2025, published workforce data shows a total of 455 whole time equivalent (wte) GPs, 248 wte nurses, 527 wte staff providing other direct patient care and 1,099 wte administrative and non-clinical staff working across BDC GP practices and Primary Care Networks. No growth has been planned for 2026/27 to 2028/29 as maintaining current workforce levels will be challenging enough.
- **Dental access:** Since assuming delegated responsibility for the commissioning and contracting of dental services in April 2023, West Yorkshire (WY) ICB has been working hard to improve dental services for those living in the area. As of March 2025, 41.6% of the adult population of Bradford and 58.8% of the CYP population had accessed an NHS dentist in the prior 12 months. Whilst below the WY average, performance is better than the England average and has improved from 40.6% (adults) and 56.7% (CYP) for the 12-month period to March 2024. Dental plans are submitted by the WY team and are an aggregate WYICB position, showing a 1.4% and 2.1% improvement in the % of adults and CYP accessing NHS dental services over the planning period, whilst maintaining current levels of just over 204,000 urgent dental appointments.

Community and Primary Care

Bradford District and Craven Health and Care Partnership

- **Community services waiting times:** The focus for this planning period is to reduce the number of waits >52-weeks and improve the % of patients seen within 18-weeks. Our Adult Community Services waiting list reduced to 8,236 in November with 3 reported waits of over 52-weeks (down from 19 in April 2025). The CYP waiting list was 2,532 with 20 reported 52+ week waits. These long waits were all for BDCFT's speech and language (S&L) services. However, these numbers have reduced to 1 adult and 1 child waiting over 52-weeks at the end of December, both of whom were seen in early January, which will bring reported waits down to zero. The Trust aims to maintain this position with pro-active waiting list management, so BDC plans show zero 52+-week waits over the 3-year period.

  Waiting lists and 18-week performance plans assumes no change for ANHSFT & BTHFT services but reflects improvement in line BDCFT plans. The % of adults waiting less than 18 weeks improves from the current September 2025 position of 89% to 94.5% by 2028/29 and the % of CYP waiting less than 18-weeks improves from 72% to 73.8%.

- **Attended community care contacts:** A new requirement for this planning round, this is the number of attended community care contacts excluding Health Visiting and School Nursing. Plans are based on FOT using April-October activity reported via the Community Services Dataset (for all providers) but with no growth planned across the 3 years.

Risks

Bradford District and Craven
Health and Care Partnership

- Challenging financial context and a lack of cohesion centrally between the stretching performance asks and financial allocations.
- Deliverability of challenging waste reduction / cost savings targets.
- Recruitment challenges to delivering some plans including IPS and Talking Therapies activity growth.
- Increasing demand.
- Reference to but not quantified impact from Airedale Bradford Collaborative Acute Services (ABCAS), Integrated Neighbourhood Health (INH) and Corporate Services workstreams on activity.
- RAAC and EPR risk to ANHSFT plans.

Bradford District and Craven Health and Care Partnership ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item number:	10
Meeting date:	13 February 2026
Report title:	Risk Register (Cycle 4 2025/26)
Report prepared by:	Asma Sacha, WY ICB – Risk Manager
Report approved by:	Sue Baxter, WY ICB - Head of Partnership Governance
Report presented by:	Asma Sacha, WY ICB – Risk Manager

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

Previous considerations:

BDC Extended Leadership Team meeting – 14 January 2026
System Quality Committee (SQC) Chair and senior managers meeting – 22 January 2026
System Finance and Performance Committee – 12 February 2026

Executive summary and points for discussion:

This report provides details of all risks on the Bradford District and Craven (BDC) Place Risk Register at the end of the current risk cycle (Cycle 4, 2025/26) in Appendix 1. 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. The full BDC Place risk register is attached at Appendix 1.

The paper includes the final Place review of the Board Assurance Framework (BAF) 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 4, 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. 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 4 2025/26
Appendix 2: BDC Place Risks on a Page Report, Cycle 4 2025/26
Appendix 3: West Yorkshire ICB Board Assurance Framework, Cycle 4 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

1. Purpose of this report

1.1 The 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.

1.3 The report sets out the current risks captured on the BDC Place Risk Register for Cycle 4 2025/26. New risks, risks marked for closure and risks rated 15 or above and risks with changes in risk score are highlighted below.

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 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.

2.3 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 – 3 March 2026
- West Yorkshire ICB Quality Committee – 3 March 2026
- West Yorkshire ICB Board – 24 March 2026

2.4 The Cycle 3, 2025/26 Corporate Risk Register the common risk mapping across the five places and the Cycle 3 Board Assurance Framework was presented to West Yorkshire Integrated Care Board on 16 December 2025.

3. Key Points

3.1 This report set out the key changes to the risk profile of the BDC place risks during risk cycle 4 2025/26 which commenced on 17 December 2025 and will end after the WY ICB Board meeting on 24 March 2026.

3.2 The ICB is undergoing organisational change with the primary focus on becoming strategic commissioners with the governance framework transitioning from 1 April 2026 and continuing to evolve during 2026/27. The Place Committees will continue to meet on a quarterly basis through the 2026/27 transitional year, however the meetings will be streamlined with their primary focus on ensuring effective decision-making and assurance; they will be running alongside shadow collaborative governance arrangements. In line with this arrangement, the Risk Manager will be liaising with senior managers from each of the Places prior to the end of March 2026 to determine which risks remain open for transfer to the ICB corporate risk register. The complete risk report will be made available to the Place Provider Partnerships for them to determine whether any risks will inform their risk registers. Risks that are not transferred will be closed and archived. An updated risk report highlighting the status and destination of Place risks will be presented to the Q1 Place Committees.

3.3 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 26 risks on the BDC place risk register:

- Ten risks are aligned to System Quality Committee (SQC)
- Five risks are aligned to the System Finance and Performance Committee
- Eleven risks are aligned to both the Quality and Finance Committees

The following changes have been made:

- Eleven high scoring risks (15+ in risk score)
- Six new risks
- Three closed risks

3.4 **High scoring risks (15+ in risk score)**

There are eleven high scoring risks in Cycle 4, 2025/26:

Risk	Sub-Committee	Cycle 4 2025/26	Update for Cycle 4 2025/26
2587 - There is a risk of an inability to deliver all of the statutory functions of the ICB in regard to AACC due to challenging workforce pressures resulting in risk to organisational reputation, financial efficiency, complaints, challenges and appeals, and staff burnout.	SQC	20 (I4xL5)	Risk status - New risk Significant staffing gaps within the All Age Continuing Care (AACC) team. The gaps may reduce if the temporary posts are approved.
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 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.	Finance	20 (I4xL5)	Risk status – static 3 cycles New delivery groups and governance structure implemented to oversee the priority programmes of work.
2447 - Renal Services Capacity - Renal Services Capacity There is a risk that as the demand for hemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity that it will not be possible to provide timely dialysis for some patients. Due to increasing demand within the local demographic and an aging and	SQC and Finance	20 (I4xL5)	Risk status – static 6 cycles Capacity remains on ongoing challenge and area of concern. The team is currently operating at 98% of available dialysis slots across both St Luke's and Skipton. As a result, the CSU has increased the risk score to 20.

limited footprint, which has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the patient group. There is a high risk of increasing down time at the St Luke's site and the satellite unit at Skipton because of the aging infrastructure. Loss of either facility for an extended period would be unsustainable without seeking support from organisations both within and without the region.			- Building work for the Skipton expansion is expected to provide four additional renal dialysis stations. Work was due to commence in Nov/Dec 2025, with the latest update from Estates indicating completion by May 2026. - Home dialysis capacity continues to be used as contingency. - Sunday dialysis sessions remain open (two rooms in use), offering twice-weekly dialysis where clinically appropriate, instead of the usual three sessions. - During December 2025, there have been several incidents reported relating to patients receiving two dialysis sessions per week instead of three, which has resulted in patient harm.
2588 - There is a risk that individuals in CHC will not be reviewed in a timely manner due to challenging workforce issues resulting in increased cost to the ICB, the ICB not delivering against its statutory duties, or individuals presenting with unmet needs. This could result in substantial financial implications for the ICB is in relation to fast track patients who receive funding for CHC without an assessment.	SQC	16 (I4xL4)	Risk status – New risk The reviews are ongoing and clinically safer than people with no care packages. However the financial risk to the ICB is very high as people are not being reviewed especially around fast track due to workforce capacity.

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 2025/26 for Right to Choose assessments (circa in excess of £2m 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, 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).	SQC and Finance	16 (I4xL4)	Risk status – static 2 cycles No further update in Cycle 4.
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.	SQC	16 (I4xL4)	Risk update – static 2 cycles The risk owner has reported that a review of the commissioning arrangements has been completed, and agreement has been reached to move funding from BTHFT to BDCT for two clinical sessions per week to increase the Districts IHA capacity.

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 (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	Finance	16 (I4xL4)	Risk status – static 3 cycles No update for Cycle 4.
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 infrastructure	SQC and Finance	16 (I4xL4)	Risk status – static 7 cycles The risk owner has reported that through the Activation Contract MyCake diagnostic tool they are seeing potential weaknesses in VCSE organisations early and they are keeping a record of impact.

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.			
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 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	SQC and Finance	15 (I5xL3)	Risk status – static 4 cycles The risk owner has reported the 2025/26 funding in place, and plan forwarded to national RAAC team for 2026/27.

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). 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.	Finance	15 (I5xL3)	Risk status – static 5 cycles Updated Government guidance on period from 2030 to new build opening.
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	Finance	15 (I5xL3)	Risk status – static 16 cycles No change reported for Cycle 4.

to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.			

3.5 **New risk**

There are six new risks in Cycle 4 2025/26. Risk IDs 2587 and 2588 is highlighted above, in addition, the following four risks were added:

ID	Risk Description	Risk score	Update
2590	There is a risk that children and young people diagnosed with Autism and ADHD in Bradford will suffer harm due to lack of access to timely treatment and medication for ADHD. Since 2021 there has been an increase in demand from CYP for diagnosis and treatment. This may impact on the long-term health of vulnerable young people, increase health inequalities, education outcomes, social outcomes and increase pressure on adult neuro-developmental waiting list and secondary care mental health services.	12 (I3xL4)	New risk Mitigations: - Clinical prioritisation of waiting list criteria to support those most vulnerable. - VSCE support whilst waiting and including follow up service.
2589	There is a risk that people in BDC who are funded by CHC who do not have a diagnosis of learning disability are not able to access statutory OT services. This is due to a commissioning gap within the community therapy services where Rehab services cannot see patients with no rehab potential and the Local Authority not assessing CHC patients for equipment. This could result in some patients not having their basic needs and not having access to vital pieces of equipment.	12 (I4xL3)	New risk Mitigations: - Request for OT assessments to be reviewed on an individual basis. - Discussion with Rehab OT and Local Authority OT.
2578	There is a risk that WY ICB will not meet its organisational and partnership safeguarding statutory requirements and safeguarding responsibilities at Bradford Place.	12 (I4xL3)	New risk Mitigations: - Consolidated WY ICB safeguarding team to review and

ID	Risk Description	Risk score	Update
	Due to Bradford Place safeguarding team being under resourced due the impact capacity within the team and the hold on recruitment. This could result in reduced partnership working and access to safeguarding expertise, impacting upon the timely response to and learning from safeguarding incidents and concerns in Bradford, potentially putting children and adults at risk of harm. This could also impact reduced response to timely safeguarding advice and expertise, which impacts upon the ability of ICB and primary care staff to safeguarding children and adults at risk. Furthermore, the impact on reputational damage, locally and nationally, as statutory safeguarding responsibilities are not met, safeguarding partnership commitments are not honoured and the ICB is not compliant with NHSE Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework		agree “priority functions” 2025/26 - Support to be sought from wider consolidated safeguarding team for specific areas of work when/where appropriate - Designated Doctor for safeguarding children to increase from 1 PA a week to 2 - 2025/26
2577	There is a risk of patient harm to the population of BD&C due to ongoing operational challenges related to the LIMS system changeover, laboratory relocation, equipment validation, and supply chain disruptions have resulted in delayed test turnaround times, specimen rejections, and poor communication with clinical teams. These issues may lead to delayed or missed diagnoses, treatment delays, and increased risk of adverse patient outcomes for the population of BD&C.	9 (I3xL3)	New risk Mitigations: -Increased Quality Team and Data Quality (IT) involvement for escalation triage - Regular updates with ICB and Primary Care representatives led by LTHFT - Communication with affected practices regarding actions undertaken and to ascertain any potential harms - Regular updates provided to Place

ID	Risk Description	Risk score	Update
			and ICB SQC and Nursing teams via AAA reporting - Ongoing action plan and assurance slides updated weekly and shared during and after update meetings.

3.6 **Risks marked for closure**

Three risks have closed in Cycle 4, 2025/26

ID	Risk Description	Reason for closure
2544	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.	Closed The risk has reached tolerance as there are no issues with the sourcing of care for CHC patients due to cost of care. CHC will continue working with partners.
2047	DOLS in PCD FUNDED CASES There is a risk of legal challenge against the HCP and potential harm to patients due to unauthorised Deprivation of Liberty (DoL) in PCD funded community cases resulting in reputational and financial damage. Where people are deprived of their liberty in their own homes as a result of PCD funded packages of care, we are responsible for seeking authorisation from the court, however the court has a large backlog and these cases are outside the scope of the existing Deprivation of Liberty Safeguards (DoLS). This is a nationally recognised problem and Local Authorities and HCPs across the country are taking a risk management approach to prioritise only the most contested cases. The planned Liberty Protection Safeguards (LPS) aim to provide a statutory process for CCGs to authorise	Closed Although this is a statutory requirement, the risk of legal challenge is low. The risk is on the WY ICB Corporate risk register. Reviewed and agreed to close the risk on BDC Place risk register.

ID	Risk Description	Reason for closure
	CHC funded cases, without the need for court proceedings, this activity has now been paused.	
2528	There is an increased risk of data breach by some of our smaller VCSE providers (21Core20+5 project providers with funding of c£540K in 25/26). Due to the fact that they have not registered for and / or published a recent self-assessment against the NHS Data Security & Protection toolkit, which is a requirement of the NHS standard grant agreement. Which could result in reputational damage for the ICB, as well as negative impact to relationships between the ICB and the local VCSE sector.	Closed Agreed to close risk, VCSA are confident all submissions will be made by May/June 2026. Training and guidance have been provided to organisations. Positive assurance has been received on the work to close the gaps.

3.7 **Change in Risk Score**
None

3.8 **Emerging risks**
None

4 Board Assurance Framework update for Cycle 4, 2025/26

4.1 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.

4.2 There will be a new ICB Governance Framework from 1 April 2025 and senior managers in Places will no longer be completing the WY ICB BAF. Their contribution to the BAF will be consolidated and archived.

4.3 From 1 April 2026 going forward, the BAF will only be reviewed by the ICB Executive Management Team.

5 Recommendations

The BDC Partnership Board is asked to:

- **RECEIVE** and **NOTE** the High-Scoring Risk Report as a true reflection of the risk position in the ICB in BDC.
- **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 4, 2025/26

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
2587	26/01/2026	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	6	(I2xL3)	Vickie Milner	Phillipa Hubbard	There is a risk of an inability to deliver all of the statutory functions of the ICB in regard to AACC due to challenging workforce pressures resulting in risk to organisational reputation, financial efficiency, complaints, challenges and appeals, and staff burnout.	1. Completion of staffing compliment and structures work 2. Work to be undertaken to understand capacity and demand across Place 3. Regular staff supervision and 1-1s in place to address any wellness/wellbeing issues 4. Support of organisation to recruit clinicians into post outside of workforce controls	1. Sickness absence due to work-related conditions 2. Inability nationally to recruit into clinical 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 (external companies/legal firms) 4. Financial challenges of increasing the workforce in current operating model, even if the workforce is available.	1. Capacity and Demand modelling will identify any potential areas of efficiency/inefficiency 2. Ability to consider economies of scale with development of WY wide functions	1. Introduction of a full digital CHC system and AI transcribe to increase efficiencies 2. Support to recruit agency support short term request to workforce panel 26.1.26	1. Significant staffing gaps remain, particularly clinical 2. AACC activity continues to be a consistently challenging environment for all staff, clinical and non-clinical due to the nature of the work and implications of decision making 3. Relationships at Place with Local Council can be strained at an operational and strategic level	New - Open
2527	10/04/2025	Finance	Enhance productivity and value for money	20	(I4xL5)	9	(I3xL3)	Karen Parkin	Mike Woodhead	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position in 2025/26, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes. This may also lead to smaller independant sectors, VCSE organisations and hospices to be disproportionately affected by reduced investment.	1. Joint planning process established across the Bradford District and Craven Place which is used to agree operational plan performance trajectories 2025/26 2. Closing the gap programme board and business case process to support shared decision making on the use of resources 2025/26 3. Established difficult decisions list containing short to long term transformation programmes which will now become the focus of 'closing the gap' 2025/26 4. Additional financial controls implemented across the NHS system in line with NHSE requirements. 5. New delivery groups and governance structure implemented to oversee the priority programmes of work: ABCAS; INH; Corporate & CtG	1. Development of a medium to long term strategic financial plan to demonstrate the path to recurrent balance. 2. Continued development of 3-5 year plan in line with national timelines 3. Control and monitoring structure to maintain pace and impact on implementing the difficult decisions list 4. In connection with the point above, clarity on the outcomes and financial impact of service transformation work being carried out by Place Priority Programmes to inform the development of the medium term financial plan. 5. Stronger links with BMDC in relation to forward plans to both drive better use of resources and to manage the system impact of decisions taken by Partners. 6. System wider review of allocative efficiency and value not yet completed.	1. System Finance and Performance Committee oversight of Place operational and financial planning. 2. System committees (F&P and Quality) jointly involved in business case review with recommendations to Partnership Leadership Executive. 3. System F&P Committee oversight of the effectiveness of transformation programmes. 4. Planning principles and financial framework agreed at ICS finance forum which set-out the approach to managing within current resources. 5. Collaboration Programme Board now oversees the work of the 3 delivery groups as part of the new governance structure. ToR have been agreed and plans on a page have been developed with monthly highlight reports going to the collaborative.	1. System wide check and challenge in August and Nov 2024 2. System wide service review complete and externally facilitated workshop - 4th October 2024. 3. Partnership / PLE development sessions on understanding financial plans, difficult choices, transformational change with agreement to change the governance and meeting structure 4. Shared future plans (difficult decisions list) with no surprises. 5. Mid year review meetings for organisations in challenge with presentations and documented letters Oct/Nov 2025. 6. Regular highlight reports from delivery groups to programme board	1. No longer term plans to demonstrate sustainability 2. No place based clinical / services strategy. 3. Follows the control gap in relation to clarity on the outcomes of priority programme's transformation work which once achieved will enable reporting on the impact of priority programme work.	Static - 3 Archive(s)
2447	25/07/2024	Both FPC and QC	Improve healthcare outcomes for residents	20	(I4xL5)	12	(I3xL4)	John Bolton	Phillipa Hubbard	Renal Services Capacity - Renal Services Capacity There is a risk that as the demand for hemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity that it will not be possible to provide timely dialysis for some patients. Due to increasing demand within the local demographic and an aging and limited footprint, which has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the patient group. There is a high risk of increasing down time at the St Luke's site and the satellite unit at Skipton because of the aging infrastructure. Loss of either facility for an extended period would be unsustainable without seeking support from organisations both within and without the region.	1. Patients who cannot be dialysed in a timely way are monitored and clinically managed on a daily basis. 2. Patients who require urgent care through lack of timely dialysis can be brought to BTHFT for treatment as acute patients, however capacity to deliver this is very limited, and emergency/ reactive dialysis carries a high degree of risk of adverse outcomes and would place severe unsustainable stress our on call emergency dialysis service which should be reserved for acutely ill inpatients. 3. Specialist nurse staffing is augmented by TNR and agency staff. 4. Patients are encouraged to take up peritoneal dialysis where clinically appropriate and where possible with the restricted theatre availability. 5. Additional resource has been put into our home therapies services to maximise opportunities for home haemodialysis and PD. We have introduced a fluoroscopic PD catheter insertion service and are strongly promoting home-based renal replacement therapies, including renal transplantation. 6. Provision of an HD service requires specialist nursing skills which can be augmented by agency or TNR nurses. 7. Plans to extend twilight shifts at Skipton to 6 days per week with funding agreed. 8. Work continues to increase use of home therapies. 9. Update Q1 - 2025/26: Feasibility studies will be undertaken in Q1, 2025/26 to explore the potential to expand dialysis provision at SLH to provide resilience in the mid-term. 10. Updated Oct 2025: Skipton services expansion by 4 stations, estimated completion by end of financial year. Options for SLH facility expansion being considered. 11. Building work for the Skipton expansion is expected to provide four additional renal dialysis stations. Work was due to commence in Nov/Dec 2025, with the latest update from Estates indicating completion by May 2026. 12. Home dialysis capacity continues to be used as contingency. 13. Sunday dialysis sessions remain open (two rooms in use), offering twice-weekly dialysis where clinically appropriate, instead of the usual three sessions.	1. The additional capacity which has been created at Skipton by opening twilight sessions is predicted to be filled within 6 months. 2. Continue to build capacity in home therapies to decrease the rate of growth of the in-centre dialysis demand. 3. Developing options to expand dialysis capacity including at St Lukes by introducing Sunday dialysis shifts and exploring an increase in the number of chairs. 4. Skipton expansion plan also being worked up. 5. Additional money (£250K) from Spec Comm to explore expansion of Skipton footprint and capacity. 6. As at 22.01.26 capacity remains an ongoing challenge and area of concern	1. Reporting progress through System Quality Committee. 2. Reporting through Executive Team meetings and Quality and Patient Safety Academy at BTHFT.	1. Reporting progress through System Quality Committee. 2. Reporting through Executive Team meetings and Quality and Patient Safety Academy at BTHFT.	N/A	Static - 6 Archive(s)
2588	26/01/2026	Quality	Improve healthcare outcomes for residents	16	(I4xL4)	6	(I2xL3)	Vickie Milner	Phillipa Hubbard	There is a risk that individuals in CHC will not be reviewed in a timely manner due to challenging workforce issues resulting in increased cost to the ICB, the ICB not delivering against its statutory duties, or individuals presenting with unmet needs. This could result in substantial financial implications for the ICB is in relation to fast track patients who receive funding for CHC without an assessment.	1. Monthly reports of overdue assessments which are broken down into categories 2. Risk assess clinical priority reviews 3. Quarterly review reports now collated and submitted to NHSE	1. Sickness absence due to work-related conditions 2. Inability nationally to recruit into clinical 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 (external companies/legal firms) 4. Financial challenges of increasing the workforce in current operating model, even if the workforce is available.	1. Capacity and Demand modelling will identify any potential areas of efficiency/inefficiency 2. Ability to consider economies of scale with development of WY wide functions	1. Introduction of AI tools to create workforce efficiencies	1. Inability to manage workload with resource in place or configured in current form. 2. Gap in assurance of delivery of service where commissioned externally 3. Inappropriate referrals coming to the team resulting in workforce capacity being further reduced.	New - Open
2541	15/07/2025	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	9	(I3xL3)	Emma Hughes	Sasha Bhat	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 2025/26 for Right to Choose assessments (circa in excess of £2m 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, 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).	1. Increased use in right to choose. Procurement and new contracts have been issued to approved WY providers with associated activity across WY and agreement that longest waiters will be prioritised with this new capacity 2. WY deep dive continues, currently looking at shared tariffs across all providers. FAQs to help manage complaints, digital options and under 5s solutions. Clinical prioritisation across WY. 3. BDCFT have allocated additional non-recurrent financial resource to increase BANDS ADHD capacity. Uncertainty as to whether the funding will continue. Further conversations will be taking place whether further funding is available for BDCFT 2025/26 - Bands review has taken place and will be fed back to Chief Operating Officer at BDCT on 14 October 2025 4. All provider maintaining a waiting list and wellbeing check completed. ND care navigator to support with offering families support who are on the waiting list. Ongoing support. 5. Commissioned Bradford Early Advice Team (BEAT) via aware to provide support while waiting - in place and ongoing 2025/26. Additional resource was provided in Apr 2025 to support with more sessions.	1. Furthering health inequalities by not being transparent to the population's constitutional Right to Choose and making sure this route is accessible to all. A letter has been developed and is awaiting system sign off but this is likely to increase right to choose referrals. 2. Shared care agreements between private providers and GPs remain problematic and inconsistent and quality assurance from private providers around assessment is an issue, leading to duplication in some cases. The quality framework for independent providers will support with this.There is a new shared care agreement between Bradford GPs and the ICB. 3. There is a gap for the adult learning disability population who are unable to access ADHD assessment from mainstream services. Work has taken place with SWYPFT and BDCFT to look at how to address this.	1.Setting the strategic vision, via your role in reducing inequalities publications & events (we have and are inputting to local strategic plans including the Bradford District and Craven Health and Wellbeing strategy, District plan and emerging Integrated Neighbourhood health programme) 2.Building confidence and skills in our workforce (we have priorities and continue our workforce programme via a dedicated series of inequalities workshops, regular newsletter and publishing key support material on our RIA website) 3. Supporting best practice (we have develop an economic accelerator programme at place working across the NHS, Council and VCSE and interventions are now running to support people back to work with long term conditions) 4.Creating opportunities to evaluate and share learning (we are evaluating our Core20plus5 programme via 3 evaluation report (first 2 completed and presented to strategic boards) and third final evaluation report being written (for October 2026).	See above	1. Still work to be done on producing key performance indicators and metrics that measure, report and assure on inequalities for the new ICB board structure at place, and will be led by WY wide approach also.	Static - 2 Archive(s)
2538	08/07/2025	Quality	Improve healthcare outcomes for residents	16	(I4xL4)	6	(I3xL2)	Belinda Sharratt	Phillipa Hubbard	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.	1. Risk also reviewed on WY risk corporate risk register 2. Standing Operating Procedures (SOP's) across West Yorkshire to be standardised (2025/26) 3. Risk escalated to children's commissioners at Place and review of arrangements complete in Bradford 4. Risk communicated to Place based Corporate Parenting Boards. 5. Demand and capacity assessment completed in Bradford by providers and report presented to commissioners 6. There is an increased reliance on other services to inform of health issues and signpost accordingly.	1. Review of the commissioning arrangements complete but changes to be instigate and impact seen 2. Long term staff absence and recruitment issues. 3. Combined Designated nurse role for Safeguarding and Children looked after does not provide the strategic oversight required. 4. Extent of influence over commissioning and provision of sufficient medical capacity.	1. Designated Nurse working with Named Nurse and Doctor to monitor performance and escalate issues. 2. The West Yorkshire CIC Group is: • Looking at a standardised approach to reduce unwarranted variation • Connecting with relevant Regional and National Groups • Seeking to influence and ensure that robust processes and procedures are in place. • Review Performance Monitoring is undertaken at each place on a monthly basis and overall performance is shared at the WY CiC group for oversight. • Ensure regular review of the WY ICB corporate risk at the bi-monthly WY CiC group meeting. • Ensure regular reporting into place provider Safeguarding Committees, Corporate Parenting Boards and WY ICB Safeguarding Oversight and Assurance Partnership for oversight. Written Statement Of Action in response to SEND inspection and improvements to date (BDC). Bradford Place position presented to the Healthy Children and Families Board Weekly multiagency triage meeting held to understand and respond to barriers and identify any risks to individual children	1. WY Safeguarding Oversight and Assurance Partnership	1. Health Data and LA data are not consistent to demonstrate an accurate picture of the issues.	Static - 2 Archive(s)
2433	29/04/2024	Finance	Enhance productivity and value for money	16	(I4xL4)	12	(I4xL3)	Karen Parkin	Mike Woodhead	IN-YEAR FINANCIAL PERFORMANCE There is a risk that the Bradford & Craven Place will not deliver the 2025/26 financial plan of a £31.7m deficit and contribute to the requirement for the ICS to break even (as submitted to NHS England on 27 March 2025). This is due to the significant level of risk contained within organisational plans (including a share of the £33.2m 'system risk' value, currently held within the ICB), and the fact that delivery is predicated on delivering efficiencies of £84.5m. Failure to deliver a break even position will result in: - reputational damage to the BDC Place, BTHT, AFT, BDCT and the ICB; also the impact on the wider ICS. - additional scrutiny from NHS England, - a requirement to make good deficits incurred in future year - likely implications on future access to capital (i.e. would be reduced). - potential detrimental impact on some patient facing services - potential detrimental impact to staff in the top down approach to cost cutting	1. Agreement of West Yorkshire ICS Financial Framework by all NHS organisations setting out arrangements in place to manage financial risk 2. Delegation of resource from WY to BDC to enable more robust budget setting at place through the planning process. 3. Review of financial principles, horizon scanning and monitoring of financial position via the West Yorkshire ICS Finance Forum as well as monitoring within each organisation. Regular reporting to the BDC system finance and performance committee and key messages to BDC PoE. 4. Implemented additional controls to manage recruitment and non pay expenditure. Other 'grip and control' measures implemented at organisation level. 5. Use of 3 Priority Programme boards and business case approvals panel to focus on key strategic and system efficiency opportunities. Clear appraisal and scoring process in place. (NB: governance is under review) 6. Monthly budgetary control procedures and reporting including close monitoring of efficiency saving plans	1. Saving schemes not fully identified to achieve efficiency target 2. Deficit plans in 2 providers with no longer term solution 3. Absence of a contingency in financial plans to mitigate against unplanned expenditure or efficiency delivery shortfall 4. Lack of robust plans to deal with the BDC share of the stretch control targets - share of the system risk (total of £33.2m in 25/26) between the ICB and providers; and decision of AGH Board to not accept a share. 5. Difficult decisions lists established, some decisions/actions taken but a coordinated system approach is required. Need to identify a programme/project lead for every scheme and implement a process for monitoring, unblocking, holding to account, delivery etc 6. Governance and business framework required to manage the above - newly formed, but needs bedding in. 7. Some gaps identified in the PWC review of controls - need re-visiting to ensure implemented and followed.	1. Overview of financial performance and risk in BDC SF&P committee with key messages to PoE. 2. SDGs, Priority Programme boards and business case approvals panel receives regular updates. 3. Organisational checkpoint and system oversight meetings. 4. Deep dives as part of financial planning process with further in-year ones when necessary 5. NHS England review of financial position on a monthly basis 6. NOF framework and additional DoF-led scrutiny of specific provider organisations 7. Outputs of PwC assurance work and associated action plan	1. BDC Place plans approved by SF&P committee with a PLE development session to ensure knowledge and understanding by senior execs. 2. Financial planning assumptions were subject to peer review and challenge across the WY ICS, particularly for those organisations in deficit.	1. Further review of risks and mitigations leading to additional unmitigated risk with no formal route to address 2. No formal requirement to achieve any further control total (linked to approach for distribution of £33.2m system risk) 3. Formal assurance structure surrounding the system difficult decisions and how this is managed N/A	Static - 3 Archive(s)
2386	09/10/2023	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Sam Keighley	Sam Keighley	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 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.	1. VCSE voices in key decision making arenas and partnerships. This is being strengthened through the Activation Contract. 2. VCSE system lead post holder involved in Wellbeing Board, POE, strategic delivery boards 3. The VCSE and commissioner forum which has a remit to develop conversations in Place about shared approaches to commissioning is due to present a paper to POE in January 2026. 4. Through the Activation Contract MyCake diagnostic tool we are seeing potential weaknesses in VCSE organisations early and we are keeping a record of impact.	• An annual programme (4 – 6 days a year) of visits to VCSE organisations so public sector staff could better understand the value, pressures and circumstances of VCSE organisations across the BDC footprint (building on successful pilot) was established in 2024 but staff are struggling to find the time to attend. • System wide commissioning strategy paper to be presented to POE in January • System support to enable VCSE organisations delivering health and care services to ensure they have robust and effective IG systems is on hold. • There has been no active progress regarding priority workstreams shift mainstream funding to the VCSE (Modelling Healthy Minds) • Comprehensive forward plan of investment in the sector. • PLE Sponsor identified to champion / hold accountability for the early achievement of the 4 financial VCSE sustainability conditions agreed in December 2022. • PLE Sponsor identified to support / hold accountability for the acceleration of conversations about creating a system wide shared set of data to measure VCSE impact. • While controls are in place, the new Activation Contract will support VCSE organisations who are supporting our Health and Care Partnership, although the capacity to do this has significantly reduced. - Taking a system approach to the reduction of contracts output - there has	• Activation Contract monitoring and evaluation • Assurance activities at key system meetings (e.g. Reports from VCS system lead / advocates • VSCE leaders network and associated network. This is resourced by VCSE infrastructure • Appointment of Insight and Impact Manager is supporting the oversight of the sustainability of the sector risk.	• The Activation Contract is now being delivered. VCS ISOs, Council and health commissioners are working collaboratively to deliver the best support within reduced resources.	• MyCake diagnostic tool resourced through the Activation Contract is providing real-time information about the sustainability of VCSE organisations supporting the health and care system. • The reduction in the Bradford infrastructure contract has impacted on the assurance activities and active involvement of the VCSE in all strategic meetings due to reduced financial and human resource.	Static - 7 Archive(s)

2314	05/06/2023	Both FPC and QC	Improve healthcare outcomes for residents	15	(5x3)	6	(3x2)	Matt Sandford	Therese Patten	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL There is a risk of long-term disruption of service provision at Airedale General Hospital due to building component failure, as the majority of the floors, ceilings and walls (83% of the building) are built of Reinforced Autoclave Aerated Concrete (RAAC) and linked infrastructure including flow of supply of electricity and other utilities (known as daisy chain) throughout the site OR the emergency plan outlines circumstances which trigger an earlier date from which services at Airedale General Hospital may no longer operate beyond 2030. Deterioration of the RAAC and/or structural framework of the building could lead to catastrophic failure of the building with partial or full collapse, despite a comprehensive programme of remedial works. This could result in the closure of substantive or all hospital facilities at the Airedale General Hospital site and a transfer for the continuing provision of services without this facility for months or years. In the event of catastrophic failure of the AGH could result in damage to the partnership's reputation, legal proceedings, claims for compensation and regulatory intervention (implications for AFT and also the NHS WY ICB due to vicarious liability). This links to risk number 2312 (risk that AFT is unsuccessful in securing funding from the new hospitals programme).	Overall Programme SRO is Chief Executive. SRO for new hospital Director of Strategy, Planning & Partnerships; and SRO for Estates including RAAC Chief Operating Officer. Management groups established: - Securing the future committee; Security the future Programme Board; and Securing the future delivery group with responsibility for the planning and co-ordination building the new hospital and management of RAAC remedial works. External groups: - Seven trusts with RAAC related issues - peer support and shared learning. - Regional RAAC programme board (monthly) - report progress against plan and share risks (all of the North of England). - National structure support group - national shared learning group from all RAAC hospitals. Other controls: 1. Remedial works funding with NHSE approval for £18.6m in 2024/25 to address structural works. 2. ANHSFT has built two modular wards so that patients can be decanted out of RAAC areas while repair work takes place. Modular wards can also be used if areas need to be evacuated. 3. Business continuity plan has been developed which describes the transfer of activity to other trusts in WYH to maintain patient safety and services. Patient safety plans developed via EPRR to transfer activity to other WYAAT Trusts. 4. Process in place for monitoring the prevalence of deterioration over time and reporting to NHSE 5. Process in place for escalating new risks relating to deterioration and call-off contract with structural engineers to seek advice on most appropriate structural solutions. 6. Active participation in the regional RAAC Quality and Risk Summits to identify themes and trends over time and escalate as required. 7. Regular Site Inspections 8. Building Information System (BIS) collates RAAC data for more efficient reporting as of 2025 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 inspections, 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 Solutions 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. 15.Regional EPRR response plans in place with receiving hospitals and plans tested through multi-agency events.	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 managed in line with recent Government publication. 3. The multi-agency RAAC emergency evacuation response protocol has been approved by the WY Resilience Forum and the Local Health Resilience Partnership. 4. The draft NEY Regional Hospital Evacuation Framework has been shared for comment in Feb 2024 and this will be used to inform the development of the WY hospital evacuation plan and so the date fot that WY plan to be completed has been extended beyond Q4 2023/24. 5. Situation extends beyond RAAC panels as deterioration in structural frame, corbels. This is now a routine process. 6. Business case process for national funding beyond 2026/27 forwarded to national team. 7.2025/2026 Inability to fully decant all affected wards to increase the pace of structural works within identified areas due to lack of non-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 and is routinely reported through WY and BDC HCP governance arrangements. RAAC is a known risk for the WY Association of Acute Trusts (WYAATT). - Emergency planning exercise held on the multi-agency RAAC protocol (6 June 2023). A further exercise to be scheduled, but date not yet agreed. - Protocol for the identification and management of RAAC which is approved by independent engineers. - Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. - Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme. - Reports to Securing the Future Programme meetings - Risk summit discussions - Meeting with NHS England national RAAC team - Ferro scanning of all building - emerging industry scanning available - Update - November 23 - emerging industry scanning available - moved from Gaps to Assurances - Update Nov 23 - guidance on degregation of panels published. We are compliant - RAAC at AGH (AFT) has been replicated back onto the BDC HCP risk register and is routinely reported through the WY and BDC HCP governance arrangements.	Emergency planning exercise held on the multi-agency RAAC protocol (6 June 2023). Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme. Latest national research programme guidance was published in the spring of 2023 and AFT are applying the learning from this guidance. Deterioration in line with previous baseline 2021/22 comparison with 2022/23 5/7% deterioration with 37% of planks with defect. Internal Audit undertaken in decmeber 2024 and action plan in place by April 2025, Legal advice sought in June 2025 and action plan in place and annual ALARP review conducted in Jan 2025 with action plan in place Memorandum of Understanding (MOU) aligned to business cases 2025/2026 NHS England funding for works for 2025/2026 now provided at £23.1m.	1, 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. 2. For 2025/26 funding in place and plan forwarded to National RAAC team for 2026/27	Static - 4 Archive(s)
2312	05/06/2023	Finance	Improve healthcare outcomes for residents	15	(5x3)	10	(5x2)	Lesley Tillotson	Matt Sandford	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - Although Airedale NHS Foundation Trust has been successful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030, there is a risk that the funds do not flow as quickly as required, resulting in a failure to open the new hospital before the current one ceases to be viable (engineers estimate 2030) (or earlier if a significant RAAC incident occurs - see related risk number 2314). In September 2024, Airedale NHS Foundation Trust received permission from the Government to proceed with the New Hospital project, despite an ongoing review into the wider New Hospital Programme - with confirmation that the project would proceed at pace due to the substantive safety risks associated with the RAAC issue. However the risk remains that the commitment to replace before 2030 overruns, or that a significant RAAC	1. Programme team has secured a place on the New Hospital Programme (NHP) with the NHP committing to prioritise RAAC Trusts in line with the Governments direction and so focus on completing the Airedale project by 2030. 2. Securing the Future Committee, Programme Board, Delivery Group and Workstreams in place to oversee New Hospital Programme and remedial RAAC works established from November 2023 3. Securing The Future Programme Director for new hospital has been appointed in April 2024 (umbrella title for both RAAC and NHP) 4. Securing The Future Programme developed 5. Liaison with National NHP 6. Refreshed SOC being submitted to NHP for Investment Committee supporting the overall national profile of investment across all Wave 1 NHP programmes. This is expected to provide greater clarity on investment and timelines. 7.Work on the more detailed OBC remains ongoing with an expected submission around 2026/2027, aligned to Government/NHP indicative construction start dates of 2027/2028.	1. Structural engineers have advised that the hospital needs to be replaced no later than 2030. Updated Government guidance on period from 2030 to new build opening. 2. Long term programme approach to be developed 3. Clarity on exact funding settlement 4. Clarity on full Hospital 2.0 requirements	1. RAAC at AGH (AFT) is registered on the NHS WY ICB risk register and the WY ICB BAF includes RAAC and is routinely reported through WY and BDC HCP governance arrangements. RAAC is a known risk for the WYAATT collaborative. 2. Place on NHP 3. Programme support funding and Enabling Works submission show programme is progressing forward 4. Securing the Future board reports to programme board and committee 5. Execs RAAC reports 6. ANHSFT BAF links to risk register to provide assurance	Internal Audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and the New Hospital Programme. Following Government review of the national programme, Airedale confirmed as a Wave 1 scheme	N/A	Static - 5 Archive(s)
2168	17/10/2022	Finance	Improve healthcare outcomes for residents	15	(3x5)	4	(2x2)	Kerry Weir	Sohail Abbas	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	System F&P Committee meets bi-monthly and planning now undertaken on a system footprint. System performance and recovery dashboards in place Transformation programme's supported to monitor delivery and impact upon performance Recovery plans submitted as part of 2023/24 operational planning process. Delivery will be monitored via SF&P Recovery plans being built into SF&P dashboard. 16.04.24: The system dashboard has been aligned to each of the priority programmes to demonstrate delivery of programme objectives and contribution towards national targets. July 2024 - Operational plan for 202425 finalised and signed off at the end of May 2024. Oct 2024 - H2 plans are being reviewed as part of winter planning. Apr 2025 - 2025/26 operational plans developed and deliver performance improvements set out in the planning guidance	Approach for monitoring and evaluation of service improvements/business cases needs agreeing Data quality issues have some impact on robust reporting and assurance. National targets/plans not yet necessarily 'owned' by all system partners/AaO programmes. Not clear if ability to review performance at a place based system level via national data/reporting mechanisms will continue in the medium to long term once ICBs are full established.	Provider performance monitoring via Trust performance groups Monitoring of system performance at SFPC Monitoring of provider quality performance at SQC Monitoring of transformation programme work/outcomes at Health & Care Partnerships A detailed quality metrics dashboard is being developed for the system	Recovery plans submitted Dashboard showing good progress against plans July 2024 - Additional CDC diagnostics capacity now available which will improve wait times performance. Co-located UTC in operation at ANHSFT from the 25th July to support improvement in A&E waiting times. Oct 2024 - Improvements being seen in some areas (ANHSFT cancer targets, diagnostic performance) but in general performance remains below national standards. Apr 2025 - Ongoing improvement r.e. elective recovery, but some challenges still remain e.g. ANHSFT 4-hour A&E performance	Impact of Covid moving forwards is unclear. Still some impact on activity and workforce. Significant backlogs remain in terms of waiting lists/times for services. The current financial position and plans to close the financial gap will impact on the delivery of national targets July 2024 - risk score remains unchanged as whilst recovery plans are in the main on track, performance is below key NHS constitution standards in some areas. Potential adverse performance impact if GP industrial action proceeds (separate risk to cross reference to). The ICB organisational change process will have an impact on staff capacity to develop programmes and deliver targets	Static - 16 Archive(s)
2590	26/01/2026	Both FPC and QC	Improve healthcare outcomes for residents	12	(3x4)	6	(2x3)	Phillipa Hubbard	Therese Patten	There is a risk that children and young people diagnosed with Autism and ADHD in Bradford will suffer harm due to lack of access to timely treatment and medication for ADHD. Since 2021 there has been an increase in demand from CYP for diagnosis and treatment. This may impact on the long-term health of vulnerable young people, increase health inequalities, education outcomes, social outcomes and increase pressure on adult neuro-developmental waiting list and secondary care mental health services.	1.Clinical prioritisation of waiting list criteria to support those most vulnerable 2. VSCE support whilst waiting and including follow up with service	1. Financial resource availability to manage waiting list	1. Prioritisation and clinical criteria 2. Business development and focused working group on clinical pathways and waiting list management	See above	1. Financial resource and clinical availability	New - Open
2589	26/01/2026	Quality	Improve healthcare outcomes for residents	12	(4x3)	6	(3x2)	Vickie Milner	Phillipa Hubbard	There is a risk that people in BDC who are funded by CHC who do not have a diagnosis of learning disability are not able to access statutory OT services. This is due to a commissioning gap within the community therapy services where Rehab services cannot see patients with no rehab potential and the Local Authority not assessing CHC patients for equipment. This could result in some patients not having their basic needs and not having access to vital pieces of equipment	1. Request for OT assessments to be reviewed on and individual basis. 2. Discussion with Rehab OT and Local Authority OT	1. No provision for this cohort of CHC patients	No provision	No provision	1. There are no OT provision for these individuals 2. Delays in care and treatment 3. Increase cost in OT provision via a private OT 4. Increases in complaints	New - Open
2578	05/01/2026	Quality	Improve healthcare outcomes for residents	12	(3x4)	9	(3x3)	Belinda Sharratt	Phillipa Hubbard	There is a risk that WY ICB will not meet its organisational and partnership safeguarding statutory requirements and safeguarding responsibilities at Bradford Place. Due to Bradford Place safeguarding team being under resourced due the impact capacity within the team and the hold on recruitment. This could result in reduced partnership working and access to safeguarding expertise, impacting upon the timely response to and learning from safeguarding incidents and concerns in Bradford, potentially putting children and adults at risk of harm. This could also impact reduced response to timely safeguarding advice and expertise, which impacts upon the ability of ICB and primary care staff to safeguarding children and adults at risk. Furthermore the impact on reputational damage, locally and nationally, as statutory safeguarding responsibilities are not met, safeguarding partnership commitments are not honoured and the ICB is not compliant with NHSE Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework	1. Consolidated WY ICB safeguarding team to review and agree "priority functions" 2025/26 2. Support to be sought from wider consolidated safeguarding team for specific areas of work when/where appropriate - 2025/26 3. Designated Doctor for safeguarding children to increase from 1 PA a week to 2 - 2025/26	1. Inability to recruit to statutory Designated Doctor for Safeguarding Children role 2. Designated Doctor for Children in Care, Deputy Designated nurse for safeguarding children and Specialist Health (Safeguarding) Practitioner for Adults and Children on long term sick 3. Other Place based safeguarding teams have ongoing capacity issues due to sickness, leavers and recruitment freeze. 4. As a result of the ongoing sickness of Associate Director of Nursing and Quality the Designated nurses for safeguarding children and adults are required to undertake additional duties and responsibilities.	1. Work of the team will be aligned with the agreed priority measures 2. Raised in AAA for Bradford Place to WY Safeguarding Oversight and Assurance Partnership 3. Monthly meetings between Director of Nursing and Quality and Designated Nurses for safeguarding children and adults 4. Monitoring of compliance with statutory safeguarding reviews	To be confirmed	1. Partnership working at strategic level will be reduced	New - Open
2543	15/07/2025	Quality	Improve healthcare outcomes for residents	12	(4x3)	6	(3x2)	Andrew Milner	Phillipa Hubbard	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 Spring 2026); Misalignment between education programmes (both in quantity and nature) and anticipated demand across all clinical professions; Capacity to host clinical placements in areas where growth will be 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 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 risk also applies to the ICB, where the impact of vacancy restrictions and the wider implications of organisational change are being particularly acutely felt, for example Continuing Healthcare 28 day performance has now dropped to 2 % due to the impact on not recruiting and increased sickness. 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.	1. Development of a data driven approach to identifying areas of most acute risk, meaning resource can be directed accordingly. 2. Engagement with WYICB and national partners. 3. Programme to build placement capacity acts BDC system in order to develop pipeline for future registered workforce- particularly in primary, community and social care 4. Place based approach to operational workforce planning, completed with performance against plan monitored through system finance and performance committee. 5. West Yorkshire ICB Strategic Workforce Transformation Forum focusing on innovative workforce development has been formed, with BDC system representation. 6. Engagement mechanisms with sectors to ensure suitability of graduates for roles within the system, with primary care an area of focus. 7. Engagement across the BDC Partnership (including through priority programmes, PLE and broader governance structure) to identify areas of pressing need so available resource can be directed accordingly. 8. System approach to review and increase workforce transformation and OD capacity through BDC Quality and Safety and Finance Committee. 9. 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 10. Reporting of workforce data via a dashboard to System Finance and Performance Committee, with bi-annual deep dive. 11. Ongoing dialogue with external partners including NHS England, Skills for Care and WYICB on data availability. 12 System approach to issue identification through BDC Workforce Priority. 13. Ongoing dialogue with internal partners including social care leads, primary care leads and VCS leads to ascertain qualitative information regarding workforce. 14. Agreement of place wide work plan for placement activity. 15. Workforce contribution to 3 BDC priority system transformation initiatives to ensure alignment	1. Inaccurate workforce data around social care sector means assessing demand is challenging 2. Detail of implications of three Darzi Shifts still emerging, with detail likely to be included within refreshed LTWP 3. Lack of clarity of national funding arrangements for workforce transformation 4. Quantitative information around proportion of graduates deemed unsuitable for employment. 5. 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. 6. Mechanisms for identifying and agreeing capacity to support workforce and service transformation are also limited. 7. 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. 8. Qualitative data is valuable alternative to consistent data sets, however it is unlikely to give full summation of workforce. This increases scope for inconsistent interpretation of areas of concern 9. System wide placement programme following completion of secondment for placements lead and inability to extend post. Reduced capacity has required streamlining of programme.	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 board (with escalation to exec team and Partnership Board). 3. Reporting at sectoral groups including BDC and WY primary care workforce fora. 4. Qualitative feedback from system leads (including DoN and lead AHP) on issues within specific professions 5. Utilisation of integrated workforce data report to identify areas for prioritisation 6. Place based Workforce Planning Group to identify priority areas 7. Interaction with BDC Priority Programmes to identify areas of pressing need 8. West Yorkshire ICB Board Assurance Framework (BAF) – BdC contribution to workforce objective through West Yorkshire People Board. 9. Reporting of workforce data via a dashboard to System Finance and Performance Committee, with bi-annual deep dive. 10. Regular reporting through Partnership Leadership Team/PLE with other priority programme boards 11. Highlight reports and project plans from each of the prioritised projects in the workforce programme.	1. Programme restructure agreed to ensure alignment with revised NHS Operating Model based on engagement from across partnership including social care, primary care, VCS, FE and HEI sectors has been excellent. 2. Programme priorities agreed with full workplan established. 3. WYICB engaged to ensure place based work is aligned with work undertaken at a West Yorkshire level. 4. Ongoing dialogue between education providers and employing bodies to resolve any issues arising 5. 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 strategy delivery boards established for each Workforce leads engaged with each programme. 6. High level of engagement across sector through BDC Workforce Priority to date. 7. Development and publication of BDC Health and Care Strategy will help identify areas of pressing need. 8. High level of engagement across sector through People Committee and BDC Workforce Priority to date. 9. 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. 10. High level workforce data against plans now included in system dashboard. 11. WY ICB figures for 2024/25 academic year show placement diversity (in terms of setting) greater in BDC than in any other place. 12. WY ICB engaged to ensure place based work is aligned with work undertaken at a West Yorkshire level. 13. Workshop health in April identified recruitment and temporary staffing as system wide priorities based upon submitted plans.	1. Data quality issues mean that ability to identify most acute areas of workforce need remains limited. 2. Placement lead secondment due to end August 2025 necessitating cessation of programme. 3. Availability of data to create consistent narrative and buy-in to programme of work across the partnership. 4. Awaiting Long Term Workforce Plan which is likely to offer detail on funding support and national workforce priorities.	Static - 2 Archive(s)
2542	15/07/2025	Both FPC and QC	Improve healthcare outcomes for residents	12	(4x3)	4	(2x2)	Nathan Atkinson	Iain MacBeath	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 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 fee uplifts between the BCA, Council and the NHS 4. Govt has provided new financial policy statements indicating 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 UKVI figures. 2. Time lag from data available from Skills for Care ASC-WDS prevents us giving real time picture. 3. Inability to significantly improve terms and conditions to attract more domestic workforce. 4. Awareness of NHS funds in the sector around 30% of totality	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 (BCA, Council, ICB) monthly 4. Departmental management meetings 5. Meetings with finance/ 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 sited on recruitment and retention of staff in the care sector	1. Partnership working	1. Further reviews will take place to identify any gaps.	Static - 2 Archive(s)

2486	24/01/2025	Both FPC and QC	Improve healthcare outcomes for residents	12	(3xL4)	6	(2xL3)	Collette Brauns	Matt Sandford	There is a risk of physical and psychological harm and longer waiting times for patients in Bradford and Craven place who require a Tier 3 weight management service due to the closure of the service at the previous provider due to capacity issues in March 2024. This may result in an increase in referrals though the Right to Choose patient choice pathways with an increase in expenditure, an increase in referrals to Tier 4 bariatric services therefore impacting on longer wait times and it could have a detrimental impact on the quality and suitability of services for our local population in Bradford and Craven.	1. Regular discussions at Executive level to ensure awareness of the risk and oversight of the development of a replacement service. 2. Regular communications with primary care to advise patients of the position if they raise concerns 3. Ongoing work to develop new model of delivery 4. Regular communications to the public so patients understand that access to the new medications will be prioritised to those who need it the most. 5. Right to Choose referral monitoring (monthly)	1. Current financial position will result in us being restricted in the service we can commission. 2. Not all practices will read the communications issued or share these updates with patients. 3. Awaiting guidance from NHSE 4. Wider media influence and public demand 5. Lack of ability to mitigate any referrals to Right To Choose providers. 6. Limited control over the quality of the service for our patients as our local WYICB does not hold a direct contract with the provider. 7. Additional private providers may become available for referrals. 8. Each place has different arrangements in place regarding pathways and providers.	1. Funding has now been secured at ELT on the 12th November 2025 for a PCN model to start in 2026 and work is underway with contracting. Previously developed a new weight management pathway in Primary Care for the roll out of Tirzepatide following the NICE TA. Worked with Bradford Care Alliance to design a new draft pathway and costings for the service and staffing. This was updated at the Clinical Advisory Board in September and a PCN leads session has been arranged for 23rd October 2025. 2. Developed a business case, EQIA and service specification with WY obesity leads and the 4 places for the new GP service to ensure consistency in service provision and tariff pricing. 3. WY Transformation Committee agreed new criteria for specialist weight management services on the 5th July 2025 to align with the NICE TA for Tirzepatide. 4. Meeting with Right To Choose provider to confirm the new criteria and discuss waiting list arrangements. 5. Worked with Bradford Care Alliance and GP practices to offer support to patients who were on the previous tier 3 specialist service waiting list. 6. Raised the issue at PLT a number of times in 2024 to ensure that strategic leaders are sighted. Will provide a further update in November 2025. 7. Fixed agenda item at the fortnightly Weight Management Steering Group.	See above	1. Funding has now been agreed to implement a new service in PCNs from 2026. 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 mean that there are challenges in developing a new service in this current climate.	Static - 4 Archive(s)
2482	14/01/2025	Quality	Improve healthcare outcomes for residents	12	(3xL4)	6	(3xL2)	Leanne Cooper	Justin Tuggey	EPR (Electronic Patient Record) There is a risk of an increase in clinical risk and workload and across system partners including primary care due to the transitioning of electronic patient records from SystmOne to Millenium use across the majority of acute services Airedale NHST Foundation Trust. This could lead to potential delays to referrals being actioned, a delay in the receipt and sharing of key discharge information from Airedale NHST Foundation Trust to external stakeholders including primary care colleagues which could impact patient outcome, experience and appropriate follow up intervention.	1. Securing sufficient digital capital funding by October 2025 2. Capacity of shared domain due other partners requirements (C&H and BTH). Confirmed in detail plan no later than June 2025. 3. Ensuring good data insight and intelligent practice exists across system partners - ongoing 4. Strategic delivery partner appointed (PWC) to support the Trust with subject matter expertise to deliver the programme effectively - ongoing 5. Oracle Health Gateway process	1. Ability to secure skills and expertise on site in the timescales available. Confirmed in detail plan in September 2025. 2. Securing sufficient digital capital funding by October 2025	1. A clear programme plan in place that reflects the immediate and long-term strategic goals of EPR deployment. 2. There is a robust governance and reporting architecture to support effective delivery, oversight, and assurance of the programme plan.	1st line : (Programme) Clinical Risk management process Revised Governance & PMO infrastructure Delivery partner key stakeholder in TAG from July 2025. 2nd line (Organisation Oversight) EPR Transformation Assurance Group Revised reporting line to FPDC Quarterly reporting to Trust Board via Delivery Partner commencing in July 2025. 3rd line (external / regulator) Independent external review by PwC commissioned and completed External assurance to be provided by NHSE at appropriate time intervals Oracle Health Gateway process NHSE Digital assurance process	1. Provision of external capital funding yet to be confirmed 2. Sufficient skills and expertise on site within EPR programme Teams - expected to commence as part of re-planning with strategic partner who will be joining the Trust in June-25	Static - 4 Archive(s)
2221	26/01/2023	Quality	Tackle inequalities in access, experience, outcome	12	(4xL3)	8	(4xL2)	Duncan Cooper	Sohail Abbas	There is a risk of failure to reduce health inequalities of the population in BDC by coordinated action at scale across organisations and programmes in Bradford District and Craven partnership, due to lack of: [1] engagement and buy-in from key system partners [2] recognised performance and financial drivers to reduce inequalities [3] action at scale to address known health inequalities [4] translation of local intelligence, research and evaluation into new models of care and transformation. This could result in widening of health inequalities.	1.The new District Plan for Bradford District which will set out the key goals and outcomes to reduce inequalities (the plan has recently been signed off by the HWB board but an outcomes framework is in development whihc will set targets and measure system perfromance). BDC partnership published its Health and Well-Being strategy (ICB) in autumn 2025 which has a strong narrative around an inequalities. 2. Agreement of BDC partnership priority board key metrics (stratified by inequalities and linked to specific actions/priorities): this remains a challenge and will progress once we begin on operationalising the full strategy (although inequalities data and intelligence is being used for the integrated neighbourhood health workshops) .	1. Strong working relationships between the Wellbeing collaborative & WB board partnerships (to strengthen health inequalities narrative outside health and social care). This is currently restricted by a wellbeing board partnership review (as development of the District plan / Wellbeing strategy is on hold until this review in 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). 2. Agreement of BDC partnership priority board key metrics (stratified by inequalities and linked to specific actions/priorities): this remains a challenge. 3. Update Cycle 1 2025/26 - This has currently been restricted by a wellbeing board partnership review (as development of the District plan / Wellbeing strategy is on hold until this review was completed).	1. Core20PLUS5 place based programme, and Health and Work accelerator reporting to BDC Executive Leadership Team and support for BDC Integrated Neighbourhood Health programme (and the Public Health Leadership team, HDRC board of Bradford Council) . New programme direction for 26/27 agreed with a INH focus 2. Population health data and segmentation model (stratified by deprivation) is within the BDC plan and supporting data, being used to inform and drive decision making as distrcit wide Integrated Neighbourhood Health planning workshops. A range of guidance documents summarising key actions and interventions for the NHS and its partners to reduce inequalities has been published and promoted. 3. Strong working relationships between the RIA team, public health and Bradford Council and VCSE representative bodies (e.g VCS Alliance, Race Equalities Network) to strengthen health inequalities narrative outside health and social care)	See above	1. Inequalities and community budgets have made efficiencies due to financial challenges. 2. The RIA core team (within BDC partnership) is at 40% capacity of 12 months ago , with reducing ability/capacity to influence system wide agendas (and further risk due to new ICB structures that do not have dedicated inequalities team or posts from BDC). 3. Still work to be done on producing key performance indicators and metrics that measure, report and assure on inequalities in the new BDC governance structure (although some of these are covered within a HOSC inequalities dedicated meeting and report. 4. As there is no BDC place inequality team in in the proposed structures, there is a RIA 3 year review and next steps (for the system) workshop in March 2026. The RIA team continue to working with system partners to ensure the work on inequalities continue across partnerships (including Work and Health Accelerator, Core20plus5, Integrated Neighbourhood Health, Anti-Racist charter, Living Well, Vaccination inequalities programme)	Static - 14 Archive(s)
2215	13/01/2023	Both FPC and QC	Tackle inequalities in access, experience, outcome	12	(4xL3)	2	(2xL1)	Shane Embleton	Mike Woodhead	LYNFIELD MOUNT HOSPITAL - There is a risk of delivering poor quality health care with a negative impact on patient safety including infection prevention and control, service user experience including privacy and dignity, additional costs for out of area bed usage and negative impact on staff wellbeing, recruitment and retention and on the organisation's reputation. This is due to the deteriorating and failing physical condition of Lynfield Mount Hospital building with £68m backlog maintenance as well being an estate requiring redevelopment this out-of-date estate has insufficient therapeutic space, large ward sizes and a lack of ensuite bathrooms. This is resulting in poor quality environment of care, issues with sewage flooding, heating systems, escalating maintenance costs and impacts on recovery leading to an increased average LOS consistently 60 days which is double than the national average of 30 days.	1. Outline BC completed and submitted 01/01/25, approved 13/02/25 (with conditions) - allowing commencement of activities to progress Full Business Case (FBC) development. 2. BDCT Project Board established with Governance Programme and key delivery team appointments made. 3. Project Delivery Group established delivering the outputs required for the full business case 4. Enabling works completed (£1.275m draw down for early works from NHSE) - revised spend profile being established for subsequent years. 5. Planning submission (reserved matters) approved in Oct 2025. 11. Early modular/MMC contractor engagement with a PSCA resulted in a higher cost than forecast of up to £15m. Additional £15m support agreed with WY ICS. 12. Detailed design (RIBA 4) & value engineering completed and architectural layout sign off including derogations have been agreed at Project Board. 13. Progress reported through Project Board monthly and Finance & Performance Committee. 14. Procurement process underway to inform the FBC. 15. Case Leads and Workstream Leads established for completion of FBC - submission expected November 2025. 16. JIC approval expected in January 2026, with contract award scheduled for March 2026 and works commencing April 2026.	See above	1. Ward to board quality assurance and oversight structures in place to identify, manage and action any emerging issues relating to quality and safety within inpatient services. Daily Lean Management, oversight of incident trend and themes, feedback from service users and staff, all triangulated with audit and quality visits. GO see framework and reports up into Quality Safety Committee and Board. 2. Maintenance work funded through revenue and capital budgets. 3. Oversight of occupancy and bed numbers in relation to safer staffing levels available, ability to deliver safe care maintained on a daily basis. Agreement in 2019 to reduce beds on Ashbrook from 25 to 21 to mitigate ward size and impacts upon quality, safety and recruitment and retention agreed and enacted. 4. Capital works undertaken to create cohorting space to support IPC on 3 wards. 5. Inpatient Clinical Risk Formulation Training and Ligature Risk Training delivered within real time clinical settings with staff teams. Content includes impacts that environment has upon the way risks within the setting presents and therefore the formulation and interventions. Assessment of the environment in the context of the persons clinical presentation and vice versa is dynamically considered and assessed to manage patient safety, privacy and dignity & experience. 6. Inpatient Services engaged in Quality Improvement Initiatives covering the following areas: *Sexual Safety; *Reducing restrictive practice; *Improving inpatient flow	1. Ward to board quality assurance and oversight structures in place to identify, manage and action any emerging issues relating to quality and safety within inpatient services. Daily Lean Management, oversight of incident trend and themes, feedback from service users and staff, all triangulated with audit and quality visits. GO see framework and reports up into Quality Safety Committee and Board. 2. Maintenance work funded through revenue and capital budgets. 3. Oversight of occupancy and bed numbers in relation to safer staffing levels available, ability to deliver safe care maintained on a daily basis. Agreement in 2019 to reduce beds on Ashbrook from 25 to 21 to mitigate ward size and impacts upon quality, safety and recruitment and retention agreed and enacted. 4. 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Ongoing increase in demand to access services, causing additional pressure that are unsustainable on workforce & assurance measures. 2. Increase in cost & maintenance demands causing additional pressures that are unsustainable (e.g. contributing >£10m p.a. in pressures re agency staff, OAPs and excess reactive maintenance costs; wasting a further c£3m p.a. (capital) on short-term planned maintenance solutions; and risking tens of £ms in further OAP costs if wards need to close). 3. Additional pressures that are unsustainable. 4. Additional pressures on workforce that are unsustainable.	Static - 5 Archive(s)
2173	17/10/2022	Finance	Enhance productivity and value for money	12	(4xL3)	12	(4xL3)	Mike Woodhead	Iain MacBeath	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures.	1. Working with BMDC and the Children's Trust to understand the issues, options being considered and system impact. 2. Review of use of intermediate care capacity. 3. Partnership Leadership Executive oversight and consideration of options available to minimise impact. BMDC are in discussions with the Department for Levelling Up and Communities. 4. An independent Advisory Panel has been established in 2024 to oversee any major budget decisions and strategies and progress against the government best value notice. The Best Value Notice has now been lifted. 5. Exceptional Financial Support has been received from the government and remains in place for several years, preventing the need for a section 114 notice. Agreement on financial assistance from Department for Levelling Up and Communities has been received.	None at present	1. System Finance and Performance Committee review of options and system impact. 2. BDC HCP Partnership Board PLE and FPC have sight of position. 3. Internal governance processes within BMDC. 4. CIPFA external review 12 August 2024	1. Initial session held by system DoFs to understand BMDC position and options already considered to manage the position. Follow-up session was on 25th October 2024, oversight is now maintained. 2. Winter Plan was finalised to help manage system pressures. 3. Better Care Fund for 24/25 agreed between partners inclusive of the national discharge funding.	1. Meeting to commence to discuss financial interfaces between the NHS and Local Authority.	Static - 1 Archive(s)
2577	24/12/2025	Quality	Improve healthcare outcomes for residents	9	(3xL3)	6	(2xL3)	John Hartley	Phillipa Hubbard	There is a risk of patient harm to the population of BD&C due to ongoing operational challenges related to the LIMS system changeover, laboratory relocation, equipment validation, and supply chain disruptions have resulted in delayed test turnaround times, specimen rejections, and poor communication with clinical teams. These issues may lead to delayed or missed diagnoses, treatment delays, and increased risk of adverse patient outcomes for the population of BD&C.	1. Increased Quality Team and Data Quality (IT) involvement for escalation triage 2. Regular updates with ICB and Primary Care representatives led by LTHFT 3. Communication with affected practices regarding actions undetaken and to ascertain any potential harms 4. Regular updates provided to Place and ICB SQC and Nursing teams via AAA reporting 5. Ongoing action plan and assurance slides updated weekly and shared during and after update meetings.	1. Limited real-time grip on issue resolution and service performance 2. Inadequate feedback and communication to referring clinicians 3. Absence of formally communicated risk mitigation strategies	1. Established robust oversight and incident monitoring systems through LTHFT led meeting - High priority - GP concerns and steps being taken to manage held weekly 2. Request for GP or primary care representative to attend the LTHFT meeting. 3. Develop and implement clear communication protocols for clinicians and stakeholders 4. Formulation of action plans to address specific issues and share detailed risk mitigation plans addressing patient harm at Place 5. Expedite resolution of operational bottlenecks impacting turnaround times and specimen processing	1. Feedback suggesting that issues are being managed and occurrences reducing. 2. LTHFT led update calls and action plans remain in place 3. Reduction in the feedback received from individual practices (no new issues reported as at 22.01.26) 4. Contact with TPP and Winpath to join the technical group are in progress as the issues are of IT interface rather than laboratory issues 5. Assurance that learning from the incident will be taken forward into future systems changes and updates	Not identified	New - Open
2544	15/07/2025	Both FPC and QC	Improve healthcare outcomes for residents	4	(2xL2)	4	(2xL2)	Vickie Milner	Phillipa Hubbard	There is a risk of the ICB not being able to source high quality and cost effective care for individuals eligible for NHS CHC due to gaps in cost for care and affordable budgets resulting in higher costs to the ICB or individuals presenting with unnecessary deterioration due to unmet needs.	- Market Management and Sustainability activity in place in collaboration with Local Council - direct conversation with Independent Sector Providers relating to gaps in local provision and areas for development - Cost setting activity is consideration of National Living Wage, Consumer Price Index as well as increased costs related to needs of someone eligible for NHS CHC.	- 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.	- Where possible, robust care management arrangements are in place to support reviews of needs. - Relationships have been developed with the Market to support ongoing working arrangements - Move to a WY ICB is supporting wider discussions regarding costs and uplifts and may support block contract arrangements in the WY area. - Contribution to the local Market Position Statement	- Case Management activity - knowledge of overdue review lists and potential impact - developing standard specifications for AACC care contracts	- Requirement for a cost setting tool to support standardised cost setting for base fees for all care home providers - risk of not accessing a placement for an individual if cost 'demands' are not met. - risk of paying more for weekly fee via 1-1 support or other over commissioned package if inflationary uplifts do not meet requirements of the sector.	Closed - Reached tolerance

2040	11/07/2022	Quality	Tackle inequalities in access, experience, outcome	4	(I2xL2)	3	(I3xL1)	Nagina Javaid	Matt Sandford	0-19 SERVICES: POTENTIAL NEGATIVE IMPACT ON OTHER HEALTH SERVICE DELIVERY There is a risk of negative impact on health services due to reduced capacity within redesigned health visitor, school nursing and oral health services resulting in inappropriate referrals to other services due to lack of early help and/intervention and increased waiting lists.	1. CBMDC Public Health services were subject to a WSOA in the Ofsted/CQC SEND inspection which took place in March 2022 which highlighted inconsistent delivery of 0 - 19 and school nursing services, along with ICB commissioned specialist nursing services. This resulted in the development of a response to the WSOA which outlines our planned service improvements and has the support of BD&C HCP. 2. Better Start Bradford and BDCFT Community Children's Services have worked together to ensure the legacy and continuation of the MECSH programme for Bradford families. This has resulted in a detailed roll out plan across all Localities as well as the introduction of the Infant to School Programme. 3. 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. 4. The work of the 0-19 connect to all 3 principles, particularly principle one, where there is a leadership team and working group set up which the focus, School Readiness, School Absence, ELSEC, MNVP, triangulation of data, talking Bradford, ready to relate etc. – all of which supports the 0-19 work. 5. Health visiting review has taken place (2025/26), the report will be produced by November 2025 - this will form a blueprint of the next phase of the 0-19 contract.	1. There was a possibility that despite additional funding demand continues to grow, however significant work has been done to understand demand v workforce capacity and needs. In addition, there is a strong principle 1 group, good leadership within HCFB and through Michelle Holgate and Susan Clayton as SROs for Principles One. Dawn Lee who leads on the 0-19 service has also been instrumental in understanding service, challenges, gaps and adapting to find solutions where there are gaps. The HV review has been helpful, its report will be a useful indication of a way forward, however we must ensure that through the open commissioning of the 0-19 service we do not destabilise the system.	1. Continued dialogue between partners about the principal risk and impact on Universal, Prevention and Early Help work and families. Alongside increasing demand on services. 2. key individuals from the 0-19 service are engaged and involved in wider service improvement conversations 3. The governance arrangements for the Healthy Children's and Families Programme Board has been refreshed and strengthened. 4. A Complex Support Needs Panel has been developed to include representation from Healthy Children's and Families, Healthy minds and Healthy Communities to better understand complexity of cases and how the system can respond.	1. DCFT Public Health Nursing performance is positive across KPIs / Metrics. 2. Principle one work (Universal, Prevention and Early Help) is progressing. 3. Through the work to respond to SEND WSOA3 the BDCFT 0 – 19 team have made significant improvements in the achievement of key performance indicators. 4. 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.	1. 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. 2. The 0-19 contract is being re-negotiated.	Static - 8 Archive(s)
2047	12/07/2022	Both FPC and QC	Tackle inequalities in access, experience, outcome	3	(I3xL1)	1	(I1xL1)	Vickie Milner	Debbie Winder	DOLS in PCD FUNDED CASES There is a risk of legal challenge against the HCP and potential harm to patients due to unauthorised Deprivation of Liberty (DoL) in PCD funded community cases resulting in reputational and financial damage. Where people are deprived of their liberty in their own homes as a result of PCD funded packages of care, we are responsible for seeking authorisation from the court, however the court has a large backlog and these cases are outside the scope of the existing Deprivation of Liberty Safeguards (DoLS). This is a nationally recognised problem and Local Authorities and HCPs across the country are taking a risk management approach to prioritise only the most contested cases. The planned Liberty Protection Safeguards (LPS) aim to provide a statutory process for CCGs to authorise CHC funded cases, without the need for court proceedings, this activity has now been paused. Financial implication to WYICB each DOLS case cost on average £2000	The PCD use a risk management approach to identify cases where there are significant objections or unresolved areas of disagreement relating to the persons deprivation of liberty which are then prioritised for legal advice. Where necessary, an approach is made to the court of protection to authorise the deprivation of liberty. The PCD has a clinical lead in post and established systems for identifying potential DoL in CHC cases. Case numbers are monitored by the PCD. We have 80 outstanding DOL's for full assessment our Clinical Lead will be undertaking these assessments.	There is insufficient resource within the CHC team to progress all identified cases of DoL and to undertake preparatory work for the court of protection. There is also a lack of capacity within the Court of Protection nationally to deal with even the current number of cases raised by HCPs and LAs.	LPS National Guidance has been published and activity regarding the resourcing and identification of process is being led by Matt O'Connor. This is now paused Updated 01.04.2025 We have an dedicated MCA/COP lead in the CHC team who is leading DOL's however is still case managing some complex cases that need to be seen in the court arena. We use a prioritisation tool and we are looking at the screening tool in the new IEG4 system that is been used from 1.4.25	12/07/2022 Active monitoring of cases continues on a weekly basis and court activity occurs as necessary. 14/09/2022 No change in position with regard to monitoring and managing this caseload. Activity is occurring on an as necessary basis 29/11/2022 Court of Protection activity continues to occur on an as necessary basis when a Deprivation of Liberty or best interest decision is challenged 24/03/2023 No change in position with regard to monitoring and managing this caseload. Activity is occurring on an as necessary basis and we still await the national guidance on the changes to process/procedures 25/5/2023 Clinical lead has been released from CHC work to prioritise the Community DOL's, currently prioritising the cases and will undertake the DOL's assessment feeding back weekly to managers with caseload.	April 24: The joint arrangement and assurance under S75 described in the update in Feb 24 remains in place. 25/05/2023 Looking at training for nurses to undertake BIA assessor course to increase the resource within the team. 12/07/2022 PCD's ability to report remains unchanged whilst the team continue to transfer data across to it's new reporting system (adam) 14/09/2022 PCD are still progressing the data input into the new information system. reporting capability on this caseload remains unchanged and limited at present. 29/11/2022 All data has been added to the new information system and is currently being validated. A reporting process that captures all Court of Protection activity is being developed and once completed, this will allow reporting on all activity. 24/03/2023 Development of activity reporting continues and at present we wait for notice of any national reporting that may be required.	Closed - The risk is on the Corporate ICB risk register, so agreed to close the risk on BDC Place risk register.
2528	10/04/2025	Both FPC and QC	Tackle inequalities in access, experience, outcome	2	(I2xL1)	2	(I2xL1)	Duncan Cooper	Sohail Abbas	There is an increased risk of data breach by some of our smaller VCSE providers (21Core20+5 project providers with funding of cE540K in 25/26) Due to the fact that they have not registered for and / or published a recent self-assessment against the NHS Data Security & Protection toolkit, which is a requirement of the NHS standard grant agreement Which could result in reputational damage for the ICB, as well as negative impact to relationships between the ICB and the local VCSE sector	1. Working with VCSE alliance BDC and WY Harnessing the power of community Team 2. Liaising with ICB contracting dept 3. Liaising with WY ICB Information Governance Lead 4. West Yorkshire wide work around contracting and procurement with the VCSE sector 5. Communicating with providers to remind them of their grant agreement requirements (Apr 2025)	1. Some smaller organisations do not have the funding, capacity, resources and skills to comply with the DSPT on a timely basis	Issue being raised at - Healthy Communities Team Meeting Reducing Inequalities Alliance Meeting Extended Management Team Meeting	1. Update from VCS Alliance (27th January 2026) is that: Organisations from the original list 22 - Organisations that registered on the DSPT website (88%) 13 - Organisations that submitted Approaching Standards (52%). 8 - Organisations that submitted a full DSPT (32%) 4 - Organisations still in the process of either submitting AS or preparing a full submission (16%). Out of these 4, only 2 haven't registered yet (8%). Training and guidance have been provided to organisations on several occasions, and VCSA will soon reach out to all the organisations regarding the new guidance and are confident that a successful submission will be reached in May/June 2026.	Risk to be closed.	Closed - Reached tolerance

Bradford District and Craven Health and Care Partnership

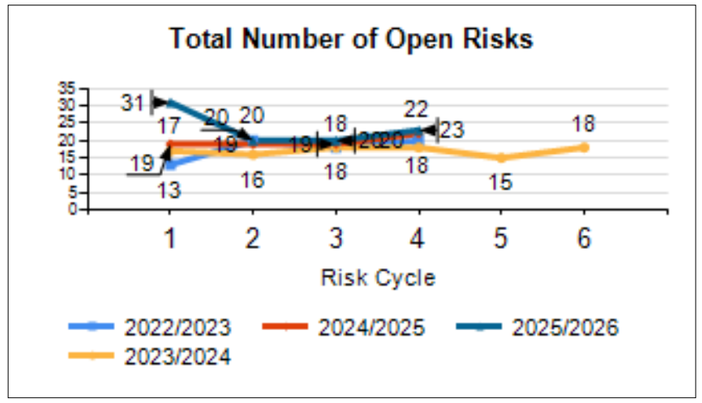
ACTasONE

Bradford District and Craven place, Risk on a Page Report Cycle 4, 2025/26

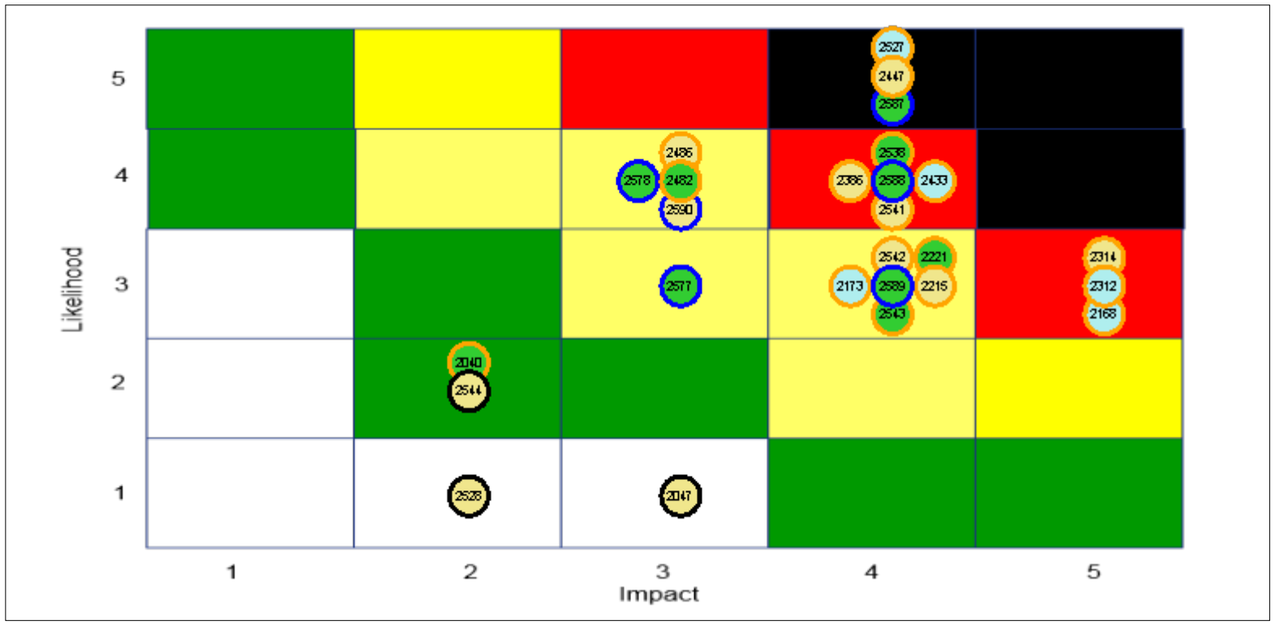
NHS West Yorkshire Integrated Care Board

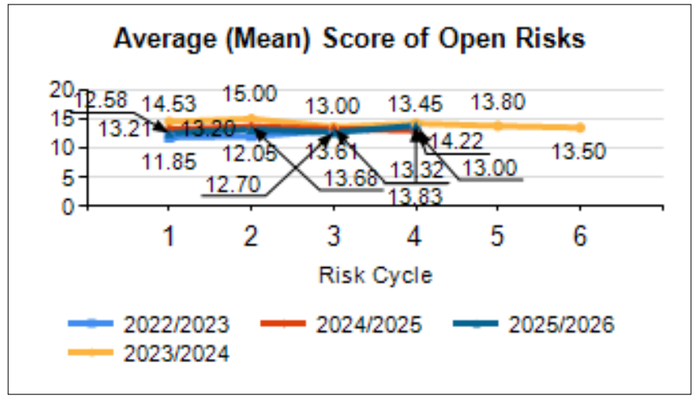
Total Place Risks	26
Finance & Performance	5
Quality	10
Finance and Quality	11

Movement of Risks		Risk Score Increasing	0
New	6	Risk Score Decreasing	0
Marked for Closure	3	Risk Score Static	17



Risk Overview (BDC place)



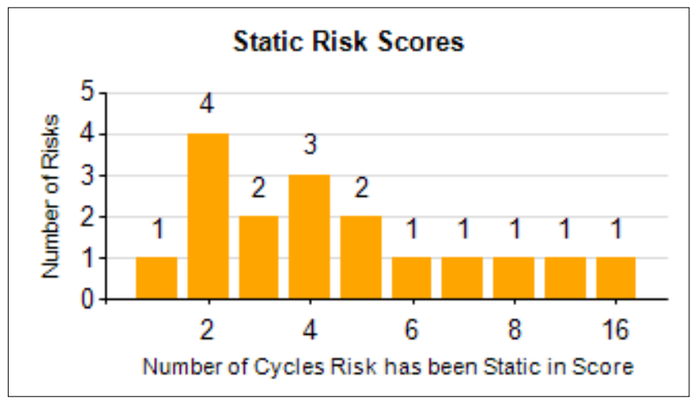


Key

- Quality
- Finance
- Both FPC and QC

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

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



West Yorkshire Integrated Care Board - Board Assurance Framework - Guidance notes for completion *(version 13, December 2025)*

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	Marginal reduction to health	Minor reduction to health	Moderate reduction in health	Significant reduction in health	

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 Local resolution	Investigation by Health Service Ombudsman Minor out-of-court settlement	Multiple complaints Judicial review Litigation expected Civil action – no defence	Litigation certain 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: 13	Date: Dec 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	12	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	Quality Committee
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	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

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 13														Dec-25
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield	
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	16	9	12	6	9	6	12	9	16	9	16
	1.3	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Open	8	16	8	16	8	12	8	16	9	12	8	12
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	6	8	4	9	4	6	4	8	4	12	4	12
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	9	2	4	2	6	2	8	2	6	2	6
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	16	9	16	9	16	9	16	9	12
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	6	12	4	12	4	12	4	9	4	12
	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	9	20	9	20	9	20	9	20	9	20
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	9	12	4	12	4	16	4	12	4	16	4	12
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	8	8	8	8	8	12	8	12	8	8
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	6	9	8	12
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required

WYICB - Board Assurance Framework - ICB and places		Version: 13	6 October 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)**			
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**	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. No change to risk score.
	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.	
5	As part of the organisational change programme the ICB is establishing a strategic commissioning function, this function will establish capabilities to understand and respond to inequalities	

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; **2402** - access GP services; **2106** - Cancer health inequalities; **2308** - Neurodivergent population **2503** - maternity
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)	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Sohail Abbas 07.01.26**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**4**	**20**	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.
	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. 7. We are working with the VCS alliance to continue the core20plus5 projects that showed significant improvements in health inequalities from April 26 onwards. 8. RIA is holding meetings with provider colleagies to discuss how the learning and work on health inequalities continue in provider partnership following the ICB changes.
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**	**Nominated lead for this risk:**	**No update**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**	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.
	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 packs 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**	**Nominated lead for this risk:**	**No update**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**	Recognise that addressing inequalities will take time and there are factors beyond our 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 **Links to place risk register:** 2475, 2240, 2445
2 Health and Wellbeing Plan	
3 Kirklees Economic, Environment and Inclusive Communities Strategies.	
Sources of assurance *(Where is the evidence that the controls work?)*	
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 Ryley**	**Nominated lead for this risk:**	**No update**

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) **Links to place risk register:** 2415, 2354, 2301, 2018
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	
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:**	**No update**

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 13	7 October 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?)*	
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
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.

Mitigating actions *(What more are we/should we be doing at ICB level?)*

1. EQIA process on any proposed service change and commissioning policy change (2025/26).
2. As part of developing the ICB operating model we are building a strategic commissioning function that will help ensure that the organisation has the right focus on reducing health inequalities and improving outcome, 2025/26
3. Our approach to integrated neighbourhood healthcare is predicated on population health management principles which ensure there is the right focus on communities with the greatest need.
4. As part of the economic accelerator programme we are focusing on improving economic participation in communities where inequalities and poor outcomes are highest.

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Partnership Board focus on 10 big ambitions
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
6	Integrated neighbourhood health board
7	Health and wellbeing boards (sign off integrated neighbourhood healthcare plans)

Links to ICB risk register *(Reference numbers/brief description)*

Risk 2309 - demand for CYP mental health services; **2451** - Delays in gender identity specialist services; **2525** - delays in health assessments of CiC; **2479** - children's hospice care

Bradford District and Craven (BD&C)	Place lead:	Therese Patten	Nominated lead for this risk:	Sohail Abbas 07.01.26

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?)*	
1	QEIA assessments in routine use
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).

Mitigating actions *(What more are we/should we be doing at place?)*

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)

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.
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

Links to Place Risk Register

2386, 2227, 2039, 2221

Calderdale	Place lead:	Robin Tuddenham	Nominated lead for this risk:	No update

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?)*	
1	Clear plan for place share of £12m led by DPH, reports to HWBB.
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.

Mitigating actions *(What more are we/should we be doing at place?)*

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 undelrying position does not deteriorate.
3. Change programme and new ICB operating model will impact on this risk and will be monitored.

Sources of assurance *(Where is the evidence that the controls work?)*	
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

Links to Place Risk Register:

2224, 1338, 2476, 2149, 1998, 1493, 62, 2092

Kirklees	Place lead:	Vicky Dutchburn	Nominated lead for this risk:	No update

ICB risk appetite	Place risk scores	Rationale for current place score

ICB risk appetite	Target (Kirklees)			Current (Kirklees)		
OPEN	Likelihood	2	6	Likelihood	3	12
	Impact	3		Impact	4	

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.

	Key controls *(What helps us mitigate the risk?)*
1	Health and Wellbeing Strategy
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.

Mitigating actions *(What more are we/should we be doing at place?)*

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)

	Sources of assurance *(Where is the evidence that the controls work?)*
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

Links to place risk register:
2240

Leeds — **Place lead:** Tim Ryley — **Nominated lead for this risk:** No update

ICB risk appetite	Place risk scores: Target (Leeds)			Current (Leeds)		
OPEN	Likelihood	3	9	Likelihood	4	16
	Impact	3		Impact	4	

Rationale for current place score

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.

	Key controls *(What helps us mitigate the risk?)*
1	Local strategy with a focus on health inequalities (Healthy Leeds Plan), with key data cut by IMD and other relevant HI metrics.
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)

Mitigating actions *(What more are we/should we be doing at place?)*

1. Partnership focus in 25/26 on programme benefits quantification should support greater assessment of potential HI impact (2025/26)
2.Review approach to incentives in line with strategic commissioning role towards the end of this financial year (March 2026)
3. Provide both challenge and support to emerging HealthCare Inequalities Oversight Group, which has a partnership focus across providers (2025/26)

	Sources of assurance *(Where is the evidence that the controls work?)*
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

Links to place risk register:
2354, 2301, 2480

Wakefield — **Place lead:** Mel Brown — **Nominated lead for this risk:** No update

ICB risk appetite	Place risk scores: Target (Wakefield)			Current (Wakefield)		
OPEN	Likelihood	3	9	Likelihood	4	16
	Impact	3		Impact	4	

Rationale for current place score

Reflects the Integrated Care Board position. Local places have limited powers to reduce likelihood.

	Key controls *(What helps us mitigate the risk?)*
1	Allocation of CORE20plus5 monies
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

Mitigating actions *(What more are we/should we be doing at place?)*

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)

	Sources of assurance *(Where is the evidence that the controls work?)*
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

Link to Place Risk Register

2128

WYICB - Board Assurance Framework - ICB and places							Version: 13	6 October 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 *(linked to place committees)*
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 *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
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. There are three pilot programmes running across WY (Leeds, BDC and Wakefield) the learning from these pilots will be shared with other areas and nationally (Approved 2025, work ongoing from 2025/26).
2	ICB medium term financial plan supports a differential investment towards primary and community care.	
3	All places are developing integrated neighbourhood healthcare plans which will respond to the ICB blueprint and describe and quantify the improvements that will be made locally. These plans will be signed off by the health and wellbeing boards.	
4	Quality Committee and ICB Board receive Integrated Performance Dashboard which reflects progress made towards integrating services and neighbourhoods.	
5	In line with the future strategic commissioning responsibilities the ICB is developing commissioning intentions and contractual mechanisms to enable and incentivise integrated models of healthcare.	
6	Places continue to develop their models of collaboration with a view to implementationin shadow form from Apr 2026.	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** (Reference numbers/brief description)
1	Published ICB strategy and local neighbourhood health plans	**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 neighbourhood delivery model health 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)	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Sohail Abbas (07.01.26)**

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 *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
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) 6. We are working with LMC on reviewing and refreshing the local enhanced service (LES) schemes with a strong emphasis on prevention, proactive care in community and digital transofrmation.
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 *(Where is the evidence that the controls work?)*	**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	
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	2221, 2486

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**No update**

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 *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
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 *(Where is the evidence that the controls work?)*
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 this risk:**	**No update**

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 *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*

1	Core20+5 is being lead by the Public Health team on behalf of the Partnership
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
3	INT data packs developed and data sharing agreements in place
4	A number of services including VCSE already aligned around communities

Sources of assurance *(Where is the evidence that the controls work?)*

1	Published Health and Wellbeing Strategy
2	The local Health and Care Plan follows directly on from the Health and Wellbeing Strategy
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.
8	WY INH Board in place

1. Programme plan in place to fully implement integrated neighbourhood teams and improve integrated neighbourhood health in line with 2025/26 planning guidance
2. Business case developed for accessing West Yorkshire SDF funds (non-recurrent) to assist with accelerating pace of implementation
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. Regular fortnightly call in place with SROs for 6 core components of integrated neighbourhood health
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)
6.Planned refresh of the objective within the health and care plan (2025/26)
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)

Links to place risk register
2475

Leeds **Place lead:** **Tim Ryley** **Nominated lead for this risk:** **Helen Lewis (23.12.25)**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	2	8	Likelihood	3	12	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.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*

1	Strong LCPs and PCNs.
2	All relevant data displayed by IMD and other key variables linked to inequalities.
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
4	LCH and Leeds City Council now have a joint digital clinical record enabling therapy and care staff to work on the same note, and with therapists jointly overseeing and designing care with the reablement team

Sources of assurance *(Where is the evidence that the controls work?)*

1	Access to Leeds data model/power BI platforms, and RAIDR to review data sets.
2	Notes of LCP/PCN meetings.
3	All LHCP programmes pay due attention to joining up services, demonstrated via minutes.

Mitigating actions *(What more are we/should we be doing at place?)*

1. Developing integrated neighbourhood clinics are in place and considering further developments (2026/27)
2. LCH and GP confederation looking at neighbourhood integration opportunities as part of the system neighbourhood health model (2026/27)
3. Community mental health programme engaging all relevant partners to improve service integration and focus on those people most at risk (new contract with VCSE 2026/27)
4. All Neighbourhood Health work proceeding at pace, including input from OD to look at the cultural barriers to integration - work ongoing 2026/27

Link to place Risk Register
2415

Wakefield **Place lead:** **Mel Brown** **Nominated lead for this risk:** **No update**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	2	8	Likelihood	3	12	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.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*

1	Wakefield Transformation and Delivery Collaborative established supported by a network of Provider Alliances with responsibility for joining up services and addressing inequalities
2	Core Senior Leadership team established across Wakefield place with distributed leadership responsibilities
3	Action plan to address the gaps following the publication of the Fuller report
4	This work is connected to the work to develop a neighbourhood model

Sources of assurance *(Where is the evidence that the controls work?)*

1	Transformation and Delivery Collaborative Chair's report to Wakefield District Health and Care Partnership highlights key discussions - bi monthly
2	Provider Alliance deep dive regarding progress against priorities reported to Transformation and Delivery Collaborative - monthly
3	Medical Director for Integrated Community Services attends Fuller Board

Mitigating actions *(What more are we/should we be doing at place?)*

1. The development of a neighbourhood model enables a targeted and more planned approach to care (2025/26)
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. The work to develop the place response to reducing economic inactivity is currently taking shape (2025/26)

Links to Place Risk Register
2397, 2429

WYICB - Board Assurance Framework - ICB and places							Version: 13	31-Oct-25
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, currently undergoing calls for evidence, and Adult Social Care workforce strategy.	
OPEN	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**16**		
	Impact	**2**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
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. Draft revised People Strategy will be presented to the WY People Board on 26 November 2025. 2. 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 2025/26 3. 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 - work is ongoing. 4. 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. This is currently paused and awaiting further national guidance. 5. 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. ICB to monitor the impact of this - 2025-27. 6. ICB workforce strategy team responding to national call for evidence, which is part of the process to refresh the NHS Workforce Plan (2025/2026)
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.	
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	
4	Workforce Place Leads and place-based plans (for further details, see Place BAF below)	
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. International recruitment is currently very low.	
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.	
7	The ICB received detail from each NHS provider of their current workforce planning and control mechanisms. These will be used to help NHSE monitor each Trusts workforce position against its operating planning submission (2025/26)	

	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Transformation Committee; Strategic Workforce Forum; People Board - agenda, papers and minutes	**2296** - YAS workforce; **2108** - cancer workforce; **2402** - general practice workforce; **2557** - ICB workforce, **2535** - ICB workforce **2537** - 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.	
4	Active data flow across wider People agenda, which is presented to the People Board and Strategic Workforce Transformation Forum.	
5	(NHS specific) Staff Survey annual results	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Andrew Milner 06.01.26**

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 signficant challenge. Current financial and organisational circumstances mean recruitment across healthcare organisations continued to be limited. As a result, risk score remains at 16.
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**16**	
	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	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. Work with Skills House within Bradford Metropolitan District Council on developing sustainable recruitment pipelines from within the Bradford and Craven area continues, with lead responsibility now being passed to BMDC. Engagement with NHS and Social Care organisations to identify an appropriate delivery mechanism within the current organisational change programmes (ongoing 2025/26 and beyond). 3. Working across the system within partners including Higher Education Institutions to develop a pipeline for registered health and care roles. System wide approach has been developed for optimising placement capacity and aligning educational and service capacity (Ongoing 2025/26 and beyond)
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 *(Where is the evidence that the controls work?)*	**Links to Place Risk Register**
1	Triple A report from SFPC to Partnership Board	
2	Highlight reports from the People Programme through a Programme Board	
3		2386, 2227, 2477, 2434, 2422, 2420, 2418, 2417, 2215, 2421,

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**No update**

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.
CAUTIOUS	**Likelihood**	**4**	**8**	**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	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 *(Where is the evidence that the controls work?)*	**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 this risk:**	**No update**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
CAUTIOUS	Likelihood	4	8	Likelihood	4	16	Whilst workforce data shows that generally the workforce is increasing at a modest rate, it is not 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 independant 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.
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.

Link to place risk register:
2498

Leeds — **Place lead:** Tim Ryley — **Nominated lead for this risk:** No update

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
CAUTIOUS	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 priorty 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?)*
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

Link to place risk register:
None.

Wakefield — **Place lead:** Mel Brown — **Nominated lead for this risk:** No update

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
CAUTIOUS	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 initaitives 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.
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: 13	30-Oct-25
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)**			Continued formal assurance is needed through Transformation Committee and Partnership Board. With the changes in Digital leadership, we are assured that there is maintained links between digital and innovation. Uncertainty around the implications of current changes with ICBs and the impact on the WY ICB research and innovation function, risk score remains the same in Cycle 3, 2025/26.	
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**2**	**8**		
	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. Continues in 2025/26 2. Annual review to bring additional rigour with lens on innovation and research (2025/26)
2	Research via Applied Research Collaborative (ARC)	
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	**2108** - Cancer workforce plan
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 09.01.26**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Recognise the impacts of the changes to the form and function of the ICB from April 2026, the reduced resource availability at BD&C Place, the ongoing emergence of the provider collaborative and the supporting governance and assurance structures. To sit against the revised strategy'Our plans for health, care, and wellbeing in Bradford District' (September 2025) BDC Risk score remains at 9 due to the ongoing period of change.
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	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. Work ongoing to identify future arrangements as Place to ensure the provision of assurance to the BDC system on the quality of services provision post April 2026. Until March 2026, the system quality insight and assurance group (SQIAIG) 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. It is proposed that, alopngside the Finance, Performance and Quality Forum (FPQ),k the SQIAIG or similar remains in place as an interim	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 and onwards.) 2. Work is progressing on the BDC clinical strategy and the role of the Clinical and Professional Forum to support streamlining of clinical pathways - January 2026 3. Governance system structures and alignment to support the wider collaborative have been revised, including workstreams for integrated neighbourhood health.
2	Priortisation exercise to maximise use of resources - We are completing a strategic review of the work of each priority area (prioritisation exercise) to ensure that available resource is focused on the areas of highest priority against national, regional and local priorities including Financial and Quality criteria whilst focussuing on outcomes for the population	**Links to Bradford place risk register:** 2419
3	Model of Distributive leadership remain in place up to March 2026 in BDC with HCP for Chief Nurse which provides opportunities to provide assurance and oversight, share best practice, learning and improvement opportunities between partner organisations	
4	Quality Team input into ICB Efficiency Savings Programme Meeting and Efficiency Plan to ensure that QEIA completed for each efficiency scheme - to ensure that risks and potential impacts to service provision and outcomes/inequalities are recognised, communicatede and mitigated where possible	
5	Quality requirements are represented with all providers and monitored through the consolidated WY ICB contract management process	
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 and Professional Forum and SQC/SQG and ICB governance structures - through AAA updates from assurance and governance committees (combined F&PC SQIAIG and meet monthly) and priority and enabler programmes.	
2	Redeveloped model/way of working for the Place (BDC) 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	Supported by shared system committees for Finance and Performance, Quality and Safety, and our Clinical Forum. The Place 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:**	**No update**

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.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**2**	**6**	
	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

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	consistency in single contracts, to help avoid variation. Consistent Independant Sector waiting times recently agreed across WY.
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:**	**No update**
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. Establish clearer connections between the WY ICB and the West Yorkshire Innovation Leadership Collaborative (Review 2025/26) 3. Chief Digital and Information Officer attending Kirklees Board Development Session to share learning, next steps (Q2, 2025/26)
2	Working across places and with WY programmes to share learning and experience, identify variation, and opportunities for improvement	
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	
4	Active participation in WY networks and programmes with evidence of having shared learning from Kirklees, and adopted it from elsewhere.	**Link to place risk register:**
Sources of assurance *(Where is the evidence that the controls work?)*		2445
1	Evidence of early adoption and innovation in place e.g. UCR, Lung Health Checks, approach to neighbourhood working.	
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 Ryley**		**Nominated lead for this risk:**	**No update**
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 priortisation. 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. 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. 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.
2	Regular contribution and representation at the ICB Quality Committee and System Quality Group	
3	Regular contribution and representation at the WY ICB Safeguarding Oversight and Assurance Partnership	
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:**
Sources of assurance *(Where is the evidence that the controls work?)*		2480, 2487
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 08.01.26**
ICB risk appetite	**Place risk scores**				**Rationale for current place score**
	Target (Wakefield)		**Current (Wakefield)**		We continue to experience a high level of system pressure in Wakefield, which can lead to variations in care from what may be experienced in other areas of the WY system. We have been particularly challenged in urgent and emergency care, access for into certain health and social care services and we have specific concerns around the quality of care delivered in the care home sector in Wakefield. There has however been several pieces of improvement work happening over the last 12 months in Wakefield to improve patient flow in urgent care and access, and we continue to work closely as a system on quality improvement in our care home sector. The score remains at a 12.
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	1. The acute provider in Wakefield has commenced a trust wide improvement programme called 'working together' adopting principles of continuous improvement and daily management to ensure better access and flow across the organisation - 2025 - 27 2. Clinical and professional engagement takes place across the district and is collated and monitored as part of our approach - ongoing 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 - 27) 5. Wakefield place based partnership is currently in development and will be operating in shadow form from April 2026.
2	Experience of Care Network - sharing good practice following feedback from service users	
3	Transformation and delivery committee established to which shares good practice and focus on improving services	
4	Patient safety priorities, development of place quality priorities, and alignment with West Yorkshire quality priority areas in place	
5	Wakefield District plan 2025-2035 sets out a joint vision for health and care services across the district, with 6 ambitions including helping people to live healthy lives and developing strong services that work for people	
6	Shared quality frameworks in place	
Sources of assurance *(Where is the evidence that the controls work?)*		

1	Reports provided of quality across the WDHCP of areas of transformation and improvement	
2	Minutes of meetings from multiple governance forums	
3	Recommendations and action plans from Care Quality Commission inspections and quality visits	**Links to Place Risk Register**
4	Local perfomance dashbords and improvement plans	None.

WYICB - Board Assurance Framework - ICB and places		Version: 13	29-Sep-25
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)**			
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**3**	**9**	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.
	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	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. High focus areas are published and shared in national and regional NHSE data packs so we all have the same information and can be used to improve performance (continuous, 2025/26) 3. As the federated data platform matures, oversight of performance will be enhanced (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 *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Minutes of Board and committee meetings	None identified
2	Minutes and action logs of System Oversight and Assurance Group (SOAG), FIPC 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	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Sohail Abbas and Kerry Weir (30.12.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**2**	**4**	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.
	Impact	**2**		**Impact**	**2**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	BDC HCP (place) governance assurance through sub-committees System Finance and Performance Committee to the Partnership Board	1. Reviewed governance arrangements, which will help to triangulate performance across the range of areas (2025/26) 2. Dashboards and performance reports to be updated to reflect 2026/27 operational planning requirements.
2	BDC HCP (place) governance assurance through sub-committees System Quality Committee to the Partnership Board	
3	HCP programme boards	
4	Partnership Board level outcomes report has been developed and includes health and inequalities metrics	
5	Finance, performance and quality forum (inbetween the FIPC and QC quaterly meetings) performance reported monthly to the extended leadership team (ELT)	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place Risk Register**
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)	2168, 2423
2	Sub Committee of Quality committee receives performance dashboard focussing on patient experience and outcomes and statutory requirements, issues discussed at Quality Committee	
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)	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**No update**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**2**	**6**	Established performance monitoring process across commissioners and providers. Recognise we have potential BI capacity issues but we are currently performing as expected.
	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	Oversight framework used as base of performance monitoring at CCPB.	(See WY response above regarding BI) 1. Calderdale has good oversight on the key national performance metrics and out perfoms in a number of areas. 2. Joint UECB across CHFT footprint monitoring urgent care performance, including winter, discharge and ambulance performance.
2	Working with partners to provide singular view at WY and place level.	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to Place Risk Register;**
1	Performance monitoring at CCPB. Papers and Minutes.	2476, 2149, 62

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**No update**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**2**	**8**	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.
	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	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. Data sharing agreement across primary and secondary care with regards to integrated neighbourhood team development (100% by Q2, 2025/26)
2	Partnership processes for sharing timely data across the system partners	
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 *(Where is the evidence that the controls work?)*

1	Minutes of Finance and Performance Sub-Committee and Kirklees Health and Care Partnership Board
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%

Link to place risk register:
None.

Leeds **Place lead:** **Tim Ryley** **Nominated lead for this risk:** **No update**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			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.
OPEN	Likelihood	1	2	Likelihood	2	6	
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*

1	System Resilience Operational and Coordination groups in place, and daily pressures meeting.
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 *(Where is the evidence that the controls work?)*

1	Minutes of meetings.
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.

Mitigating actions *(What more are we/should we be doing at place?)*

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.

Link to place risk register:
None

Wakefield **Place lead:** **Mel Brown** **Nominated lead for this risk:** **No update**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			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.
OPEN	Likelihood	1	2	Likelihood	2	6	
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*

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
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 evaulation
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 collaberative performance reporting / analytics across the Wakefield system / MYTT

Sources of assurance *(Where is the evidence that the controls work?)*

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 Collaberative, 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)
5	Through collaberative working / shared BI roles across ICB/MYTT, the ICB is kept informed of any upcoming or changes to risks to performance and reporting.

Mitigating actions *(What more are we/should we be doing at place?)*

1 Currently working on the flow of community data to extend the OPEL framework to incorporate community services (2025/26)
2 Continue to strengthen collaberative / 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 suppport performance delivery and access to timely data to support daily decision making (OPTICA, shared Patient Treatment List) Ongoing development 2025/26

Link to Place Risk Register

None

WYICB - Board Assurance Framework - ICB and places		Version: 13	7 October 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; - significant backlog maintenance, unsuitable and aged physical estate and medical equipment replacement delays. - 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.Continue to consider approaches to 'carve out' an element of operational capital to support schemes more strategic in nature (specifically including a currently assessed shortfall on the Calderdale Royal Hospital development). 2. Work with NHS England NEY and WY NHS Providers on the arrangements that will be put in place in 2026-27 in relation to management, decision making and oversight of all capital allocations and expenditure (as signalled in the model ICB blueprint) 3. Digital investments to be aligned with the model region and model ICB blueprints, and in addition to be increased to support the NHS 10 year plan. 4. (Digital) - evaluating the current operating model in alignment with the restructuring of digital, data and technology according to model region and model ICB blueprints. 5. Seeking more clarity from NHSE for overall structure of digital, data and technology in delivering the 10 year plan (2025/26)
2	Regular oversight and assurance from ICS infrastructure strategy oversight group.	
3	Digital Programme 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 Infrastructure Strategy Oversight Group; ICS Finance Forum; Digital Programme Board	**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 **2036 -** Airedale Hospital plan **2522** - NHS infrastructure investment
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.	

Bradford District and Craven (BD&C)	Place lead:	Therese Patten	Nominated lead for this risk:	Matt Sandford 05.01.26

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. 4. 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. 6. Strategic Estates Group reinstated, bringing key strategic capital/ estates leads together from across the system, focused on prioritisation of programmes and investment proposals.
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:	No update

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 affordabililty. 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?)*	
1	Reports to Committee

Link to place risk register
None

Kirklees	Place lead:	Vicky Dutchburn	Nominated lead for this risk:	No update

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	3	9	Likelihood	4	16	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 the Kirklees Estates, which will create unwarranted variation of services for the Kirklees place.
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*	
1	Estates Strategy
2	IT Strategy
3	Estates and IT leads
4	Kirklees - one public estates forum now established
5	

Sources of assurance *(Where is the evidence that the controls work?)*	
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

Mitigating actions *(What more are we/should we be doing at place?)*

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. 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. Ensure funding available flows into the Kirklees place.
4. Work with partners and stakeholders to access capital resources to support development in primary care (2025/26)
5. On going round table meeting of senior leaders to support the ongoing development of the CHFT reconfiguration

Link to place risk register:
None.

Leeds	Place lead:	Tim Ryley	Nominated lead for this risk:	No update

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	3	9	Likelihood	4	16	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.
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*	
1	Leeds City Strategic Estates Board and its Specific Programme Boards meet
2	City Wide Digital Resources are combined across Health and Social Care jointly
3	Providers have strong infrastructure to manage capital planning and building.

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.

Mitigating actions *(What more are we/should we be doing at place?)*

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. 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. City Wide Digital and Estates Strategies linked to our wider H&WB plans (2025/26)

Link to place risk register:
2530

Wakefield	Place lead:	Mel Brown	Nominated lead for this risk:	No update

ICB risk appetite	Place risk scores						Rationale for current place score
				Current (Wakefield)			
OPEN	Likelihood	3	9	Likelihood	3	12	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.
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*	
1	Wakefield Place Digital Strategy in place and now being aligned across partners
2	Wakefield Place Finance Working Group linking into the West Yorkshire Integrated
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?)*	
1	Minutes from Digital Programme Board
2	Place nominated lead on West Yorkshire groups
3	Digital maturity assessments (annually) - national programme

Mitigating actions *(What more are we/should we be doing at place?)*

1. Place digital forum brings together all sector and it delivers on the place digital strategy (2025/26)
2. Both business as usual replacement and innovation investment.

Link to place risk register:
2481, 2440

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 13	29-Sep-25
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?)*
1	Surveillance systems
2	Pandemic Plan
3	Exercises
4	Business Continuity Plans
5	

Mitigating actions *(What more are we/should we be doing at ICB level?)*

1. Awaiting findings of the national Covid inquiry to incorporate learning into plans. Specific recommendations around the NHS continues.
2. Oversight of adherence to EPRR core standards and working with providers on their compliance

	Sources of assurance *(Where is the evidence that the controls work?)*
1	EPRR Core Standards and assurance process provide evidence that plans are in place and tested - this is reported to the ICB Board annually
2	Local Health Resilience Partnership meets quarterly to review learning from incidents and exercises.
3	Local Resilience Forum (multi agency) meets quarterly

Links to ICB risk register *(Reference numbers/brief description)*

2456 - Health protection

WYICB - Board Assurance Framework - ICB and places							Version: 13	7 October 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 to consider issuing direction to all Places that there should be a shift of investment from acute hospital services to community, primary and prevention programmes as part of 2026/27 and medium term plans (2025-27) 2. Place Committees and the emergent place provider collaboratives to develop plans in line with this intent (2026/27)
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	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Karen Parkin (29.12.25)**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			1. Agree with the WYICB scores and these are relevant for place too. 2. There has not been investment in community services in the Bradford & Craven Place other than within the ring-fenced SDF such as Core20+5 and accelerator funding - small pots of funding for specific purpose. The acute sector has had higher growth compared to community. Target score increased from 4 to 6 (impact increased from 2 unlikely to 3 possible) in line with WY ICB.
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 place?)*
1	BDC Place will follow the WYICB strategy to apply 2% growth and 4.3% for additional service improvement with the objective that it reduces NEL & A&E growth	1. Financial Plans for 2026/27, first draft, build in an indicative 6.3% for community services: 2% provider growth and 4.3% for additional community services. However plans for additional services / improvement to existing services have yet to be developed (2026/27) 2. The structure of the Place Provider Partnership is in development. Requires a final model and to be implemented (Apr 2026) 3. The integrated neighbourhood health is now being developed at pace. Population cohorts have been identified and schemes are being worked up along with a timetable for implementation. (Apr 2026) 4. Primary Care LES being re-negotiated with new LES schemes that concentrates on INH and population health, more teatment in community and primary care to keep people out of hospital. (2026/27)
2	A new established governance framework which includes relevant committees and business meetings. This has a clear reporting structure. The INH delivery group will oversee the development of services and deployment of the increased resource. The Place strategy has also been published and shared with all stakeholders which aligns with the left shift to community services and is consistent with the NHS 10 year plan.	
3	The BDC ICB financial plan will align with WYICB planning assumptions and strive to align with provider plans.	
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.	

	Sources of assurance *(Where is the evidence that the controls work?)*
1	New governance framework across BDC
2	INH Delivery Group
3	Performance Report alongside Finance Report into Finance Investment and Performance Committee and ICB Board
4	Internal Audit Plan and External Audit VFM opinion

Link to Place risk register:
2447, 2386, 2227, 2486, 2040

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**No update**

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?)*
1	Finance and performance a key component of partnership board meetings. Papers and Minutes.
2	
3	

Link to place risk register:
2163, 2469

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**No update**

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)
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.	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, 2025/26

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:**
2	All investments reviewed via a priority matrix	None.
3	PMO reports and financial review against Value for Money criteria	

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**No update**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	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.
	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**
1	Finance sub-committee receives financial planning and decisions. Papers and Minutes	2414
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:**	**No update**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**4**	**12**	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.
	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**
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	None.
4	Monthly review at Wakefield Senior Leadership Team meeting	

WYICB - Board Assurance Framework - ICB and places		Version: 13	7 October 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)			
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**		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.
	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 for 2025-26 agreed by FIPC	1. Continued Chief Executive, Chair and Director of Finance targeted meetings with any NHS provider showing significant risk of non delivery of plan (2025-27). 2. Joint process with NHS England for the mid year reviews scheduled for Oct 2025. 3. Development of a robust and credible medium term financial plan (2025-27)
2 All Plans are signed off by the organisational Boards	
3 Escalation and joint approach with NHS England for Trusts.	
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	**2521** - Financial risk
2 Quarterly ICB led mutual accountability meetings with all five places and outcome letters	
3 Internal Audit and External Audit	
4 External review commissioned into Finance by WYAAT (July 2024) and across the ICS (November 2024).	
5 Agendas, reports and minutes of all meetings above	

Bradford District and Craven (BD&C) — **Place lead:** **Therese Patten** — **Nominated lead for this risk:** **Karen Parkin (29.12.2025)**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**20**	As per WYICB score and rationale. In addition, BDC part of the ICB will not achieve its financial plan target in 2025/26 and will remain financially challenged within current resource allocation.
	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 BDC follows the West Yorkhire established principles and process.	1. All actions focused on achieving the best case identified in the mid-year review process plus continued stretch on efficiency savings programmes 2026/27. 2. Financial planning underway for 2026/27 showing recurrent improvement (but still underlying deficit). Assumptions align to WY and cost pressures built in where known. The plan still requires assessment of efficiency savings. 2026/27
2 Participation in Mid Year Review process including a plan to move to best case scenario	
3 Regular detailed reporting to ELT plus fortnightly efficiency savings meetings to monitor, drive action and deliver programmes.	
4 Collaboration programme board oversees the 3 priority programmes across all BDC NHS organisations including joints plans for ABCAS, INH & Corporate services.	

Sources of assurance *(Where is the evidence that the controls work?)*	**Alignment to place risk register:**
1 Quarterly ICB led mutual accountability meetings with all five places and outcome letters	2433, 2337, 2314, 2039, 2047
2 Presentations from mid year review meetings, mutual accountability and resulting letters from WYICB	
3 Budget holder review meetings and presentations as part of mid year review process	
4 Regular monthly finance reports to ELT and minutes of meetings	
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:** **No update**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**		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.
	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:** **No update**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**		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.
	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

Leeds	Place lead:	Tim Ryley	Nominated lead for this risk:	No update

ICB risk appetite	Place risk scores					
	Target (Leeds)			Current (Leeds)		
CAUTIOUS	Likelihood	3	9	Likelihood	4	20
	Impact	3		Impact	5	

Key controls *(What helps us mitigate the risk?)*	
1	Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.
2	Strategic Finance Executive Group
3	Financial Framework and controls within each organisation at Place
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

Rationale for current place score

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.

Mitigating actions *(What more are we/should we be doing at place?)*

(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) Review of potential opportunities and mitigating financial actions within each organisation and across Place, including delaying/stopping spend, focus on efficiencies and productivity
(3) Integrated Commissioning Executive share plans between LCC and NHS and present jointly to Adults and Health Scrutiny (ongoing).

Links to Place Risk Register

2530

Wakefield	Place lead:	Mel Brown	Nominated lead for this risk:	No update

ICB risk appetite	Place risk scores					
	Target (Wakefield)			Current (Wakefield)		
CAUTIOUS	Likelihood	3	9	Likelihood	4	20
	Impact	3		Impact	5	

Key controls *(What helps us mitigate the risk?)*	
1	Monthly monitoring of Integrated Care Board delegated financial position to assurance committee including efficiency savings
2	Monthly monitoring of Wakefield partners financial position to assurance and partnership committees
3	Robust budget setting with place programmes
4	Regular sharing of information and agreements via the Integrated Care System Finance Forum
5	Consistency Checks within Wakefield against other places.

Sources of assurance *(Where is the evidence that the controls work?)*	
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

Rationale for current place score

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.

Mitigating actions *(What more are we/should we be doing at place?)*

1. Review of difficult decisions/choices across organisations/place (timing: ongoing first draft was submitted February 2025)
2. Set financial plans in line with planning guidance (2025/26)
3. Agree Quality, Improvement and Performance Productivity (QIPP) to identify savings and reduce pressures whilst improving patient quality (2025/26)
4. Work with all system partners to increase efficiency and effectiveness (2025/26)

Links to Place Risk Register

2329

WYICB - Board Assurance Framework - ICB and places							Version: 13	9 October 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)**		The changes to the arrangements in NHS England, Regions, ICB and providers are now much more aligned, with timescales that are much more likely to deliver capacity and resources in the right places. There are substantial risks of delays causing gaps in capacity, hence the need for agility and prioritisation. The EMT and Board have worked closely with partners to understand and mitigate risks. However, the current arrangement suggest the impact on our work of changes could have a higher impact than the target score. Risk score remains the same.	
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. Structured programme for organisational change overseen by EMT and Board Committees. 2. Organisational development work to across Executives to support level of agility and prioritisation required in current context. 3. Place Partnership Delivery (led by Anthony Kealy) to support the development of Place model and infrastructure will be implemented by April 2026. 4. Co-production with region of the model region and ICB to ensure smooth transition.
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 intentions received in October 2025 with subsequent development programmes.	
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 digitial priorities **2522** - Infrastructure risk
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	
4	Outputs of the programme board	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Matt Sandford 05.01.26**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
		Target (BD&C)			**Current (BD&C)**		Ongoing vacancy controls and increasing number of vacancies related to the organisational change process means that similar to other Places, Bradford Place is carrying an increased and increasing number of vacancies. A further impact will be felt following the Voluntary Redundancy process, introduced as part of the organisational change programme in 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 Oversight 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 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 4. Place level 'difficult decisions' programme to target resources at activity that delivers strategic and financial priorities. Place level prioritisation work well underway, addressing both capacity and priority as well as identifying work that will cease from April 2026 under new ICB operating model, providing updates to Partners where it is felt this work should continue as part of the PPP as well as identifying work that will transfer to central WY ICB teams etc 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. Specific Integrated Neighbourhood Team (INT) development work is underway across the BDC system is ongoing as part of national INHP pilot 2026-27 7. Work has begun locally on the development of a BDC provider collaborative approach with Place Provider Partnership development also underway - to be implemented by April 2026 **Link to place risk register** 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	Corporate Services Review and Difficult Decisions Strategy Delivery Group with scope to review Place level capacity and 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 (Health, Care and Wellbeing Strategy); Place Financial Recovery Plan and ICB Place 'Resource Office' now fully mobilised, focused entirely on ICB capacity and priorities – providing greater oversight and allocation of resource	
7	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 have been established focused on integrated acute services, integrated neighbourhood services and integrated corporate services, as our core priorities for delivery and resource management across BDC	
8	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	3 x Strategic Delivery Group meetings (Integrated Acute Care; Integrated Neighbourhood Health & Care; Integrated Corporate Support & Difficult Decisions) 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. The SDGs report into the Collaboration Programme Board, with senior partnership representatives and WY ICB representatives - with a focus on capacity and capability across place to deliver against standards and priority programmes. The Collaboration Programme Board reports into POE, for full oversight and scrutiny.	
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	Difficult Decisions programme – Partnership led and supported – Reviewed via System Finance and Performance Committee, Collaboration Programme Board and Partnership Board.	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**No update**

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
	Likelihood	**1**	**4**	**Likelihood**	**4**	**16**	

OPEN	**Impact**	**4**		**Impact**	**4**		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.

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 Partnership board regularly conducts deep dives for tranformational priorities.	2. Senior Leadership team continue to monitor risks relating to resource, intensified given NHS changes and 50% cuts.
3 Prioritisation takes place on a weekly basis to assess place workload and ability to respond to asks.	3. Working collaboration with KW partners on sharing resource in difficult situation of zero recruitment and future reduced resource.
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Tranformation delivery plan approved by Calderdale Care Partnership Board.	**Link to place risk register:**
2 Prioritisation process as part of annual planning round.	1998, 2484

Kirklees — **Place lead:** **Vicky Dutchburn** — **Nominated lead for this risk:** **No update**

ICB risk appetite	**Place risk scores**					
	Target (Kirklees)			**Current (Kirklees)**		
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**
	Impact	**4**		**Impact**	**4**	

Rationale for current place score

There are specific challenges in Kirklees place related to leadership changes in several 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.

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 Health & Care Executive to support cross sector prioritisation within the Health & Care Partnership	2. Ongoing development prioritisation and review within and across Teams in Kirklees (2025/26)
3 Business planning processes to support confirmation of priorities	3. Specific Integrated Neighbourhood Team (INT) development work across Kirklees system (2025/26)
Sources of assurance *(Where is the evidence that the controls work?)*	4. Ongoing local development of the Kirklees provider collaborative approach by September 2025.
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.	**Link to place risk register:**
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.	None
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 — **Place lead:** **Tim Ryley** — **Nominated lead for this risk:** **No update**

ICB risk appetite	**Place risk scores**					
	Target (Leeds)			**Current (Leeds)**		
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**4**	**16**
	Impact	**4**		**Impact**	**4**	

Rationale for current place score

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.

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 Capacity aligned to Healthy Leeds Plan and LHCP objectives	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 Director accountabilities finalised and objectives set by end of April	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
Sources of assurance *(Where is the evidence that the controls work?)*	4. Action plan on staff survey results most pertinent to Leeds, 2025/26
1 Healthy Leeds Plan and Business Plan reviewed monthly in line with LHCP priority work	5. Leeds Directors will continue to review capacity and reprioritise as necessary (2025/26)
2 Ongoing appraisal throughout year with all directors in place	**Link to place risk register:**
3 Staff Survey results	None

Wakefield — **Place lead:** **Mel Brown** — **Nominated lead for this risk:** **No update**

ICB risk appetite	**Place risk scores**					
	Target (Wakefield)			**Current (Wakefield)**		
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**
	Impact	**4**		**Impact**	**4**	

Rationale for current place score

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.

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 Agreed objectives for all directors	2. Working with partner organisations across Wakefield district to maximise capacity to and to deliver objectives in 2025/26
3 Wakefield place plan agreement in May 2025, signed off objectives and plans for Wakefield district	3. Reviewing everyones PDR objectives to ensure any areas that need capacity are appropriately addressed such as EDI leadership (End of Summer 2025)
4 Business planning processes that aligns both to the WY ICB 10 ambitions and the Wakefield district plan (annual review)	4. Contributing to the organisational change programme in place across WY ICB to shape the integrator teams 2025/26
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?)*	
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.	
4 Contribute to the annual governance review.	

5 Regular one to ones between Accountable officer and Cheif Executive WY ICB	**Links to Place Risk Register**
	None.

WYICB - Board Assurance Framework - ICB and places		Version: 13	6 October 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 as a result of the organisational change programme and the reduced ICB capacity.	**Lead committee / board**	ICB Board

ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**
	Target (ICB)			**Current (ICB)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	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. The organisational change programme and ICB blueprint will mean that there is significant less capacity within the ICB and a narrower remit. We will need to carefully prioritise our partnership working in this area to maximise value. Increased likelihood from 2 to 3, increasing the risk score from 8 to 12. Target score and risk appetite 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 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. As part of the organisational change programme, we are working to redesign wider partnership governance with partners including local authorities and combined authority. These governance arrangements will continue to ensure we have the right focus on wider societal issues. 2025/26
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.	
6	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.	

	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	**2535** - Organisational change
2	ICB Board receives six monthly updates on 10 big ambitions - agenda / minutes	
3	SOAG - minutes evidence review of progress against 10 big ambitions	

Bradford District and Craven (BD&C) **Place lead:** **Therese Patten** **Nominated lead for this risk: Matt Sandford 05.01.26**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**	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.
	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.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 2.The BD&C HC&P has now finalised the healthcare and wellbeing strategy and we are now implementing this through revised 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 (2026/27) 3. Ongoing development of the Place Provider Partnership model, to ensure ongoing engagement across all partners, aligning resources to target the health inequalities and population health needs of our communities. **Link to place risk register:** 2317, 2386, 2221
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 Difficult Decisions 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	All district partners (including those outside health and care) have signed up to a new district strategy to improve the wellbeing, both health and economically in Bradford district (2025 - 2028)	
6	3 x Strategic Delivery Groups (Integrated Acute Care; Integrated Neighbourhood Health & Care; Integrated Corporate Support & Difficult Decisions) 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. The SDGs report into the Collaboration Programme Board, with senior partnership representatives and WY ICB representatives - with a focus on place level delivery against standards and priority programmes, ensuring achievement of population health improvements. The Collaboration Programme Board reports into POE, for full oversight and scrutiny.	

	Sources of assurance *(Where is the evidence that the controls work?)*
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:** **No update**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**	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.
	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:** No update

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	2	8	Likelihood	3	12	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.
	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 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 *(Where is the evidence that the controls work?)*	**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 Ryley — **Nominated lead for this risk:** No update

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	2	8	Likelihood	3	12	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.
	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 Health & Wellbeing Board Strategy	1. Creation of a joint neighbourhood model between NHS and Local Authority (2025/26)
2 Active participation and alignment to Marmot City agenda	2. Monitor and report on anchor institution work to test impact for the city (ongoing piece of work)
3 Shared goals across Leeds Health & Care Partnership reflecting 10 big ambitions and requiring addressing	3. Continue to drive digital and medical technology innovation through the Integrated digital service, Leeds Academic Health Partnership and the Leeds Health & Care Hub. 2025/26
4 Continuing monitoring of metrics by ethnicity and deprivation as routine	4. Implement action plan arising from Marmot city programme led through public health (2025 - 2027)
Sources of assurance *(Where is the evidence that the controls work?)*	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)
1 Progress against 10 big ambitions in Leeds	
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	**Link to Place Risk Register**
	None

Wakefield — **Place lead:** Mel Brown — **Nominated lead for this risk:** No update

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	2	8	Likelihood	2	8	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.
	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 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 Wakefield Forward Plan includes work to deliver Health and Wellbeing Board priorities	2. The bid to the local investment panel supported protection for the previous Core 20 plus 5 funding but not protecting all of the uncommitted resource.
3 Core20plus5 funding directed to addressing social determinants, to be confirmed via the investment panel for 2025/26.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Regular reports to Health and Wellbeing Board & Wakefield District Health and Care Partnership Committee on work to address priorities	
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	**Link to Place Risk Register**
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: 13	6 October 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 *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
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	Development of commissioning intentions that reflect our ambitions around equity and fairness.	
3	EDI Oversight Group maintains oversight of statutory requirements and objectives	
4	ICB People Plan, with a strong focus on inclusivity	
5	EQIA process embedded to inform decision-making	
	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
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.	

Bradford District and Craven (BD&C)	**Place lead:**	**Therese Patten**	**Nominated lead for this risk:**	**Kez Hayat 08.01.26**

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.
BOLD	**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	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; 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. **Link to place risk register:** None
2	A comprehensive equality impact assessment has been developed with a mitigating action plan ensuring ethnically diverse staff are adequately supported throughout the organisational change process	
3	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 *(Where is the evidence that the controls work?)*	
1	Minutes of the Bradford EDI group	
2	Assurance provided via Partnership Oversight Executive - Minutes	
3	BDC Extended Leadership Team meeting, minutes.	
4	NHSE website for WRES and WDES data. WYICB PSED report on website	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**No update**

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 *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Race equality standard compliance is monitored at place level.	1. Supporting the EDI strategy in West Yorkshire (2025/26) **Link to place risk register:** None
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Outcomes of staff survey is discussed at Calderdale senior leadership team meetings	

Kirklees	**Place lead:**	**Vicky Dutchburn**	**Nominated lead for this risk:**	**No update**

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 *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
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) **Link to place risk register:** None
2	EQIAs embedded as part of PMO functions	
3	Community champions / Community voices	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	ICB (Kirklees) self-assessment against the ICF during 2025/26 (last completed 2023)	
2	Examples of EQIAs and subsquent action / mitgation	
3	Examples of voice and influence from diverse population in planning and transformation	

Leeds	Place lead:	Tim Ryley	Nominated lead for this risk:	No update

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
BOLD	Likelihood	2	6	Likelihood	3	9	ICB in Leeds works proactively in relation to EDI in respect of our workforce, 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 *(What helps us mitigate the risk?)*	
1	Compliance with the requirements of the Equality Act 2010 Public Sector Duties in relation to our workforce and commissioning responsibilities.
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 *(Where is the evidence that the controls work?)*	
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.
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.

Mitigating actions *(What more are we/should we be doing at place?)*

1. Suporting 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

Link to place risk register:
None.

Wakefield	Place lead:	Mel Brown	Nominated lead for this risk:	No update

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 *(What helps us mitigate the risk?)*	
1	Equality, Diversity and Inclusion network established for place
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 *(Where is the evidence that the controls work?)*	
1	People panel (partnership committee) receives and scrutinises delivery of equality agenda
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

Mitigating actions *(What more are we/should we be doing at 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)

Link to place risk register:
None.

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 13	7 October 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 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.						**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 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. Evaluating impact of recent NHS strucutural changes and the delivery of digital data and technology mandate across the ICB (2025-27) 2. Consolidation of BI and GPIT (2025-27) 3. To ensure resilience of the ICB on-call rota, we are consulting on a new potential structure which we will take to Social Partnership Forum (SPF) on 28 October 2025 for discussion and wider consultation with staff throughout November 2025. 4. We are currently reviewing the learning following business continuity incidents impacting on some GP practices in Bradford and Craven from which the learning will be used to inform our West Yorkshire EPRR processes (Update SOAD in Nov and full report in December 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	
10	Directorates and Places have completed Business Impact Assessments in June 2025 to support further development of business continuity plans.	
11	Data Security Protection Toolkit in Apr 2025 is complete.	
12	Cyber Security Discovery exercise is complete: we have undertaken a cyber security discovery to identify risks and mitigation to improve cyber security resilience. An action plan has been developed and implementation by June 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	**2547** - 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	

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)						Version: 13	6 October 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	1. There is a degree of uncertainty on future roles and responsibilities in relation to the green agenda as set out in the ICB blueprint. We will continue to work closely with partners to ensure that any changes in role and responsibilities is managed effectively.
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.	
6	NHS greener plan was agreed in priniciple at the September 2025 Board meeting.	
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	