Bradford District and Craven
Health and Care Partnership

ACTasONE

BRADFORD DISTRICT AND CRAVEN TRANSFORMATION PROGRAMMES

OUR YEAR IN REVIEW 2021–2022

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Welcome to our year in review

Our transformation programmes focus on the priority areas for the Bradford District and Craven Health and Care Partnership where we demonstrate our Act as One ethos, working together to meet the needs of our communities and our people (our workforce). Our year in review shares the work of our eight transformation programmes that cover services provided from pre-conception through to later life. Using an easy to follow format you can see the progress made by each programme, what we have done, what we have learned and what we are going to focus on in 2022–2023.

Our health and care partnership has a relentless focus on tackling inequalities and our programmes have an important contribution to make to achieve this. For the coming year we will work closely with a number of partners and system wide programmes such as Reducing Inequalities in Communities (RIC), community partnerships, Living Well and the Inequalities Alliance to steer us on those areas that can have the greatest impact to reduce health inequalities. We will be using NHS England's Core20PLUS5 approach to ensure we place our emphasis in the right places for the greatest impact. We plan for our programmes to focus on those living in our most economically challenged communities (we refer to this as our most deprived quintile) and two focused inclusion groups – gypsy and traveller populations and refugees and asylum seekers.

Our partnership strategy

Each programme has considered its progress and future focus against our health and care partnership's strategy and the **four Ps** that are driving the work we do.

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.

Better births

Our vision is to improve experiences and outcomes of the pregnancy and birth journey across Bradford district and Craven, with the aim of improving outcomes for maternal care and reducing disparities in experiences.

We know that for some communities there are increased risks and complications with some people disproportionately affected. For example, risks associated with pregnancy and childbirth are disproportionately higher for minority ethnic women; with the mortality rate five times higher than the Caucasian population. The Covid-19 pandemic has further highlighted these disparities with Black and Asian women up to eight times more likely to be admitted with Covid-19 in pregnancy.

Another factor affecting health outcomes is low socio-economic status which increases the chance of maternal and infant morbidity and mortality. Figures show that 34% of the district's neighbourhoods fall into the most deprived 10% in the country; children born into these circumstances are almost twice as likely to die and more likely to have illness or long-term disability. By working closely with the Maternity Voices Partnership, we ensure that the voice of the community is considered throughout and at the heart of everything we do.

What we've learned

There is a disconnect between community maternity care and support services and often this is down to the lack of suitable venues. Working together with family hubs and voluntary and community sector (VCS) organisations, we are improving access to maternity services in local communities. We are also strengthening relationships between maternity services and early help to identify and support vulnerable families.

The percentage of women able to access the specialist mother and baby perinatal mental health service is currently at 3% – the target is 10%. This is having a detrimental impact on the most vulnerable families and an urgent cause for concern, suicide is the leading cause of maternal death in the first year following birth.

Bradford district has the eighth highest infant mortality rate in England (infant mortality refers to a child sadly dying before their first birthday). The Child Death Overview Panel reports that two thirds of child deaths in the district occur before a child turns one year old. Factors which can lead to this include smoking genetically inherited conditions and unsafe sleeping – these are all priorities for us to tackle.

What we've done

Our purpose is addressing inequalities, and only through listening to communities will we tackle this. The Maternity Voices Partnership has led our work to involve people both through public sessions and within our working groups, this is facilitating strong service-user involvement in our programme.

For **our population** we have developed an enhanced pathway for midwifery support workers providing an in-house smoking cessation service, offering nicotine replacement therapy directly to service users in the community.

For **our place**, to improve accessibility for families we have identified 36 potential venues for community midwifery services. In addition to reducing the current costs, this will improve accessibility for families bringing all services together under one roof and improving experiences and maternal outcomes.

For **our partnership** we have agreed our place-based response to the recommendations set out in the Ockenden Report. Our approach was commended by Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer for the NHS, who was the keynote speaker at our safer maternity event.

We are working to increase referrals into VCS organisations to reduce the pressure on the perinatal mental health service and have circulated an at-a glance referral pathway and service directory for staff.

What we'll do next

Implementing **'Maternity Circles'**, with two pilots planned in collaboration with community partnerships. We will support families to access advice, support and signposting in their local community – whilst building social networks. This is in response to what people told us at our community engagement events, families reported feeling isolated and unaware of how / where to access support.

Maternity staffing is recognised nationally to be at critical point. Together with our local partners we are exploring career pathways to increase recruitment and work to improve retention to develop our workforce for now and the future. Safe staffing is the most essential building block to enable the delivery of continuity of carer pathways; the vision being full implementation by 2024.

Perinatal and infant mental health will continue to be a key priority of the programme. We plan to repeat the successful perinatal mental health (PMH) event this year with the aim of increasing early referrals into PMH services and support the key strategic priority of prevention of ill health.

The **'Every Sleep a Safe Sleep'** multiagency risk minimisation guidance, tool and training will be launched with a virtual event bringing partners together to explore progress to date, share evidence and best practice for safe sleeping. This will support our key strategic priority focus on children.

Children and young people's wellbeing

The vision for the children and young people's wellbeing programme is 'Brighter futures for children and young people to thrive and achieve their potential'. To achieve our vision, the children and young people wellbeing leadership team have committed to work together as a whole system to promote, protect and improve children and young people's mental wellbeing to enable them to thrive and lead full, happy and healthy lives.

Ensuring the voices of children and young people are heard throughout our governance structures and work streams is a priority for our programme. We have a team of Healthy Minds Young Apprentices who support our work with a clear focus on improving mental health and emotional wellbeing. They are also active members of our leadership team, bringing challenge, a great deal of enthusiasm and insight to our programme.

We are fortunate to be working closely with our colleagues to support the ground-breaking Born in Bradford Age of Wonder research, which aims to capture young people's journeys from adolescence through to adulthood. This research will offer the opportunity to test out and build an evidence base of what mental health approaches and interventions are effective, and for which groups of children and young people, to support and develop our future models of care.

What we've learned

The pandemic and lockdown restrictions impacted on every aspect of the lives of children and young people nationally and locally. We have seen an exponential rise in demand for mental health services and increases in the acuity (level and intensity) of need for people presenting to, and being supported by, our services. This impact is continuing to be felt across our schools, community-based services, specialist provision and acute trusts.

We have valued the commitment, expertise and steadfastness of our workforce across the system who have continued to rise to the challenges presented by the pandemic. We have adopted new and innovative ways of connecting with children and young people, from offering digital 'garden gate' visits and resource packs to support wellbeing. We are taking all the positive practice from our responses during the pandemic into our future ways of working.

As a programme we believe the mental health and emotional wellbeing of children and young people is everyone's business, and we are committed to the principles and ethos of Act as One. Our multi-disciplinary work around the crisis protocol has really showed how much can be achieved by working together in partnership. We are taking this learning and approach forward to support the delivery of our future priorities.

What we've done

For **our population**, our Healthy Minds Young Apprentices have delivered their Kindness, Compassion and Understanding campaign to 4,120 children and young people within local schools and colleges with an overwhelmingly positive response from students and teaching staff.

For **our place**, our mental health support teams (MHST) are now based within 38 of our local schools, offering one to one and group-based support, alongside whole-school approaches to mental health. We have successfully secured funding for three further MHSTs meaning 50% of our school population will have access to a MHST by 2024. We have developed an education emotional wellbeing offer for schools currently without an MHST and will continue to strive for equity.

For **our partnership**, we have worked with Children's Social Care, acute trusts, specialist CAMHS, the voluntary sector and the police to develop and implement a multi-disciplinary crisis protocol. This is for children and young people admitted to hospital with a mental health concern that have no safe discharge destination.

Bradford District Care NHS Foundation Trust has implemented a programme of rapid improvement to successfully reduce waiting times for specialist CAMHS. Added investment and continuous improvement is underway for this vital area of wellbeing.

What we'll do next

Our programme will contribute to our partnership's key **strategic priorities** as described below.

Developing and implementing one of our key priorities, our **One Trusted Referral Pathway** for children and young people's mental health services. This will provide a new multi-disciplinary, easy to navigate, single point of access for children, young people, parents, carers and professionals. The aim of the pathway is to ensure access is available to the right support at the right time, and that people have choice and control over how, where, when and who provides that support.

Our focus on **prevention and early intervention**, will focus on care and support for children and young people in vulnerable situations, with continuous improvement work across our mental health and emotional wellbeing services and crisis support.

We are continuing to build our data and insight, to support the development of the programme aligned to local needs.

Diabetes

There are over 45,000 people living with diabetes in Bradford district and Craven. Around 90% of whom have type 2 diabetes, which can be preventable. We want to improve outcomes and quality of life for people living with or at risk of developing diabetes.

Our key aims are to reduce the prevalence of diabetes, delay progression of the disease and avoid the complications that impact on long-term outcomes. We believe clinical leadership is key, so we have a Clinical Forum chaired by our clinical lead which brings together 14 different healthcare professionals involved in diabetes care.

We have embraced the Act as One ethos from the start and are proud to have successfully brought together the two earlier Bradford, and Airedale Wharfedale and Craven diabetes programmes. Our history of community-based diabetes care goes back to 2000 when the first satellite clinics were set up and last year we agreed a strategic alliance with Diabetes UK and their commitment to working in Bradford district and Craven will continue to drive diabetes innovation.

What we've learned

The inequalities in diabetes prevalence across our district correlate with areas of greater deprivation. But these areas also have some of the best diabetes care with higher numbers of patients receiving the 'nine care processes' and achieving the three treatment targets.

Covid-19 has impacted significantly on the delivery of outine diabetes care with all nine care processes affected and a reduction in the number of patients achieving the three treatment targets. Recovery has been further affected by the Covid-19 vaccination programme, staff absences and the national shortage of blood tubes that affected all services in September 2021.

We've learned that rates of diabetes are substantially higher among patients on the serious mental illness (SMI) register than among the general population. And from engaging with the Keighley Bangladeshi community, we learned how important it is to provide culturally relevant services.

Our learning aligns with our strategic goals to provide services that are relevant to people where they live, in their communities, with a focus on those living in our most economically challenged communities and with the most challenging multi-morbidity (people with two or more long-term health conditions).

What we've done

For **our population** we held two Let's Talk Diabetes engagement sessions with the Bangladeshi community in Keighley, listening to what matters to them. This has helped when planning Self Care Week stalls promoting diabetes awareness at shopping centres. We have also developed easy read, pictorial, audio and translated patient information to overcome literacy and language barriers.

For **our place**, we have established a single diabetes formulary for our partnership covering primary and secondary care to help healthcare professionals with information on medicines supporting safe, evidence-based, cost-effective practice. This is supported by the 'Assist' clinical system providing evidence-based, clinical decision trees for primary care staff. We have secured 1,000 licences for a training package designed to support the roll out of the new model of care for diabetes. We are carrying out an audit of people on quadruple diabetes therapy.

We have secured funding to pilot an inpatient podiatrist role and are recruiting dietetic support workers with language skills in our hospitals. We have piloted an opt-in model for booking 'foot check' appointments which has reduced the number of people failing to attend appointments.

Working with GP practices we have written out to people at risk of developing diabetes, inviting them to join the NHS Diabetes Prevention Programme.

For **our partnership**, we launched our long-term strategic partnership alliance with Diabetes UK which has seen us already collaborate on a 'Diabetes and Ramadan' information session. We are working in partnership with Keighley and District Community Partnership with a focus on inequalities, which included a district wide inequalities workshop.

What we'll do next

Our programme will contribute to our partnership's key **strategic priorities** as described below.

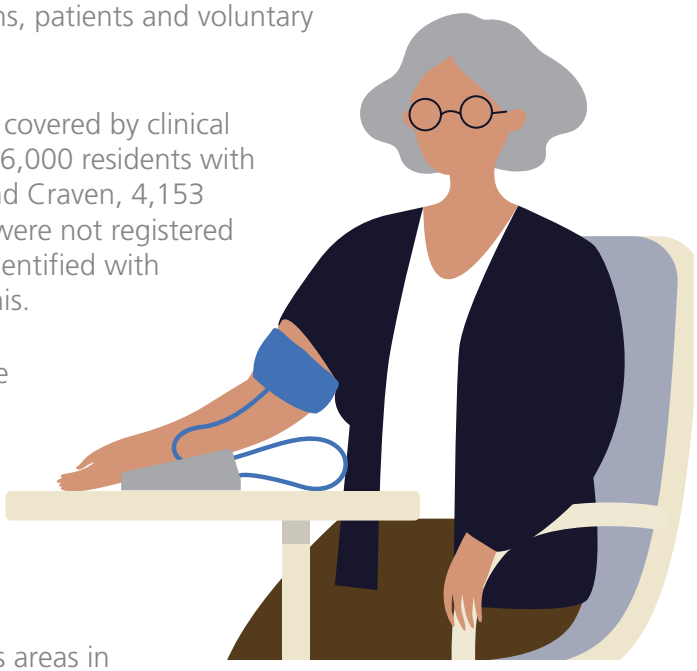
We will **restore** diagnosis, monitoring and management of diabetes to pre-pandemic levels (as per NHS Priorities and Planning Guidance 2022/23).

We aim to increase referrals to the NHS Diabetes Prevention Programme and **ensure local alternatives** are available for those who cannot or do not want to access the national programme.

We will **work with communities** to raise awareness and understanding of diabetes and learn from their experiences.

Healthy hearts

The healthy hearts programme looks to reduce the risk of heart attack, stroke and heart failure, whilst addressing health inequalities in these areas. We design and deliver transformational change in collaboration with clinicians, patients and voluntary sector organisations.



On average, each footprint (based on areas that were covered by clinical commissioning groups) in England has an estimated 26,000 residents with undiagnosed hypertension. Across Bradford district and Craven, 4,153 individuals with several high blood pressure readings were not registered on the hypertension register and 10,931 individuals identified with hypertension are currently taking no medication for this.

Our place has higher than average rates for premature deaths, increased rates of mortality linked to deprivation and a higher heart failure prevalence. Those with a serious mental illness (SMI) have higher prevalence of cardiovascular disease (CVD) compared to the general public and die, on average, 15 to 20 years earlier.

Our healthy hearts programme is aligned to two focus areas in the NHS Core20PLUS5 initiative to reduce inequalities. These are physical health checks for people living with a SMI who are at a higher risk of cardiac ill health, and hypertension case finding: undiagnosed hypertension, atrial fibrillations (irregular/abnormal heartbeat) and high cholesterol, which results in higher risk of cardiac ill health.

What we've learned

A strong collaborative approach will allow us to achieve our shared goals. By focusing on the inequalities that exist, how patients feel about accessing services, and the reason why they disengage we can shape our services around people.

Health checks have helped show us where gaps in services exist. Our transformational change approach, with a focus on inequalities, can help us close those gaps.

We've learned that good quality data and information can help primary care clinicians to identify patients that should be on a local register, so they receive added support and health checks to move us closer to average rates for cardiovascular disease, improving the quality and length of lives.

What we've done

For **our population**, we have delivered 7,000 blood pressure machines to all our primary care networks so we can roll out the 'BP@home monitoring system'. They are being given to patients at risk of developing or experiencing uncontrolled hypertension; to increase CVD prevention, identify at risk individuals, and start timely treatment.

For **our partnership**, working with voluntary and community sector organisations and primary care we've delivered 300 health checks in community settings. This has increased engagement with those who historically disengage with healthcare services. Our information video 'A guide to physical health checks for patients who live with a serious mental illness (SMI)' has been shared with those who support people with SMI.

For **our place**, we have collaborated with pharmaceutical partners to reduce hospital admissions for heart failure patients, address health inequalities and optimise patient care pathway and treatment in primary care.

Across our partnership our hospital teams are working to develop a proposal on delivering post-heart attack care closer to home for patients.

What we'll do next

Our programme will contribute to our partnership's key **strategic priorities** as described below.

We will establish a place-based approach to delivering NHS health checks for 40–79 year-olds aligning to our strategic priority of **preventing ill health**.

We will focus on delivering SMI health checks, as those engaged with mental health services have 3.3 times higher death rates for CVD.

Our collaboration with one of our pharmaceutical partners will aim to address inequalities to access and treatment for heart failure patients, supporting **our workforce** to identify those who need additional support.

In collaboration with the Independent Stroke Delivery Network (ISDN) we aim to deliver psychological support in our hospital and community settings to improve long term rehabilitation and outcomes in stroke survivors. This will allow us to **use our collective resources** to improve health and wellbeing.

Respiratory

Our plan is to understand how we reduce that factors that cause respiratory disease through prevention, and how we can increasingly support people safely at home.

Bradford district and Craven has high rates of chronic respiratory disease. The prevalence of people with asthma (43,613) or chronic obstructive pulmonsary disease - COPD - (13,362) is higher than the national average and likely to be an underestimate. Respiratory disease is the leading cause of dying early in Bradford Craven. Over 500 people die each year from respiratory disease, of those 25% of these deaths are preventable.

Our population has differing outcomes linked to deprivation. Hospital admissions from those living in our most economically challenged wards are high for respiratory conditions, with high rate of emergency admissions for asthma.

What we've learned

The link between deprivation and the wider determinants of health is stark. As the impact of Covid-19 has such a wide-ranging effect on both physical and mental health, our 'Post Covid Service' offers a holistic assessment of not only clinical need but also the social aspect of care recognising the debilitating impact of the disease. We have seen that some patients are unable to work due to Post Covid leading to financial hardship. As part of this assessment, we can refer the individual to appropriate financial support and advice.

We have developed a variety of Post Covid patient information resources in accessible formats/ easy read, available from the Living Well website. One size does not fit all, and we must be mindful that conditions, such as Post Covid, manifest themselves in many ways. We therefore regularly review our pathways, using the feedback we get from both patients and clinicians to make slight revisions that can make all the difference, such as when and how we send out information.

Over half of people 'onboarded' to the chronic obstructive pulmonary disease (COPD) service are using the Luscii app to self manage their condition, with the majority being over 65 years of age. We are aware of digital exclusion, so we also offer paper versions or discuss with patients directly their condition.

For every patient who accesses our '@home' model – including pulse oximetry (PO@Home) and COPD service – we have given out over 2,000 pulse oximeters. This is helping people to reduce their risk of silent hypoxia (where a person's oxygen levels fall to a dangerously low level before they realise anything is wrong) by regular monitoring of their oxygen saturation.

What we've done

For **our population**, we took part in the successful Self Care Week event programme. We engaged with over 40 people who had respiratory conditions and handed out different resources from the British Lung Foundation and Asthma UK. We also received positive feedback from several people about the care they currently receive and the negative impact Covid-19 has had on their condition, often because of not keeping social activities.

For **our place**, MyCare24 have set up a new system wide COPD service supporting people suffering with moderate, severe, or very severe COPD. The service monitors patients 24/7 offering care and clinical advice. This is also supported with the Luscii App which allows patients to report their daily sats digitally. We have received thousands of referrals to date, with over 1,500 patient contacts being made just in October resulting in a total of 86% of patients not requiring onward referral. Where patients did need additional input, this was in the main an escalation to a clinical assessor within the service for more clinical advice.

For **our partnership**, working together has enabled us to develop our Post Covid recovery service for patients who have residual issues because of Covid-19. We have received additional funding of over £1.1 m for treatment and care. Over 400 referrals have been received, with a high percentage of these referrals from people of Asian/British Asian heritage. The success of this service has been led by clinical teams working together within Bradford district and Craven and across the West Yorkshire integrated care system.

What we'll do next

Our programme will contribute to our partnership's key **strategic priorities** as described below with a focus on **prevention and narrowing the health inequalities gap**.

We continue to work with our two nominated **community partnerships** (BD4+ and BD5), each having very different populations but both experiencing some of the worst outcomes for respiratory disease.

We'll be supporting people to **access prevention** services such as stopping smoking and pulmonary rehabilitation. We will be providing earlier and effective diagnosis of respiratory conditions through local access to spirometry (a simple test used to help diagnose and monitor certain lung conditions).

To embed **meaningful engagement** across our district we'll be working with patients, users and carers, to understand what is important to them, how we can help them and how we can provide tools and techniques to support self-care.

Care coordination

Our programme has a core aim to develop holistic, coordinated and proactive care models with primary care networks and community partnerships across Bradford district and Craven to achieve improved patient health and wellbeing outcomes.

The programme sets out to bring together health and care services, working alongside a range of partners, including the voluntary and community sector, to provide a coordinated approach, making navigation seamless for everyone. Working with a multi-disciplinary approach, the programme promotes a proactive, patient-centred approach to ensure we have the right professional for the right person at the right time.

What we've learned

From our case studies it is clear that care coordination reduces duplication and improves staff experience. Importantly, it improves patient experience by improving service navigation, considering health and social determinants, preventing deconditioning, falls and unnecessary and avoidable consultations and instilling confidence in patients to access social p escribing services.

We've seen that having a shared record system with a clear interface between numerous disciplines is essential to create efficiencies in managing patient records. This enables teams like our proactive care teams support the development of a holistic personalised care plans.

What we've done

Going into our communities we have joined forces with four Primary Care Networks as pilot work streams (WoW, Bradford 4 Plus, Five Lane Ends and WISHH). The Proactive MDTs are supported at WISHH and Five Lane PCNs, with a total of around 300 cases seen to date.

We've created a best practice and knowledge sharing platform for pilot PCNs by working with the inner-city proactive care team developed by the Reducing Inequalities in Communities Programme.

From 2022–2023 our care coordination programme will come under the ageing well programme.

Ageing well

With life expectancy increasing we are seeing an increase in the number of people living to older and later life resulting in more people living with frailty, dementia and long-term conditions. Bradford district and Craven has the worst rate of mortality for people with dementia aged over 65. Data suggests that a large proportion of the population living with mild and moderate frailty may be under recorded. It's estimated that 35% of people aged over 65 are living with mild frailty, with only 3% identified on a clinical record.

There has been a significant impact of pandemic-associated deconditioning on people aged over 65 years. For people in Bradford (81,963) and Craven (15,868), 25% are unable to walk as far, with 20% of people less steady on their feet.

The number of patients in hospital who are medically fit for discharge has increased. This means that many people are staying longer than they need to when they could be at home or in a non-hospital setting. There has also been a decrease in the percentage of people aged over 64 who remain at home 90 days after leaving hospital.

There are digital inequalities within our 126 care homes, with many struggling to access remote monitoring due to unreliable Wi-Fi connections or training needs and there are ongoing issues with access to the local care shared record. This creates a barrier to multi-disciplinary team working and holistic care planning for our residents.

When people near the end of life we've seen that there are inequalities in palliative care provision for people living in the city area of Bradford. Significantly fewer people in the city are identified as app oaching end of life and don't achieve their preferred place of death.

What we've learned

Co-production and engagement with the voluntary and community sector is vital for reducing health inequalities across our place. We continue to build upon our partnership working and we are excited to work with the VCS Alliance on enhancing the integration between care homes and the community. Our approach to multi-agency working has been fundamental with teams across our place working in partnership around discharge pathways through the pandemic and over the winter.

Having an underpinning 'people strategy' will be key to how we deliver our priority areas with our workforce. Using our 'place' roles to support our programme delivery is something we are keen to build on.

What we've done

For **our population**, in response to the impact of the pandemic the ageing well programme focused on 'deconditioning'. Allied health professionals (AHPs) across our place led a project with Race Equality Network (REN) and 'Living Well' to develop accessible educational resources and training to raise awareness of deconditioning. As a result 15,000 copies of the 'Keeping Well at Home' self-help booklets were distributed through teams working in hospitals, community health and voluntary organisations and electronic versions were also made available in Urdu, Polish and Bengali. In addition to this project, we distributed £65,000 to local VCS organisations to deliver a range of Asset Based Community Development projects with an aim to keeping our population active and connected.

For **our place**, our programme board supported a proposal for a community dietetic service for malnutrition across our place. We saw the value of this during the pandemic and having this service will provide solid foundations for our programme priorities.

For **our partnership**, following a review of the current Telemedicine Service, programme funding is being used to support the ongoing delivery and relaunch of telemedicine. Our focus will be on communications and engagement, staff training and ensuring care homes have the necessary infrastructures to access remote monitoring. This has reduced the inequity in support to people in our care homes.

What we'll do next

We will continue to deliver our priorities aligned to national planning which are anticipatory care, enhanced health in care homes, urgent community response (UCR) and hospital discharge. We will expand and align our UCR model across the district and ensure equal access to services for our population. We are building on our **'no wrong door'** approach and exploring how a single point of access could be implemented.

We will be increasing our current **'virtual ward'** capacity across our place. Virtual wards support patients in their own home, who would otherwise be in hospital to receive the acute care, monitoring and treatment they need. In our **digital enabler** work stream we will focus on developing SystmOne comprehensive geriatric assessments (CGA) shared care plans and digital inclusion in care homes.

Our place was successful in our application to the health to set up an innovation hub, one of only four across England. This will initially be piloted with our programme with a view to developing a method for adopting and adapting proven innovations that can be shared across our local place and wider system in West Yorkshire.

Access to care

The access to care programme encompasses the work previously undertaken by three distinct programmes of work: planned care, cancer care and urgent care, alongside some dedicated specialty work. We take a strong focus on inequalities for both the elective recovery requirements (people on our waiting lists) and because of concerns that not everyone is accessing the care they need.
This can result in cancers and other conditions going undetected.

We are a diverse, committed, and innovative programme, eroding boundaries to work for the best outcomes of our population. Everyone brings a unique perspective and their area of expertise which, when joined together, delivers better results. While we are respectful and work towards national requirements, we sometimes challenge the status quo, making sure what we do fits with the needs of our health and care partnership. With our continued collaboration and trust we can see the impact we are having as a programme.

Our focus in the coming year is to implement targeted initiatives to cohorts of local people to maximise the benefits of care in communities. We know one size does not fit all and can increase inequalities.

What we've learned

Covid-19 has had a huge impact on all aspects of health and care, and people are now accessing our services in different ways, from in person to online. We need to adapt and change how we deliver care to support what meets their needs best, recognising we can't have a one size fits all approach.

We have a huge backlog of people waiting to access their operations. We have been able to work quickly through some of these lists by working in partnership with the independent sector to help clear the backlog, maximising all theatre sessions. A true example of how bringing together the best of all of our assets in Bradford district and Craven can help support people in their care.

What we've done

For **people in the community** we have:

- developed **targeted advice, campaigns and screening** to support good health and prevention
- worked in partnership across our place and with NHS Property Services to develop a **social prescribing hub** for young people
- worked with **Healthy Minds Young Apprentices** to develop a programme of workshops to support young people as they prepare to move to adult services and for becoming adults, with the intention that there is better engagement with adult health provision in the future.

For **our workforce** we have:

- designed new pathways for **Assist** (a tool to help primary care triage patients prior to onward referral using the most up to date clinical information and guidance), including paediatrics, ENT (ear, nose and throat), cardiology, vascular surgery, mental health, weight management and cancer. Assist is used by primary, secondary and community services. It now hosts around 280 locally designed pathways, templates and referral forms and receives around 23,000 hits per month
- developed consistent standard operating processes for **e-consults** across both hospital trusts, and expanded into a number of specialties. E-consult and advice and guidance allow GPs to support patients in the community with clinical input from hospital specialists, therefore reducing hospital outpatient appointments. Our increased roll out of this will mean more patients see the right clinician first time
- worked with partners, including Cancer Research UK, to develop targeted community techniques and interventions to increase **cancer awareness** and screening uptake to help reduce inequalities, particularly in areas where we have high levels of deprivation.

For **people needing care beyond the community** we have:

- developed a weekly **rapid diagnostic community hub** with both primary and secondary care clinicians to ensure people with vague but concerning symptoms of suspected cancer are seen within two weeks of referral
- introduced **A&E navigators** who work with victims and perpetrators of violent crime at the Emergency Department at Bradford Royal Infirmary and in the community
- worked with colleagues in Living Well to ensure that those who are on **waiting lists for surgery** who require additional health and wellbeing advice can access the support they need.

What we'll do next

We will support the delivery of our partnership's strategy to support people as close to home as possible and shift our focus from treatment to prevention. Our focus areas for 2022-2023 are listed below.

- Together with the voluntary and community sector, launch the **wellbeing hubs** and support them to achieve their potential and become the first port of call for people in their communities who need ongoing help with their health and care needs.
- Continue to grow **Assist** with the development of new pathways; and share new **e-consult** services in gastroenterology, vascular and pain and expand further where there is an appetite from specialties. We've learned that our reliance on digital assets is significant. Our work with local clinical systems such as GP Assist and e-consult means we are developing clinician led pathways that meet the needs of our local population.
- Develop the innovative **rapid diagnostic clinic self-referral model** – the first model in UK for people who have suspected cancer symptoms.
- Establish **community-based pain hubs** in partnership with primary care networks (PCNs), voluntary and community sector organisations and providers.
- Develop the plan for new **community diagnostic hubs** in line with national requirements, delivering additional diagnostic capacity in areas with poor access.
- Expand our 'Living with and Beyond' cancer work with community partners including developing a **community cancer exercise programme** in areas of high deprivation with culturally appropriate support
- Developing an action plan with a wide range of partners across health, care and education to address the inequalities we have identified for people. This will focus on **paediatrics** in the first instance and will dovetail with the ongoing West Yorkshire led project, 'Healthier Together'. Healthier Together is a web resource to help our communities for any child-related health needs.

Thank you

We would like to thank everyone who has supported our programmes. Our annual review is a snapshot of our work that demonstrates how we Act as One to work towards our ambition of keeping people 'happy, healthy at home'.

Thank you for reading our annual review, we'd welcome any suggestions to improve the way we share our progress in our annual review for 2022–2023. Please do get in touch with thoughts, ideas and comments: actasone@nhs.net

Bradford District and Craven
Health and Care Partnership

ACTasONE

@ActAsOneBDC

www.bdcpartnership.co.uk

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