Report of the Adults and Community Services to the meeting of Health and Wellbeing Board to be held on 3rd February 2015

Subject: **O**

Bradford District Better Care Fund – Progress towards integration

Summary statement:

The following report sets out the current arrangements/status of the Bradford District Better Care Fund. The report provides an outline of the progress towards integration across the district

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Portfolio:

Adult Services and Health

Overview & Scrutiny Area:

Health & Social Care

1. SUMMARY

1.1. The following report sets out the current arrangements/status of the Bradford District Better Care Fund. The report provides an outline of the progress towards integration across the district

2. BACKGROUND

2.1. In November 2015 the Health and Wellbeing Board received a report detailing the various iterations of the Bradford Better Care Plan submitted for approval by the Department of Health. The Board ratified the version of the plan authorised by the Chair and submitted in September 2014. That plan was judged to be ‘approved with conditions’ and a further iteration of the plan was authorised by the Chair and submitted in November 20014, a copy of the November 2014 plan is attached. This iteration of the plan was adjudicated to be ‘approved with support’,

2.2. The Bradford Plan was then subject to further points of clarification with NHS England and the submission of additional documentation. The current status of the Bradford plan is; it has been recommended for approval by NHS England and is now awaiting confirmation of this.

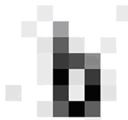
2.3. The next stage is to develop our approach locally to the Section 75 and required pooled budget, the mechanism whereby cash will flow across the system to fund the various elements of the plan. This is being led by the Chief Finance Officers in the Clinical Commissioning Groups and the Director of Finance for the City of Bradford Metropolitan District Council.

2.4. The BCF budget is £37.345m and is comprised of aligned existing funding to support the development of an integrated system of community-based/out of care and in particular intermediate care to support people to regain and maintain their health, wellbeing and independence.

3. OTHER CONSIDERATIONS

Good progress has been achieved to integrate health and social care but it is acknowledged that it needs to achieve more sufficient scale or pace to address our future financial pressures. All the organisations providing and commissioning health and social care services have been working together through the Integration and Change Board (ICB) to develop plans to accelerate the way we improve health outcomes and reduce inequalities within this challenging financial context.

A five year forward plan for Bradford, Airedale, Wharfedale and Craven was published last year demonstrating real ambition to truly transform services. There is clarity on ‘what’ is needed to create – the focus has now switched to ‘how’ we do this. Given the scale of transformation and pace of change required, there is consensus that only new and different models of care will achieve our ambitions and create a sustainable health and care system for the future.



Building this new model of care is a key priority in 2015.

3.1. **The Integrated Care for adults programme in Bradford**
This is central to delivering joined up out of hospital care and has three main objectives:

1. Improve the quality of care and experience of care by joining up health and care services around the needs of the person to support them to be healthy, well and independent
2. Delivering as much care as is safe and feasible out of hospital, as close to home as possible, with an emphasis on pre-emptive care and enablement
3. Lining up the systems and infrastructure to support the delivery of integrated care

There are two broad strands to the programme to join up care around the needs of the person and the delivery models for Bradford and for Airedale, Wharfedale and Craven are adapted to suit local needs:

3.2. **Integrated community services**
NHS and local authority social care services working together to join up care around the needs of the person at home.

- Integrated Care Teams have been established across the District, working with GPs, nurses, therapist, social workers and the voluntary and community sector.
- An Integrated Care Plan is in place so the person has one coordinated plan for their care
- Predictive risk stratification is in place for all GP surgeries meaning that teams can identify people most at risk of a hospital admission and plan their care better
- The role of Lead Practitioner who can coordinate the care of people with complex needs

3.3. **Integrated intermediate care services**

NHS and local authority social care services are working together to prevent admissions to hospital or long-term care when these can be avoided safely and is in the best interests of the person and their family.

Intermediate care is:

"a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living" (Department of Health paper Halfway Home, 2009).

The following is already in place:

- An access and triage hub in for Airedale, Wharfedale and Craven (see case study in Appendix 2 Integrated Care Hub)
- An access and assessment hub due to open in Bradford
- Joint teams providing care at home and ensuring people are discharged successfully with access to rehabilitation
- Early supported discharge from hospital

- Carers Resource Home from Hospital scheme supporting people in the early days after a discharge
- BEST+ reablement teams operating as part of the integrated service
- Intermediate care beds provided in community hospitals and social care residential care homes enabling people to recuperate and regain their independence

Case studies to exemplify the benefits of the above integrated services are set out in Appendix 1.and 2.

3.4. NHS Continuing Health Care (CHC) and Integrated Personalised Commissioning

The national framework for continuing healthcare (CHC) was introduced in October 2007.It provided for services to people who needed long term help, and whose main need was health care (rather than social care,)to be funded by the NHS. In July 2009 a revised framework was produced by the Department of Health following review of the initial national guidance. The NHS Continuing Healthcare (Responsibilities) Directions 2009 specifies that “Continuing Healthcare” means a package of care arranged and funded solely by the health service for a person aged over 18 or over to meet physical or mental health needs which have arisen as a result of illness.

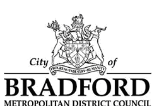
When carrying out an assessment of eligibility for Continuing Healthcare a Clinical Commissioning Group (CCG) must ensure that a multi-disciplinary team (MDT) undertakes an assessment of needs and uses that assessment to complete a national Decision Support Tool (DST). The CCG must then use the completed DST to inform a decision as to whether a person is eligible for Continuing Healthcare. Under the guidance issued by the NHS, the CCG should usually accept the recommendation from the MDT except in exceptional circumstances.

Adult and Community services is under a duty to assess any person who appears to be in need of community care services , and must also notify the relevant CCG if, in carrying out the assessment , it becomes apparent to the authority that the person has healthcare needs.

The Council’s internal audit service undertook an audit of the Continuing Healthcare system and the first report was issued 21 September 2012. A follow up report was done to determine the level of implementation of the high priority recommendations agreed in the original report.

Adult and Community services have a transformational change programme, which includes a project on implementing changes in the way people have their social care needs assessed and reviewed, this includes ensuring that people with any healthcare needs are identified, and referred for CHC assessment where appropriate.

A number of the Audit Service’s recommendations are addressed by the following:



- From December 1st Social Workers have commenced working within the CHC team on a daily basis. Positive working relationships have been nurtured prior to this date by encouraging access to the team beforehand and attendance at CHC Team meetings.
- Social Workers have full access to the CCG's patient information database which will allow better and quicker sharing of information.
- Joint finance panels are now in place to agree proportions of health and social care funding for individual care packages across Adult and Children's Continuing Healthcare. Further work on process needs to be completed; however initial work so far is positive and allows both organisations to gain more understanding of each other and achieve transparent decision making.
- A Joint Personalised Commissioning Group has been formed to discuss, share information and resolve operational issues across Continuing Healthcare and Section 117 workflows. Membership includes Directors and Senior Leadership from CCG/LA & BDCT commissioning and finance.

Areas of further development

- Work is planned to build further on the opportunities co-location of staff brings to improve the service experience for those requiring personalised commissioning and to realise efficiencies in the system.
- Dual reporting within finance will be explored via Comm Care.
- Scoping of CHC joining the Local Authority's SystmOne unit will continue.
- We are planning a pilot that will explore the feasibility of a robust joint direct payment account for individuals who are in receipt of direct payments from the Local Authority and PHB's from the CCGs.
- Approach Healthwatch to discuss the possibility of assistance in increasing our Personal Outcomes Evaluation Tool (POET) returns.
- NHS England has signalled that PHB's will be made available to people with Mental Health and Long term Conditions from April 2015. To date little guidance has been issued on this proposal though pilots are underway across the country.

Case studies of the benefits of the new integrated working are set out in Appendix 3.

4. FINANCIAL & RESOURCE APPRAISAL

As mentioned in the report, budgets of the CCG's and the Local Authority have been pooled into the BCF. These pooled funds will allow the work described in the report to take place. At this stage there are no additional financial implications, however, there will be a need to closely monitor and review the budgets on an on-going basis.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

None

6. LEGAL APPRAISAL

Whilst there is an integration of services and provisions, there is no integration of legal duties in this area and the local authority's legal duties under the Care Act 2014 will remain distinct from those of Health as set out in the National Health Services Act 2006..

7. OTHER IMPLICATIONS

None

7.1. **EQUALITY & DIVERSITY**

None

7.2. **SUSTAINABILITY IMPLICATIONS**

None

7.3. GREENHOUSE GAS EMISSIONS IMPACTS

None

7.4. **COMMUNITY SAFETY IMPLICATIONS**

None

7.5. **HUMAN RIGHTS ACT**

None

7.6. **TRADE UNION**

None

7.7. WARD IMPLICATIONS

None

7.8. AREA COMMITTEE ACTION PLAN IMPLICATIONS
(for reports to Area Committees only)

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

None

10. RECOMMENDATIONS

Members are requested to ratify the Bradford Better Care Plan submitted for approval on the 19th November 2014 and authorised by the Chair of this Committee.

11. APPENDICES

Appendix 1 **Integrated Care Hub**
Appendix 2 **Integrated Community Teams Case Studies**
Appendix 3 **Integrated Personalised Commissioning**
Appendix 4 **Bradford Better Care Plan November 2014**

12. BACKGROUND DOCUMENTS

None

Appendix 1
Integrated Care Hub

Airedale, Wharfedale and Craven Intermediate Care Hub

In order to deliver the right care vision as set out by AWC TIG an AWC Intermediate Care HUB (IC-HUB) was launched on 10 November 2014. It acts as a shared front door for health, social care and VCS intermediate, reablement and rehabilitation services. Organisations from across disciplines are working closely in a more joined way to promote seamless person centred coordinated care based around the holistic needs of local people.
The IC-HUB acts as a single point of entry into intermediate care services across Airedale, Wharfedale and Craven, enabling professionals to arrange the right care for urgent and non-urgent referrals, helping to prevent avoidable hospital admissions and effectively manage long-term conditions in the right place at the right time.
It is operated by a dedicated multi-disciplinary team of health, social care working together to provide a range of services including signposting, screening, triage, assessment, care planning, case management and care co-ordination. The triage and assessment function aims to ensure each person referred for intermediate care is placed on the most appropriate care pathway.

The aims of the HUB are to:

1. **Help people avoid people going into hospital unnecessarily**

2. **Helping people be as independent as possible after a stay in hospital**

3. **Preventing people to move into a residential home until they need to**

Since its launch the IC-Hub has recorded and dealt with 530 referrals and the model is changing custom and promoting real improved care planning. It is improving management of beds by challenging the culture of discharging from hospital to beds.

Appendix 2
Integrated Community Teams Case Studies

Please note all names used in the case studies have been annonomised

Case Study 1

This 67 year old Polish gentleman, with limited English, lives alone since his wife died of cancer a year ago. He has plenty of family support. Lukasz has had COPD for over 20 years and requires frequent antibiotics and steroids as a result of over 13 exacerbations a year. Despite this, he continues to smoke 10 cigarettes a day. He regularly attends clinic as a result of anxieties around management, but often misses scheduled appointments with the Practice Nurses.

A ‘single team’ approach

After gaining consent in March 2014, Lukasz was discussed in an ICT meeting and a substantial care plan, addressing his needs in a joined up way, was agreed. The care plan included a referral to the pulmonary rehabilitation team and the provision of an emergency supply of antibiotics and steroids to help reduce exacerbations. A medication review was scheduled with the expectation that he might experience fewer chest infections if he were prescribed symbicort in place of seretide. He is to be given a self care plan on what action to take when he experiences an exacerbation and his inhaler technique is to be assessed to ensure that he uses his inhaler correctly. It was also agreed that he should be assessed for depression and should also be given advice about smoking cessation.

Joined up care in the community

Following discussion with Lukasz‘s family, it was identified that he often missed appointments because he could not read English and often did not understand what advice he was given. With additional input from interpreting services he was supported to attend appointments with the Practice Nurse to address his health needs, including help in using his inhaler.
He was also referred to the Pulmonary Rehabilitation service but he didn’t attend the first appointment, again due to language barriers. The service has now liaised with his daughter and he is attending appointments.

How has this helped?

As a result of this integrated team approach, Lukasz now feels that he has the coping mechanisms in place to help him with his day-to-day care. He now experiences fewer exacerbations and as a result requires fewer appointments and uses the out of hours service far less than before. Whilst he has not given up smoking entirely, he has significantly reduced his daily cigarettes with support from his GP practice. Following assessment for depression he chose to receive counselling and antidepressants. He has regained the confidence he needs to continue to live independently and is much more confident in managing his COPD.

Case Study 2

RM has two children and was suffering from severe anxiety and panic attacks but was reluctant to take the medication prescribed by her doctor. She was barely leaving the house and making almost daily calls to the ambulance service, as well as several visits to A&E per week (19 attendances in 1 month period!).

A 'single team' approach

When her GP surgery was alerted to this, they met with a health visitor, local children's centre and A&E staff and devised an integrated care plan for her.

Joined up care in the community

Rebecca was given counselling via the children's centre and with the advice and support of a health promotion worker assigned to help her with healthy eating, Rebecca was persuaded to take the medication, which has helped her greatly. She was assigned a mental health worker, who worked with Rebecca to help her understand her feelings and who also gave her practical advice on relaxation techniques and how to manage panic attacks.

How has this helped?

Rebecca is now able to cook, clean, take care of her children, leave her home and function as normal. Since November, she has not attended A&E and has not phoned for an ambulance. Her most positive outcome was that she managed to cook Christmas dinner for her family for the first time.

Appendix 3
Integrated Personalised Commissioning

Case Study 1

A young person entering transition has been identified to use as a good example of integrated working across organisations. Having spent most of her childhood within a residential school, her whole care package was at risk as she turned 18. This was mainly due to her being unable to stay in her placement once she became an adult.

The provider had identified a placement which was based within their own care group which would allow her to maintain contact with her current carers and friends and would also prevent destabilising her current care package. A multidisciplinary approach (Adult Social Care, CHC, Allied Health Professionals family and the care provider) was taken to first determine whether the identified placement was appropriate and to see if other alternatives could meet her care needs. After scrutiny it was decided the placement was appropriate and Health and Social Care successfully negotiated the care fees together with the provider to achieve significant cost savings without any reduction to the care package being commissioned. The young person and their family were very happy as her carers could remain with her and this ensured her complex health needs could continue to be met with minimum disruption.

Case Study 2

Recently Nationwide and Local hospital pressures resulted in bed pressures in our local A&E departments, acute and community hospital wards. CHC In-reach nurses worked alongside the hospital discharge teams, social services, care homes and independent care agencies to identify and commission safe care packages and ensured safe discharges occurred and care packages were in place without delay. This was a crisis which hit all health and social care services and the integrated/coordinated approach Health and the Local Authority took with regard to agreeing costings and commissioning care enabled an increase in bed availability within the acute hospital settings across the district.

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	City of Bradford Metropolitan District Council (CBMDC)
Clinical Commissioning Groups	NHS Airedale, Wharfedale & Craven (AWCCCG)
	NHS Bradford City (BCCCG)
	NHS Bradford Districts (BDCCG)
Boundary Differences	Airedale, Wharfedale, City and Districts CCG areas are together coterminous with the City of Bradford Metropolitan District Council boundaries. Craven (part of Airedale, Wharfedale and Craven CCG area) is coterminous with Craven District Council and is part of North Yorkshire County Council (NYCC). As such AWCCCG is party to two Better Care Funds (CBMDC & NYCC). This plan covers the geographical area covered by the Bradford District Health and Wellbeing Board, and therefore does not include Craven district.

	AWCCCG has effective engagement arrangements and well established collaborative working with NYCC, Craven District Council and CBMDC. The transformational change and integration programmes include the AWCCCG population in its entirety and will be enabled in a consistent manner via the respective Better Care Funds. This is managed through the Integration and Change Board which has representation from both local authorities and is overseen via both Health and Wellbeing Boards
Date agreed at Health and Well-Being Board:	**18.09.14**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£ 2.305m**
2015/16	**£37.345m**
Total agreed value of pooled budget: 2014/15	**£ 14.097m**
2015/16	**£37.345m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Airedale Wharfedale and Craven Clinical Commissioning Group
By	Dr Phil Pue
Position	Chief Clinical Officer
Date	18.09.14
Signed on behalf of the Clinical Commissioning Group	Bradford Districts Clinical Commissioning Group
By	Helen Hirst
Position	Chief Officer
Date	18.09.14

Signed on behalf of the Clinical Commissioning Group	Bradford City Clinical Commissioning Group

By	Helen Hirst
Position	Chief Officer
Date	18.09.14
Signed on behalf of the Council	Tony Reeves
By	City of Bradford Metropolitan District Council
Position	Chief Executive,
Date	18.09.14

Signed on behalf of the Health and Wellbeing Board	0
By Chair of Health and Wellbeing Board	Cllr David Green
Date	18.09.14

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Five Year Forward View 2014 – 2019. Bradford District and Craven Health and Care Economy.	http://www.airedalewharfedalecravenccg.nhs.uk/get-involved/bradford-and-craven-five-year-forward-view/ NB This document is available on all three CCG websites
2 year operational plans for each Clinical Commissioning Group	The 2 year operational plans for the three Clinical Commissioning Groups have been uploaded to Unify separately.
Integrated Care for Adults Programme definition document (May 2012)	1. The Integrated Care for Adults Programme Definition Document (May 2012) set out the detailed model for integrating care and increasing the capacity and capability of community services to support more people with more complex conditions at home. The PDD was supported by a case for change for each of Airedale, Wharfedale and Craven and for Bradford. • The case for change (Airedale, Wharfedale and Craven) January 2013 • The case for change (Bradford) January 2013

	These documents use health economy and demographic data to quantify the potential to avoid unplanned admissions to secondary care in three key areas: i. People with long-term conditions ii. Ambulatory sensitive care conditions iii. Cases that could be treated in primary care Integrated Care PDD final draft v 1.18 11. Strategic Business Development Bradfor Strategic Business Development Plan AW
Better for Bradford, Airedale, Wharfedale and Craven: right care, right place, first time.	This document was agreed by the Integration and Change Board on the 17th January 2014 (subject to minor drafting amendments). It is an inter-agency agreement which sets out the specific system changes that need to be implemented across the health and care economy over the next 2 years. Integrated care provides a significant contribution to the transformation of the whole system in Bradford and the reduction of demand and associated costs to the health and care economy. Better for Bradford_ICB agreem
JSNA	**http://www.observatory.bradford.nhs.uk/Pages/JSNA.aspx**
Joint Health and Wellbeing Strategy	H&SC_W27843 PROOF-Health and W
Integrated Care Models: Evidence Briefing York Health Economics Consortium (YHEC) Telemedicine Service Evaluation and Economic Modelling Report 2013	BA Integrated Care Models.pdf Telemedicine - Final Report 13-03-12.pdf
Co-Commissioning expression of interest AWC CCG	co-commissioing response.pdf

Co-commissioning expression of interest Bradford City CCG	BCCCG Co-comm'g EoI - final.pdf
Co-commissioning expression of interest Bradford Districts CCG	BDCCG Co-comm'g EoI (12).pdf
Integration and Change Board (ICB) Portfolio Risk register (Draft pending approval)	Copy of Copy of Draft ICB _Portfolio R
ICB draft dashboard (this dashboard is still in development)	ICfA dashboard draft for ICB 20.06.1

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

High level realistic view of how health and social care services will look in 5 years:

Introduction:

Leaders in the local health and care economy, through the Integration and Change Board (ICB), are acutely aware of the challenges we face in a climate of steadily increasing demand on hospital beds as well as the rest of community health and social care services. The national requirement to reduce emergency admission by at least 3.5% is consistent with the planning undertaken for the Five Year Forward View. We recognise that in the context of increasing demand, in real terms the reduction is considerably higher than this as reflected in the commentary made by our provider partners in the acute trusts. The BCF plan will not address this in isolation as it will require whole system planning and transformation, overseen by the ICB.

From the five year forward view:
In light of our analysis of the current and future state of the health and care economy of Bradford District and Craven, the specific local challenges we face, and through listening to what our citizens say (see section 8a) and informed by the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (see section 1c), we have developed our Five Year Forward View which can be accessed in section 1c.

Our Vision:
To create a sustainable health and care economy that enables people to be healthy, well and independent.

In order to achieve this vision we will, by 2019:

- Promote self-care and illness prevention and improve the general health and wellbeing of the population of Bradford District and Craven
- Transform primary and community services and place the patient at the centre of their care
- Implement a 24/7 integrated care system across health and care economy - this is the particular focus of the BCF
- Develop and deliver a sustainable system wide model for urgent care services
- Develop and implement a system wide model for delivery of planned care interventions

This plan for the BCF is part of the delivery mechanism for the Five Year Forward View.

Our ambition is to move to a system of resource allocation across the whole health and care economy and informed by level of need and population segmentation, collectively allocate resources at our joint disposal to maximise value and outcomes for service users.

Our vision is of a health and social care system which empowers people including carers to take control, enabling them to set their own personal goals and to become the architect of their own support package with services which are responsive when people need care.

The care provided will be patient centred, co-ordinated and safe, meeting the needs of individuals and their carers. This presents an opportunity to rethink how we support people with long term conditions and the frail elderly, our largest groups of people requiring care (as evidenced through risk stratification and population segmentation), ensuring a consistency of offer seven days a week.

Care will be integrated around the needs of the individual, not organisations. Services will wrap around the person and be enabled by use of technology which will help accelerate achievement of personal goals.

We will make optimum use of the resources available thereby ensuring effective use of the financial resource. To do this organisations have agreed in the inter-agency agreement *Better for Bradford, Airedale, Wharfedale and Craven* that they will change how they work together, to deliver health, care and support in a joined up way and avoid passing people between professionals in a bureaucratic way. This will bring an end to often heard complaints, such as "The nurse and the social worker never talk to each other, they both ask me the same questions and turn up at different times".

When people have set their own goals they will be supported to achieve these, self-care will be the starting point and people will be empowered to engage in this. Care will be more proactive rather than reactive and ensure appropriate responses, including promoting health and wellbeing.

The health and social care system will use real time data to identify people who are likely to need more care and identify interventions that will maintain their wellbeing. This will decrease reliance on traditional high cost medical and social services and will free-up resources for re-investment and expansion in community services.

People who have complex needs, that need support from a number of professionals, will be supported by multi-disciplinary, multi-functional integrated teams which will agree a personalised care plan with the person, taking their goals and wishes into account. We are already implementing such models of care.

For the first time professionals will be able to share and access information through a shared IT system where one person, one record will become a reality. This will improve decision making and avoid the same questions having to be asked over again. Voluntary and Community Services will be involved in this health and care planning, so that more people can be supported in their local communities and build strong relationships that are empowering.

When needed, these multi-disciplinary integrated teams will work alongside other local agencies, such as the police, housing, faith organisations, leisure services and education, to address an individual's needs in a way that is encompassing and centred around their unique circumstances.

Enabling home care services and rehabilitation support will be available to help people be safe and competent in their own homes. Where appropriate, technology will be used to support the delivery of care in people's homes. This integrated approach will enable people to be more independent, for longer.

People's care will be coordinated by a Lead Practitioner who will be the most relevant member of staff involved in the person's care for example a nurse, therapist, social care worker, GP or voluntary worker.

The default setting for the delivery of integrated care will be the person's own home. When people do need to go into hospital, the people who support them in the community will be in contact with the hospital team and, keeping the patient and their wishes at the fore, agree a package of support that will enable the quickest possible return home.

Intermediate care services, such as community nursing and occupational therapy, will work alongside

enabling home care services to get people back on their feet and enjoying life in a way that is right for them. For those who cannot recover, care at the end of life will respect each person's individual wishes.

Given the growing ageing population, increasing public expectations, challenging financial outlook and the opportunities technology bring, we need to seize this opportunity to do something radically different to better meet the needs of our local community. By working together to meet the challenges we face, we can ensure that we continue to benefit from the best health and social care, sustain our communities and empower more people to enjoy fulfilling lives.

Our ambition as commissioners is to develop commissioning, contracting and payment models that enable services and systems to transform and integrate, delivering high quality, safe, local outcomes-focused services, seven days a week.

A comparison between the current and 2018/19 state

i. Current commissioning models

   The commissioning model is inherited from the previous Primary Care Trust. This model is one of separate CCG and LA contracts which lead to uncoordinated services based on organisational boundaries.

   We are developing a model of integrated commissioning between the three CCGs and the Local Authority to drive transformation and system efficiencies, enabling the delivery of integrated care systems.

ii. Current operational models

   Bradford, Airedale, Wharfedale and Craven's service model is based on traditional tiers of service from social care through to primary, community health, secondary and tertiary health services. New commissioning arrangements and new models of care are intended to significantly change this landscape.

iii. Initial moves to transform the delivery of care

   There is system-wide commitment to transform care and join up services. Significant progress has been made in developing integrated care teams based around local communities formed around clusters of GP practices.

   Intermediate care services have been strengthened and expanded and deliver an integrated offer across health and social care enablement services.

   Predictive risk stratification is now available in all practices and enables multi-disciplinary teams to identify people most at risk of hospital admission. Lead practitioners are assigned to coordinate care to enable the person to remain at home and manage their condition more proactively.

   Self-care and preventative approaches are being developed and over the next five years will be adopted at scale and become the norm. The Third Sector will be central to this, supported by technology.

Our Better Care Fund will be used to make a step-change in the capacity and capability of community services seven days a week. This will support the ambitions of our well-established programme of integrating health and care services and delivering more care at home. By doing this we will achieve:

- Better quality person-centred care and a better experience of care

- The right care in the right place, first time
- Maximised independence
- Reduced costs to the local health and care economy
- A turn in the curve on demand for acute care

Our approach to the use of the Better Care Fund will support the delivery of our portfolio of integration and change programmes and in particular our Urgent and Emergency Care programme and our Integrated Care programme. The two programmes are closely inter-related because getting care at home right will reduce demand on urgent and emergency care services.

Our starting point is simplifying a complex system by integrating care around people rather than organisations and increasing the availability of care at home, or closer to home that is capable of responding rapidly and supporting people with complex and urgent needs. This will enable us to reduce demand on secondary care acute services (particularly non-elective demand) and on permanent residential care.

The programme is wide ranging however we can use the BCF to target the following priority areas for the health and care economy, achieve better outcomes for people and ultimately manage demand on the whole system more effectively:

- **Maximising independence:**
  Intermediate care, rehabilitation and reablement
  Creating a 7 day integrated system oriented around enabling people to regain and maintain their health, independence and wellbeing. This requires an enabling approach across all tiers of service from social care packages of care through to complex step-up arrangements to contain and manage escalating need.

- **Dementia:**
  Delivering an integrated and person/carer-centred system that is capable of supporting people with dementia and their carers to receive flexible care that maintains their dignity and supports them in a way that does not compound their disorientation and distress

- **Falls:**
  Achieving a whole-system and proportionate response to falls and investing in an integrated system of primary and secondary prevention that enables people to remain active and mobile

- **Self-care and prevention:**
  We need to make a step-change in the way primary, community, secondary care and social care enable and support people to manage their long-term conditions

- **Proactive care and continuity of care:**
  Through care coordination and case finding supported by predictive risk stratification and integrated care records. General Practice is at the centre of a joined up system of health and care, organised into 21 communities. In some areas developments are underway to test, and progress to an enhanced primary care model.

Underpinning all of this is an infrastructure orientated around independence including community equipment, home adaptation services, telecare and telemedicine, Third Sector support and information.

Our programme integrates care both horizontally across community health/mental health services,

primary care and social care and vertically between community and hospital services. It is a whole-system programme of integration which ensures that people who use services do not see the artificial barriers between them wherever they are in the system. This will expand to include services for children.

Bradford, Airedale, Wharfedale and Craven's health and care economy is under significant challenge. Our vision and programme of transformation and integration is central in addressing this through achieving better outcomes for people and therefore reducing unnecessary dependence on the health and care system.

We have ambitions to become a fully digital health economy and we have been identified as one of three national accelerator sites for the delivery of a cross-system integrated digital care record. The Council has committed to moving to a shared platform for an integrated health and social care record which will place us at the forefront of integrated records nationally. We are also developing the contribution that telemedicine and telecare care offer in supporting people to receive care where they live.

Our transformational change programme is also underpinned by ensuring that the systems and infrastructure supports new ways of working, including utilising the collective estate more efficiently to support co-located working, integrated ICT systems and whole system workforce planning and development.

2. Changes to the configuration of services over the next 5 years:

Our Better Care Fund is central to delivery of our five year forward view strategy and does not stand in isolation. Our ambition is to have an integrated commissioning system that deploys its total resource to achieve outcomes for local populations. Strategic planning will take place on the Health and Wellbeing Board footprint. We have set out below the concrete changes that will occur and how we will achieve these.

i. **What:** Our **community health and care services** will operate together as a single system with invisible organisational boundaries and be oriented around supporting more people with more complex conditions at home and provide proactive and preventative care, enabling our hospitals to deliver urgent and emergency and planned care more effectively and to reduce the costs associated with unplanned care. The boundaries between service tiers will be much more closely aligned, particularly between primary and secondary care.

How:
We have already made significant steps to removing boundaries between providers from the user point of view through our well-developed integrated care programme.

We have also commenced co-design and will agree with all partners, patients and the public new models of care which will deliver over the next 5 years the transformational change necessary to deliver the outcomes set out above and described in the Five Year Forward View. CCGs are developing new commissioning models to enable this change to take place. These will include outcome-based specifications, capitated budgets delegated as close as possible to local communities, new commissioning models that could potentially lead to a new provider landscape in the District.

ii. **What:** **GP services** will be integral to community-based joined up care and accountable for patient care supported by an integrated system of health and care services. They will lead on the prevention of unplanned admissions with a more proactive and coordinated approach to the care of those most at risk of admission. Support for people with long-term conditions will

be more holistic and patient-centred, embedding self-care and preventative approaches.

How:
GPs and primary care providers are integral to the new model of care. Integrated Community Services are already established in 21 communities, centred on groups of GP practices, ensuring that GPs are an essential component of the integrated MDT approach. the Proactive Care Enhanced Service is the funding mechanism which enables this.

We recognise that the proactive involvement of GPs and practices in new models of care will mean that there is additional responsibility for provision of enhanced primary care which is likely to be over and above core contractual requirements.

In view of this, the CCGs view co-commissioning of primary care as a key enabler and we also recognise that there will be a need for funding to follow the patient as more proactive and preventative work is undertake in primary and community services. This approach will prevent admissions hence investment will need to be made in order to enable this additional work to be undertaken. This will be part of the financial modelling and contract negotiations.

iii. **What: We will have the right number of community beds and they will meet the holistic needs of people who need more care than can be provided at home**. They will operate as joint health and social care facilities oriented around enabling people to regain their health, wellbeing and independence.

How:
We have done some modelling to determine the number of beds needed in acute settings and this is being extended to understand the requirements in community settings.

We are establishing intermediate care assessment and triage hubs which also act as bed bureaux enabling assessment staff to have an understanding of the total intermediate care community bed resource across health and social care. The will enable people to be placed in the right setting as close to home as possible.

As part of the LA's Great Places to Grow Old programme which is part of the overall Integration and Change portfolio, Adult Services is working closely with the CCGs and NHS providers in the development of new extra care and intermediate care facilities to ensure a holistic service is established from the outset. This is part of the longer-term plans being enacted to ensure a sustainable and viable health and social care economy.

iv. What: Our **workforce** looking after the health and care needs of the local population will be planned and developed strategically across organisations and we will influence Higher Education Institutes to educate our emerging workforce to be capable of delivering our new model of care. People will be skilled in holistic care encompassing physical and mental health needs hence ensuring parity of esteem. Each community will have a skill mix to meet the needs of the local population

How:
CCGs and providers are working together to develop a Workforce Strategy. This will include:

- a strategic approach to workforce development across the health and social care economy, ensuring that ICB is sighted on the whole system in relation to the workforce ensuring that pressures or developments in one part of the system are recognised and managed.

- We will work with Health Education England and Higher Education Institutes to identify future workforce needs and plan strategically to deliver these
- We plan to develop new models of care that better meet the needs of people and this will require new types of worker and new approaches to the delivery of care. This is likely to include generic workers, skill sharing and role blurring whist preserving the specialist skills of individual professional groups.
- We are working to close the gap between primary and secondary care in a bid to provide more-person-centred, community-based care. This will require new approaches to primary and secondary medical care delivery in particular.
- We will undertake a workforce analysis to understand the current profile and inform long-range planning.
- Through the delivery of new models of care which achieve better outcomes for people we will develop a reputation as a good place to work. This will support recruitment and retention.
- We will develop our workforce strategy to build the ability to deliver 7 day services.

v. What: The **infrastructure** that supports the delivery of services will be very different with a collective approach to the use of our estate and the creation of a digital health and care economy. People expect to engage with their GPs and health and care services through modern technology. Phone calls and letters will increasingly be replaced by email, text, apps and the web.

How:

- We are developing an Integrated Digital Care Record across all partners which will deliver the NHs number as the primary identifier and enable collaborative assessment and care planning. This will be delivered by April 2015.
- The IDCR will be an enabler of patient held records and online access, supporting goal setting and self-care
- We have an Integrated Care Record in place
- We are developing an integrated estate strategy across the health and care economy and have mapped our collective estate using the SHAPE tool. We now have a clear view of the estate across the system, where services are and the condition of buildings and utilisation. The next step is to rationalise use of estate and identify opportunities for co-location of care delivery. From a patient perspective, this will be a very tangible removal of organisational and care delivery boundaries.
- We have already harnessed new assistive technologies in particular telecare and telemedicine to enable remote consultation and monitoring.
- We will establish an Assistive Technology work stream to enable us to achieve a coherent strategy and collaborative approach across the health and care economy. This will enable us to achieve a joined up approach across all assistive technologies and embed them as mainstream services.

vi. What: There is an increasing expectation by patients that services should be more flexible and be accessible 7 days a week. There is also a strong recognition that **7 day services** are a necessity to prevent people's needs escalating and requiring acute care, and to prevent delays in discharge from hospital.

How:

This is detailed in section 7b. We have a range of activity to develop this overseen by our System Resilience Group and includes contractual incentives (CQUINS) and schemes such as the Enhanced Primary Care Scheme. Longer term this approach is intrinsic to our new model of care.

vii. What: Self-care, early intervention and prevention

How:
There is an emerging programme to deliver this, led by Public Health and currently being scoped.

- We have already developed self-care packs covering dementia, COPD, heart failure to support GPs and other practitioners in encouraging self-care.
- There are additional initiatives which do not form part of the BCF but support the Five Year Forward View such as Pharmacy First which signposts people directly to pharmacies for assessment and issue of medication where appropriate in accordance with an agreed formulary
- Behavioural skills training for practitioners to support people to self-care
- We have schemes such as Champions Show the Way which activates communities to engage in self-care and health promotion activities, exploiting community assets
- We are developing health and care navigators to signpost people to more appropriate community resources
- New models of care will have a preventative focus. The self-care strategy will have a detailed delivery plan to support this

Who is delivering the care and support?
Our current provider landscape is as follows:

1. Secondary care providers:
   Airedale NHS Foundation Trust
   Bradford Teaching Hospitals NHS Foundation Trust

2. Community, mental health and learning disability provider:
   Bradford District Care Trust

3. Primary care;
   84 general practices and community pharmacies

4. Local Authority Social Care Services:
   City of Bradford Metropolitan District Council

5. Voluntary and community sector
   A wide range of providers throughout Bradford and Craven Districts.

Our programme of integration and transformation has made significant progress in enabling services to cooperate better and support achievement of our shared vision.

b) What difference will this make to patient and service user outcomes?

People using health and care services in Bradford, Airedale, Wharfedale and Craven can expect:

1. Person-centred care and nothing about me, without me
2. A rapid and timely response with proportionate, coordinated assessments and care designed to meet their goals
3. Care provided at home or closer to home
4. Reduced exacerbations of long-term conditions
5. Reduced avoidable hospital admissions
6. Regaining and retaining health, wellbeing and independence for longer
7. A reduction in premature admission to long-term care
8. Reduced dependence on NHS and social care services
9. Not to be passed between services or being excluded from locality-based service delivery due arbitrary and exclusive criteria
10. Support to self-care

An avoidable admission to hospital or long-term care will be a sign of system failure. People won't notice which organisation provides their support because services are wrapped around the needs of local people in local communities.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The primary focus of our BCF plan is to strengthen intermediate care services which are central to our strategic intent. The BCF provides some degree of protection for intermediate care services in an environment of difficult decisions due to competing priorities in a reducing financial envelope.

Strong intermediate care services will enable primary care to manage its urgent care demand enabling them to respond to acute need in the community, reduce non-elective admissions to secondary care and prevent premature admission to long-term care. This will help manage system costs and enable people to remain healthy, well and independent.

The pattern and configuration of services over the next five years will change, supported by the BCF.

We will:

a) Understand how to delegate the total NHS and care budget as close to local communities as possible to enable services to become more responsive to local need
b) Establish deep involvement of the public and service users in changes to the way we deliver services locally
c) Establish locality management and delivery of health and care services in defined local communities
d) Expand integrated health and social care intermediate care services delivered locally and in particular significantly increase the proportion of step-up care to prevent emergency admissions. Our aspiration is to move to 80% step-up and 20% step-down over time
e) Commission joint intermediate care facilities with an explicit focus on rehabilitation and enablement as part of the local solution to keeping people in their own community and avoiding unnecessary admission to care or hospital
f) Speed up access to joint assessment through ambulatory care to avoid unnecessary admissions and delays in transfers of care

g) Implement new funding and payment models: whole pathway tariff development across secondary, rehabilitation and social care services, incentivising care around the needs of the person enabling a more holistic and responsive integrated care offer
h) Shift funding around system from acute to community-based services (including where appropriate, primary care) to support the development of new models of care and create community-based capacity and capability to deliver more care at home
i) Develop collaborative approaches to the recognition and treatment of mental health problems where they are associated with the physical health of the individual to enable holistic care ensuring parity of esteem in relation to mental health services
j) Implement an integrated digital care record creating a joint health and social care information system maximising the benefits of a single shared record for patients and staff and improving the coordination of care delivery
k) Increase social care capacity in social work, occupational therapy and support staff, strengthening their impact in integrated community teams
l) Move to 7/7 availability of care and consistent service delivery across the whole week

In particular, the BCF will enable us to support the delivery of seven day intermediate care services ensuring patient flow through a joined up system at all times.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

This section sets out our approach across Bradford District's Health and Wellbeing Board footprint to understanding the population, where the greatest need lies and where to target integrated intermediate care, using the BCF pooled budget as an enabler, to have the greatest impact.

We will set out the position for the whole health and care economy and then provide additional detail split into:

i. Airedale, Wharfedale and Craven Clinical Commissioning Group area
ii. Bradford City and Bradford Districts Clinical Commissioning Groups areas

The JSNA and Five Year Forward View set out the high level population need and profile. Underpinning this are the CCG areas which have distinct profiles and needs, hence drilling down into the profiles for each area.

We have taken the following approach to this section:

i. A brief description of what intermediate care is in Bradford District
ii. Review of evidence base to influence development of new models of care, transformational change and integration and inform non elective admission reduction target
iii. Risk stratification of the whole population which identifies the people at greatest risk of an emergency admission over the following 12 months. This is therefore a very powerful whole population dataset directly linked to the ambitions of the BCF to reduce emergency admissions.
iv. A synopsis of the analysis gained from our involvement in the National Audit of Intermediate Care which benchmarks our position against all other participant health and care economies
v. Our early work to understand our whole system resource utilisation which tells us which population creates the greatest expenditure and would therefore benefit for a transformational approach to commissioning and service delivery.

This BCF plan is consistent with Bradford's Five Year Forward View which sets the context for the BCF plan. We have given an overview of the Forward View in section 2 and some more information in this section which gives a summary of the profile of need for the area. The BCF will be used locally to deliver part of the Forward View associated with the development of integrated intermediate care services which have a good evidence base nationally for reducing emergency admissions and ensuring timely and successful transfers of care from acute settings.

The JSNA tells a story of the health and wellbeing consequences of a deprived City. A summary is shown on the following page. This assessment of needs has directly driven the content of the Five Year Forward View and the Better Care fund plan within that. In the section below, we have made links to the schemes within the BCF plan.

A summary of Bradford's position as set out in the Five Year Forward View

Our Population

- People are living longer but a significant proportion live their lives in poor health
- The population is growing – the last ten years alone the population has grown by 11%
  - 23% increase in the number of 0-4 year olds
  - 26% increase in the number of 55-59 year olds
  - 17% increase in the number of over 85s
- 31% of the population live in areas included in the 10% most deprived in England
- Almost 38,000 children live in relative poverty; that is 27% of the population aged 18 years and under
- Significantly higher level of adults with learning disabilities than England average

Wider determinants of health

- 27% of Bradford households have an annual household income less than £15,000. In some areas of the district the proportion is as high as 40%.
- 10% of houses in the district are over crowded and 12.6 % of all households live in fuel poverty
- 5.5% of 16-18 year olds are not in education, employment or training
- Educational attainment is improving, but remains lower than England
- Significantly higher levels of unemployment can impact upon physical and mental wellbeing

Lifestyle Factors

- 12% of the population aged 17+, are registered as obese
- 22% of children are overweight or obese when measured in Reception, 35% in Year 6
- Obesity levels are highest in some of the more deprived wards
- 1 in 5 adults still smoke. Inequalities remain: 1 in 3 routine and manual workers smoke
- 10% of young people are regular smokers by the time they reach Year 10, 32 young people aged 11-15 years old take up smoking every week
- 19.3% of drinkers drink more than the recommended safe limits. Hospital admissions due to alcohol related harm increased by 34% between 2008 and 2011
- More disadvantaged groups are more likely to have a cluster of unhealthy behaviours

Long Term Conditions (LTCs)

- Treatment and care for people with long-term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure
- People with LTCs now account for approximately: 50% of all GP appointments; 64% of all outpatient appointments; and over 70% of all inpatient bed days
- More and more people live with more than one LTC
- 80,000 of people have been identified with hypertension, 40,000 with asthma, 34,000 with depression, 28,000 with diabetes and 21,000 with coronary heart disease. The actual number of people who have these conditions is likely to be higher than recorded
- About 1,000 people a year or 3 people every day experience a stroke
- 25% - 50% of people with high blood pressure do not have their blood pressure adequately controlled. 1/3 of patients with diabetes have poorly controlled blood pressure, resulting in potentially avoidable hospital admissions.

Health & Social Care Use

- Over 12,400 older people need assistance in maintaining independent living. A further 8,200 people require help with one or more activities of daily living
- One in ten people provide some level of unpaid care
- 2,400 people received short-term support by way of rehabilitation and re-ablement last year. Each year 11,500 people receive longer-term services – 8,500 at any one time
- 1,940 people are supported to live in residential or nursing homes
- 90% of patient contacts with the NHS occur in primary care
- There are more than 190,000 A&E attendances each year at the two hospital trusts.
- Historically non-elective (unplanned) admission rates have increased year on year
- Significantly higher levels of adults and older people using secondary mental health services than England average
- Significantly higher levels of self harm than England average

Spend

- Each year we spend around £932 million on health services for the population
- The local authority spends around £1.2 billion each year
- Each year we spend around £160 million on social care for adults across the district

JSNA-identified problem	Link to BCF schemes and projects
Our population	Capital funding including DFGs Carers services
Wider determinants of health	Capital funding including DFGs Carers services
Lifestyle factors	Self-care, prevention and early intervention
Long-term conditions	Capital funding including DFGs Carers services Intermediate care services Care Act implementation Virtual ward Early Supported Discharge Integrated teams Intermediate care beds Home from Hospital Equipment services Assistive technology
Health and social care use	Capital funding including DFGs Carers services Intermediate care services Care Act implementation Virtual ward Early Supported Discharge Integrated teams Intermediate care beds Home from Hospital Equipment services Assistive technology
Spend	Capital funding including DFGs Intermediate care services Protecting social care Care act implementation

Across the system the separate CCGs have undertaken high level analysis of activity. However as a result

of the new commissioning landscape in health and the development of the Commissioning Support Unit we have only very recently been able to move to more detailed segmentation and utilise the information from risk stratification tools to their potential.

Extensive work is underway to develop the case for change and understand the population where most impact can be achieved through imaginative deployment of the BCF as part of the delivery of the overarching Five Year Forward View. This section details the progress to date and the methods employed.

We are developing services in line with the available evidence and the BCF will assure their expansion and increased impact. Our model of intermediate care is:

- multi-agency, multi-functional and multi-disciplinary, led by senior clinicians
- comprised of step-down and step-up services in the community. The BCF will enable a steady growth in step-up provision enabling direct access to intermediate care for general practice, and will support the development of enhanced primary care models, to provide an alternative to acute admissions where appropriate and safe
- a rapid response with a rehabilitative approach aiming to discharge the person with better functional levels and therefore a reduced likelihood of dependency on the health and care system
- integrated with local authority enablement services
- an approach which aims to prevent premature admission to permanent care as well as emergency admissions
- accessible to people with dementia recognising a different approach to rehabilitation is required
- not restricted to less than 6 weeks
- not restricted to people over 65 only

We have been involved in the National Audit of Intermediate Care for the last 2 years and have submitted our data for the third year recently. Our local analysis is attached here which demonstrates strong services with areas of weakness being directly addressed by the plans facilitated by the BCF enabling an expansion of the integrated intermediate care service:

Intermediate Care Audit 010514 SUMMA

The NAIC confirmed a number of challenges for us locally which we are using the BCF to address:

NAIC finding	Local action plan
Robust commissioning arrangements are in place locally, underpinned by partnership working, multiagency strategic planning, and informed by the needs of the local population	Continue
Opportunities for providing seamless, joined up services are being missed -Bradford CCGs have not commissioned a single point of access, nor do they use a shared assessment framework	Commissioned to commence Oct '14 including an integrated health and care team, shared assessment based on Comprehensive Geriatric Assessment and single access point.
Bradford CCGs spend less than the national average on health based intermediate care services, but have one of the largest budgets for re-ablement out of those CCGs completing the NAIC	BCF will address this and help to maintain the LA's offer by protecting social care services.

Taking into account relative need, Bradford CCGs commission fewer intermediate care beds than the national average	There are an additional 24 LA IC beds in the system as a whole. Our focus is home based care.
98% of referrals to community hospital beds come from the acute trust suggesting that the majority of beds are used for step down care	Increase in step-up care being addressed as art of BCF-supported plans
Fewer people in Bradford are accessing and benefiting from health based intermediate care than in other parts of the country.	Service being expanded to improve capacity
GPs, out of hours primary care, A&E and social care are generally underrepresented amongst referrals to intermediate care services	Being addressed through service expansion
Home and community bed based intermediate care in Bradford is largely delivered by a workforce comprised of health care professionals. Social workers and social care support workers do not form a core part of the home and community bed based intermediate care teams	Fully integrated service being implemented from Oct '14
Specialist mental health workers do not form a core part of teams providing intermediate care.	Being addressed
Home based intermediate care in Bradford appears to be accessible with short waiting times to access services, and the virtual ward accepting patients 24/7.	Continue
There is no evidence that length of stay in intermediate care services in Bradford is excessive	Continue
Overall costs per services user for both home and bed based intermediate care services are lower in Bradford than the average for those organisations participating in the audit;	Demonstrates an efficient service
Robust arrangements for providing medical cover for intermediate care services appear to be in place in Bradford	Continue

Evidence

The evidence base for the impact of intermediate care is well known and can be found at:

- Social Care Institute for Excellence (2013). Maximising the potential of reablement. London SCIE
- NHS Benchmarking Network, British Geriatrics Society, Association of Directors of Adult Social Services, College of Occupational Therapists, Royal College of Speech and Language Therapists, NHS England (2013)

We recognise that the evidence is mixed in terms of reducing system costs, however our approach is to provide proactive care that pre-empts ill-health and then to ensure that people are supported to regain and maintain their optimum levels of health, wellbeing and independence. Ultimately this will reduce unnecessary dependence and demand on health and care services.

> ***'Transforming services require a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than based around single diseases) and care that truly prioritises prevention and support doe maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services are available in the right place at the right time' (Oliver et al 2014)***

We also commissioned the CSU to undertaken a national and international evidence review of integrated care models and used the outcome of this to influence development of new models of care, transformational change and inform the NE admission reduction target. The full report is included in the related document section. This review provided assurance and gave confidence that the initiatives planned or underway will realise intended benefits.

Specific models where there was evidence of outcomes delivered are:

- Kaiser Permanente, California, USA
- The Alzira Model – Valencia, Spain.
- MassGeneral Care Management Programme, Massachusetts, USA
- Virtual ward models including Greenwich (over 2000 admissions avoided & no delayed transfers of care) North West London (Curry and others, 2013)
- Marie Curie end of life nursing: significantly more home deaths and less emergency admissions than control group (Chitnis and others, 2012;2013)

Assistive Technology

Use of new technology such as telemedicine is key to transformational change and new models of care including supporting self-care. Use of this type of technology is relatively new. An independent evaluation undertaken by the University of York - York Health Economic Consortium in 2013 (please see section 1 c for further detail) demonstrates a significant impact when used in care homes and peoples own homes. When compared with a control group there was a:

- 27% reduction in NE IP care for care home residents
- 7% reduction in NE IP care for people in their own homes
- 7% reduced use of emergency services for care home residents
- 2% reduced use of emergency services for people in their own homes

This gave confidence in approach and NE admission reduction target. Use of telemedicine continues to be supported; the independent evaluation is being repeated with a higher number of individuals now using telemedicine. Results are expected during Q3

Long Term Conditions

A Long-term Condition (LTC) is defined as a condition that cannot, at present be cured but can be controlled by medication and other therapies. Examples of LTCs are diabetes, heart disease and chronic obstructive pulmonary disease.

Nationally, people with long-term conditions account for (General Lifestyle Survey, 2009):

- 50% of all GP appointments,
- 64% of outpatient appointments,
- 70% of all inpatient bed days,
- In total around 70% of the total health and care spend in England (£7 in every £10) is attributed to caring for people with LTCs,
- This means 30% of the population accounts for 70% of the spend.

The analysis undertaken locally demonstrates that the impact is even greater than concluded above. In AWC, 13% of the population account for 74% of the primary and secondary care spend (please refer to Community Care: Usage Concentration diagram later in this section). In Bradford 11% of the population account for 81% of the cost. Therefore there is an even greater imperative to address the needs of those most at risk through alternative, more effective models of care.

The care of individual LTCs is often the focus of healthcare delivery, research and training. However, increasingly, as the population in the UK ages, there are people with multiple morbidity i.e. those with two or more LTCs. This poses a big economic challenge to health and social care delivery.

Barnett et al. (2012) conducted a cross sectional study on 1.75 million people registered at 314 medical practices in Scotland as of March 2007. The purpose was to examine the distribution of multiple morbidity, and of comorbidity of physical and mental health disorders in relation to age and socioeconomic status.

The key findings were:

- 42.2% of all patients had one or more morbidities,
- 23.2% of all patients were multi-morbid,
- Relative proportions of the population with multiple morbidities increase with age as might be expected,
- However, the largest absolute numbers of people with multiple morbidities were found in those aged under 65 years – this is due to the relative size of the populations under and over 65,
- Onset of multiple morbidity occurred 10-15 years earlier in those living in the most deprived areas compared with those in the most affluent areas,
- Socioeconomic deprivation was particularly associated with multiple morbidity that included mental health disorders,
  - Prevalence of both physical and mental health disorder:
    - 11.0% (95%CI: 9-11.2%) in most deprived areas
    - 5.9% (95%CI: 5.8-6%) in least deprived areas
- The presence of a mental health disorder increased with the number of physical morbidities:
  - 6.74% (95%CI: 6.59-6.90) for five or more disorders
  - 1.95% (95%CI: 1.93-1.98) for one disorder

Given the degree of deprivation in Bradford District, the profile is likely to be similar.

Population 'Resource Utilisation' Profile:
Across the system the separate CCGs have undertaken high level analysis of activity. However as a result of the new commissioning landscape in health and the development of the Commissioning Support Unit we have only very recently been able to move to more detailed segmentation and utilise the information from risk stratification tools to their potential at CCG and district level, however we do now have a very powerful population-wide data set from operating the predictive risk stratification tool across all practices. Our initial analysis of the data is shown below.

Risk Stratification:
A two phased approach to use of data and risk stratification has been undertaken:

Phase 1: Predictive risk stratification at a local GP practice level to inform MDT assessment and care

planning, targeting those most at risk of admission.

A risk stratification tool has been available to all practices since June 2013. The tool is based on the King's Fund Combined Predictive Model (CPM) algorithm and uses 24 months of primary and secondary care data to provide a score indicating the patient's likelihood of emergency admission over the next 12 months.

The tool is updated monthly, using Secondary Uses Service (SUS) data for in-patient, out-patient and accident & emergency event details and an extract for SystmOne to provide GP clinical data.

Users are presented with a list of patients sorted, by default, to show those with the highest risk scores, and can use a number of filters to find patients based on particular criteria including:

- Age range
- Long-term conditions (e.g. dementia, asthma, COPD, diabetes, cancer)
- Admissions avoidance care status (based on data collected as part the Avoiding Unplanned Admissions Enhanced Service).

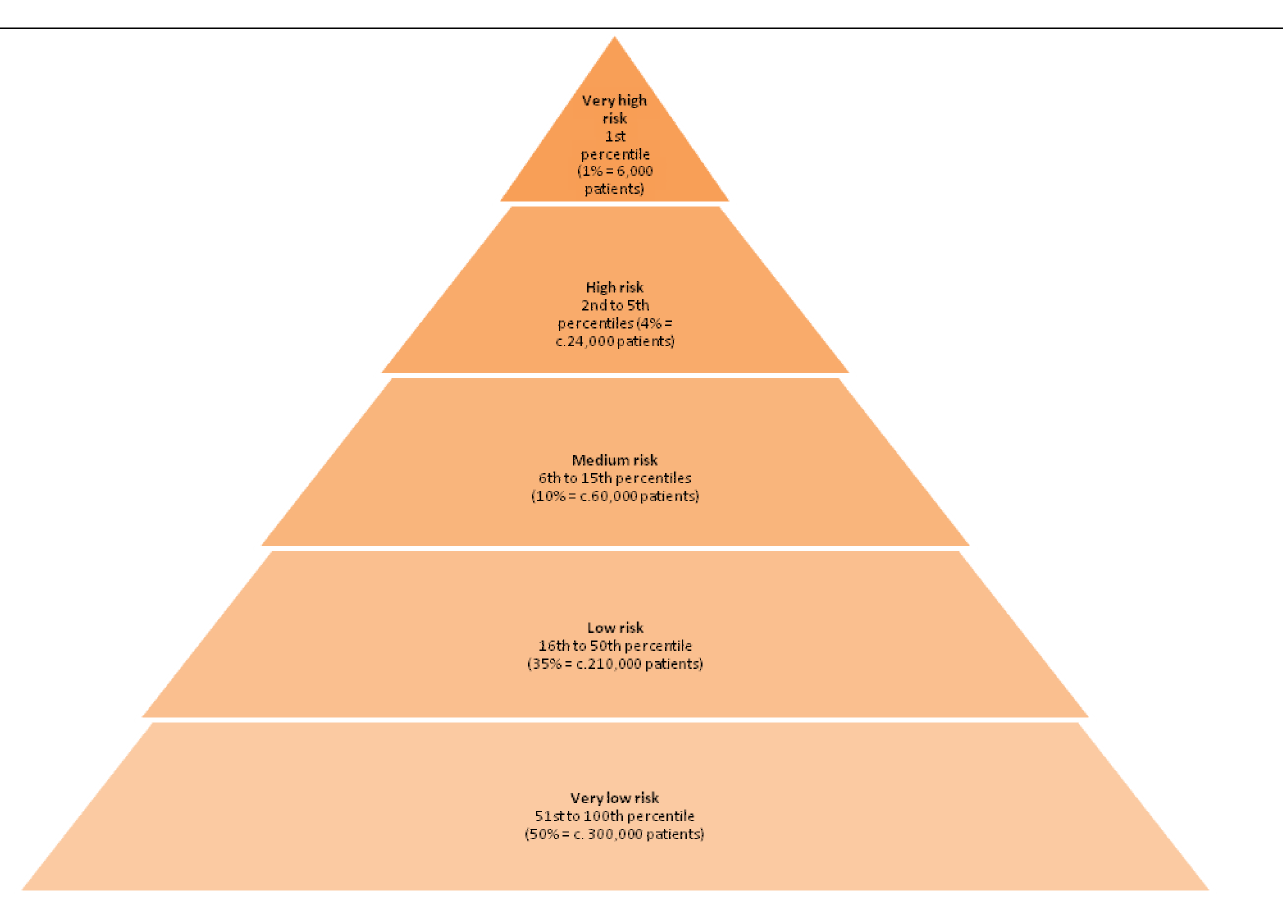
The tool also presents a high-level view of the events that have happened to each patient to review the patient's primary and secondary care service use over the past two years as well as a history of risk scores calculated for the patient over the time the tool has been available.

Patients identified using the tool, supplemented by those identified through other GP system queries and local health and social care team intelligence and knowledge, are referred on for assessment at Multi-Disciplinary Team (MDT) meetings or supported through other services, as detailed in the pro-active care enhanced service (ES).

The CCGs have also commissioned additional services to support delivery of the proactive care enhanced service (ES) and commenced development of a new model of primary care (enhanced primary care).

These schemes support and will accelerate delivery of the emergency admissions reduction target as they focus on admission avoidance and incentivise practice to focus on the top 5% of those most at risk of admission. Through this approach an increased number of joint assessments and care planning will be undertaken and new ways of working will be tested at a practice population level.

The diagrams and tables below illustrate population-level risk stratification for the Bradford district and quantify levels of service utilisation which varies by age and condition. This does not include assessment of cost.



Specific long-term conditions (LTC) by risk group

The table below shows the profile of 'risk of emergency admission' for several long-term conditions, indicating the varying profile depending on the condition involved.

	Long-term condition					Total population
	Asthma	**COPD**	**Heart failure**	**Dementia**	**Diabetes**	
Very high risk	2%	11%	22%	17%	5%	1%
High risk	8%	31%	37%	33%	17%	4%
Medium risk	18%	38%	29%	33%	31%	10%
Low risk	47%	19%	11%	16%	44%	35%
Very low risk	24%	0%	1%	0%	2%	50%
Total	100%	100%	100%	100%	100%	100%
Number of patients	**63,500**	**12,600**	**4,800**	**4,000**	**36,600**	**600,300**

This demonstrates the necessity of ensuring that people with dementia have equal access to intermediate care services. Intermediate care services are also essential to responding rapidly to deterioration in a person's condition, and preventing an avoidable admission wherever feasible and safe.

Age and risk score group

The table below shows how the numbers of patients in different risk groups varies by age. The patients' age group is taken into account by the CPM algorithm, but this shows the very significant differences

between different age groups in the population.

	Age group				Total population
	0-17	**18-49**	**50-74**	**75+**	
Very high risk	0%	0%	1%	8%	1%
High risk	1%	2%	5%	26%	4%
Medium risk	2%	7%	15%	41%	10%
Low risk	17%	36%	54%	25%	35%
Very low risk	80%	55%	25%	0%	50%
Total	100%	100%	100%	100%	100%
Total patient number	**146,100**	**264,500**	**148,700**	**41,000**	**600,300**

This demonstrates the need to target our BCF plan predominantly around the needs of older people. 75% of the population aged over 75 are in the medium, high or very high risk groups.

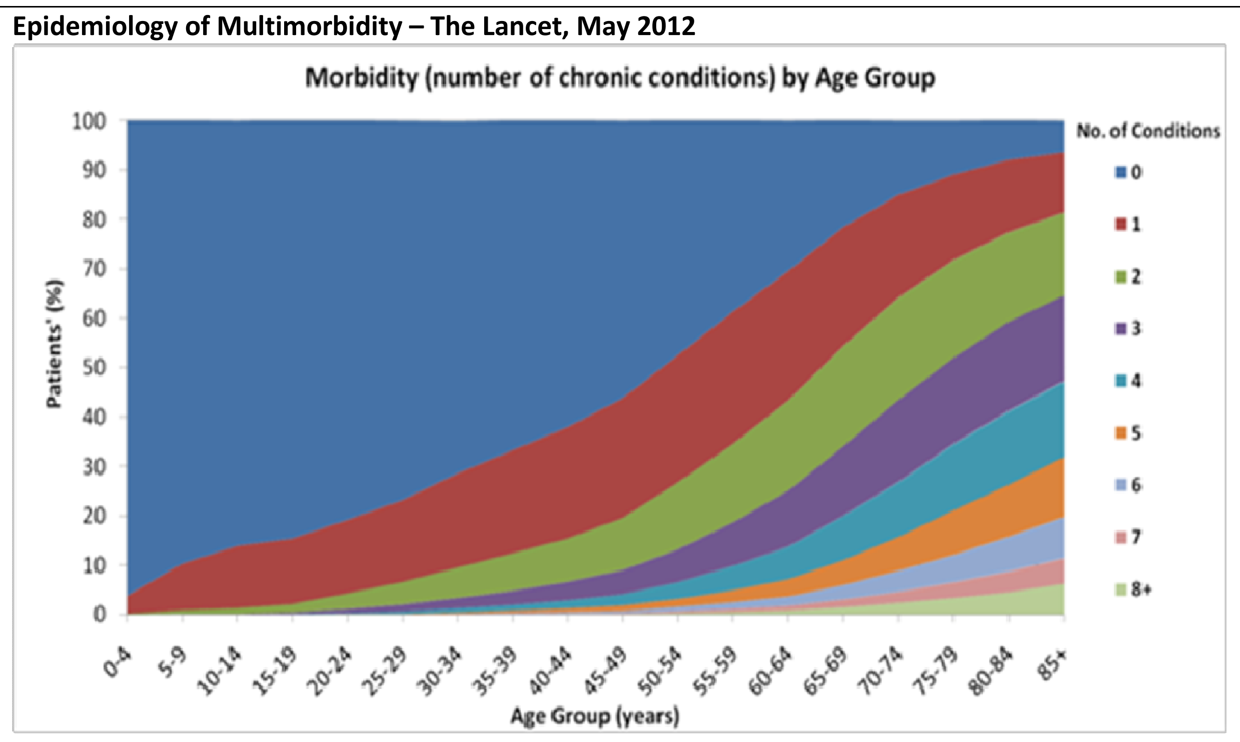
Multimorbidity and risk score group

The table below gives an overview of how patients' average risk scores relates to the number of long-term conditions that are recorded on the GP system. The CPM algorithm increases a patient's score based on whether patients have 1 or 2 or more long-term conditions, but the figures below illustrate the extent to which risk increases as a patient has more LTCs.

	Number of long-term conditions						Total population
	0	**1**	**2**	**3**	**4**	**5+**	
Very high risk	0%	1%	2%	5%	9%	20%	1%
High risk	1%	4%	11%	22%	32%	40%	4%
Medium risk	3%	14%	31%	40%	41%	32%	10%
Low risk	26%	59%	53%	32%	18%	8%	35%
Very low risk	70%	23%	3%	0%	0%	0%	50%
Total	100%	100%	100%	100%	100%	100%	100%
Total patient number	**387,200**	**126,200**	**45,800**	**20,200**	**10,200**	**10,700**	**600,300**

The following highlights the fact that multimorbidity becomes progressively more common with age. As the population ages the clinical condition of frailty increases. Frailty develops as a consequence of age-related decline which results in vulnerability. It is well recognised that between 25 and 50% of people older than 85 years are estimated to be frail, and these people have a substantially increased risk of falls, disability, long-term care and death. The current health and care system is not designed to cope with this level of complexity and services are often designed around disease specific conditions rather than an integrated holistic approach. Our vision is to transform services and place people at the centre of their care, hence a focus on frail elderly and intermediate care services is a critical starting point and a particular focus of the BCF.

Epidemiology of Multimorbidity – The Lancet, May 2012



Our analysis to date, which includes admission and readmission audits jointly undertaken with acute providers, confirms that there are many frail, older people being admitted to hospital unnecessarily. Often as an emergency on an unplanned basis as a result of community-based services not having the capacity or capability to respond with sufficient intensity of service or speed or alternative ambulatory care pathways and services not being in place. Addressing this is a focus of our BCF plan.

Intermediate care services also take a more holistic approach to the needs of the person, which is particularly important for older people who have more than one long-term condition. The implementation of the Comprehensive Geriatric Assessment led by a geriatrician and a multidisciplinary team ensures that the person's total needs are addressed, rather than following disease-specific pathways.

Ambulatory care pathways and units are being developed and the multidisciplinary integrated teams at community and intermediate tier level are pro-actively using the outputs of the predictive risk stratification to target resources at the highest at risk groups.

Phase 2 Whole system resource utilisation analysis

Whole system analysis of resource utilisation to 'stratify' the population at CCG level has been tested within one CCG (AWC) and the intention is to replicate for all three CCGs. To date, primary care, community, mental health, prescribing and secondary care data has been provided and analysed.

There have been challenges as this level of information is not routinely available through current systems. In particular the ability to source and match social care information to NHS information at an individual level has been problematic and highly challenging. We expect outstanding issues to be resolved and the social care data to be provided and matched to NHS records for analysis within the next few weeks.

Once resource utilisation at an individual level is known, through analysis, this information is built back up to a population level hence enabling population segmentation to inform commissioning and development of new models of care. Understanding utilisation at a segmented population level and associated costs will enable commissioners to determine where the greatest impact can be achieved through system

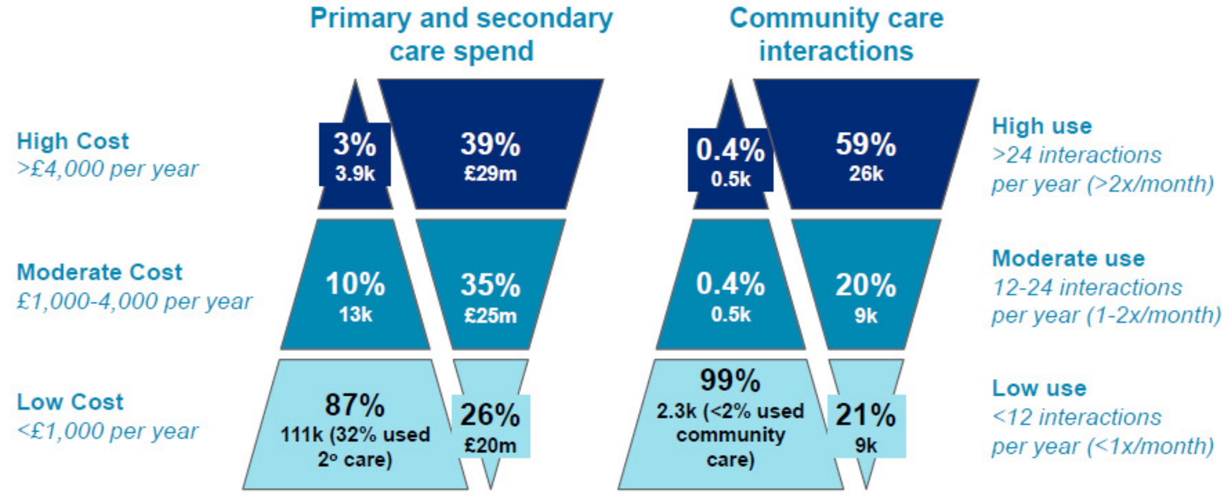
change.

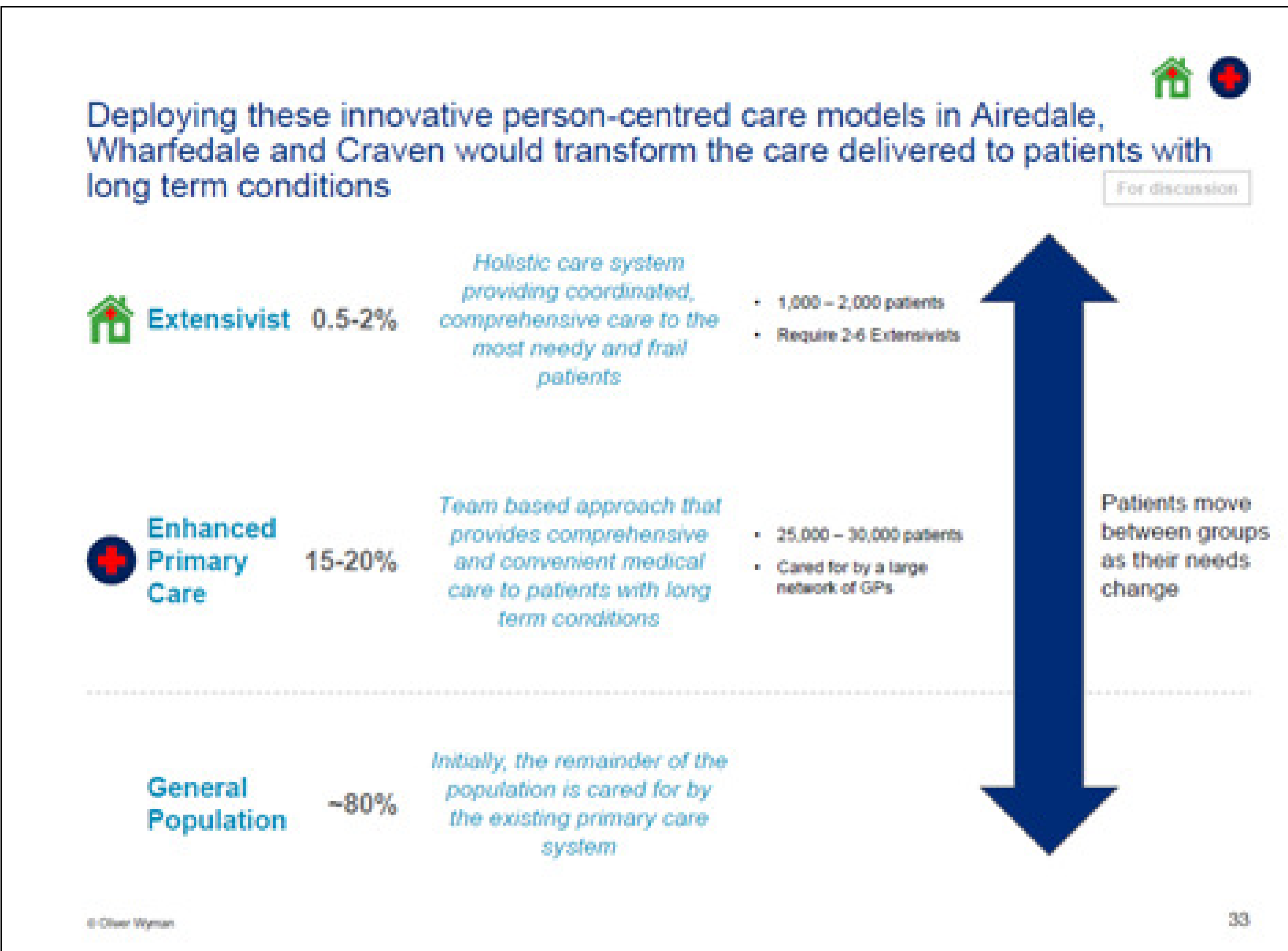
As part of the overall district there are local nuances. Airedale, Wharfedale and Craven Clinical Commissioning Group, through work undertaken by Oliver Wyman Consultants, have embarked on a detailed, whole system analysis across primary, secondary, community and social care services. The initial outcomes of that analysis are shown below. Bradford Districts and City Clinical Commissioning Groups have also undertaken initial analysis on secondary care data and this will be expanded to include community services, primary care and social care.

Analysis of this data underpins system-wide transformational change.
Our approach is to design, develop, commission and implement new models of care, informed by people's needs, to achieve our vision of radically changing outcomes and improving the quality and experience of care. It is our ambition to deliver this over the next 5 years.

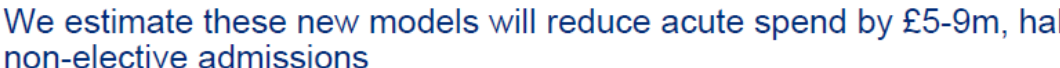
Analysis for Airedale, Wharfedale and Craven Clinical Commissioning Group area:
The following diagram is an output of the data analysis and population stratification undertaken for AWC CCG. For AWC it demonstrates that 3% of the population utilise 39% of the resource (primary and secondary care spend) and an even smaller % of the same population, 0.4%, account for 59% of community health care activity.

Once social care data is sourced and included in the analysis we expect the impact to be even greater. By changing the way care is provided for this complex population (informed by proven models in the USA) we expect to realise significant system efficiencies and deliver intended outcomes of the BCF, as the second diagram demonstrates.





The next diagram demonstrates the potential impact new models of care could have on non-elective admissions for AWC CCG only. Informed by the use of risk stratification and population segmentation, we can identify and target the most complex and costly patients and deliver care in an integrated and transformative way, ensuring that people's needs are met and are enabled to their optimum level. It is important to consider this in the context of untested change and need for significant system, cultural and behaviour change to realise the expected benefits.



We estimate these new models will reduce acute spend by £5-9m, half in non-elective admissions

For discussion

Estimated savings on acute spend

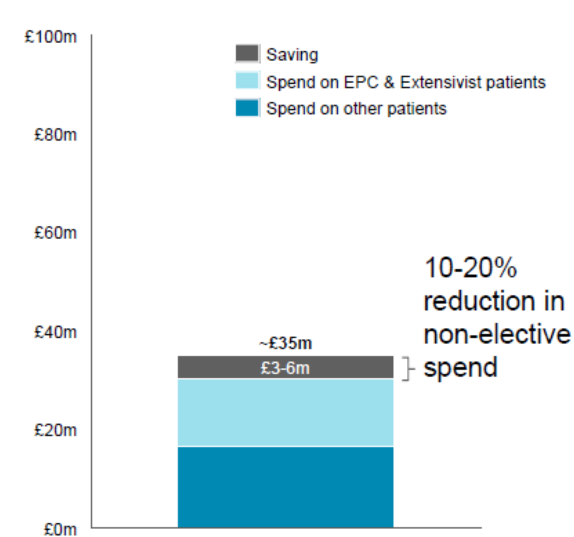
~£100m

£5-9m

5-9% reduction in total spend

£100m
£80m
£60m
£40m
£20m
£0m

Estimated savings on non-elective spend



Source: AWC secondary care data; 2013/14 Budget – AWC CCG Financial Dashboard – January 2014; OW analysis

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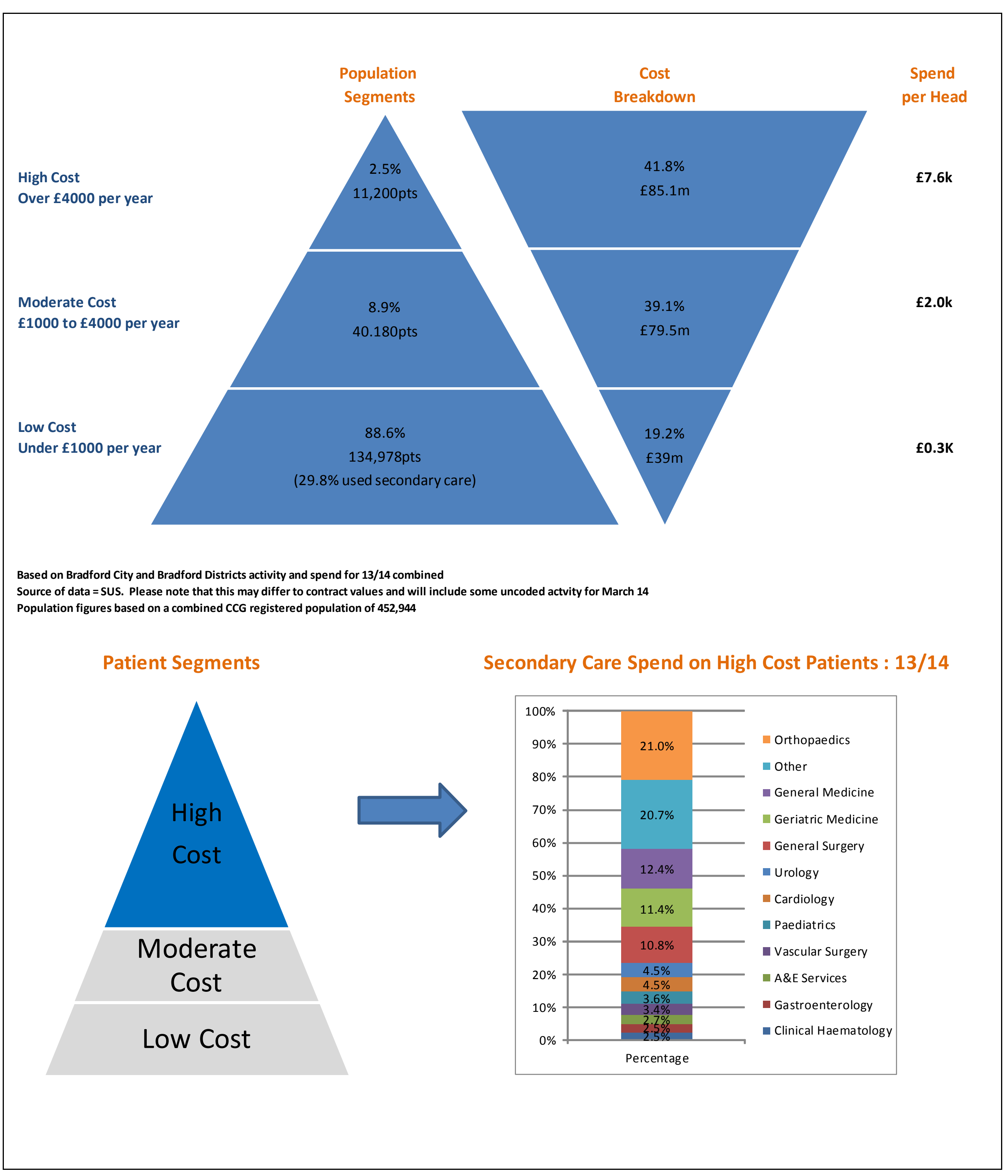


4) PLAN OF ACTION

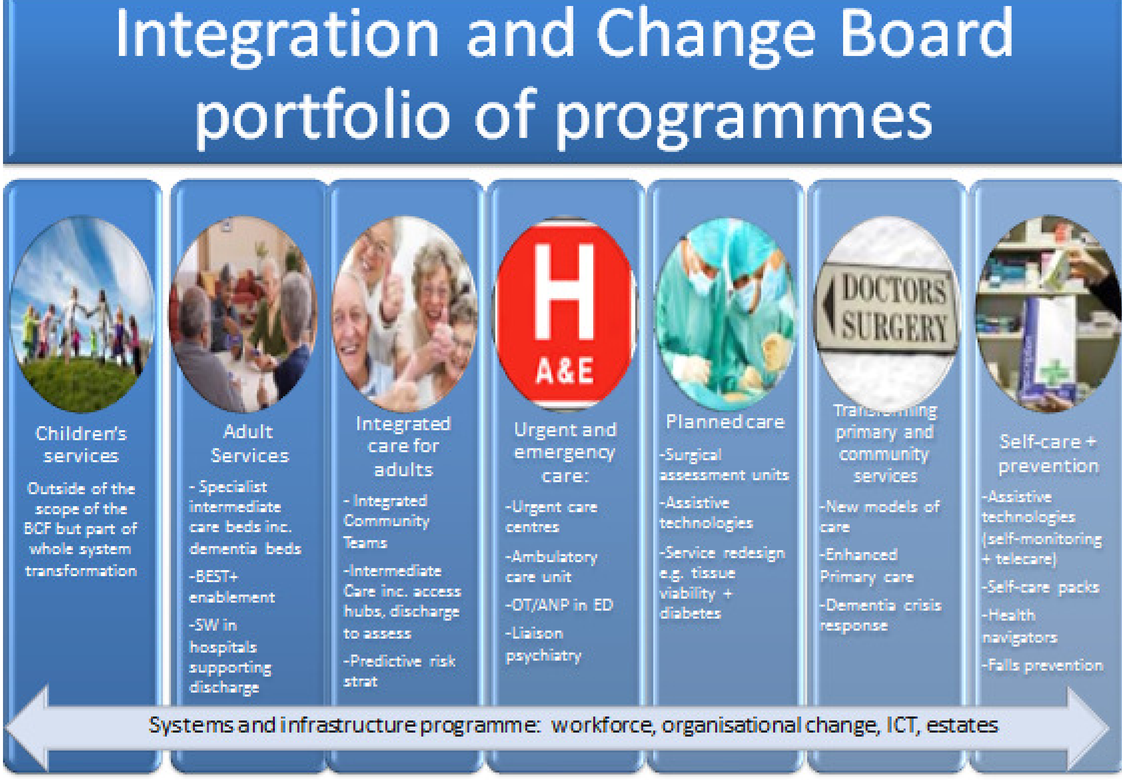
a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The Better Care Fund will support the delivery of the Integrated Care for Adults Programmes which sits within the Integration and Change portfolio overseen by the Integration and Change Board (ICB) referred to in 4b. Portfolio and programme management arrangements are in place coordinating and controlling

the activities within the portfolio to assure delivery for all partners.

The Clinical Commissioners have senior staff in place, including a Programme Director for Integrated Care who are responsible for developing strategy and working with senior operational leaders to implement change.

The full portfolio of programmes is shown below. The BCF will support delivery of these programmes with the exception of Children's Services which is outside of the scope of the BCF.



The full milestone plan associated with this portfolio is appended here. The milestone plan covers the whole spectrum of transformation and includes the Integrated Care for Adults programmes for Airedale, Wharfedale and Craven and for Bradford.

Highlevel Milestone Plan EXCEL 20140801

At the Integrated Care for Adults programme level, the latest programme plans are attached and contain full details.

BICfA combined programme plan and | AWC ICfAP Delivery Board Programme Pla

In brief, the Integrated Care for Adults programme, which has two distinct delivery arms (one for Bradford and one for Airedale, Wharfedale and Craven) has the following overarching objectives:

Integrated care programme: main aims

1. Join up services around the needs of the person
2. Increase community capacity and capability
4. Sort out our systems and infrastructure to enable joined up care
5. Reduce costs associated with non-elective admissions and long-term care

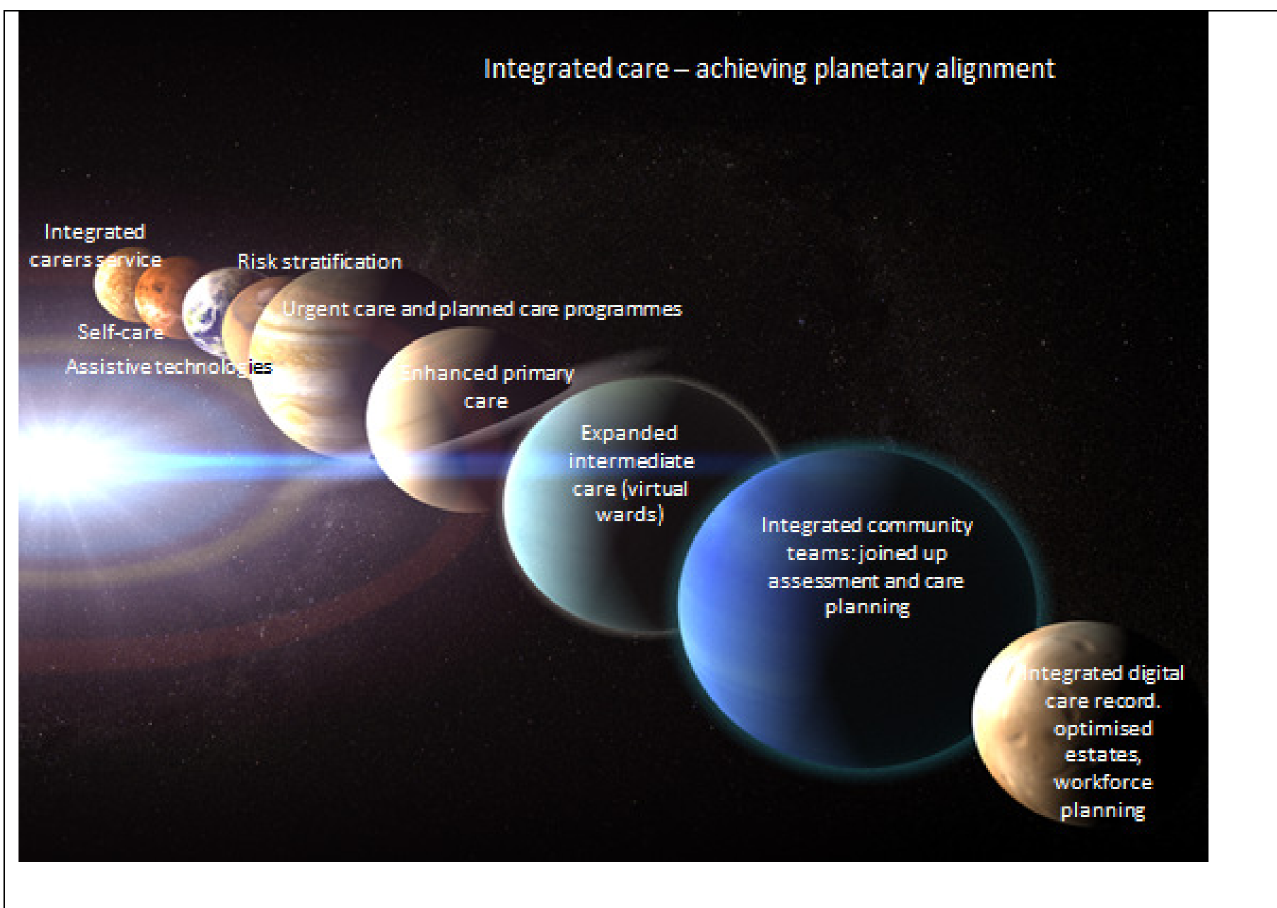
Interdependencies
We recognise that the programmes are interdependent hence being part of one portfolio. ICB has recently appointed a Portfolio Manager to oversee and manage the critical dependencies and phasing of the whole portfolio.

We know that there are strong inter-dependencies between the Integrated Care for Adults Programme and the Urgent Care Programme. The former provides part of the solution for the latter by pre-empting need and developing pro-active care around people with complex needs who are likely to have episodes of escalating need from time-to-time.

There are also strong inter-dependencies between the Integrated Care for Adults Programme, Transforming Primary and Community Services and Self-care which will be identified and managed as the scope of the latter gets defines.

Our Systems and Infrastructure programme operates across and supports all programmes in the portfolio and ensures that ICT, estates, workforce development and organisational change supports the transformation of care rather than inhibiting it.

The integration of health and social care services, including associated voluntary and community services and third sector services is a complex whole system transformational change approach which requires many complex activities across the spectrum of commissioning and provision to line-up into a whole new system. We have made significant investment in programme leadership and the programme management office in recognition of this.



b) Please articulate the overarching governance arrangements for integrated care locally

We have clear accountability arrangements for transformational change across health and social care in Bradford through an established set of governance arrangements and delivery mechanisms which we intend to keep under review to ensure that it remains fit for purpose, and responsive to the changes that maybe required in relation to the Better Care Fund. Governance arrangements for delivery of the BCF plan lie within this.

The diagram below shows the accountability and governance arrangements for the delivery of the integration and change portfolio described in section 4a.

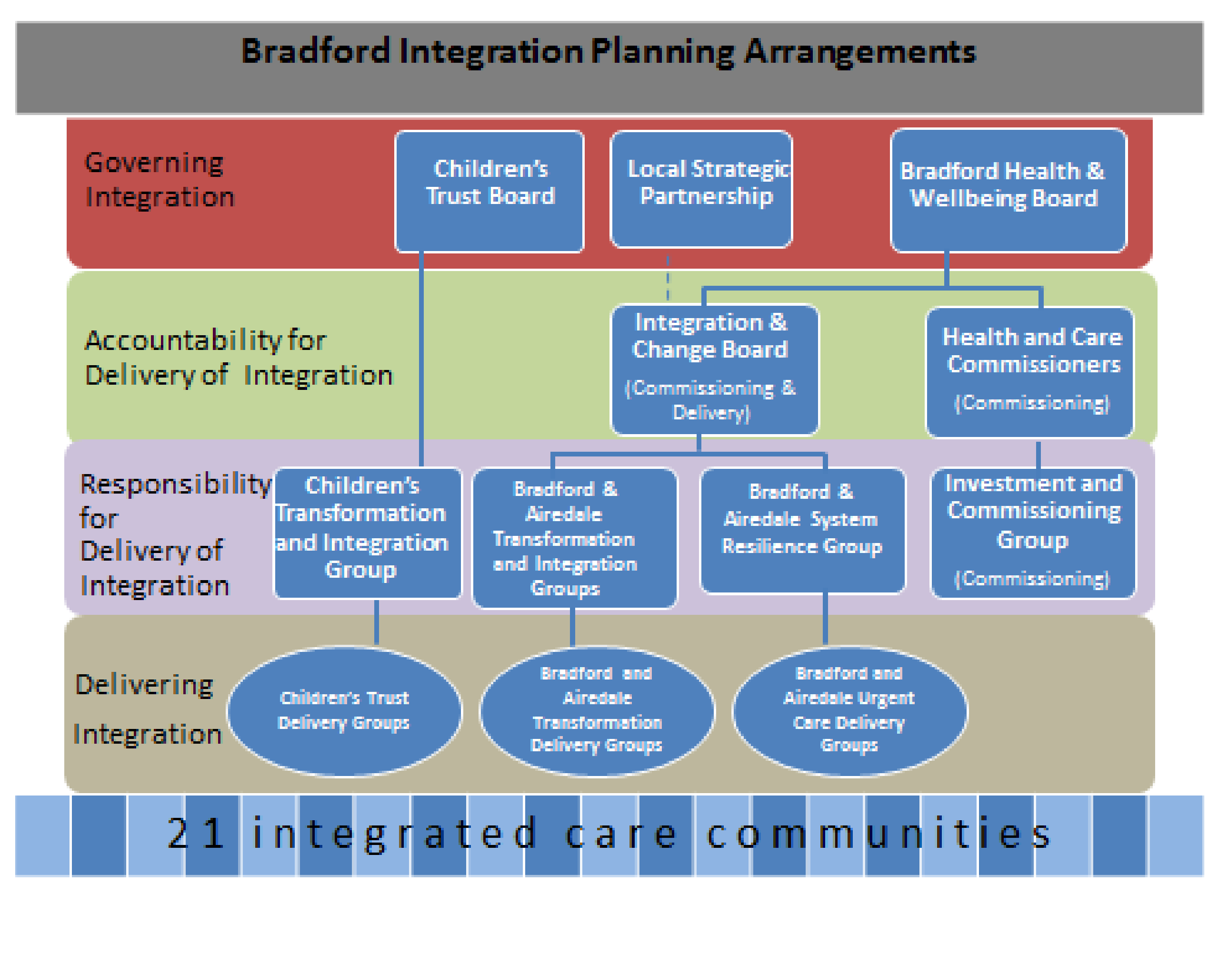
The Health and Wellbeing Board is ultimately responsible for the overarching direction and governance of integrated care and it will monitor performance against the BCF metrics and receive exception reports on the BCF action plan. The Integration and Change Board is collectively accountable to the Bradford Health and Wellbeing Board. Its main purpose is to provide system wide leadership and accountability for delivery of integration within the Bradford health and care economy. The Integration and Change Board is led by the Chief Executive of CBMDC and a membership of Chief Executives and Directors of the organisations with statutory responsibility for the delivery of health and care services. Strategic issues are dealt with at this level. ICB's approach is to consider the business of commissioning and delivering health and care for people in Bradford and think of themselves as 'Bradford Mutual' operating as a single body rather than a collective of many organisations. This allows the risks to be understood as a corporate body would do and to facilitate a shared responsibility for delivering the solution.

Accountability for commissioning health and care services rests locally with the Clinical Commissioning Groups and City of Bradford Metropolitan District Council respectively. As commissioners they work collaboratively through the Bradford Health and Care Commissioners which reports directly to the Health

and Wellbeing Board. Through its sub group, the Investment and Commissioning Group, Bradford Health and Care Commissioners will monitor delivery of the Better Care Fund plan, ensuring performance targets are being met, schemes are being delivered and additional action is put in place where the plan results in any unintended consequences.

The responsibility for delivering change rests with the two Transformation and Integration Groups (TIGs), with delivery, operational implementation and arrangements to support joint working resting with Delivery Boards for Integrated Community Teams and for Intermediate Care. Issues and risks are escalated to the TIGs or ICB as necessary for resolution. Please refer to the diagram below which explains decision making and governance arrangements.

There is a feedback loop from the 21 communities via the direct influence of GP clinical commissioners as part of the structure of the Clinical Commissioning Groups.



c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

Management and oversight of the BCF is as per the governance arrangements described above with the Health and Wellbeing Board ultimately responsible.

The ICB will oversee implementation of the BCF plans supported by the Investment and Commissioning Group, TIGs and Delivery Boards.

The Investment and Commissioning Group has responsibility for developing the Section 75 agreement on behalf of the Integration and Change Board and ultimately the Health and Wellbeing Board.

The programme management arrangements also described above include the activities associated with the delivery of the BCF plan and will therefore monitor and report risks and issues as appropriate. Remedial action will be planned and implemented proportionate to the presenting issue.

Lead officers are identified within the three CCGs and LA maintaining operational oversight of the delivery of the BCF.

Joint working is very well embedded across commissioners and providers. The Integrated Care for Adults programme has been in place for four years and much of the first two years was spent achieving a coherent vision and approach across partners. This investment has created a solid foundation for joint working and mature debate and decision making.

The ICB have agreed a set of principles under which they will operate and work together which demonstrates their commitment and the maturity of the partnership:

- Working better together is first and foremost about what is best to add value for the people we care for
- We will improve the quality of care and support available
- We will look for improvement through the eyes of the people we care for and the staff providing the care
- There will be no blame or scape-goating of or by individual organisations – we're in this together, working as a whole system
- We will continue to create a culture of trust, openness and transparency, including demonstrating a collective stewardship of resources
- We will put the interests of the people we serve ahead those of our individual organisations
- We will share our learning from working together with one another, and others as well as learning from elsewhere and will share our learning more widely
- We will build on existing work that has established strong foundations for integration
- We will collectively agree our future priorities as a whole system
- We will adopt a positive mind-set – 'we can, we will'
- Our clinicians, social care professionals, managers and others will work together to make change happen

We commit to working at pace, to achieve rapid progress, make decisions and see them through.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Capital funding including Disabled Facilities Grants
2	Carers break funding
3	Expansion of intermediate care services
4	Care Bill implementation
5	Protecting social services

5) RISKS AND CONTINGENCY
a) Risk log

The most important risks and plans to mitigate them are reflected in the ICB risk log and are managed across the system by the ICB (please refer to section 1 c Related Documentation). This includes risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

A more detailed risk log associated with BCF and the integrated care for adults programme follows in table 1). This risk log has been developed in partnership with all stakeholders. Risks and mitigating actions have been described in as much detail as is available currently. However, it is not currently possible to quantify all risks.

Table 1: Risk log

High	**12 to 16**
Medium	**6 to 9**
Low	**1 to 4**

There is a risk that:	*Likelihood of occurrence:* *1= Low 4=Very High*	*Impact on Programme Objectives: 1=Low 4=Very High*	*Level of Risk (Likelihood multiplied by impact)*	**Mitigating Actions**
1. Non-elective admissions do not reduce in line with plans because of unexpected demand or significant variation in trends	4	4	High	Planning includes demographic growth. System wide dashboard in place monitoring via TIGs and ICB Owner: ICB Timeline: Quarterly surveillance
2. There is limited evidence that community-based care and preventative approaches reduce demand on unplanned admissions and uncertainty as to whether the	4	4	High	In 14/15 we will utilise the BCF and other non-recurrent investment to expand community based capacity and capability and measure the costs,

alternative system is cheaper/more effective/efficient.				benefits and impact. We intend to double run community-based services initially to achieve adequate additional capacity and start to demonstrate the impact, effectively building the business case. Owner: ICB Timeline: Quarterly surveillance
3. Inability to cease double-running resulting in increased costs but benefits unrealised	3	4	High	Programme management and robust approach to evaluation in place. Directors of Finance leading work on system-wide financial planning. Owner: ICB Timeline: Quarterly surveillance
4. Capability and capacity doesn't materialise because of inadequate supply of newly trained staff or have the anticipated impact	4	4	High	Plan to work with HEI providers to influence pre-reg training. Whole system workforce planning approach being developed. Generic worker model planned. The medium to long term strategy to address workforce risks is currently in development in partnership with HEE. Work is also currently on going across

				West Yorkshire to reduce the risk of attrition during the 14/15 period of winter pressures. Owner: System Resilience Group Timeline as above
5. Public and political concern at move of services out of hospital (nationally and locally)	4	4	High	Communication and engagement plan in development and cross-system comms leadership proposed. HWB leading the agenda and OSC engaged. Director of Collaboration leading on managing high profile communications and engagement. Owner: HWB Timeline: Ongoing
6. As activity reduces in secondary care, beds will need to be closed to release efficiencies. Impact of specialist commissioning strategy on acute services not yet known. Demographic growth and increase in complexity of cases is likely counter any reductions achieved by	4	4	High	CEOs engaged in ICB and recognise the need for a whole-system solution to the economic and quality of care challenge Owner: ICB Timeline: Quarterly surveillance

better community services.				
7. Implementation of change not achieved fast enough to respond to financial challenge.	3	4	High	Good governance and senior leadership in place. Programme Management Owner: ICB Timeline: Quarterly surveillance
8. Adult social care services are under significant budgetary pressure and the BCF alone cannot protect current levels of service delivery or increases in demand and complexity.	4	4	High	The protection of adult social care services is fundamental to the transformation of services in Bradford, Airedale, Wharfedale and Craven and critical to enabling out of hospital care. The BCF enables services to be protected whilst developing new and integrated ways of delivering services jointly. The Integrated Change Board is identifying risks that affect the total system with the agreement from all parties to contribute to mitigate these system wide risks. The financial position of the Council is one such risk. The management of system wide risks is not confined to the BCF but will be resourced from across the totality of the

				system. Resources from BCF will be used in part to sustain social care activity. Owner: Janice Simpson DASS Timeline: Local Authority Budget Planning Process
9. Impact of external influences on providers e.g. changing political landscape (General Election May 2015), DH/DCLG policy	4	4	High	Currently, political sign up to out-of hospital care is consistent. Future position post GE not known. Owner: HWB Timeline: May 2015
10. The ability of commissioners to access timely, high quality data and analysis to inform commissioning decisions and to have a sophisticated understanding of the system and impact of changes made. Cross –reference to section 7c.	4	4	High	Support sought from national BCF team. Progress being made with CSU Owner: Area Team, CCG and LA Chief Officers Timeline: Resolve by Dec '14
11. Funding not yet secured by BTHFT and CBMDC Adult social care for integrated digital care record	3	4	High	Bid for funding in the second round of the Safer Hospitals Safer Wards technology Fund has been made Owner: IDCR Programme Board Timeline: Decision anticipated October 2014
12. NHSE PMS review of primary care contracts may	3	4	High	Ongoing dialogue with NHSE and involvement in

result in a significant reduction in practice income. This would have a detrimental impact on workforce, morale, capacity, resilience, access, recruitment, retention and ability to engage in transformationa l work				PMS review negotiations Owner: Chief Clinical Officer and Chief Officer Timeline: Ongoing
13. NHSE do not devolve sufficient resource to enable CCGs to co-commission primary medical care	5	3	High	This will inform CCGs decision to accept devolved responsibility. New models of care could still be commissioned by using alternative contracting and payment model over and above GMS/PMS contract as an 'add on' to contracts commissioned by NHSE
14. Reputation of Bradford's health and care services may suffer if the programme fails to deliver its commitments.	3	3	Medium	Strong governance and commitment at the highest level to achieve the programme. Robust programme management. External evaluation to evidence impact. Owner: HWB Timeline: Ongoing
15. Poor engagement of primary care	2	4	Medium	Clinical Executive leadership for programme in place. Use of 14/15 Proactive Care ES and additional Local Incentive

				Scheme to engage primary care to lead change Owner: CCG Clinical Chairs Timeline: Ongoing
16. Failure to redesign the workforce leading to continuing duplication of roles	3	3	Medium	System-wide workforce development and training strategy being developed. Organisational development programme and leadership in place Owner: ICB Timeline: Ongoing
17. Differing terms and conditions prevent the development of new types of worker, e.g. generic support workers	3	3	Medium	Business case to be develop outlining associated costs and benefits. ICB have authority to address this problem if required. Whole-system workforce planning strategy will address Owner: ICB Timeline: Ongoing
18. Programme management resources within commissioning and provider organisations are under pressure from the high volume of business change and reduced management capacity within the system as a whole	3	3	Medium	ICB have agreed to fund/redirect additional capacity to deliver this programme. Owner: ICB Timeline: Monthly
19. Failure of primary care to	3	3	Medium	There is opportunity to

engage and uptake enhanced primary care schemes				remodel and commission this level of service from alternative primary medical care providers. Owner: Chief Operating Officer and Chief Officer Timescale: December 2014
20. As social care migrates data onto SystmOne, there is a risk related to the accuracy of the key identifier data that Social Care currently holds. This could lead to the misalignment of NHS and social care records.	3	3	Medium	To mitigate this risk, our suppliers will only match positively, when all key identifiers are available. Exceptions will be validated, at the point when the service subsequently interacts with the service user and demographic data is checked. Groups of validated exceptions (with the added identifiers) will be sent to the NHS Batch Tracing Service ("DBS") for matching purposes. Owner: DASS. Timescale: by April 2015

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Due to the level of risk of achieving the level of reduction in non-elective admissions, the system has recognised that the element of the performance fund that is related to the expected reduction in non-elective activity will only be committed after the reductions have been achieved. If the expected reductions are not achieved, then this element of the performance fund will be used to help pay for the continuing level of non-elective activity.

If the reductions in non-elective activity are achieved, then we will use our agreed evaluation process for

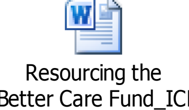
new investments to implement new schemes that have the biggest impact on the HWB key indicators.

A number of discussions are being held to develop risk sharing arrangements between providers and commissioners for 2015-16 to incentivise and facilitate system change described in the local Five Year Forward View.

Chief Financial Officers and Directors of Finance from all providers and commissioners meet on a monthly basis and formulating a financial strategy for 2015/16 is the group's main priority. A number of options have been discussed, such as fixed or capped contract values and the provision of short term support for double running costs to help manage risks to all organisations, including social care, but no agreement has been reached on this yet. Different funding models are discussed in our 5 year plan and remain the focus to mitigate and manage risk going forward given the constraints of the current system.

The embedded paper was presented by the Chief Financial Officer for Bradford Districts and City Clinical Commissioning Groups to the Integration and Change Board on the 15th August 2014 and was agreed. It represents the consensus view of the finance leads for each partner organisation on the local health economy approach to resourcing the BCF and describes in detail the risk sharing approach adopted.

The paper describes the value at risk of £4.7m and the method of calculation.



The performance fund has not been taken into account in the budgets as per the risk sharing agreement.

The Local Authority's financial plans reflect the flows of funds to it as set out in the BCF plan.

Further details will be included in the Section 75 agreement which is in development.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

As articulated in section 4 there are a range of transformational programmes within the ICB portfolio which will support delivery of the BCF:

- Children's services
- Adults services
- Integrated care for adults
- Urgent and emergency care
- Planned care
- Transforming primary and community services
- Self-care and prevention

This portfolio sits under the governance of the Health and Wellbeing Board and is therefore part of the delivery of the JHWS. The integrated care for adult programme includes intermediate care services which form the primary scheme associated with the BCF however all are intrinsically linked and support delivery.

The portfolio strategy is commissioner led and derived from joint local commissioning strategies. It contributes to the Bradford District and Craven Five Year Forward View (strategic plan). The three Clinical Commissioning Groups and the Local Authority work collaboratively to achieve a coherent approach to commissioning strategy. Implementation of business change is provider-led.

The Integrated Care Programme is one of seven that make up a portfolio of interdependent programmes overseen by the Integration and Change Board (ICB). The Senior Sponsor group is the ICB, chaired by the CEO of the LA and with CEO members from the health and care economy. The ICB reports to the HWB.

We have extensive experience of working collaboratively across the CCGs and LA to deliver change in the arena of integrated care from our experience utilising various funding streams (reablement, carer's breaks, winter pressures and NHS funding for social care).

We have developed our provider contracts to support change, through commissioning intentions, contractual incentives (e.g. CQUINs) and development of local schemes and contracts with GP practices to drive the delivery of integrated care.

The programme of integrating care and increasing community-based capacity and capability is closely related to work to improve urgent care services, the transformation of social care services and the development and delivery of the transforming primary and community services strategy locally.

To further enable integration Bradford City CCG and Bradford Districts CCGs allocated non-recurrent funding during 13/14 and 14/15 in an initiative called *"Fast Tracking Transformation".* The funded pilot projects will be evaluated prior to the end of 14/15 and some may be considered for recurrent funding. AWC CCG carried out a similar process and schemes such as the dementia crisis response service, the Gold Line for palliative care patients, and community health navigators within multi-disciplinary teams all support the delivery of the BCF vision. Whilst these were funded non-recurrently across a range of providers, including the voluntary and community sector, it is expected that the patient outcomes will demonstrate the value to continue these schemes in the future to support the delivery of our joint vision.

There is also ongoing work to transfer all provision of enhanced services that the CCG wish to continue to commission, onto NHS Standard Contracts. All general practices across Bradford now have an NHS

Standard Contract to provide ECG, ABPM and spirometry services for their listed patients and this work is underway in AWC.

In support of the current strategy to prevent strokes across the Bradford population, the provision of anticoagulation has been reviewed and re-procured from several providers as a result of the service going out to AQP. Several other enhanced services are currently being reviewed and will follow the same decision process and re-procurement route.

The three CCGs have also granted £3.2M to the Third Sector, for a range of activities in-line with CCGs priorities. There is a recognition of the benefit of working with the Third Sector and in their ability to operate close to the heart of any given community group and their ability to reach the hard to engage with. We are currently working to develop better operational relationships between CCG member practice and Third sector grant funded providers.

Personal health budgets: integration in Continuing Healthcare and personalised commissioning
Integration of the assessment and review components of the Continuing Healthcare (CHC) process has been a long held ambition locally. Co-location of health and social care staff responsible for these two major elements within the CHC process has been agreed between both parties and planning is underway to achieve this by December 2014. The aim of co-locating staff is to improve the experience service users and their carers have of CHC process by better co-ordination of assessments, more timely decision making and a more integrated approach to commissioning care packages between the two services. This is particularly pertinent as the NHS introduces personal health budgets in a similar vein to the Direct Payments scheme overseen by Local Authorities for many years now.

Being a pilot area from 2013 for personal health budgets (PHBs) has meant locally we already have patients in receipt of full fund continuing healthcare (CHC) with such budgets. From October 2014 all patients in receipt of CHC will have the right to have a PHB. This change is intended to give patients and carers greater control and personalisation when planning care for their continuing healthcare needs. The co-location of staff and plan to integrate elements of the process and care package commissioning where it makes sense to do so, is a key element in our ambitions for patients and service users. Our aim is to reduce duplication of effort and information gathering, shorten decision making times and be able to react with better co-ordination when patient/service user needs change and care packages need to respond to reflect that change.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Our BCF, 5 year forward view, and 2 year operational plans across the 3 CCGs have been developed collaboratively across health and care commissioners and providers, with each of the schemes ensuring alignment to improved outcomes for our local citizens.

This approach ensures that our BCF plan aligns with the CCGs and local authorities commissioning plans and that of health and care providers in the district, who have each been equally integral to the development of the Five Year Forward View and are all fully signed up to its priorities. The delivery of our Five Year Forward View is being overseen by a range of groups relevant to the seven programme areas within the portfolio.

At present, we are currently developing the narrative to our 2 year operational plans to ensure we can fully commit to the intended outcomes within our Five Year Forward View. The local authority will be considering these commitments and intentions as part of its current budget and planning cycle.

There is joined-up responsibility between the individuals accountable for the delivery of the plans and of the wider strategic framework. Further detail on this can be found in section 4. Any risks that emerge as we progress in the delivery of the BCF and our operational plans will be managed via the governance structure outlined also in section 4. We are also currently developing an approach to align CCG and local authority planning mechanisms. The CCGs have committed to sharing our plans with the local authority prior to the commencement of their budgeting and planning cycle.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Co-commissioning is viewed positively as an enabler to move further and faster in transforming primary care and in implementing BCF plans as it should provide local commissioners with a greater degree of influence over commissioning and resourcing decisions for our populations across the health and care economy. Elements of enhanced GP services referred to in *Transforming Primary Care* are embedded in several of the local transformational programmes – particularly those of Integrated Care for Adults, Primary & Community Care and Urgent & Emergency Care.

Following discussion with, and support in principle from their member practices, all three CCGs submitted expressions of interest to NHS England in co-commissioning general medical practice. Co-commissioning is viewed as a key enabler to delivering transformation, integration and new models of care. The ability to co-commission will support delivery of the BCF schemes through commissioning to meet individuals' holistic needs across the system, in particular the ability to commission new models of care supported by a wraparound community and social care infrastructure.

The CCGs are in dialogue with NHSE regarding degree of delegation of responsibility and timescale. This includes consideration being given to CCGs co-commissioning local APMS contracts which are due to end March/June 2015 as this presents a timely opportunity to commission differently for a defined population.

Across West Yorkshire, discussions are ongoing as to how co-commissioning arrangements may be implemented. It is anticipated that joint committees will be set up with the NHS England Area Team and each CCG to engage in joint commissioning.

All three CCGs have a track record of effectively managing conflicts of interest impacting on general medical practice through delineation of strategic and assurance responsibilities and having separate clinical boards/executive groups and governing bodies. The CCGs have been actively engaged in supporting NHS England in the continuous improvement of quality in general practice and recognise that co-commissioning would bring with it additional responsibilities and accountabilities.

Engagement has been undertaken through membership meetings, executive and boards meetings and membership development sessions. Benefits and disadvantages have been explored; details and solutions will be worked through should the CCGs Expression of Interest be progressed. Issues raised

were mainly associated with the management of conflicts of interest and the potential negative impact on relationships across the member practices – particularly in respect of managing performance issues or quality concerns. Discussions with members and NHS England are ongoing.

Please see 'Related Documentation' section for full EOI for each CCG

In addition to the pro-active care enhanced service which complements the BCF, the CCGs have developed local schemes which focus on 'transforming primary care' and developing enhanced primary care. These will absolutely support delivery of the BCF metrics and schemes. The schemes have been scrutinised by the governing body to ensure any conflicts of interest have been managed. The schemes focus on incentive and outcomes based commissioning informed by risk stratification and local intelligence and knowledge.

Risks:
The risks relating to primary care (and particularly general medical practices) that may impact on the delivery of the BCF schemes are associated with reduction in practice income which will be significant for many member practices. This is expected to have a detrimental effect on workforce, capacity, resilience and access. Mitigating actions will have to be agreed with NHS England and the CCGs.

There would be an additional risk if practices did not engage or take up the proactive care enhanced service, but this has not been realised as all practices signed up and are delivering. Should practices not engage in the enhanced primary care scheme this would have an impact of BCF however this would not be significant due to the alternative additional schemes. This has however been reflected in the risk log

Confirmation of the resource NHSE is able to release to support CCGs to undertake this additional responsibility will influence the final decision. NB. If co-commissioning is not undertaken by CCGs it does not present a risk to delivery of BCF schemes or an obstacle to commissioning new models of care. However, this would need to be secured through an alternative contracting and payment models, over and above the GMS/PMS contract.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The Local Authority is acknowledged for its role in maintaining vulnerable adults to live in their own homes or when absolutely necessary to live in more institutional settings (residential and nursing care homes). The Local Authority routinely mobilises a range of different services to safeguard vulnerable adults preventing their situations from deteriorating to a point where formal health and care services might be required.

The Local Authority informs the development of different housing options to meet the needs of the population, including wheelchair standard accommodation, supported and extra care supported housing to meet the needs of vulnerable adults. Highways services and transport planning play an important role in reducing or eliminating the physical barriers in the community that limit people with disabilities to be independent.

Community Wardens, Street Cleaning and Waste Services provide a network of intelligence about vulnerable adults who might be beginning to deteriorate who with some early intervention can be prevented from entering a spiral of decline which necessitates formal health or social care services having to get involved. Public Health in the Local Authority is well placed to consolidate the total efforts of the Council to drive up improved health outcomes and reduce the health inequalities across the district.

Adult Social Care is greater than the range of services directly provided by the Local Authority and includes all those services delivered through the voluntary and private sectors. It not only delivers support services to vulnerable adults but it creates employment and supports the local economy. Adult Social Care within the Local Authority has an expertise; infrastructure and systems in place which supports the local health system to prevent avoidable admissions to hospital and to ‘pull’ people out of hospital when medically fit for discharge. Existing local services have demonstrated good success in this area, with the ability to further improve performance.

Protecting adult social care is defined through the ambitions of the Five Year Forward View and the detail of this Better Care Fund submission. Protecting Adult Social Care will allow services to continue to be delivered to people at the ‘substantial’ level of the Fair Access to Care Services eligibility criteria and meet the expected eligibility criteria of the Care Act. Protecting Adult Social Care will allow the local health and social care system to continue to function and transform to meet the growing demand for services in the light of net reductions in the available cash across the system.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Adult Social Care currently supports 24/7 service delivery to facilitate hospital discharges and admission avoidance. The BCF will allow these services to expand and therefore have an optimum impact on the use of acute care, for both planned and unplanned electives. The services will deliver fewer avoidable admissions but will also contribute to discharges before the expected trim point for some individuals.

An expansion of intermediate care services to include residential, nursing and domiciliary/reablement care integrated with NHS intermediate care services will allow these resources to be flexed in response to seasonal and occasional increases in demand (this will also support delivery of the Urgent Care Strategy and System Resilience plans). The need to expand intermediate care services is supported in the emerging national evidence and the findings of the National Audit of Intermediate Care referred to earlier in this plan at Section 3 and the evidence base referred to in the same section.

The range of schemes to be delivered through Adult Social Care will mean the health and social care system will retain a suitably trained and experienced non-professionally qualified work force. Work force development in particular recruitment and retention is problematic for some professions and changes in the skill mix between professional and non-professionally qualified staff will allow for more services to be delivered within the available financial resources.

The funding made available through the BCF to 'protect adult social care' will enable the Local Authority to better co-ordinate at a corporate level its various prevention activities whether that is in relation to air quality, getting people more active, healthy eating, energy efficiency or falls prevention. Prevention will focus on getting the right information, advice and signposting to people at the right time to ensure they are enabled to take control over their situation. Prevention activity will include some direct support for people with regard benefit take up; access to good housing, employment and other services to improve mental wellbeing. Prevention will promote all aspects of self-care and better care for people living with long term conditions. It will also target people to prevent or delay onset of life limiting conditions. The focus of prevention activities will be more closely linked to improved health and social care outcomes upstream of the need for formal treatment or support services.

Local demographic changes mirror to some extent the national picture of increasing numbers of people over 65 years, increased complexity of support needs, including dementia. In addition to the increasing numbers of people in need of formal support services there are greater expectations of people to be able to remain in their own home rather than have to move into more institutional care. Deprivation and diversity factors also have an impact on specific health condition profiling. Protecting adult social care will allow the opportunity for the health and social care system to realise the accepted benefits of Personal Health and Social Care Budgets. We have provided an outline of local demographic challenges in Section 3.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

We can confirm that £1.35m has been identified locally from the additional £1.9b nationally for implementation of the new Care Act duties.

The total allocation from the BCF to protecting adult social care is £5.950m this includes £1.35m for implementation of the Care Act.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The Care Act brings an increased level of assessment activity to Adult Social Care and subsequently there is likely to be increased financial commitments to people arising from this. Modelling activity is being undertaken at a local and regional level to estimate the financial impact of this. At this time the 'Lincolnshire Modelling Toolkit has been completed for 2015/16 and 2016/17. The impact for 2015 is calculated to be £1,594,520. We have begun work on the Surrey and Birmingham models and will have the results from these over the coming weeks.

A Senior Responsible Officer for Implementation of the care act is appointed supported by a Programme Lead linking to a Transformation Programme Office. Progression of the system changes required are reported to a Programme Board which includes the Chief Executive, Director of Finance, Strategic Director of Adult and Community Services, Director of Collaboration (NHS) and other heads of department from across strategic support services. This in turn is reported into the overarching Integration and Change Board set out in section 4 of this plan. These governance arrangements ensure that the mobilisation of BCF activity is sighted on the implementation of the Care Act and vice versa.

v) Please specify the level of resource that will be dedicated to carer-specific support

£1,039,000 has been identified within the BCF for carer-specific support. The modelling toolkit referred to above has indicated a considerable growth in the numbers of carers who will require an assessment and subsequent provision of services. The overall financial impact is identified as £1,240,387. Locally we are mobilising a new integrated and jointly commissioned with local CCGs Carers Support Contract with a voluntary sector provider, the specification for this new service includes some provision for expected impact of the Care Act.

The likely range of services carers identify as best supporting them to stay well and continue in their caring role is not prescribed. In line with making things personal we will look to utilise direct payments and other forms of personal budgets to respond to identified needs. The risks to all aspects of the Care Act lie in the funding available to discharge the new duties, the mitigation for this is the transformation of the whole system to ensure best value for the Bradford pound. The risk is included at item 8 Section 5 Risks and Contingency.

The Care Act sets out new duties and responsibilities to support people in their caring role, revised definitions of a 'Carer' are predicted to lead to an increase in the numbers of Carers coming forward for assistance from the Local Authority.

In Bradford the CCGs and the Council have pooled funding to jointly commission a third party Carers Specific Organisation to discharge its duties and more in support of Carers.

The role Carers play in maintaining people living with LTC in their own home is well documented, not only for the financial contribution this makes to the whole Health and social care system, but also the 'quality of life' contribution the relationships bring. Cares have a direct impact on the numbers of people being admitted to residential and nursing care. Carers have a significant impact on preventing non-elective admissions to hospital by providing that 24 hour support to individuals when they are ill without which hospital would be the only other alternative.

The contract specification and procurement process has delivered an excellent provider of Carers services, a local organisation with good engagement with Carers and voluntary sector organisations across the District. The contract specification includes the requirement for Carer experience feedback (see Annex 1 Scheme No 2) in order to determine the effectiveness of all interventions. The feedback will be used to work with the provider and other organisations to amend and adapt their offer accordingly.

Extract from service specification describing the service and carer-perspective outcomes:

The aim of the service is to promote, support and improve the mental, physical, emotional and economic well-being of carers, so they can continue in their caring role, look after their own health and wellbeing and have a life of their own in terms of opportunities for work, training, education, leisure and social interaction.

1.1.1 Service Outcomes

The service will:

- *Promote and deliver services in line with legislation, guidance, best practice and research relating to carers as well as responding to local carers needs over the lifetime of the contract; the service needs to continually demonstrate innovative ways of designing, promoting, delivering and monitoring services and include carers in decision making from the outset.*
- *Work in a spirit of partnership with commissioners and providers in the statutory, voluntary, community and independent sectors to achieve shared goals*
- *Ensure that staff have relevant knowledge, experience, qualifications and skills to support carers receiving the service to ensure that positive outcomes are achieved and that the requirements of the Contract are met*
- *Ensure that staffing arrangements provide sufficient flexibility to enable adjustments to respond to changing need and make best endeavours to enable continuity of staff, and ensure the continuity of provision of the service during periods of staff absence due to holidays, sickness, maternity leave or for other reasons*
- *Ensure the service is carer led by involving carers in decision making and regularly consulting with carers with regard to service quality*
- *Consult and work with other well-established forums and provide a platform by which carers' voices will be listened to by local decision makers*
- *Encourage carer participation in the development and improvement of local services*
- *Undertake on-going publicity, promotion and awareness raising activities across the geographical boundaries including planning the delivery of the Annual Carer Rights Day and Carers Week*
- *Seek opportunities, in partnership with other groups and organisations where appropriate, to secure additional funding/resources to support the carer agenda*
- *Work with NHS111 and commissioners to ensure their details are uploaded to the Directory of Services*

1.2 Expected Outcomes

As a result of the service, carers will:

- *Have relevant and timely information and advice that helps them to care safely and sustainably and to pursue their own life choices*
- *Be supported to plan for their own lives including planning for the future and for emergencies*
- *Have access to a carers personal budget (or small grant) and will be designing and directing their own support*
- *Be well informed about and using the health and wellbeing services that they need themselves to enjoy good physical and mental health*

- *Have opportunities to have a break from caring*
- *Have good emotional support and feel less stressed about caring, and less isolated*
- *Be supported to maintain better relationships and provide better support for the cared-for person*
- *Be well informed about benefits and financial choices*
- *Be supported to find work and/or retain their employment status*
- *Identify themselves as carers at an early stage*
- *Be recognised and valued as expert care-partners*
- *Be able to balance their caring role with paid work, education, training and other important roles*
- *Be able to take part in activities with other carers, to access community services (e.g. leisure) and / or to volunteer*

Evidence supporting our approach to carers services:
We know that carers represent about 10% of the population and have an impact on a much broader swathe of the population who need care. It is therefore imperative that our strategy supports this part of the population.

National evidence:
We have based our strategy on national evidence arising from the Department of Health's work on what the future priorities should be for the National Carers Strategy. The Department of Health also asked the Standing Commission on Carers, the Governments expert advisory group, for its views on future priorities. Drawing on the Standing Commissions advice and the responses, four priority areas are identified in 'Recognised, Valued and Supported – Next Steps for the National Carers Strategy':

- Supporting carers to identify themselves as carers at an early stage and involving them in designing local care provision and in planning individual care packages
- Enabling carers to fulfil their educational and employment potential
- Personalised support both for carers and those they support
- Supporting carers to remain healthy

The Draft Care Bill
The Care Bill which is currently going through the various parliamentary stages is a Bill to reform the law relating to care and support for adults and the law relating to support for carers. The Bill promotes significant new rights for carers by recognising them in law in the same way as those they care for and making it easier for carers to get an assessment of their needs for support from their local authority.

Additional evidence is available from:

http://www.york.ac.uk/inst/spru/research/pdf/CarersLit.pdf

http://static.carers.org/files/systematic-review-15-jan-3840.pdf

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The re-introduction of a performance related element to the BCF presents no immediate impact on the

Local Authority. Failure to release the held back amounts of the BCF may affect future distribution of the fund in subsequent years.

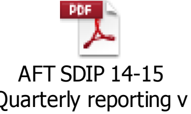
b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

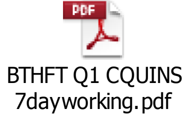
NHS Services 7 Days a Week:

For **Airedale Foundation Trust (ANHSFT)**, in accordance with the NHS standard contract technical guidance, we have included a service development improvement plan (SDIP) as part of the overall contract which sets out actions that the provider will take during 14/15 to commence implementation of the recommendations of the review into 7 day services and the associated clinical standards. An action plan has been developed and is monitored as part of the SDIP through the service development groups at both acute providers.

The ANHSFT SDIP and 7 day service action plan is attached here:



For Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), plans have been agreed for implementation of the recommendations of the review into 7 day services which include CQUIN funding in 2014/15 to enable this at Bradford teaching Hospitals NHSFT. Evidence of the quarterly monitoring of this plan is attached.



In 15/16 and beyond, we believe that the clinical standards that will have most impact should be reflected in the national quality requirements section of the NHS standard contract and in time all clinical standards should be included.

In relation to provision of integrated health and social care 7 day services, the BCF creates additional capacity for both health and social care staff at intermediate care level and system resilience funding provides dedicated resource in the intermediate care hub and also at community team level.

This allows proactive MDT assessment, care planning and care delivery to meet patients' needs 7 days a week and facilitates timely discharges, preventing delayed transfers of care. As the impact of service change and the BCF is realised this will allow a real shift in resource to secure and expand this additional provision 7 days a week and will identify any additional capacity gaps to be addressed.

It is important to note that the BCF is not the only mechanism for funding services which support system change and 7 day services. For instance, patient transport, GP out of hours services, in-reach Advanced Nurse Practitioners, social workers and occupational therapists in Emergency Departments to facilitate return home rather than admission. A dementia crisis response team has been commissioned and acute liaison psychiatry has been extended with links to on-call and crisis resolution. For the limited amount of time the service is not in place, 24/7 on-call arrangements are in place if patients present with a need.

Risks associated with delivery and sustainability of 7 day services relate to workforce, recruitment and retention, creating capacity and capability and identifying solutions to enable the different pay terms and conditions of health and social care to be overcome and so creation of a new type of workforce with different skills, blurred boundaries and generic working.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Social care does not currently use the NHS number but will do by April 2015 as part of the delivery of the Integrated Digital Care Record.

The adoption of the NHS number as the primary identifier will be in place by April 2015 across health and Adult Social care across the Bradford district. The NHS number is currently used by all NHS organisations across the district and will be adopted by Adult Social Care as part of the migration to SystmOne. SystmOne will be used across Health and Adult Social care to enable the delivery of Integrated Digital Care Records across the district.

Clinical Systems that use the NHS number as the primary identifier are already in place across the NHS partners. As part of the districts commitment to Integration and Transformation, during 13/14 the Local Authority (CBMDC) worked to create a revised Adult Social Care 'customer journey' process that will assimilate new integrated care pathways supporting the newly created 'integrated community teams' across the District and referrals to and from intermediate care.

CBMDC will then migrate its social care records to SystmOne to facilitate the development of an Integrated Digital Care Record across the district. CBMDC will start by adopting the NHS number as the primary case identifier and then will work to define the required Social Care functionality in SystmOne during 2014, prior to full system adoption in April 2015. This integrated solution will make significant steps towards achieving paper light status across the Bradford, Airedale, Wharfedale and Craven health and social care economy.

To date, the Local Authority/Adult Social Care has not captured the NHS number as an identifier and will therefore be matching it as it migrates its data to the Integrated Care Record (SystmOne). The process of matching client data to identify the corresponding NHS number will carry risks, related to the accuracy of the key identifier data that Social Care currently has recorded. Name, address gender and date of birth data, will be used to cross check the NHS number. However, as some of these identifiers can be missing from certain existing social care records, or changes not updated, or associated to duplicate cases, it will not always be possible to make a robust match and any errors could lead to the misalignment of health and social care records.

To mitigate this risk, our suppliers will only match positively, when all key identifiers are available. Exceptions will be validated, at the point when the service subsequently interacts with the service user and demographic data is checked. Groups of validated exceptions (with the added identifiers) will be sent to the NHS Batch Tracing Service ("DBS") for matching purposes.

All GP Practices across the district, including Craven use SystmOne.

Bradford District Care Trust (BDCT) currently has half the organisation using SystmOne through various Community and Mental Health services, other specialist Mental Health services currently use RiO. BDCT has already integrated RiO and SystmOne in an acute care pathway through the Clinical Records Viewer, the first Mental Health trust in the UK to achieve this. BDCT plans to ensure the specialist Mental Health services are provided with systems that are fully compatible with the existing community/GP users as well as other partner organisations. This will give users access to real time information on the patients in their care, ensuring that key information is not over looked.

Airedale Acute has implemented a SystmOne PAS which allows access to the primary care record (the first hospital based deployment in the UK), and plan to develop this further. The functionality now in place manages the flow of patients through the hospital. The next phase (e-discharge, e-prescribing) can be characterised as 'clinical, that is applying functionality to support clinical activity and a move to paper light'. Out of Hours GP provision (local care direct) use SystmOne for urgent care provision. Bradford Teaching Hospitals have several instances of SystmOne to support e-consultations and A&E and are currently exploring EPR options.

Safer Hospitals Safer Wards Fund: partners in Bradford District have been successful in securing £6.6m from the Safer Hospitals Safer Wards technology fund to develop an Integrated Digital Care Record centred on the patient and not the organisation. However this fund does not include Craven District which is under the commissioning remit of Airedale, Wharfedale, Craven Clinical Commissioning Group for health services and North Yorkshire County Council for social care services. As NYCC social care system of choice is Liquid Logic there will be inevitable barriers unless there is a specific project to lead on solutions which enable Craven social care to be included in the approach to integrated care records and systems within Bradford, Airedale, Wharfedale and Craven hence local people could be disadvantaged due to the inability of social care staff to access and use the integrated records.

To resolve this, the North Yorkshire Better Care Fund will allocate funds to create a solution to link the NYCC Liquid Logic system into the Bradford, Airedale, Wharfedale, Craven Integrated Digital Care Record.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We will implement Integrated Digital Care Records across the District by May 2015. This is being governed through our established Integrated Digital Care Record programme (IDCRP) which is part of the Integrated Care Programme. Bradford health and social care economy have been awarded national Accelerator/Exemplar status by NHS England for the level of digital maturity that we are demonstrating (via the Safer Hospitals, Safer Wards Technology Fund award).

The Integrated Digital Care Record programme will enable a shared record environment (across Bradford, Airedale, Wharfedale and Craven), in which information about patients/service users interaction with primary, secondary and social care will be accessible to all practitioners who have a legitimate relationship with that individual (given the individual has consented to share their care record).

CBMDC's contribution to the programme is a project to migrate social care records from the current Adults Integrated System to SystmOne (which is being used as a hub to host the shared record environment).

SystmOne is linked to the NHS Spine and will enable care records to be maintained and viewed in real time by all practitioners, and ultimately by the service user. The process will require CBMDC to implement the NHS number as the unique identifier. This will be adopted and go live at the beginning of

May 2015.

Impact of integrated digital care records

Integrated case recording

- A single record of all clinical and social care information entered about an individual across care settings will enable close integration and interoperability with community, GP and acute health systems-appropriate visibility across the health & social care pathway between health and social care systems.
- Support the transition from referral, assessment and care planning processes that are duplicated across both health and social care, reduce waste and bureaucracy by working as a more efficient aligned care provider unit.
- Case note tracking either in electronic or paper form scanned into the system, accessible to all health and social care practitioners.

Care and pathway management

- Enable complex care pathways to be developed with partner organisations, patients and their carers (revised customer journey). Scheduling interventions and supporting self-care and reduced acute, social care and primary medical intervention. Enabling efficient scheduling of resources (across the service provider community).
- Better shared visibility of data will help minimise delays in care and provide opportunities for earlier intervention and prevention.
- Enable service users in different parts of the District to have equal access to health/care support through the potential for allocation to an integrated care pathway and through e-consultation and sharing of information about available support options across health and social care.
- Support timely and planned discharge of patients from hospital and the delivery of the intermediate care tier of service-Virtual Ward, ACCT, Brain Injuries Unit etc**.**

Operational management and business intelligence

- Improved visibility of patient activity across care settings, by service and clinician.
- The ability to extract activity and other information from the Integrated Care Record and other systems to support service delivery. This includes real time dashboards of information to enable early warning of operational and clinical issues, waiting time/case allocation problems and visibility of the performance of individual services and clinicians.
- Give visibility of activity & demand and give early warning of capacity issues or potential safety or quality breaches (safeguarding adults/children; lone-worker staff security).
- Meet mandatory and commissioner reporting requirements and support much more proactive service management, demand management and forecasting/modelling of activity, resource and finances.
- Potentially support the Estates strategy by optimum use of/a potential reduction in, the overall demand for building stock (community office bases-if they share a system health and social care staff can ‘touch down’ in each other’s buildings).

Information management

- Information used to drive integrated care across the entire health and social care sector,

both within and between organisations.

- Information regarded as a health and care service in its own right for us all – with appropriate support in using information available for those who need it, so that information benefits everyone and helps reduce inequalities.
- Information recorded once, during the first contact with practitioners, and shared securely between those providing our care – supported by consistent use of information standards that enable data to flow (interoperability) between systems whilst keeping our confidential information safe and secure; avoiding duplication.
- Integrated care records progressively become the source for core information used to improve our care, improve services and to inform research, etc. – reducing bureaucratic data collections and enabling us to measure quality.
- An information-led culture where all health and care professionals – and local bodies whose policies influence our health, such as local councils – take responsibility for recording, sharing and using information to improve our care.
- An information system built on innovative and integrated solutions and local decision-making, within a framework of national standards that ensure information can move freely, safely, and securely around the system.
- Health and care professionals will be able to access relevant records online – simply, securely and all in one place.
- Information standards will be set nationally for the whole health and care system, so that different parts can connect and communicate with each other and to improve the consistency and quality of information.
- More standardised and useful recording of information in our records, wherever possible capturing data at the point of care.
- Over time, the information from combined records will replace cumbersome national data collections.

Technology

- Data from our records will be combined and linked together with other data in a secure environment which would overcome some of the current risk for specific services e.g. Adult Protection.
- The shared system provides the ability to more effectively collaborate over commissioning and to monitor pooled budgets and funding. The platform is centrally hosted and can therefore more easily provide the facility to provide virtual/remote access to service providers whether they are from the Health, voluntary or private sector.
- A shared, hosted, platform is not reliant on ageing or unsupported partner systems and has one single integrated interface.

To further support the continued delivery of integrated care records we will develop an integrated approach to capital developments and investment that supports the objectives of maintaining people at home.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Partners have established systems and processes for the effective management of Information

Governance. They are committed to maintaining a minimum of level 2 performance against all requirements in the IG toolkit.

- We are committed to ensuring that appropriate IG controls will be in place.
- We are committed to obtaining and maintaining a minimum of level two on all IG Toolkit requirements.
- We are committed to upholding the values of Caldicott 2, and to fulfilling our duty to share.
- The confidentiality of service user information will be respected
- The duty to share will be met in order to ensure that members of the care team have access the data that is necessary for the delivery of safe and effective care Information that is shared for indirect care purposes should be anonymised.
- The rights of service users to object to their data being shared will be respected

We have designed our organisational structure in such a way to give sufficient precedence and priority to information governance, through the IT and data sharing group.

As an accelerator site for the Integrated Digital Care Record, further assurance will be developed through that process.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The function of 'Lead Practitioner' has been agreed across partners and is in the process of being implemented (see the model in the next section). All people identified through the multi-disciplinary team (MDT) process which focuses on people at high risk, identified through predictive risk stratification and clinical intelligence, have a Lead Practitioner allocated.

MDTs consider the top 2% of the community population most at risk of admission by using the CPM predictive risk stratification tool, now available in all GP practices across Bradford, Airedale, Wharfedale and Craven. This will be expanded to take a more proactive approach to the care of people lower down the risk stratification tool with long-term conditions in particular.

All people identified as needing an integrated approach to their care because of their risk of admission have an Integrated Care Plan and a Lead Practitioner allocated to coordinate their care. The role of the Lead Practitioner is to coordinate the person’s care, being the main point of contact and ensuring that the right services (mainstream and specialists) support the person at the right time.

We have incentivised our primary provider of community services (Bradford District Care Trust) through their contract CQUIN scheme to embed the function of Lead Practitioner as business as usual.

The new enhanced primary care schemes are outcome based and include an emphasis on increased pro-active care to those most at risk of admission to hospital. This will enable a higher proportion of individuals to have their needs jointly assessed and integrated care plans developed and put in place, it is likely that this will mean that 5%+ of those at risk as identified via predictive risk stratification will be targeted by the MDTs hence accelerating delivery of the BCF outcome measures. CQUIN schemes have been agreed with acute and community providers which incentivise providers to engage in this approach hence all parts of the system are working together.

The Lead Practitioner can be any professional (GP, occupational therapist, social worker, nurse etc) and is matched to the predominant needs of the person being cared for.

Our approach is described in the document appended here.

Lead Practitioner role profile final 2013 12 1

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

There are 21 communities across Bradford, Airedale, Wharfedale and Craven all of which operate multi-disciplinary Integrated Community Teams. The ICTs convene to consider people identified through the Predictive Risk Stratification as being at high risk of a hospital admission (the tool is available in all 84 GP practices). In recognition of the fact that the PRS tool does not report in real time, nor include people supported by social care, the teams also identify people with complex needs through their day-to-day practice and knowledge of their caseloads. The needs of people who also have dementia or mental health problems are also included ensuring truly holistic care.

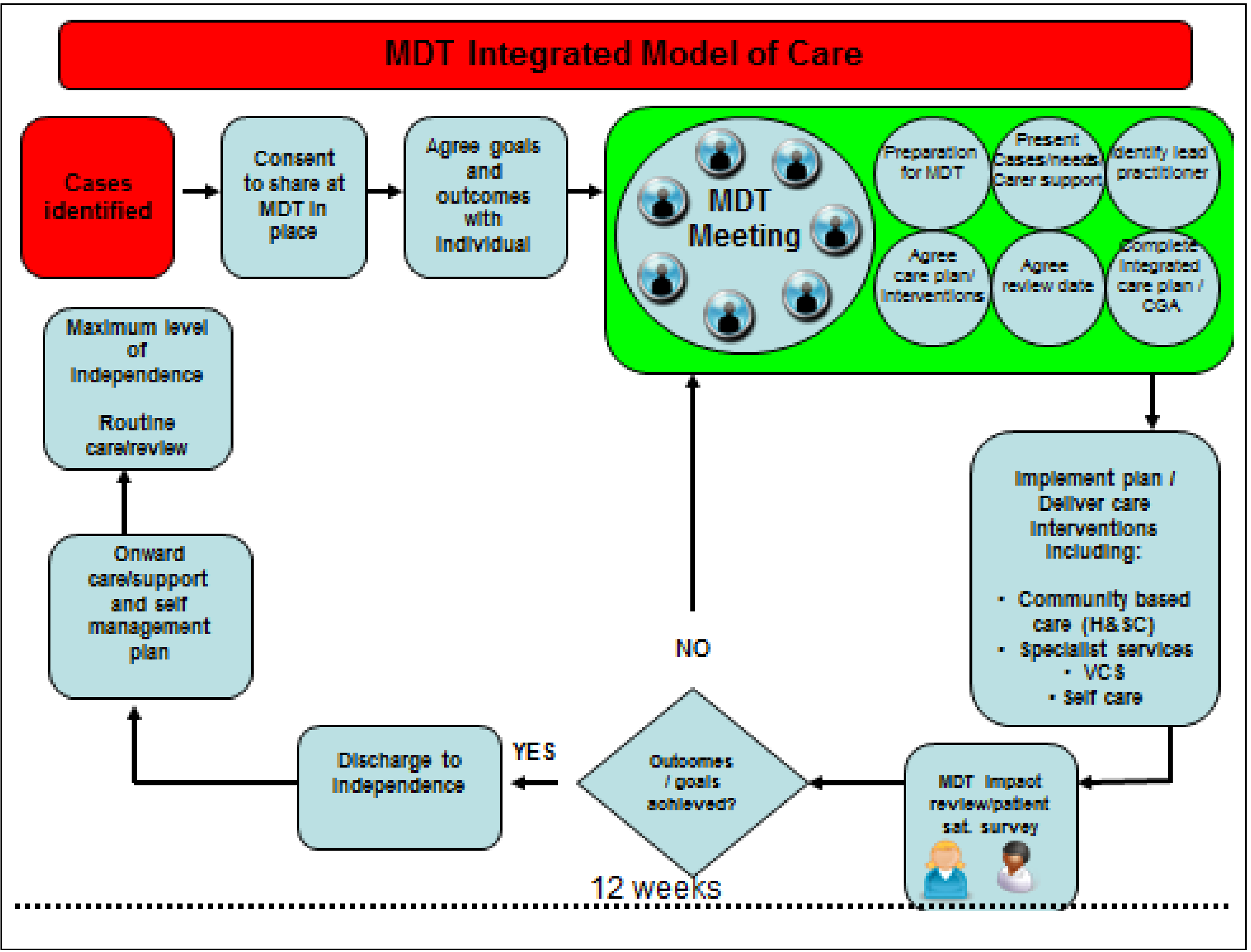
The PRS gives an indication of risk only and the MDT meeting explores further the nature and degree of that risk and does initial care planning. For people with very complex needs requiring a multi-professional/agency approach, a 'Lead Practitioner' is assigned who is responsible for coordinating the further assessment, care planning and delivery for the person, ensuring that the care is joined up across agencies with the person's needs central. This has been described in detail in the section above.

In addition, and as part of the national Enhanced Service Proactive care for 14/15, all people older than 75 have a named GP accountable for their care, regardless of whether they are supported by the Integrated Community Team for their community. AS GPs are central to our Integrated Community Teams, these two concepts operate together and provide belt and braces assurance for older people that their care will be coordinated.

To support GPs and practices to deliver the requirements of the Proactive Care Enhanced Service and support GPs to coordinate care for older people, the CCGs have made additional investment to the value of £5 per head of registered population which is part of the BCF pooled budget.

This element of the funding is to support new models of care delivery primary care. We have developed an 'enhanced primary care scheme' and a Local Incentive Scheme for GP practices which complements the CQUIN scheme with acute and community providers so all partners are incentivised to undertake an increased number of joint assessments and agree integrated care plans. These approaches together will support GPs to coordinate care for vulnerable and older people.

The concept of Lead Practitioner follows the patient across service tiers including intermediate care



iii) Please state what proportion of individuals at high risk already have a joint care plan in place

All practices are participating in the 'pro-active care' enhanced service. A predictive risk stratification tool is in place which is used to identify those most at risk of hospital admission, the top 2% of these are targeted and discussed in multidisciplinary, multi-agency team meetings and have integrated care plans agreed and put in place.

A review of 'Read' codes has been undertaken and 42% of those most at risk of admission have codes assigned to their records to indicate care plans are in place. The Pro-active Care Enhanced Service incentivises GP practices to ensure care plans are in place for all of the top 2% hence we have confidence that as a minimum the top 2% of those at risk of admission will have plans in place by the end of September.

In addition the CCGs have made additional investment in an 'enhanced primary care scheme' or a Local Incentive Scheme for GP practices and have agreed a CQUIN scheme with acute and community providers so all partners are incentivised to undertake an increased number of joint assessments and agree integrated care plans.

Whilst the CCGs do not contract directly with the Local Authority social care service, over recent years reablement funds and NHS funds for Social Care have directly supported social care services to develop and actively engage.

All of the above will support delivery of the Pro-active Care Enhanced service and as a result a greater number of people most at risk of acute admission will be targeted with more pro-active coordinated care and the number of those being assessed and with care plans in place will significantly increase from 2%.

As of 1 September 2014, 42**% of high risk of hospital admission** have one or more of the following care plans in place (with Read codes):

- Admission avoidance care plan (XabFm)
- Emergency health care plan (Xaaft)
- Health and social care plan agreed (XaVzx)
- End of life advance care plan (XaRFF)
- Dementia advance care plan(XabEk).

All practices within the district are participating in the 'pro-active care' enhanced service hence we have confidence that all of the top 2% will have care plans in place by the end of September, particularly as this is a requirement of the pro-active care enhanced service.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

In line with the NHS Constitution and the functions and duties of clinical commissioning groups, public engagement and participation underpins our decisions and is threaded throughout the development of our plans and strategies via the groups, forums, and meetings we have established.

As the BCF forms part of our five year Forward View we have engaged as part of this systematic process rather than explicitly with regard BCF. We have taken into account view of patients, service users and the public to inform the development of our approach. We will continue our programme of engagement with regard plans and strategies, of which BCF is part and continue to develop plans taking into account feedback. The remainder of this section describes our processes for engagement.

In recognition that we could be working smarter, we have a joined up approach to engagement which has been championed by the Bradford and Airedale Health and Wellbeing Board with a **cross agency group** having been set up to support integration, minimise engagement fatigue in our communities and derive best value from the available resources.

In addition to this, a communications group has been established specifically to bring together resources from partner organisations in support of the integrated care agenda.

The Health and Wellbeing Strategy, Health Inequalities Action Plan and local five year forward view all clearly state a commitment to involving local people in designing the health and social care services they access.

We have a range of strategic partnerships including older people, learning disabilities and physical disabilities led by people from the communities to ensure involvement in the planning and development of health and care services. These partnerships report into the Bradford District Partnership to ensure alignment with our plans and strategies.

The CCGs have **strategic communications and engagement groups (hereafter known as engagement reference groups)**

Our approach to communications and engagement is overseen by our communications, engagement and equalities reference groups (CEERGs) in Bradford CCGs and the public and patient engagement reference group (PPERG) in Airedale, Wharfedale and Craven. These groups lead our engagement work to support the delivery of our plans and strategy, and are chaired by our Lay Members with broad representation from local people and our partners and stakeholders including from: patient networks; Healthwatch; voluntary and community sector; local authority; and providers.

Alongside this, the following are embedded in our day to day practice:

The CCGs and CBMDC have **established communications and engagement plans**, mechanisms, tools and techniques in place to support the integration agenda across agencies and geographic boundaries and will

continue to develop these, building on best practice and driving innovation.

These ensure that the following requirements are met:

- Individual patient participation
- Community and public participation
- Insight and feedback reporting

We are also working to develop a community asset based approach, empowering local groups and communities to facilitate engagement and ensure voices from across all of the groups which make up our populations are heard as we plan and design services. These will all support the work of the partnerships.

The following are embedded in our day to day practice:

Grass Roots reporting - this brings together intelligence from a variety of sources to provide the CCGs with an understanding of what local people, carers and stakeholders are saying about their experiences of local NHS services. Data is now collected from a wide range of sources, working in partnership with patient groups, Healthwatch, the voluntary and community sector and NHS providers to give a broad picture of patient experience and inform and support decision making.

The reports are an integral part of the governance of the organisations and, as such, are currently considered by the CCGs' governing bodies and quality committees.

All feedback is themed and forms part of the CCG working groups, ensuring patient experience is a mainstream part of the CCGs' work.

Local health forums
We have worked with the five Health and Wellbeing Hubs over the last 18 months as another way of harnessing local views and experience and forging stronger partnerships with voluntary sector organisations.

A joint project between the CCGs, local authority, Healthwatch, the VCS and other partners has seen the appointment of a project worker to strengthen the links between the patient and community groups, the hubs and the Health and Wellbeing Board.

We are also working together with the Health and Wellbeing Forum which works to ensure the involvement of the voluntary and community sector (VCS) in the planning, development and delivery of health and social care service provision. The forum achieves this through effective partnership working with the overall aim of improving health and wellbeing in the Bradford District. The forum is responsible for ensuring robust information sharing and representation of the VCS on our delivery groups.

Delivery Groups, patient groups and patient and community group networks
As part of our integrated work, local patients sit at our delivery groups (please see section 4 for the diagram. This ensures health and care commissioners receive direct patient feedback into the development of all of the projects within the Integrated Care work programme. We also have a number of networks that have developed at pace over the last year with meetings covering subjects including

stroke, self-care and mental health, all supporting the integration agenda. Steering groups are in place and members of these now sit on the CCGs' strategic engagement reference groups. We have three patient groups networks, each reflective of the population and community they operate in, and they have played crucial roles in shaping and influencing the planning and buying of local health services.

Partnership working with Healthwatch Bradford and District

Strong partnership working is evident across the health and social care community including with local Healthwatch, a representative of which sits on the CCGs' engagement reference groups, quality committees as well as at the Health and Wellbeing Board. We work closely with Healthwatch to extend reach into different groups and communities, particularly those who are hard to reach. Healthwatch contribute regularly to our Grass Roots insight and support the reach of our asset based approach to engagement.

Patient stories

Patient stories, views and experiences are routinely fed in from day-to-day contact to the planning and decision making process of the integrated care programme. This includes local people attending the Governing Body meetings of the CCGs to share their stories.

Ongoing dialogue

There is an ongoing dialogue with patients, members of the public, local groups and organisations and we will continue to use the existing channels such as newsletters, web and digital media, community engagement and networks, working closely with the area coordinator's office, as well as taking advantage of emerging technologies and opportunities

We are have areas of our **websites** which are dedicated to our approach to engagement and include opportunities for local people to work with us and feedback about what has changed as a result of their input. We also use our website to feedback on our progress with our work and keep the public abreast of where we are going to hold conversations with local communities about future services

We also work in partnership with local people on **specific areas of work, such as Urgent and emergency care**, c**ommissioning an accessible information service, stroke services and so on, ensuring that local people influence commissioning activities.**

Call to Action

The NHS Call to Action was a programme of engagement that aims to provide an opportunity for local people to contribute their views to the debate about health care provision in England.

Locally, the engagement built on ongoing dialogue with communities and individuals and was supported by Healthwatch and CBMDC. Findings were reported nationally but also used to inform the development of services across the district.

A range approaches were used to ensure people from different communities and backgrounds had the opportunity to have a voice. These included linking with Bradford Soup Kitchen, engaging with central and eastern European communities at their place of work – a local car wash, joint evening sessions with CBMDC.

Themes from the above engagement activity and structures (including Grass roots, Call to Action and specific work around improving access to psychological therapies, mental health and anticoagulation) has been fed into the development of the Better Care Fund plan. In addition it was shared with Bradford

Health Overview and Scrutiny Committee in March and feedback taken into account.

The importance of working with the Third Sector and community groups in helping people to understand and access appropriate low level support was underlined and shows that the direction of travel for the CCGs is in line with what people want of services.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Bradford has three NHS Trusts:

- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Bradford District Care Trust

Providers across the health and social care economy, including the voluntary and community sector have been involved in the development of the BCF plan for Bradford District. The approach has been led by the Health and Wellbeing Board and overseen by the Integration and Change Board (CEOs of the local health and care economy and the CEO of the CBMDC) ensuring involvement at the highest level.

As an example of provider engagement, the ICB (of which providers are partners) led the process and convened a BCF Task and Finish Group comprised of the Directors of Finance from all partners, representatives of the Transformation and Integration Groups for both AWC and Bradford and led by the CCGs' Chief Finance Officers.

Both TIGs include representation from the Voluntary and Community Sector and have received regular briefings and their views influenced the Task and Finish Group.

Task and Finish Groups took place on:

9th June 2011
11th August 2014

As a principle within the delivery of the Integrated Care for Adults programme of which the BCF is an enabler, providers lead the operational delivery of the transformational change and chair the various Delivery Boards in AWC and in Bradford. Acute providers have also been sighted on this through the System Resilience work.

Airedale NHS Foundation Trust's (ANHSFT) Operational Plan outlines their Right Care vision, and the elements of the Better Care Fund are detailed throughout the plan. External assurance by Monitor and NHS England demonstrated that ANHSFT's plans were in line with commissioner intentions for the future.

Modelling has been undertaken to identify the potential reduction in emergency admission for both acute trusts and the consequent financial impact. This was undertaken as part of contract negotiations for the 14/15 contract and specifically for the BCF planning process.

Their responses are shown in Annex 2.

All partners have been involved of the development of the Five Year Forward View.

The Integration and Change Board is one of the most important forums for partners to develop a shared understanding of both the challenge to the local health and care economy and the solutions required. The Board has a programme of development to support this facilitated externally. This work with stakeholders is increasing their engagement and ownership of the financial challenge, and in particular the need to establish new models of care delivery to reduce cost, much of which is driven by non-elective admissions.

Whilst the Five Year Forward View describes the problem, we are still developing the commissioning strategy to deliver this, much of which is described in this plan.

There is a risk that the schemes within the BCF do not realise the level of ambition and this is clearly reflected in the risk log as risk number 1.

ii) primary care providers

Within Bradford, Airedale, Wharfedale and Craven there are 84 providers of primary medical care. All are members of one of the three CCGs. Having delegated authority to the respective CCG clinical board or executive group it is these groups which have had more detailed involvement in development and monitoring of the BCF and will 'sign off' on behalf of their members the final plan. Each CCG is also represented (both clinically and managerially) on the TIGs and ICB which reports to the HWB hence engagement has also been undertaken through these fora (please refer to governance structure in section 4).

Representatives of primary care providers are members of the various programmes of work which support the BCF (see governance structure in section 4) hence they are engaged in these programmes and so the BCF. This includes representation from the Local Medical Committee. The 'transforming primary and community care' programme, the outline strategy for which has been agreed by CCGs has senior commissioner representation from the CCGs, NHS England (West Yorkshire) and BMDC and provider representation from general medical practices (in-hours and out-of-hours), BTHFT, BDCT, the VCS assembly, and the local medical, optometry and community pharmacy committees. There is a clear recognition of the interdependencies of the *transforming primary and community care* programme with the other programmes within the portfolio overseen by the ICB.

In addition primary care providers through their CCG member representation are engaged through membership meetings, TIGs and through broader meetings such as Integrated Service Development meetings which includes a broad range of stakeholders. The areas of development undertaken through these forums all contribute to delivery of the programmes of work referred to earlier, which form part of the BCF plan.

The implications of the delivery of BCF plans are reflected in the unit of planning '5 year forward plan' and also in CCG commissioning intentions. This recognises that should work clearly 'shift' from acute to primary care, where this can be quantified and improves quality this should be recognised and funded.

The ‘enhanced primary care scheme’ referred to in section 6 c) is an example of this.

iii) social care and providers from the voluntary and community sector

We have strong partnership arrangements with social care and the voluntary and community sector who are equal partners around the Transformation and Integration Groups. The VCS have representatives who are responsible for disseminating information to their sector and ensuring feedback from the VCS influences developments such as the BCF plan. The VCS representatives from the TIGs briefed the VCS Health and Wellbeing hub in September.

We also provided a support session with VCS partners providing details about the BCF process.

We have a strong local VCS market and range of consultation methods with VCS represented on a range of stakeholder groups including the Transformation and Integration Groups.

Much of the engagement activity has already been described in b (i) and (ii) above.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers’ plans for 2015/16 consistent with the BCF plan set out here?

The impact of the BCF on the health and social care system (and in particular acute providers) has not been assessed in isolation. Basic modelling which compiled the financial plans for all acute trusts, mental health, social care and Clinical Commissioning Groups was undertaken as part of the Five Year Forward View. This highlighted the overall financial challenge to the system and not just the funding associated with the BCF. Commentary from the two acute trusts can be found in Annex 2.

In our locality we are very mindful that the BCF is just one element and has been taken into account when planning for all services. We recognise a key priority is non elective activity and investments in schemes takes into account the impact on providers. As part of our assessment for investment we specifically assess acute activity and impact, this assessment is undertaken jointly with all providers, not just commissioners, recognising the impact of acute contract values.

The five year modelling includes our original trajectories for the reduction in non-elective activity. Our plans, provider and commissioner assumption were checked for alignment by Ernst & Young and summarised in the 5 Year Forward View.

As part of our annual contracting process providers share Cost Improvement Plan programmes and these are triangulated against commissioner QIPP, BCF and Transformation plans.

For commissioners, our QIPP plans are directly aligned to the BCF plan and other submissions to NHS England as part of our assurance process. QIPP is monitored regular by CCG boards and ICB.
As part of our regular and open book approach all organisations share financial plans on an annual basis,

ensuring assumptions, commissioning intentions, QIPP and CIP plans aligned.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1
Scheme name
Capital Funding including Disabled Facilities Grants (DGF)
What is the strategic objective of this scheme?
The inclusion of DFGs in the BCF is mandated by the national guidelines and is welcomed locally as an enabler of integrating this service into a wider range of services that support people to remain at home and optimise their independence, health and wellbeing. The BCF will fund the continuation of this scheme which directly supports the vision of achieving integrated services which maximise people's independence, health and wellbeing. To improve the physical environments of people's homes to increase their independence and or to support carers (unpaid and paid) in their caring role. Disabled facilities adaptations should contribute to reducing the cash value of personal budgets. Capital funding contributing to the development of Extra Care and other Supported Housing. Capital funding to the Local Authority is available to support all service areas. Service developments include improvements to the environment of existing services which impact on the quality of lives/experience of people using services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The service to be delivered includes and assessment of need, structural feasibility of proposals and the construction of and installation of disabled facilities. The service is available to all residents in permanent accommodation across the district. The service is available to children with disabilities as well as adults. The service is available to people who meet the current threshold for support operated across Bradford and will be in line with the national eligibility criteria set out in the Care Act Regulations. The service supports people to continue to live in their home. The model of care supported by these schemes is to promote independence and increase people's control over their situation. Evidence suggests that where choice and control are improved for people then higher levels of satisfaction are experienced.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Assessment of need is undertaken by the Local Authority Occupational Therapy Service, Technical Specifications completed by the Local Authority. Most installations are delivered from framework contracts managed by the Local Authority. In some circumstances individuals will manage the whole process of securing technical drawings and their own construction company. Major capital schemes including the development of extra care and intermediate care residential are managed within the Local Authority with the construction works being delivered through a competitive tendering process.
The evidence base **Please reference the evidence base which you have drawn on** - **to support the selection and design of this scheme** - **to drive assumptions about impact and outcomes**
The DFG service is a statutory scheme and represents a continuation of the same. Capital programmes are subject to robust business cases that demonstrate the necessity of the scheme to meet the needs of the population of vulnerable adults. The schemes need to demonstrate their financial viability demonstrating how they contribute to overall service quality improvement and value for money.
Investment requirements **Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan**
Capital grants £3,208k
Impact of scheme **Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan** **Please provide any further information about anticipated outcomes that is not captured in headline metrics below**
With regard to the DFG, there is no causal relationship which might be evidenced by a metric and there is therefore no specific metric to report on DFGs which can explain the likely impact of the scheme on non-elective admissions, admissions to residential and nursing care. DFG's (funding home adaptations) can sometimes be the only service provided for an individual. The methodology behind the patient experience metric will be extended to DFG's. This has been included as it is a mandatory part of the BCF plan, and there is no requirement in the guidance to provide a metric. DFG's support people to remain independent at home and prevent dependence on NHS and social care packages. DFGs are part of the overall approach to reducing unnecessary dependence on the health and social care system. Disability Facilities Grants are statutory grants available to all households with a disabled member. The grants are accessed via an occupational therapy assessment

undertaken by the Local Authority to determine eligibility and to design the appropriate adaptations. The grant is means tested and is awarded to the person with a disability.

Disabled Facilities Grants are provided to individuals to improve their home environment to reduce the impact of their physical environment on their ability to live independently or to use their home safely. The grants are provided to allow ease of access and egress to a person's home and to facilitate movement around the home.

The impact of the provision of disabled facilities adaptations has a direct impact on the numbers of people admitted to residential and nursing care. In many instances the provision of disabled facilities support carers both paid and unpaid to be able to deliver the hands on physical care that some individuals need.

The adaptations in many cases allow for the safe delivery of care, in particular back care of the carers as a result of moving and handling activities. Back injuries and other strain injuries account for a significant number of absences form work across the system. Injuries may involve non-elective admissions of the carer, they most certainly will consume Primary Care and Out Patient Services including access to therapies and medicines. The consequence for some cared for individuals is they may temporarily be admitted to hospital while step up care is arranged.

Disabled facilities adaptations can also reduce the risk of falls within a person's home, for example the use of stair lifts to safely negotiate the stairs may prevent or delay a fall which would lead to demand for primary care, possible Ambulance Service, A & E, admission to hospital, follow up out patients and access to therapy services. What we do understand is the first fall can lead to a spiral of deterioration for an individual with a loss of confidence, a risk of social isolation, depression and a rapid decline to a point of needing on going health and social care services.

They enable people to mobilise within their home (where this is not prevented through the impairment) thus enabling access to facilities to maintain hygiene, good nutrition and hydration, socialisation, and mobility. All of these support the person to maintain their health and wellbeing and reduce risks.

There are potential impacts on pressure care, falls, mental health, circulatory problems and so on, however it is not possible to link these to reduced non-elective admissions or evidence them through a metric.

An ancillary benefit to the health and social care scheme is when trying to transport people to and from hospital for emergency and non-emergency purposes; this can be carried out using standard conveyance arrangements (lower cost).

The metrics to monitor this particular scheme will include outcome impact surveys of self-determined quality of life improvements.

Feedback loop **What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?**
In addition to using the outcome survey's with people, we will review all admissions to residential and nursing care to establish if the person has previously had a DFG and what the significant changes have been to result in the admission.
What are the key success factors for implementation of this scheme?
Critical to the success of the DFG is the ability to meet demand for assessments in a timely fashion and to subsequently deliver a usable disabled facility shortly thereafter. The Capital schemes committed to over the coming years need to attract a suitable mix of tenants with sufficient levels of support needs who otherwise might be in risk of being admitted to permanent residential or nursing care. The development of intermediary care facilities will create an optimum environment to meet the needs of people either stepping down from acute or non-acute care. The service will equally need to be suited to meet the needs of people requiring to be stepped up from the community to prevent an avoidable admission to acute care.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
2
Scheme name
Carers Break Funding
What is the strategic objective of this scheme?
Bradford Council along with statutory health partners want **carers** in the Bradford District to be recognised and valued as being fundamental to strong families and stable communities, to have opportunities to live healthy, fulfilling and enjoyable lives including fulfilling their employment and educational potential and, to have a life of their own alongside their caring role. Health and social care systems are increasingly reliant on carers and as more pressure is felt on all services and resources, the viewing of carers merely as an extension of those they care for is potentially very damaging in terms of the health and wellbeing of carers themselves. Evidence shows that breaks for carers can lead to positive outcomes for the carer, the cared-for and the economy by: • Improving health and wellbeing outcomes for patients and recipients of care • Improving health and wellbeing outcomes for carers, who suffer disproportionately high levels of ill-health • Reducing unwanted admissions, readmissions and delayed discharges in hospital settings • Reducing unwanted residential and nursing care admissions and length of stays
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The funding will be used to improve the health and well-being of carers either through the provision of a carers' small grant payment or a voluntary and community sector service which will enable the carer to take a break from caring responsibilities including taking up a training opportunity. The services will be targeted at carers (i.e. someone who spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems). The service will support carers, irrespective of whether the person they care-for has a formal care plan in place and who: • live in or care for someone who lives in the Bradford Metropolitan District • are former carers whose caring role ceased no more than 12 months prior • reside with, or separately from the person they care for

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Bradford Council along with local health partners have procured an Integrated Carers Service which is built around a central hub which provides a drop in and meeting opportunity for carers as well as a base for the staff team. The service will also have a number of spokes into and around integrated care areas (groups of GP practices) to try to identify carers at the earliest possible opportunity. In addition to the core service provisions of information and advice, emotional and practical support and emergency planning, the provider is expected to refer and signpost carers to support available either for themselves or the person they care for.

The proposal will ensure there is a wide range of diverse and high quality support options for carers available through the voluntary and community sector to which the Integrated Carers Service provide can refer and signpost to.

All services will also be promoted through the Connect to Support e-marketplace giving carers and professionals access to the range of support available.

Contract monitoring of the Integrated Carers Service as well as monitoring of the additional support will be undertaken by the Commissioning and Contracting Team in Adult & Community Services and will provide assurance both in terms of service delivery and quality.

The evidence base
Please reference the evidence base which you have drawn on
- **to support the selection and design of this scheme**
- **to drive assumptions about impact and outcomes**

There is a significant body of evidence demonstrating both individual (carer) and financial benefits of supporting carers, for example:

- The University of Leeds estimate that the cost of replacing the unpaid care provided by carers in Bradford would be £1.1billion.

- Social Return On Investment study which estimated annual gains to society of at least £73 million, set against annual funding of less than £5 million in carers support

- *"Carers and Personalisation: Improving Outcomes"* makes a series of recommendations including "developing a range of support options and opportunities to match the diverse needs of carers and the outcomes they wish to achieve in their lives"

- *"Making it Real for Carers"* states that *c*arers want the space to be someone other than a carer and to engage in activities in their community.

- Local evaluation of carer small grants and breaks services demonstrates that carers value these types of support

- The Lincolnshire Modelling Toolkit which has calculated and additional level of assessment activity to the value of £156,600 and a further £1,083,788 for personal budgets.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

-Carers support £1,039k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Intended outcomes include:

- Carers receive timely and appropriate short breaks activities to enable them to feel recognised and valued as individuals and help them to live healthy, fulfilling and enjoyable lives

- Carers are supported to manage their caring role as long as they wish to do so with minimal intervention by statutory health or social care services

- Breaks are available that adapt to individual carers' needs including access and cultural needs

- The number of carers across the district who have access to breaks that will help to improve their health and well-being is increased

- Involvement in carers support networks of carers from groups and communities that traditionally have not accessed carers services is increased

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Contract monitoring of the Integrated Carers Service as well as monitoring of the additional support will be undertaken by the Commissioning and Contracting Team in Adult & Community Services and will provide assurance both in terms of service delivery and quality. Each small grant and breaks provider will provide data regards:

- Total number of carers accessing the service broken down by protected characteristics
- Total number of grants/breaks provided
- Outcomes achieved for carers
- Records of any complaints or compliments the service receives
- Relevant financial data

Analysis of the data will be presented at the multi-agency Carers Partnership and will be used to inform future needs analysis.

What are the key success factors for implementation of this scheme?

• Greater understanding of the impact of support for carers at a joint strategic level • Improved partnerships within the voluntary and community sector • Carer’s report improved quality of life.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
3
Scheme name
Expansion of intermediate care services
What is the strategic objective of this scheme?
• To contribute to the delivery of the Five Year Forward View • To contribute to reducing the overall financial challenge by reducing demand on acute care • To support the delivery of the shared vision by providing a robust and sustainable integrated intermediate care service to the residents of Bradford District. • Protect funding for intermediate care services expanded during 14/15 across all contributing partners (BDCT, BTHFT, CBMDC, ANHSFT and VCS) • To secure a responsive needs driven service to provide rapid response to people in need and avoiding emergency admissions whenever safe and feasible • Creating an enabling and self-care approach to improved health, wellbeing and independence and improving people's experience whilst also delivering better outcomes in terms of care and safety • Ensure that people with mental health needs and in particular dementia have equal access to intermediate care services • For agencies to work in partnership to provide a truly integrated service including trusted assessments and role blurring • To enable delivery of a 24/7 service and a move towards an increased level of 7 day working enabling an increased level of admission prevention and earlier supported discharge • To increase the availability of step-up care significantly to prevent avoidable admissions and support GPs to manage their urgent care demand. The default setting will be people's own homes but supported by specialist beds across the LA and NHS where this is not possible • To increase the number of people receiving proactive joined up care through development of new models of care. Including developing an approach to enhanced primary care building on the Proactive Care Enhanced Service, embedding the Lead Practitioner Role, new types of worker including generic workers, extensivist practitioner, and comprehensive community nursing services • To develop the infrastructure in the community that has the capacity and capability to deliver an alternative offer to acute care
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The integrated intermediate care service is made up of a number of initiatives that all work together to deliver the objectives above. Through the use of the BCF, our intermediate care services are being expanded and mainstreamed to ensure that they have a definite impact on emergency admissions. The following describes the service model which is currently in place and the expansion being supported by

the BCF.

Current service	Change supported by the BCF, delivering the metrics	How this will be delivered
1. Intermediate care teams operating in a virtual ward-type approach, comprised of: • Early supported discharge • Multi-disciplinary team providing home based care delivered by a range of health and care professional employed by a range of partner organisations but operating as an integrated team. This includes: o Voluntary and community sector including a Home from Hospital scheme and carers' support o Geriatricians o Advanced nurse practitioners o Social workers o mental health workers o therapists o Enablement workers • Home care enablement services	• We will expand of capacity in the intermediate care virtual ward services. This includes additional geriatricians, therapy, nursing and home care reablement staff. The expanded service will deliver more capacity to support people to remain at home and avoid permanent residential care (see reablement and residential admissions metrics)	• Programme of recruitment, training and skills development. As part of the expansion, there is a major programme of Workforce and Organisational Development including generic workers, skill sharing, role blurring and addressing different terms and conditions.
	• The existing isolated elements will be brought together as a single service supported by Organisational Development to achieve culture change.	• Engagement of staff in developing new ways of working, senior clinical leadership, organisational leadership and organisational development support
	• Establishment of new access and assessment hubs, providing a single point of access, triaging all referrals and ensuring that the appropriate integrated care package is commenced. This will include bed bureaux for LA and NHS intermediate care beds, hence optimizing utilisation and care closer to home.	• Taking into account local geography, two sites have been identified to enable co-location of the service elements which will be critical to the cultural change and efficient operation of the integrated services. This is supported by the necessary systems and infrastructure enabled by the Integrated Digital Care Record and supported by assistive technology.
	• A new approach and cultural change to Early Supported Discharge will be developed to achieve a Discharge to Assess approach thus preventing unnecessary delays on discharge and enabling rehabilitation and the right package of care and support at home (see reablement and residential admissions metrics)	• More capacity is being made available in the community (beds and virtual wards staff). Cultural change to enable staff to recognise the complexity of need that can be supported safely at home will be supported by necessary training and development. Joint working across health and social care staff will support this and acute staff will be able to increase their confidence from their colleagues with more community-based experience.
	• Increase direct step-up access from GP services to intermediate care	• Facilitated through establishment of the hubs to provide direct advice and easy access to services.
	Delivering the metrics: The changes described above will directly contribute to the delivery of the following metrics: 1. Avoiding emergency admissions and readmissions 2. Residential admissions 3. Reablement 4. Delayed transferred of care 5. Patient/service user experience	

2. Intermediate care beds for when people cannot be supported at home safely with care being provided by the above team in a range of settings including NHS, Local Authority and independent sector beds, and working alongside care home staff to deliver an enabling service	• Funding for LA intermediate care beds secured by the BCF • Supporting the strategic development of LA Extra Care/Intermediate Care facilities to achieve additional capacity across the district • Alignment of NHS, LA and independent sector intermediate care beds to optimise capacity	• Alignment of BCF funding to beds and strategic developments • as above • Creation of a Bed Bureau in each IC hub giving visibility of bed capacity across the providers and district
3. Specialist intermediate care beds for people with dementia, led by the Local Authority	• Joint working between the NHS and LA to utilise the specialist dementia care skills to avoid hospital admissions for people with dementia and provide care in an environment less likely to exacerbate their condition. • Developing additional observation and basic nursing skills	• Programme of training and skills development. As part of the new approach, we will put in place a major programme of Workforce and Organisational Development including generic workers, skill sharing, role blurring and addressing different terms and conditions.
4. OTs , ANPs, geriatricians and acute liaison psychiatric staff working in A&E to divert admissions and enable people to return home with or without support from the virtual ward or other community-based services	• Service secured though the BCF pooled budget.	• Quick and easy access to the IC hub and through this access to the right response for the person.
5. Seven day hospital-based social workers and senior home care staff to facilitate discharges	• Service secured though the BCF pooled budget. • Additional capacity in the community will support successful discharges 7 days a week thus enhancing the 7 day SW and home care assessment service	• This service element will become part of the IC hubs, thus fully integrating the discharge pathway for complex patients.
6. A non-weight bearing pathway providing short-term residential care to ensure that people immobilised by a cast maintain their function and are better able to engage in full rehab when they can weight bear	• Service secured though the BCF pooled budget.	• This service element will become part of the IC hubs, thus fully integrating the discharge pathway for complex patients.
7. Palliative care nursing and enablement support to enable people to die in their place of choosing	• Service secured though the BCF pooled budget. • This is an important function of the BEST enablement service, providing the care to support people to die at home as part of an integrated service response. This facilitates discharge and prevents unnecessary admissions at the end of life •	• This service will be integrated into the overarching intermediate care service to ensure joined up delivery of care.
8. Champions Show the Way mobilising the volunteer community to enable people to engage in self-care	• Service secured though the BCF pooled budget.	• Service delivered through the CCGs' contract with BCDT.
9. Home from Hospital schemes providing practical support to people on discharge from hospital including food hampers with basic provisions to address any immediate needs which may otherwise have delayed discharge	• Service secured though the BCF pooled budget.	• Delivered through the CCGs' contract with Carers Resource • This service will become part of the intermediate care hub to ensure an integrated approach, practical support and signposting to relevant support

or left the person vulnerable.		services post-discharge.
10. Integrated community equipment services enabling people to have their nursing needs met at home and to enable people to be as independent as possible.	• Service secured though the BCF pooled budget. • More effective management of the resource and improving timely access	• The hubs will have direct access to prescribing community equipment to facilitate discharge or maintenance of people at home.
11. Supporting ambulatory care pathways e.g. home-base IV antibiotic therapies, DVT pathway, heart failure diuretics etc	• Increased availability of community-based ambulatory care pathways • A cultural change to support staff to recognise opportunities for ambulatory care as opposed to admission.	• development of protocols and development of staff to acquire the skills to deliver them • Programme of training and skills development. As part of the new approach, we will put in place a major programme of Workforce and Organisational Development.
12. NHS funding transfer to adult social care schemes contributing to the overarching intermediate care service	• Funding for LA intermediate care beds secured by the BCF • Supporting the strategic development of LA Extra Care/Intermediate Care facilities to achieve additional capacity across the district • Securing funding of community equipment services • Securing funding for domiciliary care packages for older people, people with learning disabilities and mental health problems (especially dementia), people with physical and sensory impairments. • Securing funding for BEST+ enablement support service (part of the integrated virtual ward offer) • Securing funding for Crisis Response for older people • Securing funding for LA beds to be used flexible to support admission avoidance, urgent care, early discharge, carer support/respite, avoidance of admissions to long-term care • Securing funding for Safe and Sound telecare service supporting people to be independent at home and thus reducing the likelihood of admission to hospital, permanent residential care or unnecessary dependence on health and care packages of support. • Securing funding for Dementia day care, thus supporting carers to continue to care for people and avoiding permanent residential care. • Securing funding for Direct Payments to enable people to manage their care and support arrangements independently and creatively • Securing funding for the Incommunities Trustcare falls service. This provides rapid response for non-injurious falls, thus avoiding unnecessary call-out of ambulance services and conveyance to hospital.	• Through securing these critical social care services, this enables the services to be integrated into the overarching health and care system offer. • This forms part of the BCF pooled budget and is a key enabler of the delivery of the strategy to transform the local health and care economy, led by the Health and Wellbeing Board.

13. Reablement funds contributing to the overarching intermediate care service	•	•
14. Assistive technology (telecare) supporting people with long-term conditions and at the end of life	• Securing funding for Safe and Sound telecare service supporting people to be independent at home and thus reducing the likelihood of admission to hospital, permanent residential care or unnecessary dependence on health and care packages of support. •	• We will work with assistive technology providers (InCommunities, LA, NHS providers) to transform assistive technology from a specialist resource to a mainstream enabler of integrated delivery of care at home • Assistive Technology will form a 'menu of care' to be used as an enabler to add value to the integrated community teams in delivering care as close to home as is feasible, safe and responsive. These technologies will be combined to provide a synergistic platform to deliver proactive care for people with long-term conditions
15. Primary Care (GP) proactive care Directed Enhanced Services and operating as part of Integrated Community Teams	• Schemes to further enhanced Primary Care (GP) delivery of the Proactive Care Enhance Services increasing the number of people at risk of hospital admissions receiving proactive care at home, support to self-care and integrated care (MDT) support.	• £5 per head included within BCF pooled budget • Development and agreement of service specifications with outcome indicators and service level agreements • Local Incentive Schemes • national ES schemes for Proactive Care Enhanced Service • Funding of administrative support to facilitate an increased number of MDT meetings and therefore increased throughput of assessment and joint care planning and care coordination.

Cohort: All adults, including people with dementia and other mental health needs.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

i. City of Bradford Metropolitan District Council Adult Services
ii. NHS Airedale, Wharfedale and Craven Clinical Commissioning Group
iii. NHS Bradford City Clinical Commissioning Group
iv. NHS Bradford Districts Clinical Commissioning Group

Providers:

AWC service

Airedale NHS Foundation Trust (intermediate care)
City of Bradford Metropolitan District Council Adult Services
VCS Carers Resource (Home from Hospital Scheme)
BDCT mental health and community services

Bradford service
Bradford Teaching Hospitals NHS Foundation Trust (intermediate care)
City of Bradford Metropolitan District Council Adult Services
VCS Carers Resource (Home from Hospital Scheme)
BDCT mental health and community services

Delivery chain:
We have clearly assigned roles for delivery. Delivery is managed through a programme management approach reporting to Delivery Boards and the Transformation and Integration Groups.

We have established a performance dashboard providing high-level monitoring of system change enabled through new models of care demonstrating the impact of change on the health and care economy and delivery of BCF metrics.

There is a clear framework for commissioning led by the three Clinical Commissioning Groups in the Area and by the Local Authority social services department. We also commission services jointly where appropriate.

A Section 75 agreement is being developed to provide a legal footing for the pooled budget from 1st April 2015.

Delivery will be assured through contracts and contract monitoring with the providers.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence base for the impact of intermediate care is well known and can be found at:
- Social Care Institute for Excellence (2013). Maximising the potential of reablement. London SCIE
- NHS Benchmarking Network, British Geriatrics Society, Association of Directors of Adult Social Services, College of Occupational Therapists, Royal College of Speech and Language Therapists, NHS England (2013)

In addition we commissioned the CSU to undertaken a national and international evidence review of integrated care models and used the outcome of this to influence development of new models of care, transformational change and inform the NE admission reduction target. The full report is included in the related document section. This review provided assurance and gave confidence that the initiatives planned or underway will realise intended benefits.

Specific models where there was evidence of outcomes delivered are:
- Kaiser Permante, California, USA
- The Alzira Model – Valencia, Spain.
- MassGeneral Care Management Programme, Massachusets, USA
- Virtual ward models including Greenwich (over 2000 admissions avoided & no delayed transfers of care) North West London (Curry and others, 2013)
- Marie Curie end of life nursing: significantly more home deaths and less emergency admissions than control group (Chitnis and others, 2012;2013)

'Transforming services require a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than based around single diseases) and care that truly prioritises prevention and support doe maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services are available in the right place at the right time' (Oliver et al 2014)

Use of new technologies such as telemedicine are key to transformational change and new models of care including supporting self-care. Use of this type of technology is relatively new. An independent evaluation undertaken by the University of York - York Health Economic Consortium in 2013 (please see section 1 c for further detail) demonstrates a significant impact when used in care homes and peoples own homes. When compared with a control group there was a:

- 27% reduction in NE IP care for care home residents
- 7% reduction in NE IP care for people in their own homes
- 7% reduced use of emergency services for care home residents
- 2% reduced use of emergency services for people in their own homes

This gave confidence in approach and NE admission reduction target. Use of telemedicine continues to be supported, the independent evaluation is being repeated with a higher number of individuals now using telemedicine. Results are expected during Q3

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Funding streams (cross reference to Template 2, tab 3 HWB expenditure plan):

-Virtual ward (Bradford) £3,509k
-ACCT (Airedale Collaborative Care Virtual Ward Team) £787k
-IC support in the community (Enhanced Primary Care) £500k
-Mental health and palliative care community support £630k
-Reablement (CCG) £1,315k
-Reablement (LA) £1,685k
-Early Supported Discharge £592k
-Community equipment £1,387k
-Intermediate care beds £2,853k
-Intermediate care performance fund £3,363k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The intention is to enable many more people to be cared for in their own homes or communities. People will have increased access to enablement and this will support them to remain within their own homes for as long as possible, without being admitted either back to acute care or long-term residential care.

We would anticipate that this would have the following impact:

- Reduction in the number and complexity of ongoing social care/continuing healthcare packages as people are supported to become more independent
- Reduction in emergency admissions to hospital. We anticipate that there will be a reduction of 2257

Finished Full Consultant Episodes resulting in a total saving in 15/16 of £3,362,930. This appears in the HWB Benefits Plan tab 4 on Template 2 split into Virtual ward (people remaining in their own homes with support) and Intermediate Care beds (where people have a level of complexity which means that they can't be supported in their own homes, but can still remain in the community and avoid an admission to hospital.

The figures are based on the experience of the impact of existing intermediate care services. The increase in activity is directly proportionate to the investment to expand the services.

- Early Supported Discharge (and Discharge to Assess) will reduce length of stay and acute bed days in hospital. The expected reduction in delayed days is 132 days. This is small due to the low level of delayed discharges currently being experienced. By securing the services that have achieved this and then expanding them, this will enable partners to maintain and improve on this position. This appears in the HWB Benefits Plan tab 4 on Template 2.
- Drive up the quality and effectiveness of assessments by joint working and a holistic approach to people's needs, particularly for complex scenarios with multi-factorial components (home environment, mental health or dementia, multiple long-term conditions, frailty etc.). By getting the assessment and joined up care planning right first time, there is likely to be less need for repeated assessment or poor outcomes.
- People (and their carers) will experience better care and support. We will use the ASCOF metric (Improving people's experience of integrated care) to ensure that we are achieving the anticipated impact and that our new models of care deliver tangibly better outcomes for people that have long-lasting effects, ultimately reducing dependence on the health and care system. Please see HWB Supporting Metrics tab 6 in Template 2.
- More people will be able to live independently at home after discharge from hospital as a result of better joined up, proactive care. This will be demonstrated through the reablement metric. Please see HWB Supporting Metrics tab 6 in Template 2.
- Fewer people will be admitted to permanent nursing and residential home (including placements directly from hospital) as a result of coordinated assessment, care planning and delivery. Please see HWB Supporting Metrics tab 6 in Template 2.
- Carers will have an improved experience of support through the delivery of an integrated carers service coordinating all the available support to carers across the District (see Annex 1, Scheme 2)
- People with dementia (and their carers) will have a better experience of intermediate care services. We have ensured that their access to intermediate care services is explicitly included. Supporting more people at home is particularly important for people with dementia to reduce distress and compounding their condition. We will expect to see an improved experience for people reflected in the patient experience metric. Please see HWB Supporting Metrics tab 6 in Template 2.
- We anticipate improved GP engagement as a result of the BCF and overarching Five Year Forward View. This will support more innovative approaches to the delivery of primary care. GPs are central to the delivery of integrated care services. We have supported this through Enhanced Primary Care schemes/incentives. These will be subject to independent evaluation including delivery of qualitative and quantitative outcome metrics (including supporting a 3.7% reduction in emergency admissions). The impact of this on patient care is access to more person-centred, proactive care, and early identification of problems including diagnosis of dementia. Please see HWB Supporting Metrics tab 6 in Template 2.

Demographic growth is being built into contracts with acute Trusts, but part of the overall savings will be to prevent these additional emergency admissions from materialising and hence to manage the rise in numbers of older people.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Integration and Change Board has commissioned a system-wide dashboard to monitor impact across the whole system. The draft dashboard can be found in the Related Documents section.

In addition, we will take into account evidence from providers as part of the contract quality assurance process for example patient satisfaction questionnaires. This is also included in CQUIN schemes.

What are the key success factors for implementation of this scheme?

Key Success Factor	In place/planned	Stepped approach
1. **Staff**, Including: • recruitment • retention • Training and development • Skills • Skill mix • Working patterns (inc. 7 day services)	Planned	Phased implementation. Recruitment commenced. Implementation through provider partnerships and OD programme
2. **Cultural change**, including: • Engagement and involvement of staff • Organisational development programme • Co-design	Planned	OD plan agreed. Implementation through provider partnerships
3. Strategic partnerships, including: a. Health and Wellbeing Board b. Governance c. Shared Vision and commitment	In place	Governance kept under review to ensure delivery
4. **Public support,** including: a. Consultation and engagement b. Co-production	In place	Included in ongoing public engagement work.
5. **Delivery through partnerships**, including a. VCS b. Partner agencies committed to Integrated working c. Primary Care	In place	Continuity of joint working arrangements, co-design, development of primary care.
6. Appropriate deployment of resource a. finance **b.** staff		Five Year Forward View setting our shift of resources to community-based proactive care BCF central to delivery. Monitoring of impact through metrics

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
4
Scheme name
Care Act Implementation
What is the strategic objective of this scheme?
To implement the Care Act across the Bradford District.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Care Act sets out a wide range of duties and powers on Local Authorities to deliver services to people resident in their area. Implementation will be in two phases, changes required by April 2015 and those due to come into effect in April 2016. At present Local Authorities are awaiting the Regulations to support the Primary Legislation before finalising the detail of some of the changes being put in place.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The delivery chain includes the Local Authority, the Local Health System, Private and Voluntary sector organisations. The delivery/governance arrangements are set out in Section 7 (iii) of this plan.
The evidence base **Please reference the evidence base which you have drawn on** - **to support the selection and design of this scheme** - **to drive assumptions about impact and outcomes**
The financial evidence for the investment is subject to certain modelling, of which the Lincolnshire Toolkit has been applied. At this time the additional financial resources necessary are £1,594,520 for additional finance and needs assessments.
Investment requirements **Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan**
Care Bill Implementation £1,350k
Impact of scheme **Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan** **Please provide any further information about anticipated outcomes that**

is not captured in headline metrics below
The outcomes anticipated from the implementation of the Care Act are well documented through the legislative process that brought the Bill into law. The ambitions in summary are to improve people's experience of joined up systems at the point they need to access them. The implementation of Part One of the Act in April 2015 will ensure people have good access to advice and information to allow them to make choices about their care and support.
Feedback loop **What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?**
Implementation of the Care Act will be monitored through the normal suite of performance indicators returned to Government. Additional feedback will be sought through various existing partnership groups of people who use services and their carers.
What are the key success factors for implementation of this scheme?
Implementation of the Care Act is dependent on equipping the local authority and wider health workforce with the necessary knowledge and resources to empower people to have more healthy, active and independent lives.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
5
Scheme name
Protecting Adult Social Care
What is the strategic objective of this scheme?
To enable the Local Authority to continue to deliver the ambitions of the Five Year Forward View, the BCF, Urgent Care Strategy as well as business as usual
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
£4.6m of the BCF will fund the costs of Bradford Council's Adult Services activity. The Council's financial position is characterised by the overriding need to reduce costs significantly. Its published Medium Term Financial Strategy shows that, before BCF funds, the Council needs to close revenue budget gaps of £13.8/22.5/65.7m (cumulatively) over 2015/16 to 2017/18 – and this is ***after*** delivering an already approved savings package of £23.3/52.8/52.8m (cumulatively). In percentage terms, taking all approved and further required savings into account, this equates to a cumulative cost reduction requirement of 8/17/26% of the Council's cost base. With a budget of £125m, Adult Services accounts for 30% of the total Council budget, and is required to make a significant contribution to the cost reductions. The contribution from the BCF will be used to mitigate the overall financial constraint on Adult Services. The funds will be applied internally to all the activities described elsewhere in this submission which contribute to the reduction of activity in the health sector. The figure of £4.6m has been agreed under the governance arrangements established under the Health and Wellbeing Board and involving CCGs, local trusts, and the Local Authority, to make local decisions on the deployment of the BCF. *Please refer to the detailed explanations set out in Scheme 4 above for each of the Subject Headings below .(Delivery Chain, Evidence Base, Impact, Feedback and Success)
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Adult Social Care activity is heavily driven by referrals from the health system primary and secondary care. Adult social care supports people to better manage their conditions which has knock on effect for the consumption of health specific services to include GP's, Pharmacy, Community Nursing and Therapies. It further impacts on the use of acute and non-acute hospital provision.

The evidence base **Please reference the evidence base which you have drawn on** - **to support the selection and design of this scheme** - **to drive assumptions about impact and outcomes**
Evidence base for this course of action is contained within the detailed minutes of the overarching Integration and Change Board detailed at Section 4 Planning for Action in this plan.
Investment requirements **Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan**
Protecting social services £15,127k
Impact of scheme **Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan** **Please provide any further information about anticipated outcomes that is not captured in headline metrics below**
The funding in it's entirety will ensure the Local Authority can continue to contribute to the overall priorities of the Better Care Fund, namely reduce non-elective admissions, better support people following planned admissions and ultimately reduce the total numbers
Feedback loop **What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?**
The use of Statutory Performance Measures (ASCOFF, POETS, Complaints etc) as well as Sector Led Performance Improvements will be utilised to ensure the service offer to Bradford people delivers the right care in the right place, first time
What are the key success factors for implementation of this scheme?
The key success factors will be measured by the sustainability of the health and social care system.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Bradford & Airedale
Name of Provider organisation	Airedale NHS Foundation Trust
Name of Provider CEO	Bridget Fletcher
Signature (electronic or typed)	Bridget Fletcher

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	12,289
	2014/15 Plan	11,870
	2015/16 Plan	11,443
	14/15 Change compared to 13/14 outturn	-3.41%
	15/16 Change compared to planned 14/15 outturn	-3.60%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	419
	How many non-elective admissions is the BCF planned to prevent in 15-16?	427

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	**Strategic context:** Airedale is committed to working with commissioners and local health and care economy partners in pursuit of our shared *Right Care* vision. Key to realising our vision is transformation, innovation and integration to better support patients (and their carers) at home/closer to home to reduce hospital admissions, A&E attendances, bed days and length of stay. This is something we have been pursuing for some time through the use of Telemedicine in patients own homes and nursing and residential care homes," Gold Line" for End of Life care, and the work of the Airedale and Craven Community Collaborative Teams which have already reduced admissions and A&E attendances and improved patient care. With reference to the impact data you have produced, we have reviewed and tried to reconcile with our own projections. We cannot reconcile the figures as they do not allow for any underlying growth or if they do include this,

		we would require a 10~11 % reduction from our current forecast trajectory which we feel is unrealistic given current performance levels.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	As we have already signalled, the underlying trend for Airedale & Wharfedale has shown a year on year increase of 3-4% in acute admissions with the current forecast trajectory for 2014~15 indicating a 7% increase from 2013~14 (this is after the hospital admission avoidance schemes we have already introduced) and this does not seem to have been factored into the trajectories from outturn 2013~14 to plan for 2015~16. The figures presented for outturn 2013~14 and plans for 2014~15 appear to be lower than the actual demand currently being experienced which would indicate a lower baseline is expected than is already occurring. To achieve the net impact on the underlying trend to deliver the indicated plan for 2015~16 would require an annual reduction of 10~11% in admissions which appear to be unrealistic given the evidence to date. We feel that the realistic plans going forward would at best reduce the underlying trend of 3-4% growth down to a smaller % in the short term and therefore reducing the future growth. The investment through the BCF should therefore reduce future growth (which may be 300~400 spells each year) resulting in future plans only showing small changes from the underlying baseline at this stage. The impact of self-care in the future (3 ~5 years) may have a greater impact and reduce the level of admissions further but this will need further testing.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We have considered the underlying trend in admissions and have been working with you on new models of care and pathways for managing admissions through Ambulatory care pathways ,Telemedicine, new models in A&E and Intermediate care teams which has resulted in reduced admissions which had we had not, would have resulted in further increased levels of admissions. Our financial strategy is to manage future growth down so that we can work within the existing baseline resources but the forecast trajectory indicated assumes a much greater reduction below the existing baseline which could result in a significant overtrade which would need managing through a risk pool. In line with our shared Right Care vision, to meet the underlying growth we need to work with our partners to

		strengthen the current service offer with extension to 24/7 services for ambulatory care, combined GP/Consultant services and the front end in A&E and AMU, whilst developing self-care models of care using Technology and a single care record in conjunction with the A&CCCT teams.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Bradford & Airedale
Name of Provider organisation	Bradford Teaching Hospitals NHS Foundation Trust
Name of Provider CEO	Clive Kay
Signature (electronic or typed)	Clive Kay

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	43,365
	2014/15 Plan	44,131
	2015/16 Plan	40,809
	14/15 Change compared to 13/14 outturn	1.77%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-766
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,545

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We agree with the principles that have been developed to actively reduce emergency admissions, there is considerable risk in meeting the 2014/15 levels in this paper, given the current level of growth in acute admissions. The risk associated with delivering the admissions levels continues into 2015/16 however we are working with the CCG to develop alternative models of care. **Strategic overview** The Bradford Health economy has established strategic work streams for both integration and urgent care. BTHFT is a member of both boards and is in full support of the developments that are underway across the health economy.

		There is a recognition that the aim and objective requires from the Health Economy is to reduce emergency admissions, however further work is required to establish plans to support delivery. Services are being jointly developed to facilitate the reduction in emergency admissions and these include: • Expansion of the Virtual Ward • Developing an Urgent Care Centre • Developing an Ambulatory Care Unit • Development of Surgical HOT clinics **2014/15** The developments noted above are in the development stage, with a view to be in place for winter 2014. Scoping work is still underway to assess the impact that these schemes will have on emergency admissions. The current level of emergency activity is exceeding plan, with a forecast overtrade of 2,178 admissions in 2014/15 (for B&A CCGs) – the forecast is based on a straight line projection of activity from Month 4, and is equivalent to a 7% increase over planned activity levels. The growth in demand will stretch the current planned reduction. The schemes commissioned above will reduce emergency admissions in 2014/15 to contribute towards bringing the CCGs activity closer to plan. The scale of the reduction is to be confirmed, and we cannot provide assurance that the schemes will fully deliver the 2014/15 planned emergency volumes. BTHFT are aware of the risks to the service and the financial plan that a reduction in emergency admissions will bring. The services under development will be provided by BTHFT and as such this will mitigate the financial risk associated with the reduction in emergency admissions. **2015/16** There has been a 7% growth in emergency admission from the planned activity levels in 14/15

		to the forecast outturn. In order to deliver the volumes included in the BCF submission real emergency reductions would need to be reduced by 9%. Further assurance is required from the commissioner on how the activity reduction will materialise in 2015/16. The 2015/16 financial and service risk to BTHFT will be fully quantified, including mitigating actions, when the schemes to deliver the 15/16 reduction are known. Our current financial plan assumes that the financial impact for the Trust is neutral. The commissioner and provider have agreed that Marginal Rate Emergency Threshold will only be adjusted to reflect demographic and population changes. No adjustment to the threshold will be made for planned services changes to aid reduction in emergency admissions.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	BTHFT are working closely with the commissioners to develop the new services outlined above. Early indications are that there will be minimal financial risk to BTHFT. Services will be realigned to deliver the new service models that will be commissioned to support the reduction in emergency admissions in 2014/15. The implications for BTHFT in 2015/16 will be assessed when the commissioning changes to reduce emergency admissions are known. Having reviewed the risk log included in the overall CCG submission we can confirm that the main risks that we have highlighted have been included within the log (pace and scale of transformation to deliver the required reductions in emergency admissions).