Bradford District and Craven
Health and Care Partnership
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# Bradford District and Craven Health and Care Partnership Joint Forward Plan

DRAFT

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## Purpose of this Plan

The Bradford District and Craven Health and Care Partnership has developed its Joint Forward Plan:

- To provide a single view for the system on how the partnership will operationalise its strategy;
- To provide clarity for the Partnership Board so it can hold our system to account for the delivery of its key transformational objectives; and
- To enable West Yorkshire Integrated Care Board (ICB) and NHS England to recognise and understand how our plans contribute to the delivery of the West Yorkshire Forward Plan and Integrated Care Strategy.

## Overview

Bradford district and Craven stretches from Bradford city centre, past Keighley in the Aire Valley, through the large market towns of Ilkley and Skipton, to Ingleton in the Craven basin. As a partnership we serve a GP-registered population of over 657,579 people in this mixed urban and rural area covering 597 square miles (of which Craven is 454 square miles). Craven GP practices, serve around 7.5% of our population (c50,000). Bradford district and Craven represents around 25% of the population of West Yorkshire of 2.6 million people.

Bradford District is an ethnically diverse area, with the largest proportion of people of Pakistani ethnic origin in England. 1 in 4 people describe themselves as Asian/Asian British compared to 1 in 10 for England and there is a high proportion of our population in Bradford City and Keighley who identify as being from a Black, Asian or Ethnic Minority background. Conversely, most people in the Bradford wards of Craven, Wharfedale and Worth Valley are from a White British background.

More than a third of our population live in poverty. Whilst wards around central Bradford and Keighley appear in the 10% most deprived wards in the country, wards in the Wharfe Valley are in the 10% least deprived nationally.

We currently have a young population, with the fourth highest proportion of under 16-year-olds in England and a higher proportion of babies, infants, children, and young people than the average for England. The proportion of the working age population is lower in Bradford than the average for England. However, the largest increase in our population has been in older people, and this is predicted to further grow, bringing with it the challenges associated with managing increasing long term conditions and the potential impact on the social care sector.

## The Bradford District and Craven Health and Care Partnership

The Bradford District and Craven Health & Care Partnership is part of the West Yorkshire Integrated Care System. Our partnership brings together the local NHS, other health and care providers, our two Local Authorities, Healthwatch, and voluntary, community and social enterprise (VCSE) organisations, to arrange and deliver services for people who live in Bradford District and Craven (bdcpartnership.co.uk).

By coming together as a formal partnership, building on our years of collaboration, we know that we can improve value and maximise health and wellbeing outcomes, making the biggest difference we can. By seizing this opportunity, we can shift the conversation from the provision of 'good health and care services' to creating the right environments for 'good health'.

Our guiding principle as a partnership is to 'Act as One'; with each organisation working together as one team, pursuing one vision. It acts as a guide in our decision-making and in how we work together.

## Engagement

The services we deliver, directly impact the lives of people. We are therefore committed to ensuring that the work of our partnership is influenced by our population through conversations and engagement. Connecting, listening to, and having a consistent feedback

loop with communities on an ongoing basis will also help us build trust.

This is something that is being demonstrated through the partnership's 'Listen In' engagement work and through our 'Listening Rooms' project as part of our local equity, diversity and belonging programme.

Our engagebdc.com website provides further information on opportunities for people to get involved and influence decision making locally from involvement exercises through to formal consultations and gives people an opportunity to join our mailing list and receive updates on issues that matter to people.

## Challenges

Our diverse population itself creates challenges and there are stark health inequalities that exist across Bradford district and Craven, with people living in the most deprived wards having a much shorter life expectancy than those living just a few miles away. In terms of healthy life expectancy (the average number of years that a person can expect to live in full health that is, not hampered by disabling illnesses or injuries) then this gap increases to nearly 20 years i.e. people living in the areas of worst socioeconomic deprivation spend on average 19 years of their lives in ill health.

However, there are other areas of risk to delivering this plan including:

- Demand: There is an increasing demand for all health and care services and our population is presenting to services with more complex conditions. Managing this alongside our targeted work to address the backlog from the Covid-19 pandemic has resulted in significant system pressures.

- Workforce: There are also significant challenges with recruitment and retention of our health and care workforce and the pandemic has had a negative impact on the wellbeing of staff.

- Estates: Lack of available estate and equipment to address increasing demand and the management of people in the community is a challenge and there are also some specific constraints around our existing estate that need to be managed.

- Finance: Our health and care system is under significant financial pressure, which has been exacerbated by the current financial climate and cost of living crisis. Whilst our system has a surplus plan of £1.8m for 2023/24, to meet this plan we need to deliver a very significant level of efficiency savings totalling £73m (6%). This does not take account of the financial pressures in social care and other non-statutory providers.

## Our Strategy

Our Health and Care Partnership Strategy sets out our strategic ambition to reduce health inequalities and improve population health and wellbeing for the people of Bradford district and Craven. We are committed to our partnership vision of keeping people 'Happy, Healthy at Home' through the actions taken to support our population to stay healthy, well, and independent throughout their whole life (Figure 1).

Figure 1: Our Partnership Strategy

This strategy aligns with the broader scope of the Bradford District Plan, the Wellbeing Board Strategy for North Yorkshire (Craven), and the West Yorkshire ICS Strategy.

Population health management is our common and consistent approach to targeting improvements in the wellness of local people. Through data, we are designing new models of proactive care that make best use of our collective resources, ensuring value.

To deliver our strategy we have identified five priority areas of work (Figure 2) and five enabling programmes (Figure 3).

Figure 2: Our 5 Priorities linked to our Purpose, Population, Place and Partnership

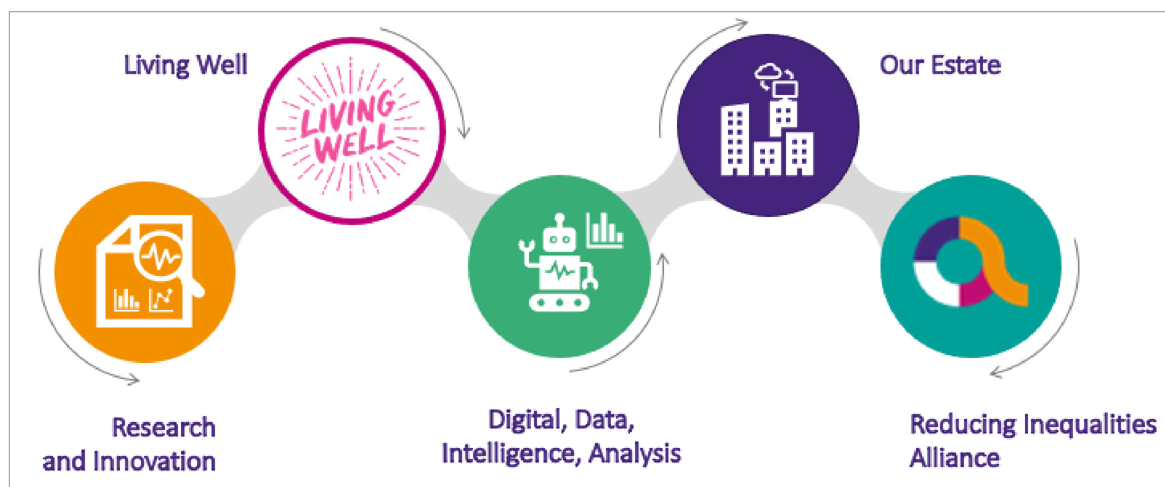


Figure 3: Our 5 Enabler Programmes

The priority workstreams of Bradford District and Craven focus on the actions that we need to take specific to our population and communities, and those things that require the close working relationships of the stakeholders who make up our partnership to deliver in collaboration. However, there are interdependencies between the work at place and the work at West Yorkshire. We work with colleagues across West Yorkshire where this affords us the scale required to tackle issues we can't address alone, and where this provides greater efficiency or where variation is un-warranted.

This, our first Joint Forward Plan sets out the aims of our priority and enabling programmes of work for the next five years and our commitments for 2023/24. This is set within the context of our partnership strategy and our operational plan (Figure 4).

Figure 4: Our Joint Forward Plan 2023

Together, these are the foundations of our operating framework as a Health and Care Partnership.

## Our Purpose

Our four primary purposes as a health and care partnership are:

- Improving outcomes in population health, healthcare, and wellbeing;
- Tackling inequalities in outcomes, experience, and access;
- Enhancing productivity and value for money; and
- Supporting broader social and economic development.

Lives in Bradford District and Craven are being cut short. People living in deprived areas of our district are more likely to die sooner than those in more affluent. To stop people dying early and to help people have a healthy and happy life, we need to work together to create a fairer district for all. To do this we will look to create opportunities for everyone to access quality care, stable jobs, fair pay, good housing, and education.

As part of this effort, we've created the Reducing Inequalities Alliance. The alliance aims to support and coordinate collective action to reduce inequalities in Bradford District and Craven. It is made up of allies across our partner organisations.

### Reducing Inequalities Alliance

Our four aims are:

- Setting the strategic vision for reducing inequalities: The Reducing Inequalities Alliance aims to inspire a shared vision for reducing inequalities in health (and the determinants of health). This will need a culture where addressing inequalities is everybody's business. For this to happen we need to challenge existing processes. We need to apply the inequalities lens to all projects, programmes, objectives and outcomes. Collectively we need to support and influence local strategies for a systematic approach to reducing inequalities;
- Building confidence and skills in our workforce to reduce inequalities: We want to make reducing inequalities part of everything we do as a workforce. We have created this workstream to encourage everyone across the whole system to work towards this common purpose. We want to support individuals and organisations to know how their work is helping to address inequalities. The purpose of this workstream is to support staff to understand their role in reducing inequalities and to increase leadership capacity within the alliance of partners;

- Supporting best practice in the ways we work, the skills we use and the evidence we draw on to reduce inequalities: We want to support our workforce to deliver best practice in reducing inequalities. This includes improving the skills and tools we use to assess and reduce inequalities, the evidence base we draw on (both local and international), and the data we use (from personal stories to data led intelligence); and

- Creating opportunities to evaluate our work and share learning: We are committed to reducing inequalities, and to achieve this we need to develop a clearer understanding of 'what works'. A key function of the Alliance is to create the time and space to share learning with our partners, so that we can do this together. The purpose of this workstream is to facilitate the capture and share insight across our place.

In 2023/24 our plans include:

- Continue to support our workforce with our communications programme including our call to action, short animations/films, newsletters, and conference/workshops.

- As we approach the final year of the Reducing Inequalities in Communities (RIC) programme we are developing plans for sharing the learning from this work, and funding successful projects longer term.

- Supporting our Community Partnership (CPs) to develop plans on how they can reduce inequalities. We have developed a 'reducing inequalities' toolkit and evidence and data pack for each CP. The toolkit provides a lightweight but systematic framework for planning, designing, and assessing action.

- Supporting our system priority programmes to address health inequalities with deliverable actions, funding initiatives and working with community partnerships and GP practices facing the highest levels of inequalities to close the gap via our Core20PLUS5 programme and Health Inequalities Premium (additional funding for the 35 practices with the highest combination of deprivation and health challenges) .

- We will continue to work with partners to embed addressing inequalities through their planning and activity, including:

    - Direct input to a broad range of programmes (e.g. Serious Mental Illness, Children & Young People, Digital Inclusion, Universal Healthcare)

    - Creating key messages for inclusion in partner organisations' induction programmes (via the People Plan)

    - Supporting participants in the West Yorkshire Improving Population Health Fellowship

- Aligning our activity with other key enabler programmes

## Our Population

For our population, we will all:

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

We have identified three specific areas of focus for the next five years: Access to Services; Mental Health and Children Young People and Families.

### Access to Care

Our vision is to ensure that our population can access the care they need in the place that is the most appropriate to deliver it. We will achieve this by:

- Improving access to health and care for the communities we serve;
- Removing the barriers that create inequalities to accessing care; and
- Ensuring our people receive the right care in the right place first time.

Our focus will be on tackling the major health conditions experienced by our population, improving access to elective (planned) care services, re-designing how people access urgent care, and ensuring collaboration across providers where there are benefits in doing so (Figure 5).

The latest Global Burden of Disease study shows that the top five causes of early death for the people of England are: heart disease and stroke, cancer, respiratory conditions, dementia, and self-harm. Our focus on major health conditions (LTCs) is a key priority in the NHS long term plan as well as for our place ensuring we can diagnose and treat these conditions earlier, prevent our population from developing a LTC, and support people to manage their condition following a diagnosis.

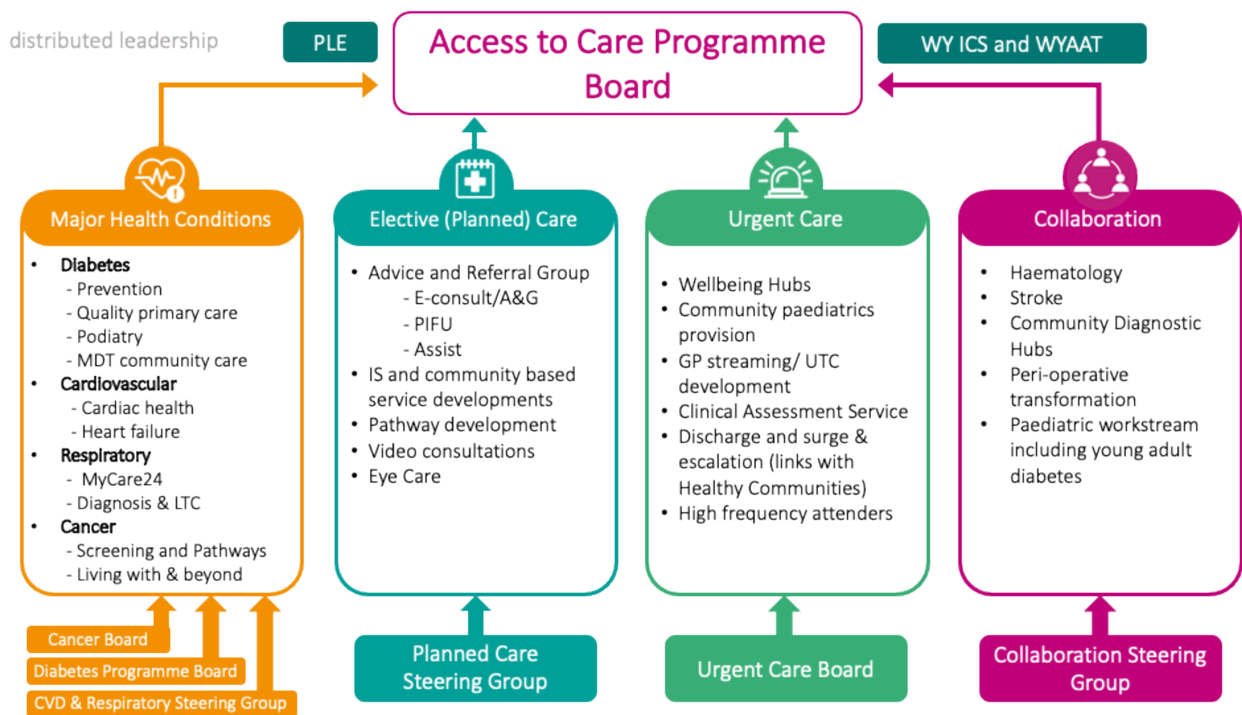


Figure 5: Access to Care workstreams

During Covid, we took the opportunity to develop more community-based pathways of care and maximise the support of the independent sector to continue our planned care work. Our focus has turned to how we can maximise the opportunities in the digital arena focusing on aspects such as e-consults and Assist pathways to support GPs with referrals, patient initiated follow up and the use of digital devices; and patient optimisation as part of their ongoing support and care whilst awaiting treatment.

We also continue to collaborate across secondary, primary, and acute care on new service developments or changes to how and where people are cared for, such as VCSE and primary care community models of care reducing the reliance on traditional hospital-based care pathways.

Urgent Care, whilst still transformational, has very specific operational requirements it must deliver which are nationally driven but our urgent care agenda is system focused and encompasses all partners across hospices, VCSE, and the social care sector. We have developed in partnership services such as the Wellbeing Hubs and community paediatric hubs to move activity into the community. This recognises that urgent care services might be the most familiar and therefore first point of contact, but we are opening up access to other services to ensure people can receive the right care for their need closer to their home.

Collaboration is supporting our teams to work collectively on areas of improvement and opportunity to make a difference to how, where and who delivers care to people in our communities.

We have recruitment and capacity challenges, significant demand increases and will often have to respond to changes in the local, regional and national landscape so we work collaboratively to develop initiatives once and implement these system wide.

In 2023/24 our plans include:

- An additional 7,700 outpatient appointment appointments, 9,600 inpatient and day-case procedures, and an additional 18,100 diagnostic tests above 2019/20 activity. Doubling Patient Initiated Follow Up (PIFU) activity over 2023/24.
- Reduction in our overall 18-week waiting list and the number of people waiting more than 52 weeks for hospital treatment, with the elimination of waits over 65 weeks by March 2024.
- Improving 6-week waiting times performance for access to diagnostic tests towards the March 2025 expectation of 95%, including opening a Community Diagnostic Centre.
- Improvement in cancer waiting list backlog (those still waiting for treatment beyond the 62-day national standard) and plans to over deliver against the 75% 28-day faster diagnosis target by March 2024.
- Improve A&E 4-hour performance in line with the 76% national recovery target by March 2024.
- Manage the impact of increasing emergency hospital demand via admission avoidance schemes, improved hospital flow and discharge, and additional beds resulting in a reduction in patients in hospital who no longer meet the criteria to reside and reducing average bed occupancy levels in line with the 92% national expectation.

# Healthy Minds

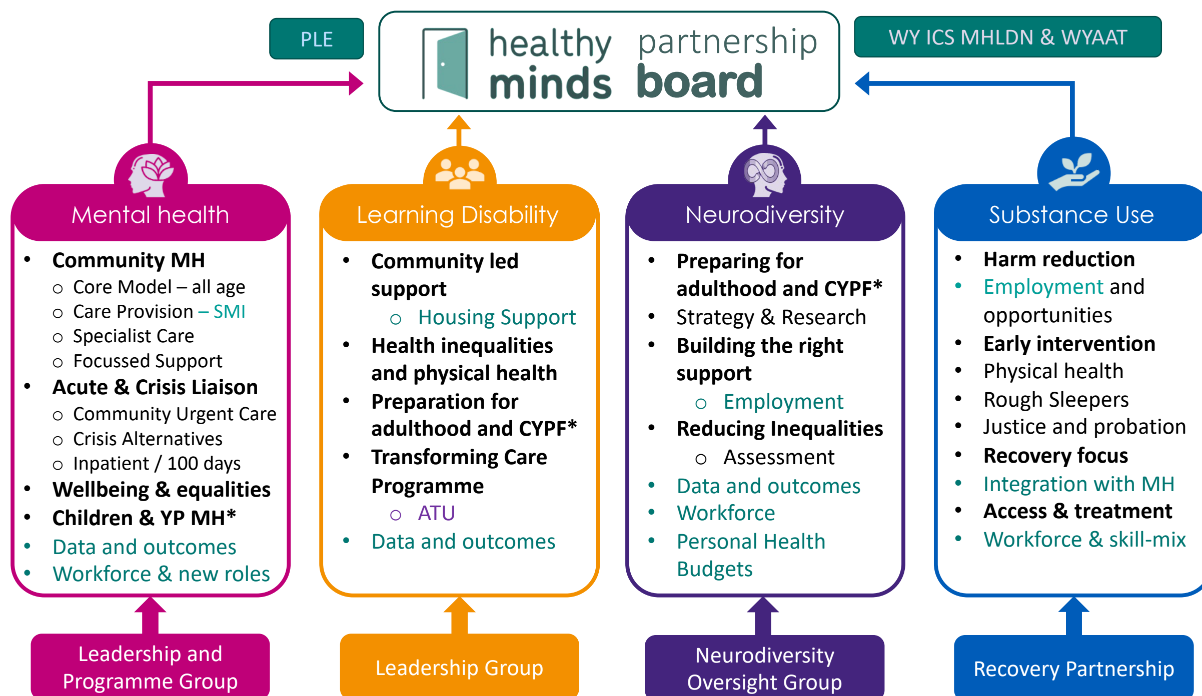


Figure 6: Health Minds Workstreams

Through our Healthy Minds priority work (Figure 6) we will:

- Increase the years of life that people who have mental health needs, substance use issues, live with a learning disability or neurodiverse needs, live in good health.
- Achieve a reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population.  In doing this we will focus on early support for people across their life journey.
- Establish new and integrated models of primary and community mental health care to support adults and older adults who have severe mental illnesses, so that they will have greater choice and control over their care and be supported to live well in their communities.
- Establish an improved comprehensive round the clock crisis service across our district that can meet the continuum of needs and preferences for accessing high quality crisis care in the least restrictive and most appropriate place – whether it be in communities, people’s homes, emergency departments, multi-agency or inpatient settings.
- Work as a whole system to promote, protect and improve children and young people’s mental wellbeing to enable them to lead full, happy, and healthy lives.

- Promote the health of people and reduce the inequalities gap in access and support to services and support to achieve independent living.
- Work together with people with learning disabilities to reduce health inequalities, uphold people's rights and help them achieve their aspirations, ensuring that people get the right support at the right time in their local community or least restrictive setting.
- Transform the lives of people who are autistic/neuro-diverse. We do this to enable them to live the lives they choose, achieve their personal goals, feel valued and know their voices are heard. Together, we transform lives
- Deliver a world class substance use treatment and recovery system, reduce the use of recreational drugs and deliver fair opportunities for people.
- Across all workstreams, we will maximise the opportunities to improve addressing the wider determinants of health and deliver hope, choice, and independence as core themes to our approach.

In 2023/24 our plans include:

- Increase the number of people who first receive Improving Access to Psychological Therapies (IAPT) recognised advice and signposting or start a course of IAPT psychological therapy from 12,237 per annum from quarter 4 2022/23 increasing to 13,164 per annum from quarter 4 2023/24.
- Increase the number of women who have had at least one attended contact in the year with Perinatal Mental Health Services, which is face to face, or by video, from 78 in quarter 1 to 104 in quarter 4.
- Further improve our recorded dementia diagnoses to estimated dementia prevalence rate to 69% (above the national recovery target of 66.7%).
- 5.5% growth in the number of children and young people aged 0-17, supported through NHS funded mental health services, receiving at least one contact.
- Reduce the number of inappropriate adult acute mental health out of area placement (OAP) Bed Days to no more than 90 bed days in quarter 4 2023/24.
- Increase the number of adults and older adults receiving at least two contacts with core community mental health services by 4%

## Children and Families

Our children and families partnership work (Figure 7) focusses on:

- Best 1001 days: Improve the outcomes for maternal care across Bradford District and Craven and reduce disparities in experiences by working as a whole system;
- Universal prevention and early identification: Children and young people are at the heart of all we do. Universal and targeted services work together seamlessly. All babies, children and families are able to live a healthy, happy life, and when they do need additional help, they receive information and support they need easily and as early as possible. Inequalities are reduced and every child, young person, and family with additional needs is identified and supported by skilled and confident workers (and peers or volunteers) at the right time, in the right place, by the right people. Families' strengths are built on so they can develop skills to build healthy relationships and social connections;
- Pathways and services: A vision will be developed with service users and pillar workstreams, but the areas of focus will initially be to look at physical health, emotional wellbeing and mental health and learning disability and neurodiversity services; and
- Complex care: To improve the health and well-being, and reduce inequalities, of children and young people (aged 0-25) of Bradford District Craven who have complex health and care needs.

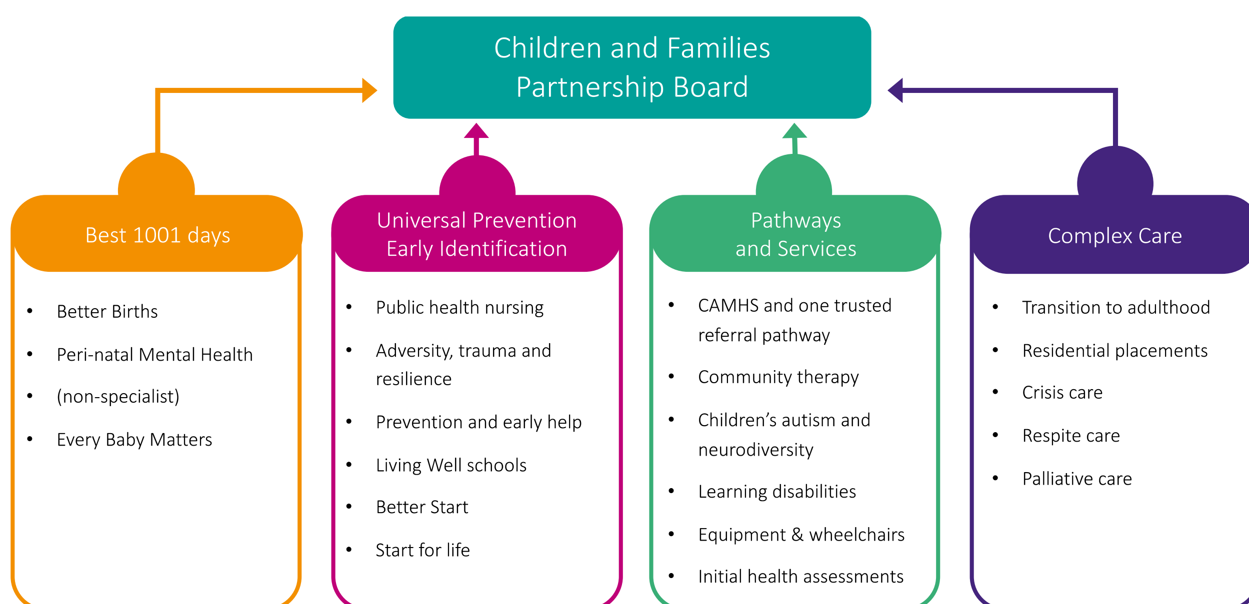


Figure 7: Children and Families workstreams

We will work in partnership with the new Bradford Children's and Families Trust and are working at place on creating a child friendly place/city.

In 2023/24 our plans include:

- We will continue to deliver the actions from the final Ockenden report for maternity and neonatal services, ensuring that all women have personalised, safe and equitable care so that outcomes (stillbirths, neonatal mortality, maternal mortality and serious intrapartum brain injury) will improve.
- We are working collaboratively across our health and care partnership to provide support to meet children and young people's identified needs, to reduce reliance on the requirement for a formal diagnosis for autism. This includes a commitment to reduce the current waiting times for autism assessments.
- In addition, we are committed to improving waiting times for children's community therapy services.
- We will work with partners to demonstrate improved outcomes to the health and wellbeing of children and young people with special educational needs and disabilities (SEND) ensuring they receive timely support'.
- We will consider the specific needs of children and young people and reflect Core20PLUS5 in plans to reduce health inequalities.

## Our Place

We will all:

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

## Living Well

Living Well is Bradford District's whole system approach to obesity and improving wellbeing. Our vision is to create a district where we are all making it easier for everyone to live a healthy and active lifestyle. We aim to enable the places and organisations in which we live, work, learn and play to promote health and wellbeing by making it easier for people of all ages to adopting healthier behaviours and become better able to care for themselves.

Living Well is made up of multiple delivery projects which together enable the system to achieve our aim through the following four workstreams (Figure 8):

- Individuals and families: enabling behaviour change through provision of accessible personalised support services directly to people and families;
- Communities and Organisations: enabling behaviour change through facilitating adjustments to policies and practices in schools, businesses, health and community settings to create health promoting places across the district;
- Physical environment: enabling behaviour change through facilitating physical changes to our environment to default people into being more active and have a healthy balanced diet; and
- System Enabler projects: enabling behaviour change through the Living Well core support offer e.g. communications, and education offers to the public, workforce, and policy makers.

Figure 8: Living Well workstreams

In 2023/24 our plans include:

- Improving wellbeing through embedding prevention offers into care pathways for adults by making it easier for people and clinicians to access the Living Well Service offers to help people adopt healthier lifestyle behaviours as a normal part of their care.
- Increasing awareness and referrals into our new weight management service for children and families and develop a blended pathway model to include other services.
- Establish a viable service model for the new weight loss medications and agree a clear pathway for the thousands of eligible adults.
- Strengthen individual and community capabilities, to create healthier places and reduce health inequalities at locality level. This includes work to improve health literacy, understanding the barriers to behaviour change and developing the social movement into grassroots community settings.
- Finalise and start implementing actions from the Physical Activity Strategy and the Food Strategy across the health and care system.
- Aligning shared priorities to create effective and efficient system enablement to help achieve our vision.
- Stakeholder engagement and increasing partners understanding of how they can contribute to the whole systems approach.

## Research and Innovation

Research is an enabler for transformation and innovation in the health and care arena. There is already a strong ethos and track record of healthcare research collaboration within the Bradford District and Craven area which has been in existence for many years. This has been reinforced by the inception of the Bradford Institute for Health Research where partners across the area have collaborated to increase the research opportunities available to the population.

As a City of Research (CoR) we intend to:

- Promote a CoR 'Research as One' culture and partnership that provides excellent quality and research opportunities and equity to the Bradford and Airedale population, which will include both our urban and large rural communities;
- Enable a Research Ready Community (RRC). We already have good engagement in some areas but will increase the awareness and the benefits of research and stimulate our communities research 'appetite' and enthusiasm to be involved and drive our research agenda;
- Working with research funders, public sector, and industry partners, attract more research income. This will enable greater collaborative working across the region delivering research which meets local and regional health and social care needs and NHS ambitions; and
- Build effective and inclusive communication channels to connect with our communities to encourage greater collaborative opportunities.

By doing this we will support and enable innovative care and services across the health and care partnership.

We intend to collaborate across four key areas (Figure 9):

1. Development of research ideas and development of people to create new research and deliver research studies;
2. Governance of research to be harmonised to ensure that Bradford place has a consistent aligned governance response to research;
3. Delivery strategies to ensure that opportunities can be offered to as many of our population as is possible; and
4. Dissemination of the products of research back to staff but also the participating population.

Figure 9: Overview of City of Research planned activity themes

There is an additional cross cutting theme of communication and engagement where we will promote the importance of research, demystify and encourage people to take part in research and to enable all staff to see the value of research and the contribution they can make to it.

Within our communication and engagement, we shall work with all our collaborators to:

- Raise awareness around research in key areas: our population; our staff; and our students;
- Demystifying research: understanding what research is and isn't with staff and population; and consideration of health literacy;
- Highlight the benefits of research: better patient outcomes; better quality of care; access to new and novel treatments; and upskilling of staff and career progression;
- Improve access to research opportunities: joining the local registry; and be part of research the national directive; and
- Adopt a Collaborative approach: Research as One; sharing of workforce; primary/community and secondary care all working together; and developing the next generation health and social care professional/researcher.

Examples of research as an enabler to service improvement and development include: Focus on air pollution; and Join us Move Play

## Our Partnership

We will all:

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

Our priority areas for the next five years are: Healthy Communities and Workforce, alongside our Digital and Estates enabling programmes.

## Healthy Communities

Our Healthy Communities priority programme has four aims:

1. To improve population health on community footprints;
2. To work with communities to identify what matters to them and provide them with the opportunities and resources;
3. To focus on a small number of things that are identified to address inequalities in health and care for our population; and
4. To join up the community offers of different services and providers delivering health and care in the community (NHS organisations, Local Authority Teams, and VCSE)

To do this we work across three footprints (Figure 10):

- Community partnerships;
- Locality collaboratives; and
- Place based community health and care integration.

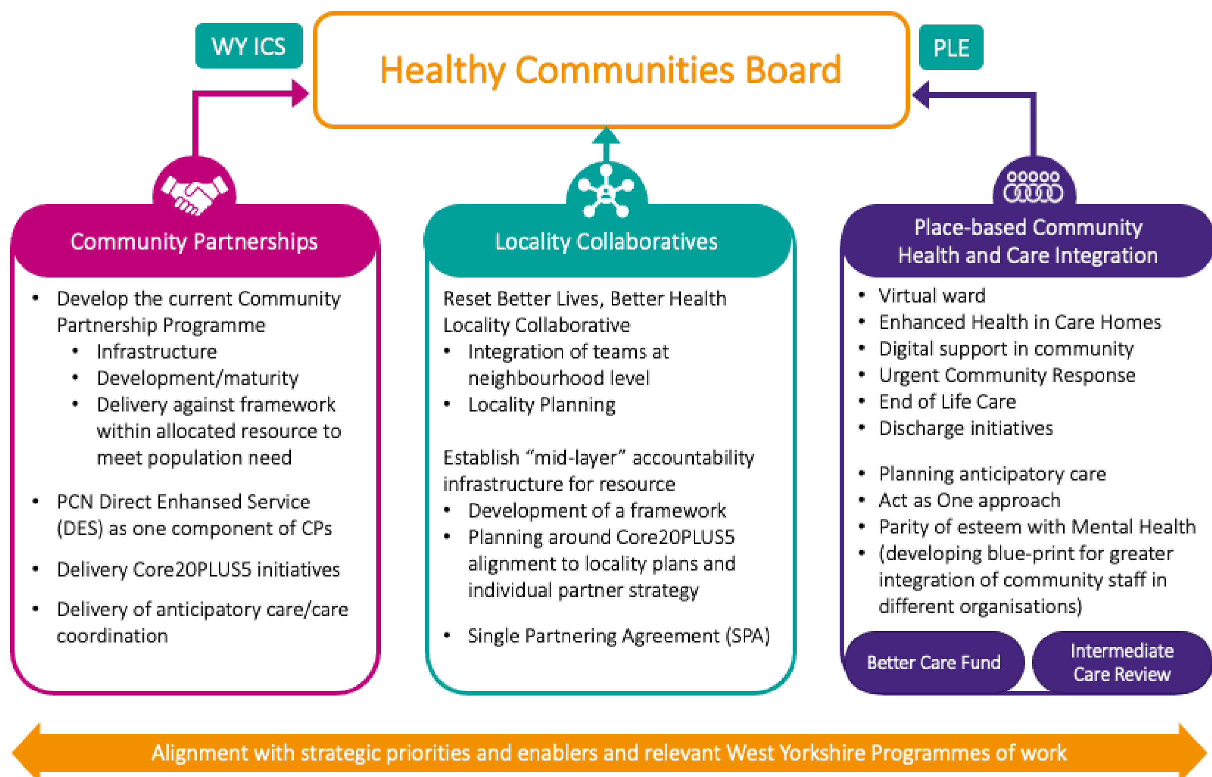


Figure 10: Healthy Communities Workstreams

In 2023/24 our plans include:

- 15% growth in Urgent Community Response activity to avoid hospital admissions.
- An increase in the number of Virtual Ward beds to 155 by April 2024 across a range of specialties using a blended model providing both technology enabled and face to face support and interventions.
- Plans to improve Community Services Waiting times for some services but with the need for a more detailed review and understanding of the issues that need addressing.
- Ongoing work to further improve hospital discharges and ensure community services are in place that enable people to return home and enable them to remain there without a re-admission.
- A 2% reduction in emergency hospital admissions for ambulatory care sensitive conditions (those conditions that can be managed within a primary or community care setting).
- A 2% reduction in the number of our over 65 population who need hospitalisation as a result of a fall.

- Support more people to remain at home rather than enter long-term residential care.
- 2% growth in GP appointments (just over 90,000 additional appointments in 2023/24).
- Development of and implementation of an operating model that integrates Health and local authority teams working within neighbourhoods to meet the population's needs.
- Use of Core20PLUS5 funding to deliver changes that matter to local people to address health inequalities.
- Planning and implementation of proactive care models to support people with complex health needs to remain supported at home through multi-disciplinary care teams.
- Development of local Community Partnerships.

## Workforce

Workforce is both a priority in its own right and is also an enabler to the other 4 priorities (Figure 11). To align with the HCP priorities, we have refreshed the priorities within our people plan to ensure alignment.

Figure 11: Workforce workstreams

Our People Plan is inclusive of all our health and care partners and is focused around the following four Pillars.

- Looking after our people: For our people to be safe and well at work, physically and psychologically, with quality health and wellbeing support for everyone;

- Creating a sense of belonging: To create a compassionate and inclusive culture where everyone feels they belong, have a voice, and feel empowered to make a difference;
- Developing new ways of working: To transform the way we deliver care by maximising digitalisation and enabling our people to act as one; and
- Growing and retaining our workforce: To grow our collective workforce for the future by recruiting and retaining our people. To be the best place to work; enabling people to progress and fulfil their potential by providing 'careers for life'.

Each pillar is led by a Director of Human Resources within the Health and Care Partnership. This allows us to collaborate on our sector and organisational plans.

In 2023/24 our plans include:

- Growth in our hospital workforce as we focus on reducing our vacancies.
- Growth in staffing to support new initiatives including our pharmacy transformation work, additional day case capacity, additional virtual ward beds, children's assessment unit plans and increase in midwifery to support continuity of carer and Ockenden roles.
- Growth for mental health investment funding in children's and young people's mental health, perinatal mental health, and psychological therapy services.
- A reduction in sickness and turnover and a shift from using agency to local bank staffing over the next three years.
- A mix between domestic recruitment/newly qualified and the use of apprenticeships along-side international recruitment.
- Further development and recruitment to the Additional Roles Reimbursement scheme (funding for a range of new primary care roles).
- The development of new ways of working to ensure we have the right roles and capacity to support immediate priorities.
- We will continue to 'grow our own' through proactive work with schools via our place-based Careers and Technical Education (CTE) Board. We will also continue to grow the number of schools we work with on a regular basis; building on the interview technique sessions and school assemblies delivered in 2022.

## Digital, Data, Intelligence, Insight

The aim of our Digital enabling programme is to best support the needs of our population and the requirements of our colleagues through providing class leading enabling digital technology. The programme has the following six workstreams:

- Work as One: Any staff member should, with minimal effort, be able to work from any other sites owned by a partner organisation and be able to access all the resources required to perform their role;
- Shared Care Records: To achieve seamless sharing of relevant health and social care information among organisations across the place to ensure seamless transition of care and our people improving their access to and journey through our services;
- Digital Inclusion: No citizens of Bradford District will be excluded from having access to digital devices, adequate affordable connectivity and the necessary skills to use them to improve their livelihoods;
- Digital workforce: Ensure we have sufficient skills capacity to meet with the current and growing demand for Digital, Data and Technology (DDaT) workforce;
- Cyber Security: Create a cross organisational Cyber Security Working Group where members will contribute to the ongoing cyber readiness and share, resources, knowledge, tools, and costs (economies of scale); and
- Information Governance (IG): To develop, implement and embed an effective IG framework that will support appropriate clinical and organisational record management and record sharing within the Bradford District & Craven footprint enabling our shared care record

The workstreams will deliver priority objectives through formal priority themed groups, with clearly identified aims and deliverables with a focus on 'getting the basics right' by investing in increased system interoperability and data sharing.

We also have an ambition to make the data that partner organisations hold work harder, to enable population health insights that will improve health outcomes, and by giving health and social care professionals all the information they need wherever they are working. Our 'Data as One' work will continue to draw all the organisations in the partnership closer together, mitigating perceived administrative barriers for the VCSE sector (e.g. supporting IG accreditation) and establishing closer working with the local authorities.

In 2023/24 our plans include:

- Completing a digital maturity assessment to measure progress towards the core capabilities set out in What Good Looks Like, utilising the framework for all the priority work streams as a measure of success.
- Developing the right data architecture in place for population health management (PHM).
- Putting digital tools in place so patients can be supported with high quality information that equips them to take greater control over their health and care.
- Continuing the sharing of resources, knowledge, learnings, and tools to maintain a strong Cyber response to all threats.
- Mapping the current IT infrastructure, bottlenecks, technical constraints and limitations across organisational sites and identifying and sharing good practice which may be applied across partners. Agreeing long-term convergence principles (e.g. technology, support model) and strategic principles.
- Developing a whole system DDaT workforce plan.
- Progressing our Digital Inclusion work including: Developing the Digital Inclusion Index with YemeTech, to identify key priorities and associated support on a locality basis; Securing funding for the appointment of Digital Inclusion Officers in communities; Developing further the idea of a digital bus for Bradford; Developing the creation of a digital device donation offer for Bradford; and Seeking opportunities to extend the Digital Health Champions

## Estates

Our vision for our estate reflects those set out in the Naylor review where we will:

- Provide a modern estate equal to delivering our vision for health and social care;
- Ensure our strategic estates planning reflects changing delivery models;
- Align with future clinical service strategies;
- Proactively maintain our assets and reduce backlog maintenance; and
- Replace what cannot cost-effectively be maintained.

Our NHS infrastructure is essential to the long-term sustainability of our ability to meet healthcare needs for our population; unlocking efficiencies and helping manage demand. It is also fundamental to high-quality patient care, from well-designed facilities that promote quicker recovery, to staff being better able to care for patients using equipment and technology that they need.

We are redesigning the way we deliver and receive care and support, ensuring that our local population receive exceptional care now and into the future. At the heart of the desired future state is a strong primary and community-based, 'out of hospital' model of care that cares for most of the health and wellbeing needs of the local population.

The model is a coalition of primary, community, mental health, social care, VCSE and urgent care services. Focusing on personalisation, designing support based on delaying and preventing the need for care through proactive care planning, strengths, and asset-based approaches. Our estates strategy will shape how we operate and where we focus our resources, to support this model.

We have clarity in terms of an agreed ambition to plan for the next generation, with an estate that is fit to deliver health and wellbeing for our population in ways that reduce inequalities and improve population health. We recognise the need to work in partnership in the best interests of our population, this is our anchor.

As we shape our system strategy, we are considering what services might be best centralised on each hospital site, with hub and spoke approaches to different specialties and pathways of care. We approach our planning by viewing our estate as a whole, with core services on both acute trust sites, including, but not limited to, Emergency Departments and Maternity Services.

## Community Diagnostic Centre

Wherever possible, we want services to be provided in local neighbourhoods. Only when the safety, quality and cost-effectiveness of care are improved by providing it at a greater scale will services be provided elsewhere. This already includes diagnostics, outpatients, endoscopy, and minor surgery. We were successful in securing national funding for a local Community Diagnostic Centre, which will enable us to deliver a better diagnostic service and more personalised experience by providing a single point of access to a range of services in the community

## Integration of our services

In developing our Estate Strategy, we plan to use this as an opportunity to provide greater detail about our plans to ensure that the estate is focused on the optimum location of services to achieve our ambitions of investing in wellness, reducing inequalities and bringing care closer to home.

Our emerging clinical strategies are shaping our future estate needs, along with a programme of required projects, investment, and associated system benefits. Work has begun on considering the new models for providing social care services, which entails reconsidering the location and potential co-location with health services. This provides an opportunity to align with the reconfiguration of community and primary care estate.

We have worked collaboratively to gain a shared understanding of the totality of our community estate and how we can rationalise and increase value from this together. This asset review will be used to shape and inform plans for our locality model of working.

In 2023/24 our plans include:

- Developing our 'hub and spoke' locality model of health and care service delivery aligned with parliamentary constituency boundaries.
- A Community Diagnostic Centre at Eccleshill and a business case for a 'spoke' centre in Airedale.
- A new day-case facility at St Luke's Hospital.
- Managing the impact of Reinforced Autoclaved Aerated Concrete (RAAC) at Airedale Hospital ahead of the building of a new hospital and co-located Urgent Care Centre.
- Modernising the estate of Lynfield Mount Hospital.

## Oversight and Assurance

The Bradford District and Craven Health and Care Partnership is led by an independently chaired Partnership Board, which operates with delegated authority from the West Yorkshire ICB.

The Partnership Board agrees our place-based strategy and associated high level budget allocations. It receives assurance from following three committees:

- Quality: Provides assurance on the quality, safety and effectiveness of services and the contribution services make to improving health outcomes for local people;
- People: Ongoing assurance of the delivery of the partnership's people plan and that the outcomes of the four pillars of the integrated people plan are being achieved; and
- Finance and Performance: Provides a collective focus on financial and performance outcomes.

The Board is also advised and informed through a comprehensive process of public involvement, a citizens forum, and a clinical and professional forum (Figure 12).

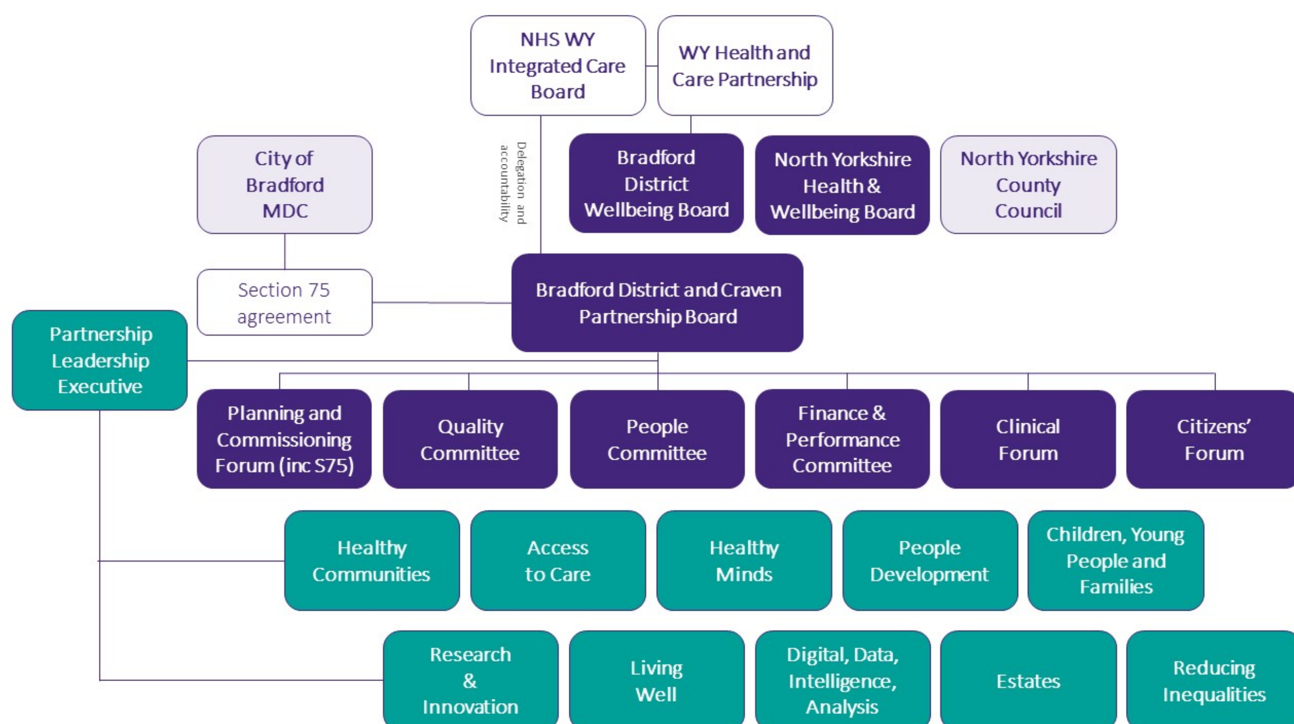


Figure 12: Our Partnership Governance Structure

The implementation of our strategy is led by the Partnership Leadership Executive (PLE), which is accountable to the Partnership Board. The PLE is a muti-sectoral, senior leadership group, chaired by the Place lead, accountable to the West Yorkshire ICB chief executive.

The PLE oversees our Priority and Enabling Programme Boards, the engine rooms through which our plan will be delivered alongside our Place based ICB functions (Figure 13).

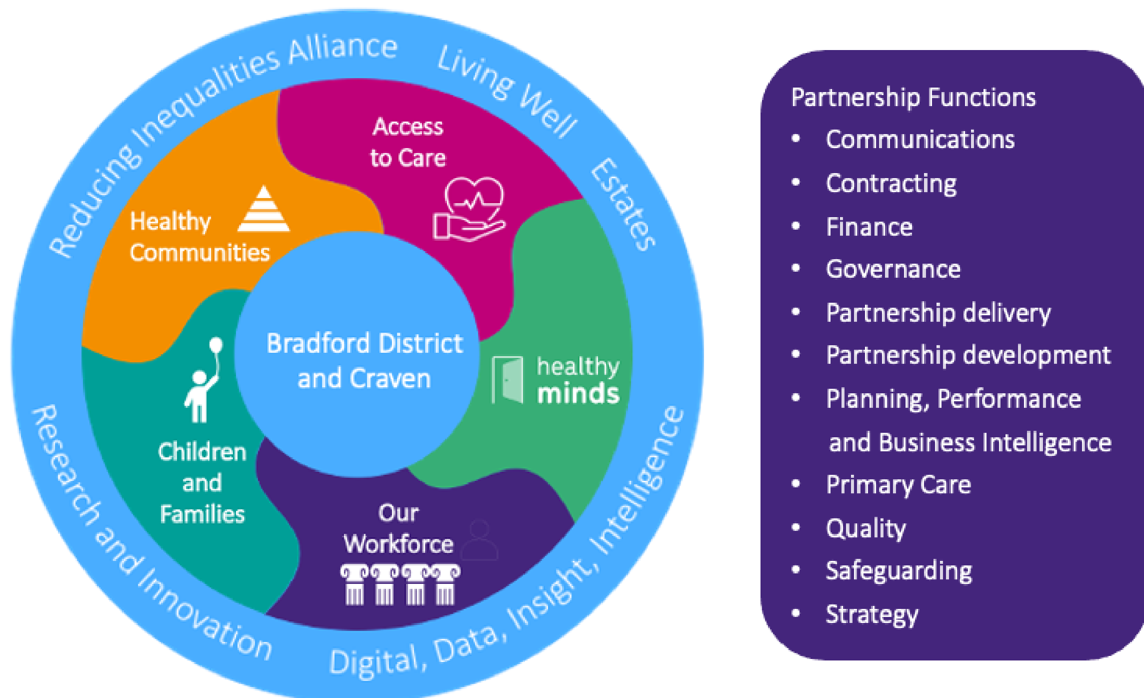


Figure 13: Our Partnership Operating Model

The Partnership Board will agree our local Joint Forward Plan, following advice and recommendation from the PLE. Thereafter, the PLE will receive regular updates on progress with implementation of the plan, whilst our Priority Boards and enabling programmes, will oversee delivery of individual initiatives which contribute to achievement of our goals.

## Metrics

Our overall long-term measure of success will be to increase the healthy life expectancy of the population of Bradford District and Craven. However, whilst there are some clear outcomes and metrics identified within this plan in relation to our immediate commitments for 2023/24, there is still further work needed to define the measures to demonstrate delivery towards our longer-term objectives. These measures will need to demonstrate that the work of programmes, both individually, and collectively, are delivering their aims and objectives.

Each of our programmes is at different stages of maturity, and work is underway to help them scope out the key performance metrics that the programme boards and workstreams

need to provide assurance and aid decision making. This work also needs to ensure alignment between Bradford District and Craven, and the West Yorkshire measures of performance and impact.