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Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 6 October 2016 at 4.30 pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Carmody **Gibbons**	**Greenwood** **Bacon** **A Ahmed** **T Hussain** **Nazir**	**N Pollard**

Alternates:

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Barker **Poulsen**	**Berry** **S Hussain** **H Khan** **Mullaney** **Shaheen**	**Griffiths**

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer
Jenny Scott	Older People's Partnership

Notes:

- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
- The taking of photographs, filming and sound recording of the meeting is allowed except if Councillors vote to exclude the public to discuss confidential matters covered by Schedule 12A of the Local Government Act 1972. Recording activity should be respectful to the conduct of the meeting and behaviour that disrupts the meeting (such as oral commentary) will not be permitted. Anyone attending the meeting who wishes to record or film the meeting's proceedings is advised to liaise with the Agenda Contact who will provide guidance and ensure that any necessary arrangements are in place. Those present who are invited to make spoken contributions to the meeting should be aware that they may be filmed or sound recorded.
- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From:
Parveen Akhtar
City Solicitor
Agenda Contact: Palbinder Sandhu
Phone: 01274 432269
E-Mail: palbinder.sandhu@bradford.gov.uk

To:

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended –

That the minutes of the meeting held on 1 September 2016 be signed as a correct record (previously circulated).

(Palbinder Sandhu – 01274 432269)

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Palbinder Sandhu - 01274 432269)

B. OVERVIEW AND SCRUTINY ACTIVITIES

5. ACCESS TO NHS DENTISTRY IN BRADFORD DISTRICT 1 - 8

Healthwatch Bradford and District will present a report (**Document "L"**) on continuing problems with access to NHS dentists in the district.

Recommended –

That the problem of lack of access to NHS dentists in the District, as highlighted by Healthwatch's survey, be noted.

(Victoria Simmons – 01535 665258)

6. NHS ENGLAND DENTAL COMMISSIONING UPDATE 2016/17 9 - 32

NHS England – North (Yorkshire and Humber) will submit a report (**Document "M"**) which provides an update to the Committee since the last update in October 2015 on the current commissioning and commissioning plans for dental services in the Bradford and Airedale area encompassing:

- Access
- Performance
- Public Health
- Other Dental Updates

Recommended –

The Committee is asked to consider and comment upon the information presented within the report.

(Caroline Coombes – 01274 432313)

7. NHS BRADFORD CITY CCG AND NHS BRADFORD DISTRICTS CCG DRAFT PRIMARY MEDICAL CARE COMMISSIONING STRATEGY 33 - 104

The Clinical Commissioning Groups (CCGs) in Bradford are producing a Primary Medical Care Commissioning Strategy which outlines the approach that will be taken to the commissioning of primary medical care services within Bradford over the next 5 years. The strategy outlines the proposed end state and focuses on six key areas: access; quality; workforce; self-care and prevention; collaboration; and estates, finance and contracting.

The strategy is currently in draft form and is out to public and stakeholder consultation. NHS Bradford City CCG and NHS Bradford Districts CCG will present **Document "N"** which contains the draft strategy and invites feedback from the Committee to inform the final version.

Recommended –

The Committee is asked to feedback its comments on the Draft Primary Medical Care Commissioning Strategy to inform the final version of the strategy.

(Vicki Wallace – 01274 237524)

8. CLINICAL COMMISSIONING GROUPS' ANNUAL UPDATE 105 - 128

The Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups will submit **Document "O"** which provides an update on achievements and challenges for 2015/16.

Recommended –

That the report be noted.

(Michelle Turner – 01274 237796)
(Julie Lawreniuk – 01274 237642)
(Sue Pitkethly – 01274 237317)

9. ADULT AND COMMUNITY SERVICES ANNUAL PERFORMANCE REPORT 2015/16 129 - 150

The Director of Adult and Community Services will submit **Document "P"** which sets out a summary of the Adult and Community Services Department for the financial year 2015/16 across a range of national performance indicators.

Recommended –

Members are invited to comment on the report.

(Bernard Lanigan – 01274 432900)

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Report of Healthwatch Bradford and District to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6th October 2016

Subject: Access to NHS Dentistry in Bradford District

L

Summary statement:

Report from Healthwatch Bradford and District on continuing problems with access to NHS dentists in the district.

Portfolio:

Health and Wellbeing

Report Contact: Victoria Simmons,
Manager Healthwatch Bradford and District
Phone: 01535 665 258
E-mail:
Victoria@healthwatchbradford.co.uk

1. Summary

Healthwatch Bradford and District have major concerns about access to NHS dentists in Bradford District; members of the public report difficulty in finding practices accepting new patients.

In a survey of over 1,000 local people, 43% of adults and 30% of children had no access to an NHS dentist.

On the NHS Choices website, there are currently no practices listed as accepting new adult patients for NHS treatment, and only two indicate that they can accept children.

Healthwatch are concerned that little progress has been made to increase access, despite the development of a proposal by NHS England to open up new appointments in the worst affected areas of the district by re-investing resources from commissioned but unused UDAs (units of Dental Activity).

2. Background

Since Healthwatch Bradford was established in 2013, we have been hearing growing concerns from the public about difficulty with accessing NHS dentistry. It is the most common reason for people contacting Healthwatch Bradford and District, with people trying to find a dentist but finding that no practices are accepting new NHS patients.

Healthwatch has been working to raise the profile of the issue of access to NHS dentists, in order to seek improvements in the commissioning of NHS dentistry for the district.

Since this issue was last discussed at this committee, we have met with representatives from the Local Dental Committee and NHS England who felt more evidence that there were difficulties with access to NHS dentists was needed. Healthwatch carried out a public survey, speaking to over 1,000 people, to gather this evidence.

Healthwatch organisations from across West Yorkshire have been involved in a Task and Finish group which was set up by NHS England to explore ways of improving access to NHS dentists across the region.

3. Report issues

The appendix to this report gives a summary of findings from the Healthwatch survey carried out at the beginning of this year. It indicates that there remains a significant issue with a large proportion of the district's population not able to access routine NHS dental care.

43% of respondents to our survey did not have access to routine NHS dental care. Many of these people reported experiencing dental pain, and 10% had attended A&E as a result. A lack of primary care dentistry is creating pressure on urgent and emergency care services.

30% of parents in our survey told us that their children did not have an NHS dentist, with many parents saying that their children had never seen a dentist. We heard accounts of children who had not had access to routine dentist check-ups having to have teeth

extracted in hospital – and even after this secondary care intervention they had not been able to access ongoing care to help prevent future problems.

The poor oral health of children in Bradford is a particular concern with our District's rate of tooth decay in children at 46% compared to national average of 28%. While much good work is being done in the district with schemes like Building Brighter Smiles, a lack of access to routine dental care for families undermines Public Health work on prevention and education.

In our survey, 74% of those who did not have an NHS dentist said that they had tried to find one, but had been unable to. It is very difficult and frustrating trying to find a dentist in our area who is offering appointments for new NHS patients. Healthwatch regularly check NHS Choices and ring round local practices, in order to try to help people who contact us about this problem.

At the time of writing this report, there were no practices in Bradford listed on NHS Choices as accepting new NHS patients. The nearest listed as taking patients was in Armley, but when we called the practice they advised that in fact they had no appointments for at least three months and that we should call back in November. In September 2016, a 'mystery shopper' exercise conducted by Healthwatch across the whole of West Yorkshire identified only 2 practices in the region which were accepting new NHS patients.

During one week in December 2015, dental practices across West Yorkshire were asked to make a record of the number of calls they received from people who were seeking an NHS dentist and who the practices had to turn away. 52% of West Yorkshire NHS primary care dental practices took part. 2,500 calls were made to these practices from patients trying to make an appointment unsuccessfully. The areas in which there were most calls were Bradford and Kirklees.

At the meeting of this Overview and Scrutiny Committee in October 2015, NHS England reported that people looking for a dentist are signposted to NHS 111 and that this would provide an improvement in the information provided. There was also a commitment made to consider local options for improving information to enable patients to access services. The experiences of people who contact Healthwatch for advice indicate that there has been no improvement on this issue.

NHS England Pilot Scheme

NHS England established a Task and Finish Group to explore the difficulties with access to NHS dentistry across West Yorkshire and to make commissioning recommendations to NHS England. This group included the Local Dental Network and received input from representatives from Healthwatch in Bradford and Kirklees.

A business case was developed in April 2016, which set out clearly the need for action to be taken in Bradford, e.g.

> *"The West Yorkshire Oral Health Needs Assessment highlights a lack of accurate signposting to dental services, with NHS Choices not always being up to date. The Bradford and Kirklees areas, in particular, show very few practices accepting new NHS patients. This has been echoed by Healthwatch, Local Care Direct and the Local Dental Committees. The result is a high volume of often unnecessarily*

repeated calls to 111 and, in turn, a high volume of patients seen in Unscheduled Dental Care that could have been seen more appropriately in Primary Care."

"Increasing Costs: In 2014-15, the overall overspend for all Unscheduled Dental Care providers against budget was £1,523,736. If no action is taken it is anticipated that this will increase as patients are unable to secure routine dental care."

"The number of patient complaints that NHS England receive about primary care dental services are rising: 44 were received in 2013-14 while 90 were received in 2014-15, an increase of 105 %. Records of the reason behind each dental complaint are not held, but the experience of the Contracting Team in completing responses is that the majority are connected with not being able to access NHS dental services."

The recommendation put forward by the Task and Finish Group was to set up a pilot project where 6 dental practices in the Bradford City, 6 dental practices in Bradford District and 6 practices in the North Kirklees CCG localities would be offered a financial incentive to treat up to four new patients (depending on need) over one hour, every day of the week (Monday to Friday). This would result in approximately 360 new patients seen each week in a primary care setting - approximately 18,288 new patients over the course of 2016-17.

This business case was based on analysis of the 'claw-back' monies reclaimed from commissioned and paid-for UDAs (Units of Dental Activity) which were not delivered by dental practices. Additional investment in the proposed pilot scheme would be offset by the predicted under-delivery of UDAs – essentially reinvesting money already in the system which would otherwise be reclaimed by NHS England.

Healthwatch welcomed this pilot scheme, along with other proposals made by the Task and Finish Group to improve signposting services for people searching for a dentist, and to carry out a further needs assessment for vulnerable groups in our area.

To our knowledge no action has been taken by NHS England, we have not received any recent updates on the progress of the pilot scheme.

Healthwatch across West Yorkshire are keen to continue to work with NHS England and others on this issue and to look at ways to potentially improve access. We are carrying out some analysis of the rates at which patients are recalled for routine dental check-ups across the region. Many patients who have an NHS dentist are recalled for a check-up every six months, although NICE guidance states that adults who have healthy teeth only need to see a dentist every two years. If recall intervals for dentally fit patients could be increased, this would potentially open up appointments in which dentists could see new patients.

4. Options

n/a

5. Contribution to corporate priorities

n/a

6. Recommendations

- That the Committee note the problem of lack of access to NHS dentists in the District, as highlighted by Healthwatch's survey.

7. Background documents

n/a

8. Not for publication documents

n/a

9. Appendices

Headline findings from Healthwatch survey & extracts from responses.

Access to NHS Dentists - headlines from our survey

Healthwatch Bradford spoke to 1,019 people in a survey carried out from January to March 2016.

We talked to people in the local transport interchange, bus stops, shopping areas, the city market, pharmacies, community and advice centres, children's centres and GP practices. The survey was also promoted through the local media, Healthwatch website, and social media.

Headline findings:

- **43% did not have an NHS dentist**
- **30% of parents told us their child/children did not have a dentist**

For those with a dentist:

- 39% of people with a dentist had experienced problems finding a dentist in the past
- 21% who had a dentist said it was difficult for them to get to their current dentist, with many travelling out of the area to see an NHS dentist
- Most who had a dentist reported that they were happy with their care

Trying to find an NHS dentist:

- 403 people had no dentist but wanted to find one
- 74% of people said they had tried but couldn't find a local dentist accepting NHS patients
  - 45% had contacted local dentists
  - 31% tried internet searches
  - 28% asked family and friends
  - 25% had used NHS Choices
  - 17% had contacted NHS 111
- 21 people said they didn't know how to find an NHS dentist

Impact

- 10% of those who don't have routine NHS dental care have had to attend A&E because of dental pain
- A further 20% of people have used emergency dental services
- Other people told us that they had resorted to 'DIY dentistry' including extracting their own teeth

These quotes are a small sample taken from responses to our survey and illustrate some of the difficulties people in Bradford are experiencing with access to NHS dentistry.

BD3. No dentist:
"My younger sister (10 years old) had toothache, it was very bad and she was crying a lot. We took her to the big hospital (A&E) but they said they didn't have dentists there who could help, so just gave her some gel. In the end she had to go to Leeds to see a special dentist. They found she had holes in her teeth and some needed to be taken out. She went twice or three times to Leeds. We all had to go on the bus. Now it's all ok. But still don't have a dentist, she doesn't go to the dentist for check-ups and nobody else in the family has been to the dentist since we've lived in the UK."

BD18. No dentist:
"Cannot find dentists taking on NHS patients. My son has recently turned 6 and never had dental check-up only the flourish varnish [through school]. Wondering on long term impact of my son not seeing a dentist. I have also called dentists and told waiting list is full. Call back in 6-12 months. So call them at a later date and told again to ring in 6-12 months as can't add me to the waiting list!"

BD4. No dentist:
"I waited 8 years and even then I had to pay private. I ended up with severe gum disease with not being able to find a dentist and to even deal with this is meaning me having to pay private. Dentists that could take on NHS dentists are instead just offering private care. Many won't even reply to email if you ask about NHS treatment. I've ended up extracting one of my own wisdom teeth which in this day and age is ludicrous. Dentistry has in effect privatised itself."

BD7. No dentist:
"All dentists on NHS Choices who claim to be accepting NHS patients when contacted are offering private appointments for the next day but to see an NHS dentist they have a list consisting of 100s of people. It is impossible to find an NHS dentist in Bradford. No dentist will accept NHS patients. Even those who claim they are accepting will look in your mouth and then fail to offer you another appointment."

BD12. No dentist:
"Used to have dentist but was taken off list after cancelling my check-up appointment as I had just come out of hospital the day before. I then lost a family member 2 weeks after and haven't been able to find an NHS dentist since. I have attended both A&E and emergency dental services to have a tooth looked at."

BD18. Has dentist, previously had difficulty:
"We moved here in 2011 and I have only just got my family an NHS dentist in Jan 2016- our first appt is July 2016. It has taken me 4.5 years to find an NHS dentist, having tried all the options on your list. During this time I have attended A&E with dental pain/problems. It has been ridiculous trying to find an NHS dentist. I was entitled to free dental care when I was pregnant, but my private dentist wouldn't accept this. I called the NHS dental line (Leeds) and left several messages with no one responding to my calls."

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Report of NHS England – North (Yorkshire and Humber) to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 06 October 2016

Subject: NHS England (West Yorkshire) Dental Commissioning Update 2016/17

M

Summary statement:

This report provides an update to the Bradford Health & Social Care Overview Scrutiny Committee since the last update in October 2015 on the current commissioning and commissioning plans for dental services in the Bradford & Airedale area encompassing:

- Access
- Performance
- Public Health
- Other Dental Updates

Neil Coulter
Senior Primary Care Manager
NHS England – North (Yorkshire and The Humber)

Dr Shirley Brierley
Consultant in Public health, Public Health Department
City of Bradford Metropolitan District Council

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Portfolio:

Health and Wellbeing

1. Summary

This report provides an update to the Bradford Health & Social Care Overview Scrutiny Committee since the last update in October 2015 on the current commissioning and commissioning plans for dental services in the Bradford & Airedale area encompassing:

- Access
- Performance
- Public Health
- Other Dental Updates

2. Background

At its meeting of 8 October 2015 the Committee resolved:

'That an update report be submitted to the Committee during the 2016/17 municipal year and that it include details in relation to commissioning models and work being undertaken with Public Health'

3. Report issues

Appendix A of this report provides the NHS England (West Yorkshire) Dental Commissioning Update

4. Options

Members may wish to comment upon the information provided within this report

5. Contribution to corporate priorities

Bradford District Joint Health and Wellbeing Strategy Priority 6 ("to improve oral health of under 5's")

6. Recommendations

The Committee is asked to consider and comment upon the information presented within this report

7. Background documents

Report NHS England – North (Yorkshire and the Humber) to the meeting of the Health and Social Care Overview & Scrutiny Committee held on 8 October 2015 – NHS England (West Yorkshire) Dental Commissioning Update 2015/16

8. Not for publication documents

None

9. Appendices

Appendix A – NHS England (West Yorkshire) Dental Commissioning Update

APPENDIX A : NHS England (West Yorkshire) Dental Commissioning Update - Health and Social Care Overview & Scrutiny Committee to be held on 6 October 2016

NHS England (West Yorkshire) Dental Commissioning Update

Introduction and Summary

This report provides an update to the Bradford Health & Social Care Overview Scrutiny Committee on the current commissioning and commissioning plans for dental services in the Bradford & Airedale area and the activity position in the district.

A copy of the updated work plan for the Local Dental Network (Yorkshire & the Humber) is attached for the Committee's information at **Annex 1**, and the Committee is asked to note the following key updates:

- Access
- Performance
- Public Health
- Other Dental Updates

1. ACCESS

Investment Pilot Proposal

Following the publication of the West Yorkshire Oral Health Needs Assessment, the West Yorkshire Local Dental Network established a Task and Finish Group to examine Access to Primary Care Dentistry and Unscheduled Dental Care in the area. This work was being done in collaboration with Healthwatch and other stakeholders, including Public Health England, and first stage includes/impacts on: access - in hours, access to unscheduled services, and how patients can be more appropriately signposted to dental services.

The group considered a wide range of information and data including (levels of access, commissioned activity performance, level of key stakeholder and media interest.

The group considered key findings that included:

- Data taken from the National GP survey identified (dental questions):
    - 62.4% of people in West Yorkshire were successful in getting an appointment when new to a practice in (January 2016) between July and September 2015.
    - For Bradford Districts CCG and Bradford City CCG areas the position is 58% and 54.2% respectively. In North Kirklees CCG area the figure is 54.9%.
- The Local Dental Committee supported a survey of practices within West Yorkshire to better understand the numbers of patients contacting local dental practices and if they couldn't be accepted at the practice what advice was given to patients.
    - 52% of West Yorkshire NHS primary care dental practices took part
    - 2,500 calls were made to these practices from patients trying to make an appointment unsuccessfully
    - The areas in which the volume of calls were greatest, when taken as a percentage of population, were Bradford and Kirklees
    - Two thirds of the practices advised patients to call 111
- NHS England Data identified:
    - Significant under delivery of contracted UDAs in 2014-15, particularly in Bradford where access issues have been identified. (The group commented that one of the factors for under delivery of UDAs in an area where dental care is difficult to access may be related to the high treatment needs of patients in a socially deprived area, and the increased number of DNAs. It is recognised that the current national contractual arrangements pose significant challenges for Practices in ensure that patients with complex needs are provided for.
    - In the Bradford City and Districts area 10,485 UDA's were under delivered (under 96 % of the UDA budget)In addition there were 12,611 UDA's under delivered between 96% and 100% of the contract sum. However in North Kirklees area only 359 UDAs were undelivered
    - Bradford City CCG area had the lowest figure for New Patients Seen in 2014-15, the only negative figure at -254
    - 2014/15 UDC overspend of £1,523,736

The Group prepared a number of pilot project proposals that may seek to improve access (particularly in the areas of Bradford City, Bradford Districts and North Kirklees areas) that comprised:

- Pilot Project to Increase Routine Access in Identified Areas of West Yorkshire

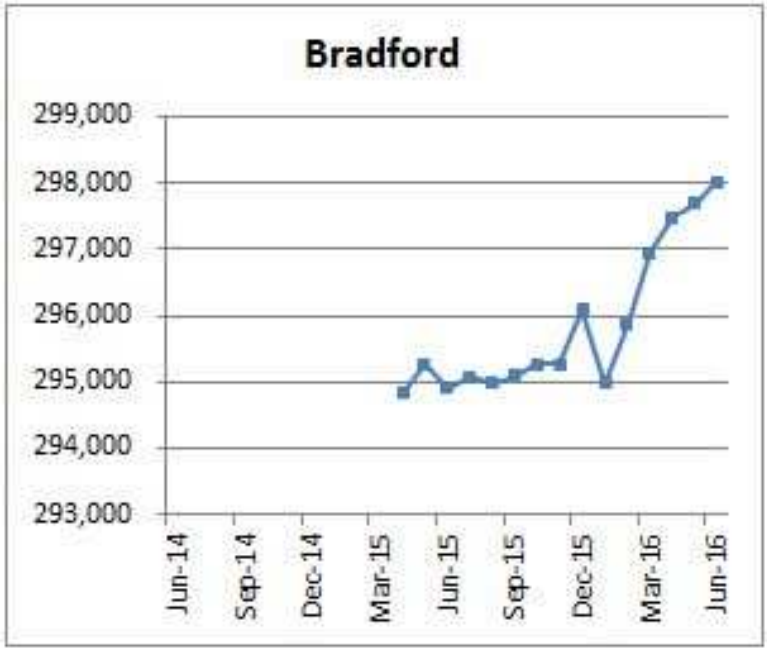
- Pilot project to support vulnerable groups
- Pilot Project to Improve Signposting in Identified Areas of West Yorkshire

These proposals were considered by the Director Team of NHS England – North (Yorkshire and The Humber). Advice from Directors was to expand the assessment across the whole of Yorkshire and The Humber area, for which we have responsibility. Before any investment could be considered to support such pilots, due to considerable resource constraints, it was necessary to develop an evidence base to demonstrate the identified areas in West Yorkshire were the priority areas as compared with any other area in Yorkshire and The Humber.

This further work has commenced with support from colleagues across the region and will be discussed again with Directors in the future.

Performance – Total Patients Seen

Overall patients accessing dental services across practices in the Bradford & Airedale (B&A) area has been steadily increasing as can be seen in the following graph which measures each quarter total patients seen in the previous 24 months period:



The latest reporting period quarter - June 2016 - has 298,028 patients seen. This is an increase of 3,127 patients seen as compared to the position at June 2015. The current numbers represent 56.1% of population. For comparison, 59.9% of the population of West Yorkshire accessed dental services over the same period, while 55.1% of the population of England accessed dental services over this period.

Noting this overall position, it is acknowledged that there are individual areas that still face challenges on demand/access, and it remains that there are still many patients who have difficulty in securing access to an NHS dentist.

Performance – Commissioned Activity Delivered (2015/16)

The following table shows the outturn position for commissioned activity (UDAs – Units of Dental Activity) across West Yorkshire, and then broken down by metropolitan areas in West Yorkshire, and separately by CCG areas. As a standard it should be noted that the national dental contract asks practices to deliver a minimum of 96% of their individual annual commissioned activity.

Area	UDAs Commissioned	UDA per 1000 Population	Value of Contracts	Average UDA Value	Total Activity Delivered	% UDAs Delivered	Clawback for Undelivered UDAs
West Yorkshire	3,921,816	1,762	£ 112,181,460	£ 28.60	3,842,341	97.97%	£ 1,987,602
Bradford	819,302	1,568	£ 24,225,280	£ 29.57	801,351	97.81%	£ 502,517
Calderdale	385,700	1,892	£ 10,730,483	£ 27.82	381,548	98.92%	£ 185,369
Kirklees	759,769	1,798	£ 22,265,938	£ 29.31	757,619	99.72%	£ 170,714
Leeds	1,306,611	1,739	£ 36,020,171	£ 27.57	1,265,078	96.82%	£ 1,001,073
Wakefield	650,434	1,996	£ 18,939,588	£ 29.12	636,745	97.90%	£ 127,928
NHS AWC CCG	176,994	1,118	£ 4,917,234	£ 27.78	175,186	98.98%	£ 86,247
NHS Bradford City CCG	178,174	2,180	£ 5,645,867	£ 31.69	175,318	98.40%	£ 87,684
NHS Bradford Districts CCG	464,134	1,396	£ 13,662,180	£ 29.44	450,846	97.14%	£ 328,587
NHS Calderdale CCG	408,249	2,000	£ 11,403,582	£ 27.93	404,141	98.99%	£ 185,369
NHS Greater Huddersfield CCG	437,631	1,842	£ 12,433,794	£ 28.41	434,635	99.32%	£ 135,524
NHS Leeds North CCG	354,998	1,786	£ 10,261,959	£ 28.91	350,732	98.80%	£ 110,658
NHS Leeds South and East CCG	477,282	2,026	£ 13,041,684	£ 27.32	455,932	95.53%	£ 369,790
NHS Leeds West CCG	474,331	1,499	£ 12,716,258	£ 26.81	458,414	96.64%	£ 520,625
NHS North Kirklees CCG	299,589	1,616	£ 9,159,044	£ 30.57	300,390	100.27%	£ 35,189
NHS Wakefield CCG	650,434	1,993	£ 18,939,588	£ 29.12	636,745	97.90%	£ 127,928

End of year out-turn of activity 2015/16 – 801,351 UDAs were provided by NHS dentists in Bradford during 2015/16, a total of 97.8% of the commissioned activity. Only 5 practices in the Bradford area have underperformed (by more than the 4% tolerance allowed in the national dental contract) for the past 2 years. Renegotiation of these contracts will now take place in line with the national commissioning guidance with a view to withdraw if appropriate the monies linked to underperformance (approximately £95k forecast).

Performance - Reinvestment following under-performance in 2014/15

The table below shows where NHS England has been able to recommission activity, recurrently, that has been removed from other practices due to under-delivery.

Contract Number	Provider	Address1	Address2	Address3	Postcode	Former PCT Area	CCG Locality	Recurrent UDAs awarded	Cost of activity
101338/0138	Whitecross Dental Care Ltd	Westend	40 Little H	BRADFORD	BD5 0AL	Bradford	NHS Bradford City CCG	1000	£ 26,000
772038/0001	Mr Z Hussain	Dental Su	10 Southb	BRADFORD	BD7 1AD	Bradford	NHS Bradford City CCG	1000	£ 22,720
190551/0001	Dentistry@ Ltd	134 Holme Lane		BRADFORD	BD4 0PY	Bradford	NHS Bradford Districts CCG	1000	£ 26,000
230200/0001	Mr S Gardner	Whitehill	Whitehill	HALIFAX	HX2 9HD	Calderdale	NHS Calderdale CCG	700	£ 18,200
123811/0001	Carnegie Dental Clinic Ltd	9-13 Leeds Road		SHIPLEY	BD18 1BP	Bradford	NHS Bradford Districts CCG	700	£ 18,200
973793/0001	Mr RB LAD	Dental Su	460 Idle R	BRADFORD	BD2 2AR	Bradford	NHS Bradford Districts CCG	700	£ 18,200
							Totals:	**5100**	**£ 129,320**
This Practice was awarded the additional activity but it was not made recurrent as they did not meet the conditions of the service agreement:									
190268/0001	Bailiff Bridge Dental Practic	629 - 631 Bradford R		BRIGHOUSE	HD6 4DN	Calderdale	NHS Calderdale CCG	1000	£ 26,000

Unscheduled Dental Care (UDC)

Demand for UDC in West Yorkshire is increasing - the average activity per month has risen from;

2013/14 - 5,790
2014/15 - 6,661
2015-16 - 7,240

Budget outturn consequently is increasing:

2013/14 - £3.03m
2014/15 - £3.93m
2015/16 – £4.25m

It should be noted that this increase in spend is accounted for as part of the overall spend on services including primary dental care.

Opportunities to improve access

Notwithstanding ongoing budgetary pressures, as part of a larger commissioning team across Yorkshire and The Humber in the event there is identified growth in budgets going forward there may be increased opportunity to use this money to address acute access in specific areas (e.g. Bradford) to greater effect.

Recall intervals

NHS England is supporting Healthwatch to look at ways to improve patient education relating to dental recall intervals which may support improved access. Healthwatch is also supporting a more in depth project on benchmarking patient recall intervals.

Signposting

Signposting patients to NHS choices continues to prove challenging due to the frequency / pace at which dental contractors need to open and close books so that new and existing patients can be managed. We are currently looking at ways of trying to improve overall signposting for NHS Primary Dental Care.

2. PROCUREMENTS

Unscheduled Dental Care (UDC)

Unscheduled Dental Care contract procurement - all of Yorkshire & Humber UDC contracts have been extended until September 2017 to allow for a full procurement process to be followed. These contracts provide services to patients who do not have a regular dentist and require emergency treatment. As with the orthodontic procurement, a single plan is being made for the whole Yorkshire & Humber region to ensure a quick procurement can take place with minimal service transition time, and no impact on patient services.

Primary Care Orthodontic Services

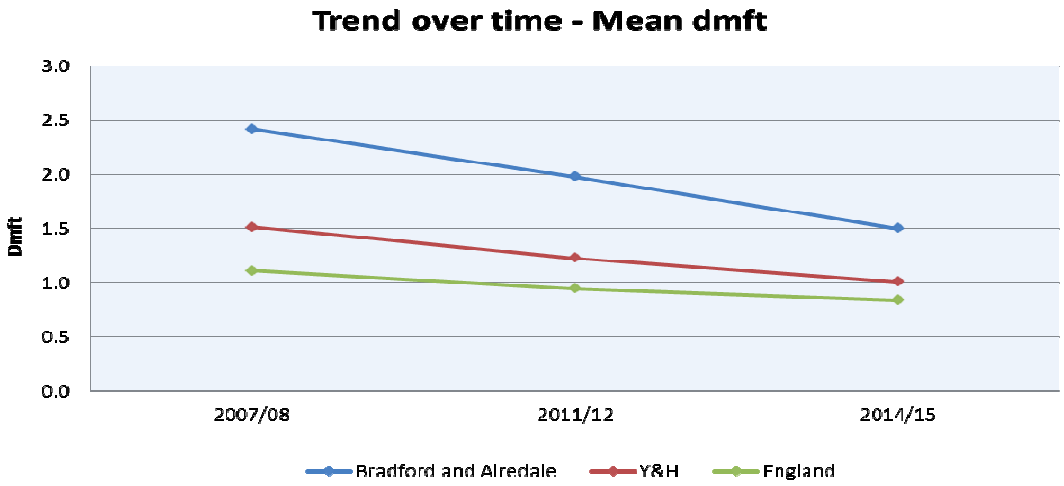
The majority of orthodontic contracts in Yorkshire & Humber will expire in 2017, and there is a Yorkshire and the Humber region wide piece of work ongoing to develop a procurement plan in which large numbers of contracts will be procured in separate tranches, over a three year period. It has not yet been established at what stage the procurements for Bradford practices will take place although it has been confirmed that current contracts will be extended as required to facilitate the process. This committee will be updated at a later point when the procurement process has been concluded, including details on how patient access and treatment under these services will be managed.

3. PUBLIC HEALTH

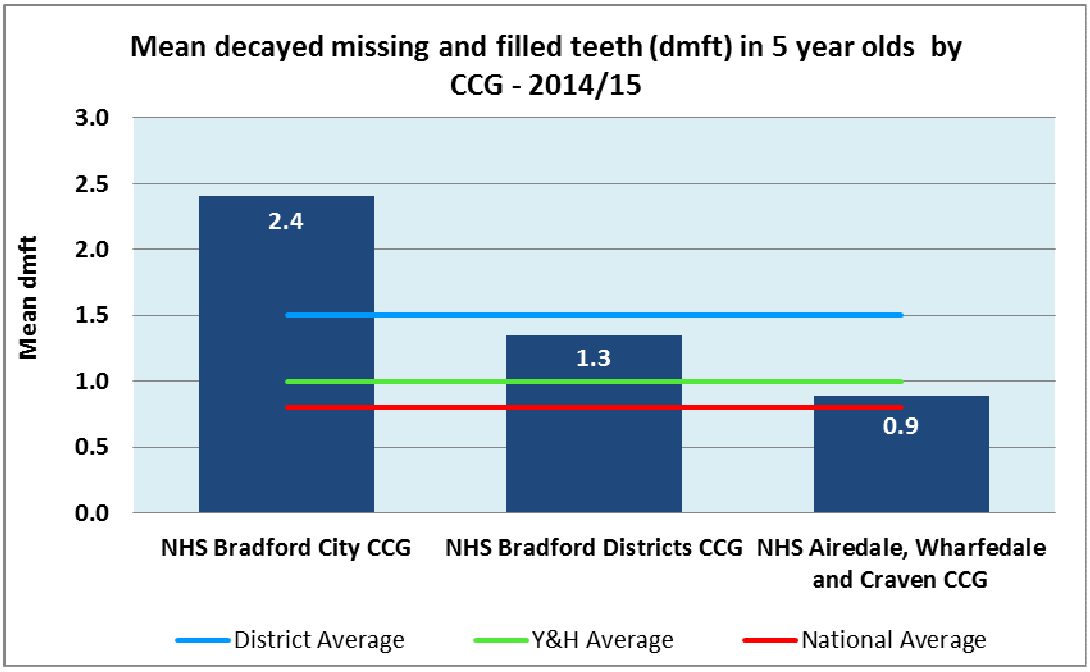
NHS England continues to work with Public Health colleagues to enable delivery of the dental agenda, the West Yorkshire Dental Network, and supporting prioritisation and improvements in oral health. We are committed to strengthening networks and sharing of agendas, priorities and work streams for consideration.

Update on the Oral Health of Children in Bradford District

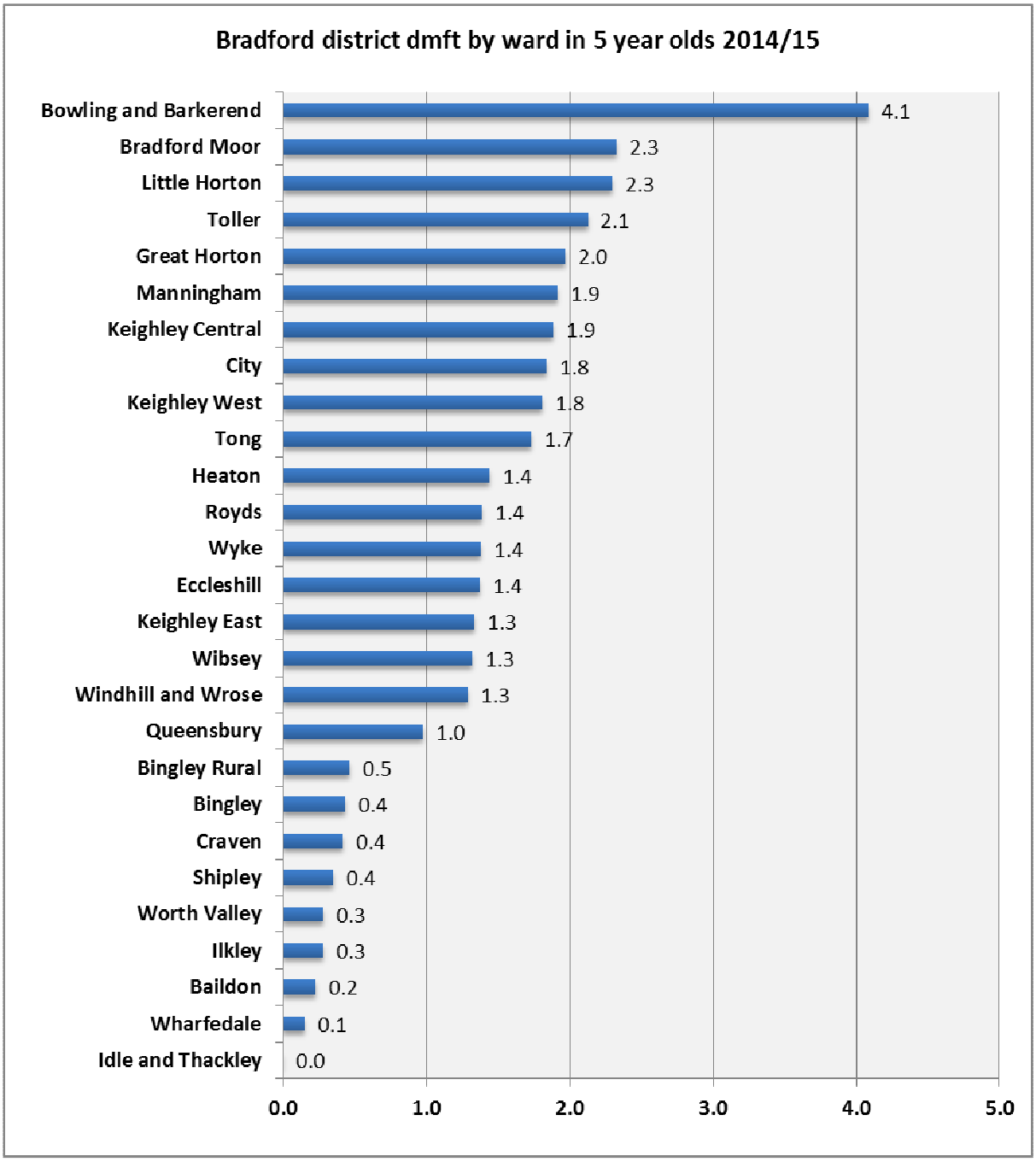
The oral health of young children is monitored by a 3 yearly survey and the latest survey for 2014/15 shows a significant improvement for Bradford district; the average, (or mean), decayed missing and filled teeth (dmft) in 5 year old children was 1.5 in 2014/15 . However, rates of decay and dmft in children remain above regional and national averages and hence, there still needs to be a major focus on prevention and early intervention work in this area.



In addition, when analysed by Clinical Commissioning Group (CCG) for Bradford, there is significant variation for dmft in 5 year olds; with the highest average dmft in 5 year olds being in Bradford City CCG as below:



Oral health is also worse in more deprived areas of the district and some wards have significantly higher dmft rates than others as below:



Please note: Results are not displayed for Bolton and Undercliffe, Clayton and Fairweather Green, and Thornton and Allerton as fewer than 15 children were examined. Due to the small numbers involved within these wards, statistically robust estimates cannot be produced.

Prevention and early intervention to promote good oral health is key for children and Public Health commissions a number of universal and targeted evidence based interventions to improve the oral health of children which include;

- Oral health promotion by Health Visitors at 6-12 months for all infants
- Community based fluoride varnish programme for children aged 2 to 4 years with over 10,000 children recruited each year

- Tooth brushing programme 40 primary schools with more than 25% free school meals or priority 1 schools
- Childcare settings to receive First Steps to Healthy Teeth Award ; 274 in 2015/16
- 35 Dental practices recruited to health promoting practice award programme
- Around 1200 children taking part in oral health programmes in Islamic schools, Mosques and Madrassas

In addition, public health promotes evidence based messages in the media about how children and families can improve their oral health. Full details of oral health data analysis and oral health commissioned programmes is available in **Annex 2**.

4. OTHER DENTAL UPDATES

Yorkshire & Humber Dental Commissioning Strategy

This is currently being developed to inform all of the commissioning decisions in the region, including opportunities to distribute move under delivered activity freed up monies and funding (from clawback for example) to areas of higher need. This will also be used to inform how dental monies are used if practice contracts end, specifically linking to the Dental Needs Assessment produced by Public Health England in 2015 which identified areas of deprivation and clinical need. Undertaking this on a Yorkshire and the Humber footprint (previously distribution was considered within the West Yorkshire footprint only), will generate more opportunities for re distribution on a wider geography.

Dental prototype and development of new national dental contract

NHS England continues to support the development of a new national contract and 3 prototype practices exist in West Yorkshire. One of which in Bradford, The Rayner Dental Practice joined the scheme on 1 January 2016. The contract reform programme is led by the Department of Health. The programme is currently in a period of learning and evaluation and the outcomes of which will inform any decisions as to roll out potentially due in autumn 2017 for action in 2018/19.

At this point the timescales for the new dental contract are still to be confirmed nationally.

Oral Surgery Referral Management Service (RMS) and Intermediate Minor Oral Surgery (IMOS)

NHS England – North (Yorkshire and the Humber) have recently commissioned an Oral Surgery Referral Management Service (RMS) that enables all minor oral surgery referrals from primary care dental providers to be processed along a common referral pathway for the population of West Yorkshire. In addition we have reviewed and commissioned an increased amount of Intermediate Minor Oral Surgery (IMOS) provision across West Yorkshire, including a provider in both Bradford (North) and Bradford (South). We expect the new pathway to:-

- Improve patient experience – providing more ‘local’ choice, based on patient’s needs

- Reduce demand on secondary care, thereby reducing issues with the 18 weeks referral for dental treatments
- Improve competency standards of primary care dental providers by reducing inappropriate referrals, making sure that the right patient is seen by the right level of service in a timely manner
- Potential for effective financial management

To support this pathway a Managed Clinical Network has been established, to provide evidence based advice and guidance on any changes that may be necessary to the West Yorkshire oral surgery common pathway.

ANNEX 1 : Yorkshire and Humber Local Dental Network work plan

Dental work plan – Yorkshire and the Humber

Workstream	Project	Type	Action	project completion date	Lead
ACCESS	**Referral Management System (RMS)** initially for oral surgery in WY, but with a view to expanding to include other dental specialities across the wider locality	Procurement	Recommended bidder report to DCMT April 16 mobilisation phase. Stakeholder event 14th September 2016	01/10/2016	Mike Edmondson
		Review	Review effectiveness of RMS, consider expansion for other dental specialties Benchmarking info now available Consider expansion to Sheffield for IMOS.	Ongoing Timescales?	Mike Edmondson
	Primary dental care access	Service review	Review of existing systems and models for patients to access primary dental care in order to consider consistent model across Y&H NY – review of North Lincs required, WY – Awaiting feedback from North region on poor access issues SY&B – practice closure in Rotherham, over use of unplanned care in Doncaster, no complaints re closure, survey being done at DAC re Doncaster	Ongoing – but need to agree forum to consider outcome	Constance Pillar (NY&H) Mark Jenkins (WY) Carolyn Ogle (SY&B)
	Signposting of services Ensure local people in Y&H have access to accurate information in an appropriate format on how to access NHS dental services	Service development	Comprehensive review/assessment of signposting systems, culminating in consistent model to ensure access to accurate information, in appropriate format to support • Accurate, up to date info on NHS Choices • Signposting through NHS Choices • NHS E to collaborate with Healthwatch and	Ongoing – but need to agree forum to consider outcome	Constance Pillar (NY&H) Mark Jenkins (WY) Carolyn Ogle (SY&B)

			dental practices in relation to info on acceptance of new NHS patients and services provided Development of a model of improved signposting which includes a small number of GDPs in a pilot possibly as part of urgent dental care review		
	Unplanned Dental Care	Service review and subsequent procurement	Comprehensive review of unplanned dental care requirement across Y&H, with a view to the procurement of a consistent model Scoping paper being pulled together 26th July commissioning meeting to consider way forward	01/04/2017	Heather Marsh/Carolyn Ogle/David Iley
ORAL SURGERY	Managed Clinical Network (MCN) for oral surgery in West Yorkshire	Recruitment/ pilot study	Business Case for recruitment of clinical lead to chair oral surgery MCN for WY supported by DCMT Appointment made piloting 3 sessions per month Benchmark with regional work	13/10/15 01/07/2016 December 2016	Mike Edmondson
		Review of pilot study	Comprehensive review and assessment of MCN, considering scale, scope and benefits of the pilot oral surgery model for WY, with a view to understanding wider geographical needs and benefits.	To be completed by 01/04/2018	Mike Edmondson
	Intermediate Minor Oral Surgery (IMOS)	Procurement (Phase 1) – West Yorkshire	Procurement and Evaluation strategy submitted to DCMT procurement completed for 6/8 schemes in West Yorkshire, remaining 2 to go back out to market	Completed 2nd phase	Mike Edmondson
		Service review	Baseline review of NY oral surgery pathway Also need to review SY&B in relation to 2care providers Outcome of review to scale, scope and benefits of IMOS in NY (currently no tier 2 services available) OMFS to be considered across wider geography	December 2015 Spring 2016	Jane Ollerton/Paul Stones Mike Edmondson

		Procurement (Phase 2) - North Yorkshire	Procurement and Evaluation strategy to be developed for NY area where appropriate National steer on contract form has determined PDS.	Autumn 2016	Mike Edmondson
ORAL MEDICINE (OM)	**Review OM provision** Ensure appropriate commissioner is able to identify commissioning intentions and future strategy	Service review – if this is relevant for NHS E	Comprehensive review and assessment of OM provision across Y&H, in context of: national guidance, C&D, finance, referral management and clinical governance. Consultant in Leeds has funding to set up MCN across Y&H need to link with LDNs	01/04/2017	Mike Edmondson
PAEDIATRIC DENTISTRY & COMMUNITY DENTAL SERVICES (CDS)	**Review Paediatric Dentistry and CDS provision across Y&H** to identify commissioning intentions and future strategy *(primary and secondary care dental care project)*	Service review **Hull/Leeds 650/350**	Comprehensive review and assessment of paediatric dentistry and CDS. Project group established is undertaking • stocktake of current provision • paediatric review of current services -inc SY&B GA issues Vulnerable group OHNA drafted, PHE supporting procurement project Consultation planned, support from Healthwatch – market event 6th July 16 Service reviews being completed, vision doc to be shared, additional staff to support procurement poss across North Clarendon activity for paeds need to review referrals	September 2016 September 2016	Constance Pillar Jane Ollerton/Paul Stones
ORTHO	**Review orthodontic provision across Y&H** **i**dentify commissioning intentions and future strategy *(primary and secondary care dental care project)*	Service review	Comprehensive review and assessment of orthodontics provision across Y&H -national guidance, demand, activity, finance, referral mgt and clinical governance. Review TOR to consider Y&H geography STA blanket sign off received Plans to consult with NHS E NoE dental commissioning group, Y&H LDNs and Ortho MCNs prior to finalisation	Summer 2016	Mark Jenkins to Sept 16 Sept onwards TBC

			Orthodontic health equity audit completed Paper to DCMT July 16 re contract length Paper to describe approach to 3 year strategy also to DCMT August 16 Stakeholder event 7 July to inform plan Procurement and Evaluation Strategy Sept 16		
RESTORATIVE DENTISTRY	Review Restorative Dentistry provision across Y&H to identify commissioning intentions and future strategy *(primary and secondary care dental care project)*	Service review	Comprehensive review and assessment of Restorative Dentistry provision across Y&H, in context of: national guidance, demand, activity, finance, referral management and clinical governance. Awaiting national guidance LDI issue with referrals reviewing T3 criteria across the patch	01/04/2017	Mike Edmondson
PREVENTION	**Undertake health equity audits in primary care including unscheduled dental care and orthodontics** *To identify how dental services are distributed and actions needed to provide services relative to need*	Service review	• NHSE received project plan from PHE • NHS E commissioned PHE to undertake the work • NHS E to consider finding of HEA in commissioning appropriate services the population Data requirements currently being drafted Time line for completion will be influenced by BSA capacity to support this	Project plan Nov 2015 Dec 2015 HEA report May 2016 (data dependent)	PHE Primary Care leads to agree local influence with LDNS
	Service review and OHNA of vulnerable groups across Yorkshire and Humber *To inform commissioning of CDS and oral health improvement programmes. support implementation of commissioning guide on special care dentistry*	Service review	• See review of CDS provision	December 2016	NHS E/PHE

	Prevention *All commissioned dental services are re-orientated towards prevention to improve and reduce oral health inequalities*		• All LDNs to have prevention work stream as part of work plans • NY&H IPP approved by DCMT 16-07/16 • Prevention embedded in service specifications for new or recommissioned services through KPIs and/or CQUINs • Contractual levers should be used to ensure implementation of DBOH through performance management against DAF	See above Ongoing	LDNs/NHS E
	Implementation of national commissioning guidance	Service review	• NHS E and PHE to attend the national meeting to support implementation of the guides • Commissioning of care pathways in oral surgery, special care and dentistry and orthodontics should reflect guidance in the relevant national commissioning guide	October 2015 Ongoing	NHS E with support from PHE

ANNEX 2 : Summary of Oral Health Services and Oral Health Data for Bradford district- Health and Social Care Overview & Scrutiny Committee to be held on 6 October 2016

Summary: An update report to the Committee detailing the commissioning models and work being undertaken with Public Health and update on oral health data for Bradford district

1. Summary

1.1 This report details the Public Health contribution to improving oral health of children and young people within the Bradford district. Universal and targeted oral health prevention and early intervention is key in children to improve longer term outcomes in relation to poor oral health and address inequalities.

1.2 Oral health is referenced in the 'Best start in life and beyond: Improving public health outcomes for children, young people and families' which provides guidance to support the commissioning of the Healthy Child Programme. It is also an important part of local commitment to tackle oral health and a key part of:

- Bradford and Airedale Joint Health and Wellbeing Strategy 2013-17
- Health Inequalities Action Plan 2013-17
- Children's Trust Board & new Children & Young People's Plan
- Integrated Early Years Strategy for children 0-7 years 2015-18

2. Background

2.1 Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Guidance produced by local authorities in 2015 details the LA statutory responsibility for commissioning oral health improvement within their district. Significant inequalities in oral health continue to exist with children in deprived communities having poorer oral health than those living in more affluent communities.

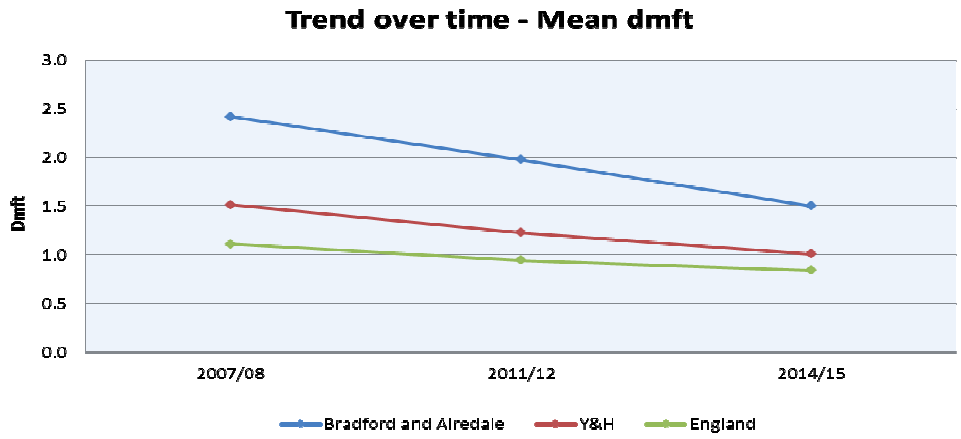
2.2 Local authorities are also required to provide or commission oral health surveys in order to facilitate:

- assessment and monitoring of oral health needs
- planning and evaluation of oral health promotion programmes
- planning and evaluation of the arrangements for the provision of dental services

- reporting and monitoring of the effects of any local water fluoridation schemes covering their area
- the dental data required for the single data list and the public health and NHS outcome frameworks.

3. Update on Oral health data

3.1 The latest oral health survey for 5 year olds decayed, missing and filled teeth (dmft) was published May 2016 for 2014/2015 is as follows:



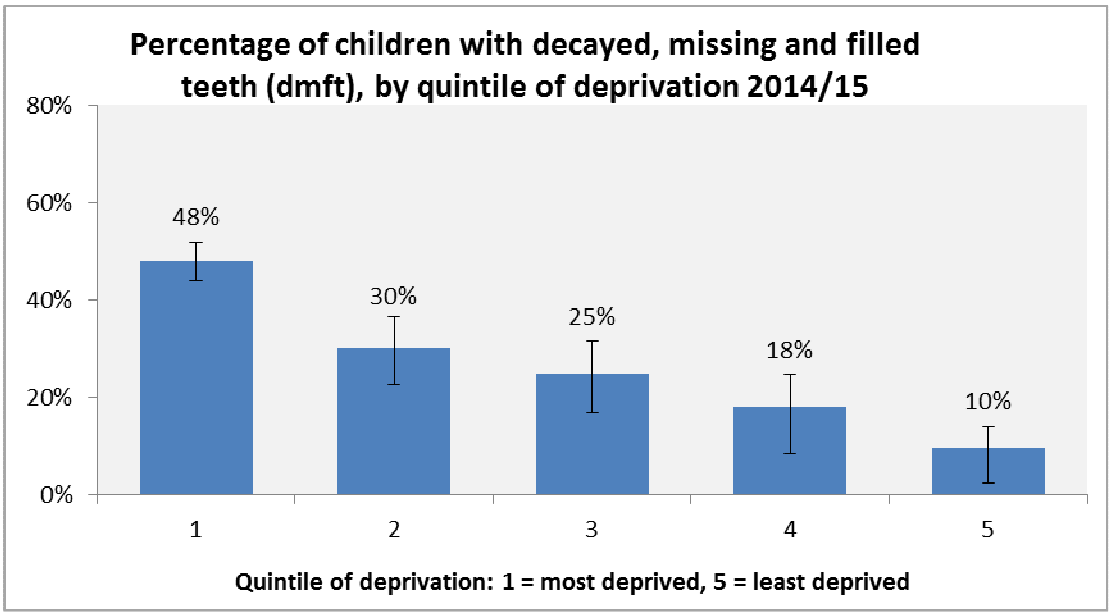
Below is also a table showing the mean decayed missing and filled teeth(dmft) for 5 year olds over time for Bradford district against Yorkshire & Humber and England; this shows a significant reduction in Bradford district over that time and at a faster rate than regionally or nationally:

	Mean Dmft			Reduction in mean dmft since 2007/08
	2007/08	2011/12	2014/15	
Bradford and Airedale	2.42	1.98	1.50	**-0.92**
Y&H	1.51	1.23	1.01	-0.50
England	1.11	0.94	0.84	-0.27

3.2 The proportion of children with dental disease at age 5 years was 37%; higher than regional (29%) and national (25%) figures

3.3 Average dmft of 1.5 per child has improved but is still higher than regionally (1.0 dmft) and nationally (0.8 dmft)

3.4 Higher rates of dental disease and dmft in deprived parts of the district as shown below.



3.5 Overall significant improvement since 2008 at faster rate than regionally and nationally

3.6 The main findings for Bradford district were as follows:

- 62.5% of the sample population had no experience of visually obvious dental decay
- Average number of teeth affected by decay (decayed, missing or filled teeth - dmft) per 5 year old child was 1.50 in the district – an improvement since the last survey in 2012 (dmft of 1.98); this compares to 1.0 dmft for the region and 0.8 dmft nationally
- For those who experienced any obvious decay, the average dmft was 4.0
- The percentage of 5 year olds with dental decay has reduced from 46% in 2012 to 37% in 2015
- Children's dental health has continued to show overall improvement since 2008
- Hence since 2012, in 5 year olds in Bradford the mean number of decayed missing and filled teeth has improved by 24%.
- The proportion of children with decay has improved by 19%

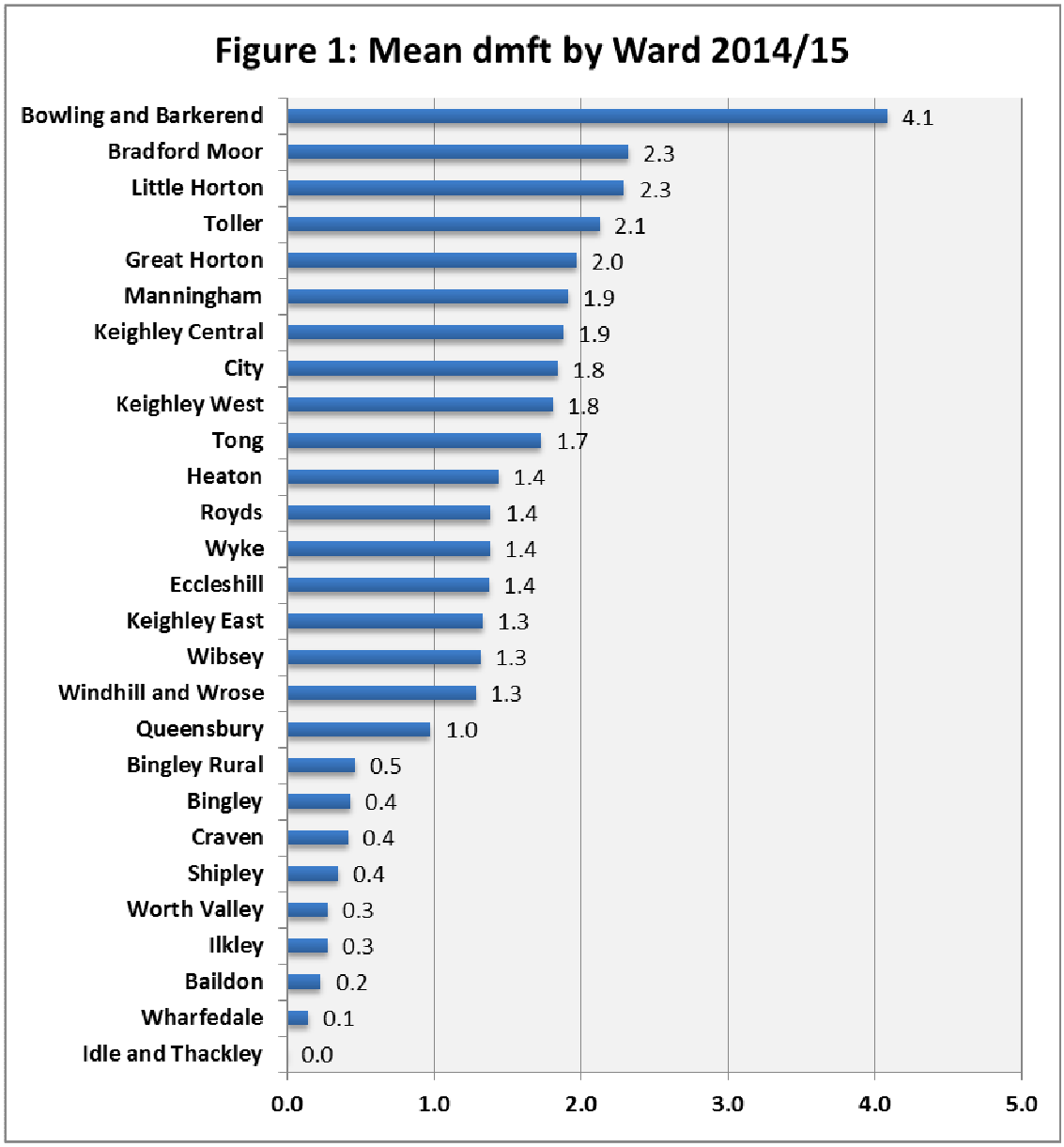
3.7 In 2012 Bradford had the highest mean number of decayed missing and filled teeth in Yorkshire and the Humber in 2012 - this is no longer the case as Wakefield and Hull have a worse dmft.

3.8 When the oral health of 5 year olds in 2014/2015 was examined by ward, stark inequalities were demonstrated as shown in Figure 1 below. Wards with significantly higher levels of disease than the district average:

- Bowling and Barkerend (dmft 4.1)
- Bradford Moor (dmft 2.3)
- Little Horton (dmft 2.3)

Wards with significantly lower levels of dental disease than the district average:

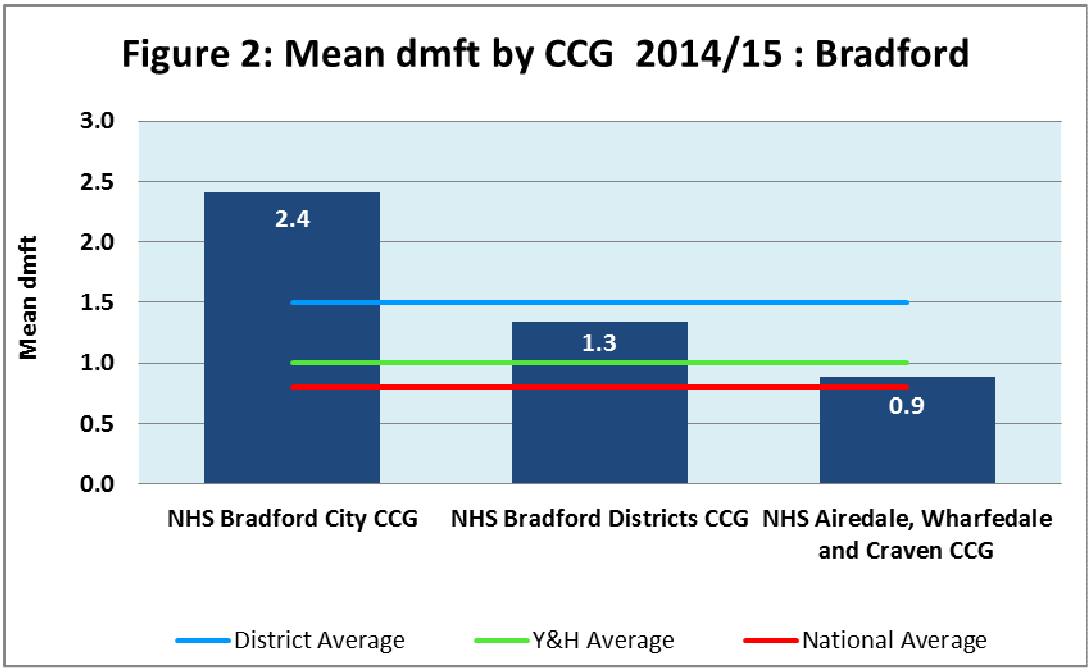
- Idle and Thackley (dmft 0.0)
- Wharfedale (dmft 0.1)
- Baildon (dmft 0.2)



Please note: Results are not displayed for Bolton and Undercliffe, Clayton and Fairweather Green, and Thornton and Allerton as fewer than 15 children were examined. Due to the small numbers involved within these wards, statistically robust estimates cannot be produced.

3.9 The oral health of children in 2014/15, was also examined by CCG's across the Bradford District (see Figure 2), which showed the following:

- Bradford City CCG had higher levels of disease than the district average (dmft 2.4)
- Bradford Districts CCG had lower levels of disease than the district average (dmft 1.3)
- Airedale, Wharfedale and Craven CCG had lower levels of disease than the district, and regional average (dmft 0.9)



4 Contribution to corporate priorities

4.1 Oral health is a key priority for the district and is within the District's Health and Wellbeing Strategy and Health Inequalities Action plan, as well as in the Districts Oral health strategy and an action plan. This is important given the demographics and local inequalities such as:

- Just over half a million people live in the Bradford District
- One of the most deprived Local Authorities in England
- Almost a quarter of the population is aged under 16 and is increasing (24 %)
- Diverse population - 54% of school children are from ethnic minority groups
- Overall life expectancy is lower than national averages and high rates of cardiovascular disease, obesity and diabetes

4.2 Oral health has also been included as a key priority and target for children centres and for health visiting which is now also commissioned by the council.

4.3 Public health in the council commission oral health improvement programmes which include both targeted and universal programmes, as well as our statutory function in relation to epidemiology and screening.

4.4 These improvements are due to a number of programmes running across Bradford district, which are receiving wider attention. In a recent report, produced jointly by Public Health England and the Local Government Association, the Council's "Building Better Smiles" programme was featured as a case study.

5 Oral Health Services for children

5.1 Bradford Council's Public Health team has worked hard to keep children free of tooth decay through commissioning a number of evidence-based programmes under the banner of 'Building

Brighter Smiles'. These programmes reach young children in a variety of early years settings and includes a focus on prevention, early intervention and both a universal and targeted approach focused on areas of greatest need within the district. Partnership working and training initiatives to ensure parents, carers, education and health workers are aware of best practice for oral health have been integral to the success of these 'Building Brighter Smiles' programmes. Details about the key programmes and activity is outlined below:

Key oral health services for children:

Ref	Quality Requirement	Performance Indicator	Threshold	Actual 14/15	Actual 15/16
2	% of 6-12 month health visiting contacts with oral health promotion within reporting period	% of 6-12 month health visiting contacts with oral health promotion within reporting period		89.9%	91%
3	Community based fluoride varnish Programme (for children aged 2 to 4 years)	Number of new children recruited to fluoride varnish programme within the recording period	7,500	10,698	10,710
		Number of children receiving 1 or more applications of fluoride varnish within recorded period	12,000	15,634	17089
		Total number of applications to children recruited in target range within recorded period	18,000	19,329	20570
4	No. of all schools where 25% or more take free school meals (or IMD priority list) taking part in evidence based 2-year tooth brushing program	No. of all schools where 25% or more take free school meals (or priority 1 schools) taking part in evidence based 2-year tooth brushing programme		40	40
5	% childcare settings to achieve First Steps to Healthy Teeth award	No. childcare settings to achieve First Steps to Healthy Teeth award		239	274
6	No. dental practices recruited to the health promoting practice award programme	No. dental practices recruited to the health promoting practice award programme	35	35	33
10	Number of children recruited to programme in Islamic schools, Mosques and Madrassas.	Number of children recruited to programme in Islamic schools, Mosques and Madrassas.	1,200	1,281	1285

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City of Bradford MDC
www.bradford.gov.uk

Report of the Bradford CCGs Draft Primary Medical Care Commissioning Strategy to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6th October 2016

Subject: NHS Bradford City CCG and NHS Bradford Districts CCG Draft Primary Medical Care Commissioning Strategy

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Summary statement:

The CCGs in Bradford are producing a Primary Medical Care Commissioning Strategy which outlines the approach that will be taken to the commissioning of primary medical care services within Bradford over the next 5 years. The strategy outlines the proposed end state and focuses on six key areas: access; quality; workforce; self-care and prevention; collaboration; and estates, finance and contracting.

The strategy is a key underpinning aspect of the Sustainability and Transformation Plan (STP) for the district as strong, high quality, sustainable primary care is a critical part of our health and care system.

The strategy is currently in draft form and is out to public and stakeholder consultation. We would like to invite feedback from the Health and Social Care Overview and Scrutiny Committee to inform the final version of the strategy.

Portfolio:
Health and Wellbeing

Report Contact: Vicki Wallace
Phone: (01274) 237524
E-mail: victoria.wallace@bradford.nhs.uk

1. Summary

1.1 The CCGs in Bradford are producing a Primary Medical Care Commissioning Strategy to inform and direct the commissioning of primary medical care services over the next 5 years. The strategy is a key underpinning aspect of the Sustainability and Transformation Plan (STP) for the district as strong, high quality, sustainable primary care is a critical part of our health and care system.

1.2 This strategy is currently in draft form and is out to public and stakeholder consultation. The CCGs wish to invite the Health and Social Care Overview and Scrutiny Committee to feedback as part of this consultation to inform the final version of the strategy.

2. Background

2.1 In April 2015 NHS Bradford City CCG and NHS Bradford Districts CCG accepted delegated responsibility from NHS England to commission primary medical care services. This relates to GP practice services and includes all services deliverable under core General Medical Services and Personal Medical Services. It also includes Enhanced Services, the Quality and Outcomes Framework and locally commissioned services. This does not include dental, community pharmacy or optometry services.

2.2 The strategy sets out the future direction of primary medical care services in Bradford over the next 5 years and focuses around six key areas; access, quality; workforce; self-care and prevention; collaboration; and estates, finance and contracting.

3. Report issues

3.1 The development of this strategy needs to take into consideration the national direction of travel outlined in NHS England General Practice Forward View (attached as appendix to this report). This focuses on five main areas: investment; workforce; workload; practice infrastructure; and care redesign. This document outlines some national ‘must do’s’ which we have to commission locally, for example extended hours.

3.2 The Primary Medical Care Commissioning Strategy is not a standalone strategy for the transformation of health services in Bradford. This strategy links to other strategies which are already in place (e.g. Urgent and Emergency Care Strategy 2015 – 2019) and others in development (e.g. Mental Health Strategy). There is also a key relationship with the Sustainability and Transformation Plan as primary medical care services have a responsibility in closing the health and wellbeing gap, care and quality gap, and the funding and efficiency gap.

4. Options

4.1 The Health and Social Care Overview and Scrutiny Committee are asked to feedback their comments on the Draft Primary Medical Care Commissioning Strategy to inform the final version of the strategy. This can be done:

a) verbally at the meeting
b) via email to consultation@bradford.nhs.uk
c) online at https://www.surveymonkey.co.uk/r/9VM32KX
d) combination of all of the above.

5. Recommendations

5.1 The Health and Social Care Overview and Scrutiny Committee are asked to feedback their comments on the Draft Primary Medical Care Commissioning Strategy to inform the final version of the strategy.

6. Background documents

6.1 None

7. Not for publication documents

7.1 None

8. Appendices

8.1 Appendix A - Primary medical care commissioning strategy 2016 to 2021 public and stakeholder consultation document.

8.2 Appendix B - NHS England General Practice Forward View April 2016

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Bradford City Clinical Commissioning Group
Bradford Districts Clinical Commissioning Group

Primary medical care commissioning strategy

2016 to 2021

Introduction

We want to create a sustainable health and care economy that supports you to be well, healthy and independent.

To do this, we are developing a new primary medical care commissioning strategy which looks at the services delivered by GP practices in Bradford.

The strategy will set out what we need to do to improve quality, reduce variability in care and make sure that our services are sustainable for the future.

The primary medical care commissioning strategy is all about getting the best outcomes for you, our patients. We would like patients and the public to let us know:

"what are your three main concerns regarding primary medical care (GP services) and have we addressed them in our strategy?"

Why this strategy matters

The majority of care is delivered by primary medical care services – they underpin our health and care system. In Bradford, we need to change our current system so that it meets the needs of our population.

To do this, we need to look at new ways of working and how we can innovate so primary medical care is sustainable and effective for the future.

There are three big challenges that primary care medical services in Bradford are facing;

1. increasing levels of demand, and more patients with multiple complex conditions,
2. meeting the expectations of seven day services alongside developing the workforce to match,
3. significant financial pressure alongside the need to adapt and change the way services are delivered.

What the primary medical care commissioning strategy will do

Our primary medical care commissioning strategy is based on the following vision:

"to commission and deliver excellent primary medical care for everyone in Bradford"

We hope to deliver our vision by focusing on the following areas of improvement:

- **improving access –** making sure all patients have access to primary medical care services,

- **improving quality –** making sure all patients get consistent, high quality and safe care,

- **building the workforce –** creating a highly skilled, integrated team of health professionals,

- **self-care and prevention –** empowering and supporting all patients to take ownership and control of their health and wellbeing,

- **collaboration –** working closely across practices, with patients and our partners,

- **estates, finance and contracting –** making sure buildings and the services we commission are equipped to deliver modern, future-proof services.

By focusing on these key areas for improvement, by 2021, we aim to achieve the following outcome:

"to deliver a sustainable model of primary medical care which is fully integrated within the wider health and care system and ensures people in Bradford have timely access to high quality, safe services."

The key areas for improvement

1. Improving access

Improving access is all about making sure that everyone in Bradford has equal access to primary medical care services. To enable this, we are looking at improving access to services (core, out of hours and extended hours) and improving the use of digital technology.

We will be:

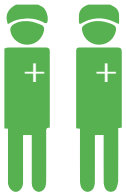
- encouraging practices to work together to improve access to services,
- increasing the number of practices offering online services including appointment booking and repeat prescription ordering,
- commissioning 'virtual primary medical care' which will support email and video consultations,
- making sure all patients have access to the same services – even if they are not offered by their usual GP practice,
- using technology to support patients to manage their own condition and stay independent,
- working with providers to improve access to GP out of hours services in the short term and building a sustainable model for the future,
- enabling patients to be signposted to the right service at the right time by ensuring providers maintain the directory of services (DoS).

2. Improving quality

Improving quality is about ensuring all patients receive consistent, high quality, safe care, no matter which primary medical care service they use. We will be looking at the management of patients with long term conditions, continuity and high quality care and making sure mental health is treated with the same importance as physical health.

We will be:

- making sure all patients have a personalised care plan,
- commissioning pathways of care that are system-wide, support early diagnosis and self-care,
- ensuring mental health and physical health and treated with the same importance by commissioning services that treat patients as a 'whole-person',
- commissioning services which focus on prevention and are outcomes-based, in line with clinical guidelines and best practice,
- commissioning evidence based support tools for health professionals to use which provide consistent, high quality care,
- using our quality work group to develop plans against the areas with the greatest need / most variation.



3. Workforce

In Bradford we need to develop a sustainable, highly skilled, motivated workforce which is integrated with the rest of the health and care system. We will be looking at how we can evolve the primary medical care workforce, attract people to the profession and encourage them to work in our city.

We will be:

- planning our workforce needs around the current and future needs of the population,
- taking a long term view to encourage people, especially young people, to train and work as a health professional,
- developing the current workforce to work across organisational boundaries,
- upskilling the existing workforce through training and development sessions, including the use of digital technology to create efficiencies,
- promoting Bradford as a great place to work and continue to invest in recruitment programmes,
- encouraging patients to self-care and reduce their reliance on health professionals,
- commissioning services to provide people with other routes into care other than their GP (removing the role of GPs as gatekeepers)

4. Self-care and prevention

We want to empower and support patients to take control of their own health and wellbeing. This could be by maintaining general health and wellbeing through making lifestyle changes or knowing how to treat minor ailments at home with a first aid kit. Adopting a healthy lifestyle can help prevent the onset of more serious conditions and give people the confidence and skills to live well.

We will be:

- providing people in Bradford with consistent messages about self-care and prevention,
- giving our workforce the tools they need to promote self-care and behaviour changes amongst patients,
- making sure that self-care is core part of the care pathway,
- utilising the self-care and prevention work that has been a part of the Bradford's Healthy Hearts and Bradford Beating Diabetes programmes,
- encouraging the workforce to be advocates for self-care and wellbeing,
- supporting a system-wide approach to prevention,
- promoting of preventative screening programmes and reviewing immunisation programmes.

5. Collaborative working

We need to be able to deliver primary medical care at scale. Therefore, we will be working with our GP member practices to develop a new model of care that allows services to share functions, rather than work individually. As part of this we will be looking at how we can use our assets better and co-produce services with patients.

We will be:

- working with our stakeholders and GP practices to identify the new model of care for primary medical care services and the relevant processes to deliver change at scale,
- increasing our work with patients in designing services and decision making,
- if possible, when commissioning, encourage providers to operate as a network of practices,
- ensuring that primary medical care services underpin our move towards an accountable care system (a system which spans health and social care to improve health outcomes. provide positive patient experience and make the most of funding available),
- working with the local authority and public health to establish formal links with education so that health education starts at early age.

6. Estates, finance and contracting

To support the changes outlined in the primary medical care commissioning strategy, we need to ensure that we have a solid infrastructure. This involves making sure that buildings are fit for purpose and multi-use, commissioning contracts are based on outcomes and that contracts are fair.

We will be:

- reviewing primary care buildings that are out of date or underused and make sure we are making the most out of existing estates,
- develop new contracting approaches which support the integration of services,
- making sure we commission services based on outcomes so that you get high quality services.

What you have already told us about your experiences of primary medical care

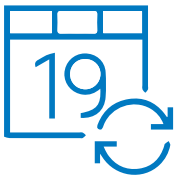
We want to make primary medical care services work better for you. In developing this strategy, we have taken into consideration the feedback that you have given us through our previous engagement work. The key themes you tell us are:

Keep good face to face access and offer telephone appointments

Extended opening hours

Ability to book appointments online

Better use of technology e.g. Skype and virtual surgery



More flexible appointment systems

Access to education and information about managing your own conditions

Increase the use of text/ telephone reminders to reduce the number of appointments that are 'do not attend' (DNAs)

Consistency for people with long term conditions to see the same person

Clear concise information is required about how practice appointment systems work

How this strategy fits with other programmes

The primary medical care commissioning strategy will form part of our move to become an accountable care system by 2020/21. The accountable care system aims to improve population health outcomes, experiences of care and make sure there is value for every pound spent on the NHS.

Our strategy is also a key part of the work we are doing as part of our 'out of hospital' programme. This programme is all about making sure you get the right care, in the right place at the right time – reducing unnecessary stays in hospital.

We are building on the themes outlined by NHS England in the *Five Year Forward View* (October 2016) which set out plans for transformation.

Key themes outlined in this were around patient experience, providing care closer to home and moving away from hospital based care. Our primary medical care commissioning strategy has also been built on the *General Practice Forward View* (April 2016) which looks at five key pressures on general practice nationally; investment, workforce, workload, practice infrastructure and care redesign.

We have taken the recommendations and key themes outlined in the *Five Year Forward View* and the *General Practice Forward View* and applied them to what primary care looks like in Bradford.

How to give your views

online form: http://www.bradfordcityccg.nhs.uk/bradford-city-ccg/get-involved-/give-us-your-views/

email: consultation@bradford.nhs.uk

post: Primary medical care strategy engagement, Freepost RTEK-UHKG-UBEK, Douglas Mill, Bowling Old Lane, Bradford, BD5 7JR

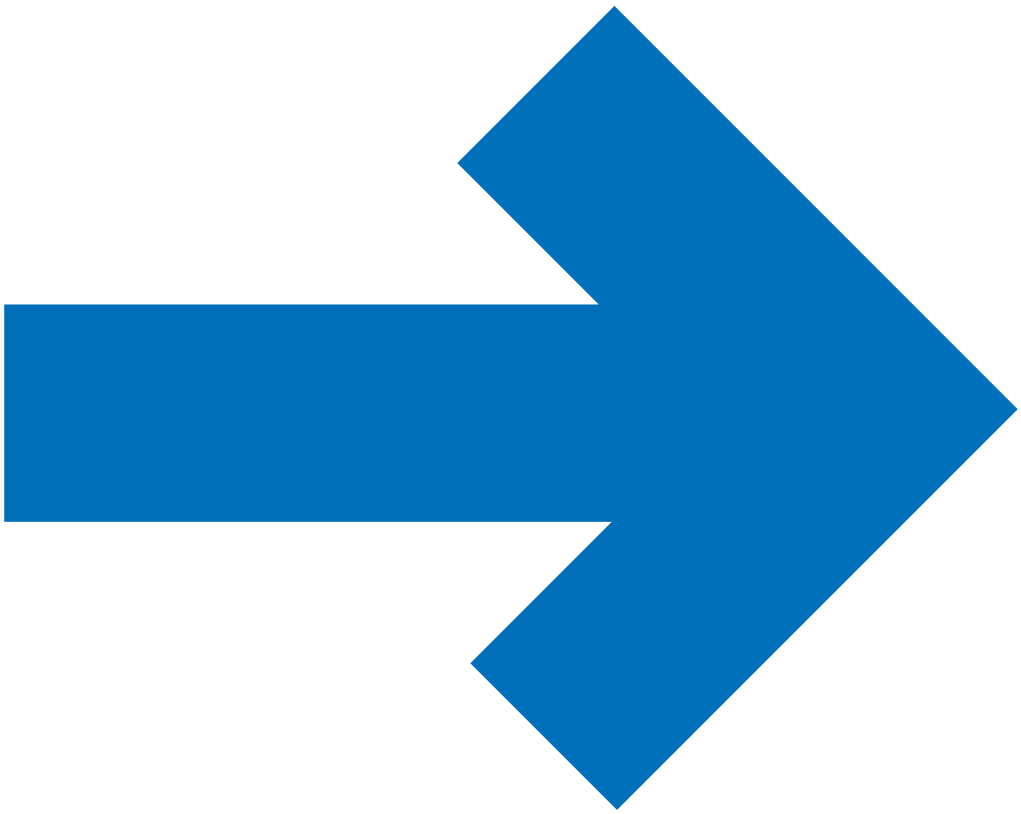
attending the drop in session: 8th September, 3pm to 4pm, Carlisle Business Centre, Carlisle Road, Bradford, BD8 8BD

The closing date for comments is 14 October 2016.

NHS England

GENERAL PRACTICE FORWARD VIEW

APRIL 2016



Developed in partnership with:

Royal College of General Practitioners

Health Education England

#GPforwardview

General Practice Forward View

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Classification: Official

Gateway publication reference: 05116

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email: england.contactus@nhs.net

Contents

Introduction

There is arguably no more important job in modern Britain than that of the family doctor.

GPs are by far the largest branch of British medicine. A growing and ageing population, with complex multiple health conditions, means that personal and population-orientated primary care is central to any country's health system. As a recent British Medical Journal headline put it – "if general practice fails, the whole NHS fails".

So if anyone ten years ago had said: "Here's what the NHS should now do - cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs", they'd have been laughed out of court. But looking back over a decade, that's exactly what's happened. Which is why it's no great surprise that a recent international survey revealed British GPs are under far greater pressure than their counterparts, with rising workload matched by growing patient concerns about convenient access.

A recent report on GP workload pressures by the Primary Care Foundation and NHS Alliance said this:

"The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote to improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice."

So rather than ignore these real pressures, the NHS has at last begun openly acknowledging them. We need to act. This document sets out exactly how. It contains specific, practical and funded steps – on investment, workforce, workload, infrastructure and care redesign.

On investment: by 2020/21 recurrent funding to increase by an estimated £2.4 billion a year, decisively growing the share of spend on general practice services, and coupled with a 'turnaround' package of a further £500 million. Investments in staff, technology and premises, and action on indemnity and redtape.

On workforce: pulling out all the stops to try to double the growth rate in GPs, through new incentives for training, recruitment, retention and return to practice. Having taken the past 10 years to achieve a net increase of around 5,000 full time equivalent GPs, aiming to add a further 5,000 net in just the next five years. Plus 3,000 new fully funded practice-based mental health therapists, an extra 1,500 co-funded practice clinical pharmacists, and nationally funded support for practice nurses, physician associates, practice managers and receptionists.

On workload: a new practice resilience programme to support struggling practices, changes to streamline the Care Quality Commission inspection regime, support for GPs suffering from burnout and stress, cuts in redtape, legal limits on administrative burdens at the hospital/GP interface, and action to cut demand on general practice.

On infrastructure: new rules to allow up to 100% reimbursement of premises developments, direct practice investment tech to support better online tools and appointment, consultation and workload management systems, better record sharing to support team work across practices.

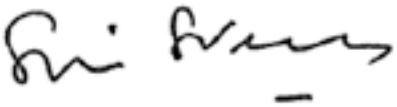
On care redesign: support for individual practices and for federations and superpartnerships; direct funding for improved in hours and out of hours access, including clinical hubs and reformed urgent care; and a new voluntary contract supporting integrated primary and community health services.

One of the great strengths of general practice in this country has been its diversity across geographies and its adaptability over time. So one size will not fit all when it comes to the future shape and work of primary care. But in the round, this support package is likely to herald a 'triple reinvention' - of the clinical model, the career model, and the business model at the heart of general practice. In his preface to this document Arvind Madan describes what this could mean from the practice and the patient perspective.

Thanks go to the many GPs, other NHS professionals and patient groups who've helped shape this urgent 'to do' list - including particularly our partners at the Royal College of General Practitioners, the British Medical Association's General Practitioners Committee, Department of Health, Health Education England, the National Association of Primary Care, NHS Alliance, the Family Doctors Association and in local CCGs and Local Medical Committees right across England.

Looking back over nearly seventy years, there have been key moments in NHS history when the health service has stepped up to support and strengthen general practice and wider primary care. Think: the New Deal for GPs in 1966. Think: new contractual models in the 1990s and 2000s. If properly implemented, the wide-ranging measures in this document may perhaps come to be seen as a similar inflexion point.

But be that as it may, the vital thing is to roll our sleeves up, get practical, and together begin to make a tangible difference, now, for practices and for our patients.



Simon Stevens
Chief Executive, NHS England

GP services for the future:
Dr Arvind Madan

The public relies on general practice services for the health and wellbeing of themselves and their family. It is one of the great strengths of the NHS, and is recognised time and again in international comparisons.

Over my 20 years as a GP demand for appointments, and particularly their complexity, has increased beyond recognition.

There has been a steady rise in patient expectations, a target driven culture and a growing requirement for GPs to accommodate work previously undertaken in hospitals, or in social care. This has resulted in unprecedented pressure on practices, which impacts on staff and patients. Small changes in general practice capacity have a big impact on demand for hospital care, so the need to support general practice in underpinning the whole NHS has never been greater.

However, a typical morning in general practice currently comprises a long arduous struggle through appointments, phone calls, repeat prescriptions, results, letters and home visits. Before you get time to look up, much less take a break, it is the afternoon and you have to start all over again.

Running the practice or having a meaningful conversation with staff is relegated to the edges of the day. Almost every practice is struggling to balance rising workload within tighter financial constraints. Add to this the strain of recruitment issues and it becomes easy to see why morale is so challenged. Clinicians increasingly feel unable to provide the care they want to give, and understandable resentment of working under this pressure is growing.

Yet patients rightly expect and deserve high quality care from a familiar team of healthcare professionals they know and trust. We know these relationships rest at the heart of how every general practice functions. They are fundamental to what we do, namely person-centred coordinated care of complex physical, mental and social issues, within the context of the individual, their families and the wider community.

I joined NHS England at the end of last year, in part driven by my frustration with how I felt high quality primary care for patients was being undervalued. Since starting I have made three observations. Firstly, there is a deep-seated recognition of how a strengthened version of general practice is essential

to the wider sustainability of the NHS. Secondly, there is acknowledgement of historic underfunding in general practice and the need for this to be reversed. Thirdly, practices themselves seem more open to new ways of working than at any time I can recall. As much because we want patient care to improve, as we recognise our survival depends on it.

Most observers now agree that the solution lies in a combination of investment and reform. It requires action from NHS England, clinical commissioning groups (CCGs), health and care organisations, and practices themselves. We know there is no single cause for the issues we face, and that no single part of the system acting in isolation can fix it either. We need a concerted approach of initiatives, involving all stakeholders, across a number of key areas.

The General Practice Forward View represents a step change in the level of investment and support for general practice. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to accelerate transformation of services. NHS England is committing to an increase in investment to support general practice over the next five years. Furthermore this will be supplemented by GP-led CCGs as they act to transform local care systems. This transformation will be built around patients, around the wider workforce, around the redesign of our workload and organisation of care, and creating a satisfying and rewarding career for everyone working in general practice.

Some patients want to be partners in their own care. They want the knowledge, skills and confidence to take more responsibility for their health and feel more in control of their outcomes. Channelling this growing patient appetite for services that help patients to help themselves unlocks both a better patient experience and a way to alleviate practice workload. No amount of reform of the existing system will work unless we also partner with our patients to manage demand more efficiently.

The GP is an expert medical generalist and must be properly valued as the provider of holistic, person-centred care for undifferentiated illness, across time within a continuous relationship. These are core strengths of general practice and must be preserved within any change. However, patient demand and GP shortages mean that we no longer have the time to use our expertise on patient issues that can be safely and competently managed by others. Wider members of the practice-based team will play an increasing role in providing day-to-day coordination and delivery of care. Greater use of skill mix will be key to releasing capacity, if we are to offer patients with complex or multiple long-term conditions longer GP consultations.

In the way we currently view practice nurses as an integral part of the practice team, the GP Access Fund schemes are already showing how a broad range of healthcare professionals can contribute to providing care, for example advanced nurse practitioners, clinical pharmacists, physician associates, physiotherapists and paramedics. Staff are navigating patients to a wider range of alternative services such as primary care access hubs, social prescribing

initiatives (including the voluntary sector) and pharmacy minor ailment schemes. Pharmacists remain one of the most underutilised professional resources in the system and we must bring their considerable skills in to play more fully.

We all accept that we have a long way to go to hit the ambitious recruitment targets set for primary care, but we must use every effort to try, as this will be necessary for much of the reform required. NHS England, alongside Health Education England and CCGs, will support a series of initiatives to grow and train the workforce in response to this challenge.

A common reason for poor morale is the daily struggle with growing workload. Much of this is generated by a fragmented system, over which practices feel they have little influence. Our first and most pressing priority must be to alleviate this wasteful burden, which takes away from direct patient care. We know we cannot work any harder, so we have to find ways to work differently. A key requirement for wider system change is the urgent need to identify and eliminate needless workload.

But this is a challenge when it is difficult to find time to look up from the day job. For GPs to believe in a better future we must first start to feel the impact of changes now. Some of the new measures within this document are specifically designed to provide immediate relief to existing pressures. We need to tackle issues such as irrelevant communications, duplicate reporting, unwieldy payment systems and streamline oversight and regulation.

Teams need support and space if they are to adopt new ways of working. This is why NHS England plans to invest in a national development programme at individual, practice and network or federation level. I have been struck by how positively received the recent NHS England and BMA roadshows on releasing capacity have been. However, this should be viewed as the start of a journey in supporting practices to build the capacity and capabilities required within our teams. We must and will go much further.

We will also develop different ways of managing clinical demand. In addition to increasing self-care, use of different triage methods and a broader workforce sharing the burden, we also need to grow capacity through a network of locality primary care access Hubs (as seen in the GP Access Fund areas) and increase clinical personnel behind services such as 111, for example, nurses, pharmacists and dentists.

It is becoming increasingly normal for general practices to work together at scale, and already over half the country have formed into networks or federations of practices. In the future there will be greater opportunities for practices to work collaboratively in larger groupings for the benefit of more sizeable populations, yet maintain their unique identity and relationship with their own patients. Larger organisational forms will enable greater opportunities for practices to increase their flexibility to shape, buy or build additional services, working from a more effective platform with other local health and care providers, including community health services, social care and voluntary organisations.

GPs must feel confident in the vision of where general practice could go and how it will feel to be a GP in the future. A significant proportion of demand must be managed through helping patients to stay well, self-care and navigate to other team members, or alternate services.

GPs' core role will be to provide first contact care to patients with undifferentiated problems, provide continuity of care where this is needed, and act as leaders within larger multi-disciplinary teams with greater links to hospital, community and social care specialists.

Primary care professionals will increasingly work at different organisational levels, for example, their own practice, a neighbourhood of practices and across the local health economy. This will open up opportunities in pathway design, service leadership, education, training and research, or developing areas of clinical interest. Specialists will develop more community facing roles, supporting primary care colleagues in developing case management expertise, both in person and remotely. There will be greater use of technology to connect primary care with others, for the sharing of best practice and sourcing of timely advice. These changes will develop a more unified team approach, in a variety of career structures, with satisfying and rewarding opportunities for both clinicians and non-clinicians, and a more coordinated experience of care for patients.

The General Practice Forward View will not solve all the issues we face immediately, but it does set a new direction and opportunity to demonstrate what a strengthened model of general practice can provide to patients, those who work in the service, and for the sustainability of the wider NHS. General practice has risen to challenges in the past and, with support from leaders across the system, it will again.

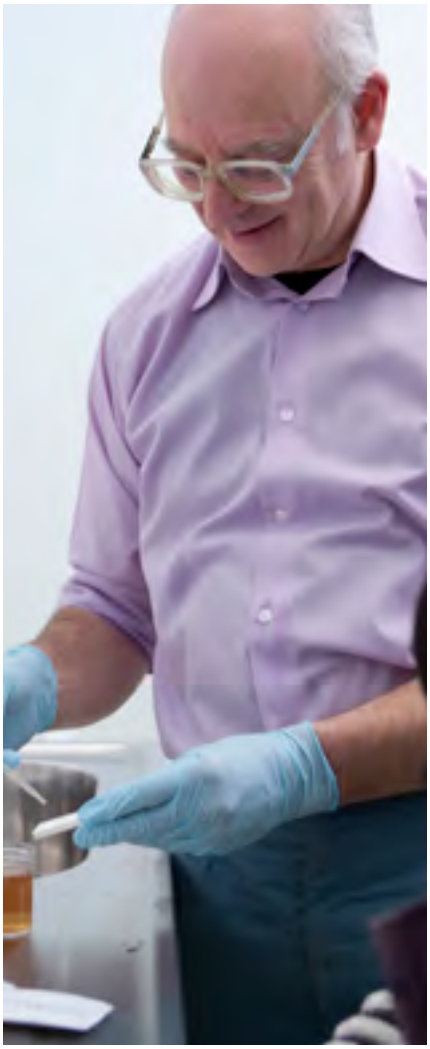
Dr Arvind Madan
GP, Director of Primary Care,
NHS England

Chapter 1: Investment

We will accelerate funding of primary care

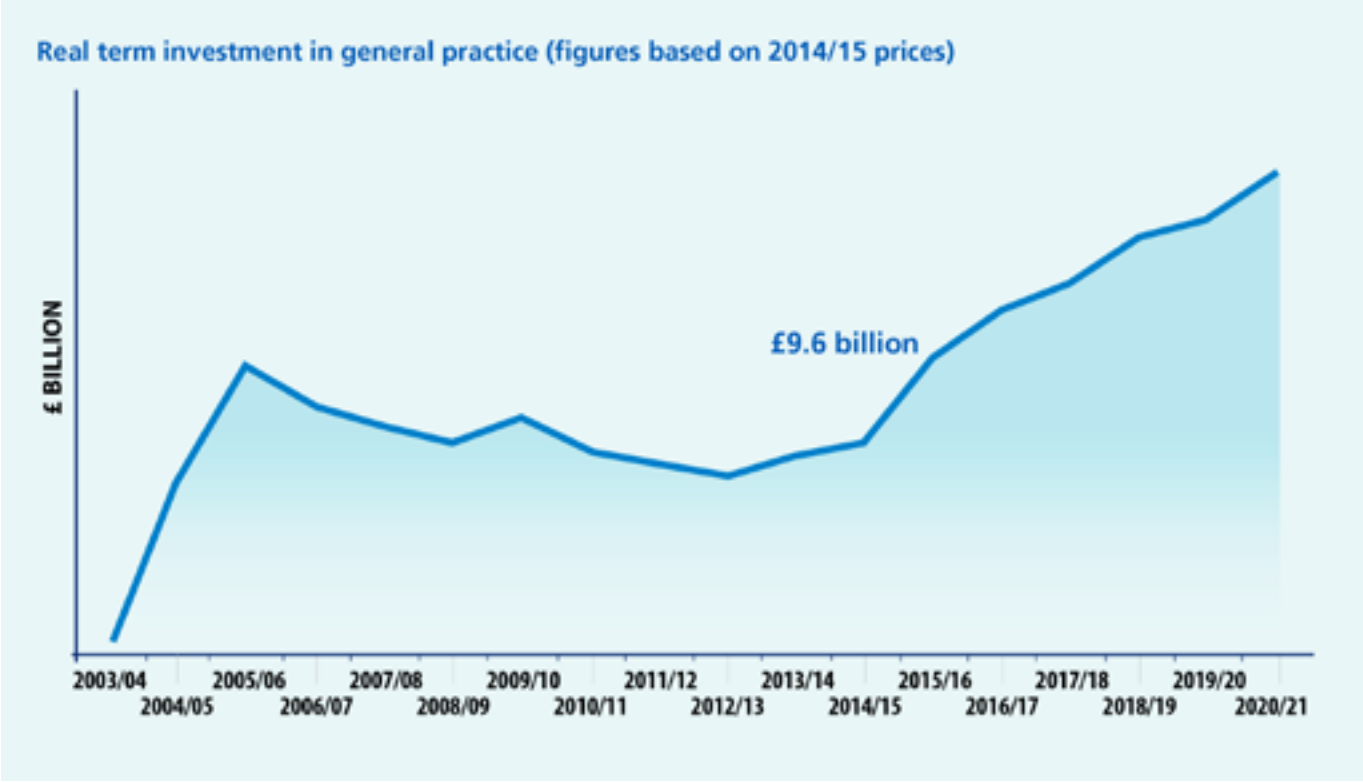
We will increase the levels of investment in primary care:

- By investing a further £2.4 billion a year by 2020/21 into general practice services. This means that investment will rise from £9.6 billion a year in 2015/16 to over £12 billion a year by 2020/21.
- Represents a 14 percent real terms increase, almost double the 8 percent real terms increase for the rest of the NHS.
- This is the expected increase nationally. Investment is likely to grow even further as CCGs build community services and new care models, in line with the Five Year Forward View.
- This includes capital investment amounting to £900 million over the next five years.
- Will be supplemented by a Sustainability and Transformation package, totalling over half a billion pounds over the next five years, to support struggling practices, further develop the workforce, tackle workload and stimulate care redesign.
- A new funding formula to better reflect practice workload, including deprivation and rurality.
- Consult the profession and others on proposals to tackle indemnity costs in general practice by July 2016.



The Five Year Forward View recognised that primary care has been underfunded compared to secondary care, and that this must change. The historic strength of general practice is being weakened by the relative under-investment in general practice that has occurred over the past decade.

Since the creation of NHS England in 2013, each year there have been real term increases in primary care funding. On the back of the Spending Review, which committed £10 billion a year more above inflation for the NHS by 2020 to back the Five Year Forward View, we know we need to sustain and accelerate growth in investment.



Package of investment in general practice[1]

We are committed to increasing the proportion of investment going into general practice services. This should reach over 10 percent by 2020/21, and will rise further as CCG investment in general practice rises also. Overall investment to support general practice services will rise by a minimum of £2.4 billion a year by 2020/21. This represents a 14 percent real terms increase, significantly more than that anticipated for CCG allocations.

The additional investment we are making in introducing new care models will benefit general practice too – and this will ensure investment rises at least in line with the plans set out above, and potentially even more.

For 2016/17, NHS England has allocated an additional £322 million in primary medical care allocations, providing for an immediate increase in funding of 4.4 percent.

Plus local investment

For the first time, the Planning Guidance for the NHS has made securing the sustainability of general practice, and in particular addressing workforce and workload issues, one of nine national 'must dos'. Every part of England has been asked to produce a Sustainability and Transformation Plan (STP), which will include plans to secure and support general practice, and enable it to play its part in more integrated primary and community services. These plans will be completed by July 2016. National actions on their own will not be enough – local leadership and investment will be vital.

Plus a five year general practice Sustainability and Transformation package

We have created a national £508 million five year Sustainability and Transformation package for general practice to help further support struggling practices in the interim, develop the workforce, stimulate care redesign and tackle workload.

This package will include:

- £56 million, to include a new practice resilience programme starting in 2016/17, and the offer of specialist services to GPs suffering from burn out and stress (see chapter 3)
- £206 million for workforce measures to grow the medical and non-medical workforce (see chapter 2)
- £246 million to support practices in redesigning services, including a requirement on CCGs to provide around £171 million of practice transformational support and a new national £30 million development programme for general practice (see chapter 5).

We will also continue to support capital investment in general practice through a programme of investment estimated to reach over £900 million over the next five years.

Fairer distribution of funding

The Carr-Hill formula applies a weighting (to General Medical Services (GMS) contracts only) to reflect the comparative workload associated with different patient groups.

[1] As part of agreed devolution arrangements, Greater Manchester has been allocated a transformation fund which includes an appropriate share of NHS England funding for primary medical care initiatives. It will be for Greater Manchester to determine how it is spent in the local area.

Many believe that the Carr-Hill formula is now out of date and needs to be revised to reflect changes in the population and the impact of this on comparative workload. NHS England is working with the BMA to review the Carr-Hill formula to specifically examine the impact of deprivation, age and other factors that influence practice workload. This work will be concluded in the summer of 2016, and form the basis of discussion with the BMA about changes that might be needed.

A minority of practices are yet to undergo their PMS contract reviews. We are committed to ensuring this process is completed in the interest of equity across all practices. However, in the interests of stability, these changes are being phased over a minimum of four years, ensuring there is a water tight reinvestment plan for all savings in local general practices, and engaging in individual conversations with practices that are particularly challenged.

CCG plans for reinvestment must be published before the full impact of Personal Medical Services (PMS) reviews are implemented for individual practices.

Tackling rising costs of indemnity

Indemnity costs have risen in the NHS in England significantly in recent years. This is the result of the rising number of claims, and the rising level of awards made by the courts, with the cost of care packages doubling every seven years. This is despite the fact that on objective measures, the quality and safety of care provided by GPs has never been higher. GPs tell us that these costs are distorting decisions about whether to remain in work (particularly for those choosing to work part-time), whether to work in GP out of hours and urgent care services for non NHS trust providers, and whether to deploy the wider clinical workforce (where costs for nurse indemnity can be the equivalent of medical indemnity).

NHS England has taken initial steps to alleviate these pressures through:

- the establishment in 2014/15 and 2015/16 of a £2.5 million 'winter indemnity' scheme to help with the costs of those working out of hours
- taking into account increases in indemnity costs, amongst other factors, in agreeing funding for the 2016/17 GP contract.
- working with the medical defence organisations and indemnity insurers to meet the needs of new ways of delivering care. For example, through products that treat the delivery of services across practices outside of core hours (with shared access to patient records) as similar to in-hours working, rather than charging the out of hours rate. This is in recognition of access to the patient record.

Some GPs have called for general practice to have Crown indemnity. This would mean it is not possible to sue for damages and that the small minority of patients who had suffered harm as a result of clinical negligence would not have recourse to any financial compensation. We do not believe that this is the intent of the profession, and this form of immunity does not apply to other health services.

Rather, we believe that the shared aim of all those working in the NHS is to bring down the overall costs associated with negligence claims in an appropriate fashion, and ensure that the way that those costs are borne does not dis-incentivise excellent clinical staff from working in the NHS or restrict access to justice.

The Department of Health will be consulting shortly on the options for introducing a Fixed Recoverable Cost scheme to cap the level of recoverable costs for claimant lawyers on clinical negligence claims. The aim is to make the cost of claimant lawyers more proportionate to damages and defence costs.

We and the Department of Health are also committed to reviewing the way in which costs are funded. Any changes would have a bearing on historical claims and handling of past liabilities. This is complex with the potential to create unintended financial consequences if mishandled. The Clinical Negligence Scheme for Trusts (CNST) is a risk-pooling arrangement for trusts, and requires every organisation to contribute funds. The rising costs of CNST has been an issue for providers in other sectors, and to date, we have not seen evidence that access to CNST would bring down the costs for practice partnerships. There would be significant implications for the treatment of historical claims, for the insurance market in general, and it might increase costs to practices. So this is not a simple solution.

The Department of Health and NHS England will instead bring forward proposals in July 2016 for discussion with the profession, medical defence organisations, the commercial insurance industry and the NHS Litigation Authority. This will consider potential solutions, including considering:

- how personal costs of indemnity and clinical insurance can be contained, provided certain clinical governance standards are met – with the objective of reducing the overall costs to the individual;
- reducing indemnity costs for individuals in particular circumstances, such as GPs who wish to remain in the workforce on a part-time basis past a certain age; and
- enable new models of care such as Multispeciality Community Providers (MCPs) to take on corporate indemnity, freeing up individuals working in those new models from the burden of personal indemnity costs.

In principle, GPs should be no more exposed to the rising costs of indemnity than our hospital doctors, and any solution will need to address this.

Taken together, this represents a significant programme of work to reform indemnity in general practice, addressing some short-term pressures whilst looking to bring down the overall costs to the system.

Better Care Fund

The Better Care Fund (BCF) requires CCGs and local authorities to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation. In 2016/17, the minimum size of the BCF has been increased to £3.9 billion.

From April 2016, CCGs, local authorities and NHS England will be able to pool budgets to jointly commission expanded services, including:

- additional nurses in GP settings to provide a coordination role for patients with long term conditions;
- GPs providing services in care and nursing home settings;
- providing a mental health professional in a GP setting; and
- hosting a social worker in a GP surgery.

CASE STUDY

Wider integration of health and social care - Sunderland (MCP vanguard)

Through the Better Care Fund all of Sunderland's resources for out-of-hospital care from both the CCG and local authority are now contained within a single pooled budget of over £160 million. From April 2015, a Provider Management Board took on the leadership for redesigning existing services and investing new funds in additional GP and nursing sessions in integrated teams and a 24/7 Recovery at Home service.

Co-located multidisciplinary teams, working across several practices, provide an enhanced level of care to patients with complex needs. These are often frail older people and/or people with multiple co-morbidities both at home and in supported housing, including care homes, identified via a risk stratification approach.

Chapter 2: Workforce

We will expand and support GPs and wider primary care staffing

The General Practice Forward View cannot be delivered without sufficient recruitment and workforce expansion. Therefore NHS England and Health Education England (HEE) have set ambitious targets to expand the workforce, backed with an extra £206 million as part of the Sustainability and Transformation package. We will also support the development of capability within the current workforce and support the health and wellbeing of staff.

Expansion of workforce capacity

Plans to double the rate of growth of the medical workforce to create an extra 5,000 additional doctors working in general practice by 2020. This five year programme includes:

- Increase in GP training recruitment to 3,250 a year to support overall net growth of 5,000 extra doctors by 2020 (compared with 2014).
- Major recruitment campaign in England to attract doctors to become GPs, supported by 35 national ambassadors and advocates promoting the GP role.
- Major new international recruitment campaign to attract up to an extra 500 appropriately trained and qualified doctors from overseas.
- Targeted £20,000 bursaries in the areas that have found it hardest to recruit into GP training.
- 250 new post-certificate of completion of training (CCT) fellowships to provide further training opportunities in areas of poorest GP recruitment.
- Attract and retain at least an extra 500 GPs back into English general practice, through:
  - simplifying the return to work routes further, with new portfolio route, and other measures to reduce the length of time.
  - launch of targeted financial incentives to return to work in areas of greatest need.

A minimum of 5,000 other staff working in general practice by 2020/21. This five year programme will include:

- Investment in an extra 3,000 mental health therapists to work in primary care by 2020, which is an **average of a full time therapist for every 2-3 typical sized GP practices.**
- Current investment of £31 million to pilot 470 clinical pharmacists in over 700 practices to be supplemented by **new central investment of £112 million** to extend the programme by **a pharmacist per 30,000 population** for all practices not in the initial pilot – leading to a further 1,500 pharmacists in general practice by 2020.
- Introduction of a new Pharmacy Integration Fund.

- A general practice nurse development strategy, **with an extra minimum £15 million national investment** including improving training capacity in general practice, increases in the number of pre-registration nurse placements, measures to improve retention of the existing nursing workforce and support for return to work schemes for practice nurses.
- **National investment of £45 million** benefitting every practice to support the training of current reception and clerical staff to play a greater role in navigation of patients and handling clinical paperwork to free up GP time.
- Investment by HEE in the training of **1,000 physician associates to support general practice.**
- Introduction of pilots of new medical assistant roles that help support doctors, as recommended by the RCGP.
- **£6 million investment** in practice manager development, alongside access for practice managers to the new national development programme.
- £3.5 million investment in multi-disciplinary training hubs in every part of England to support the development of the wider workforce within general practice.

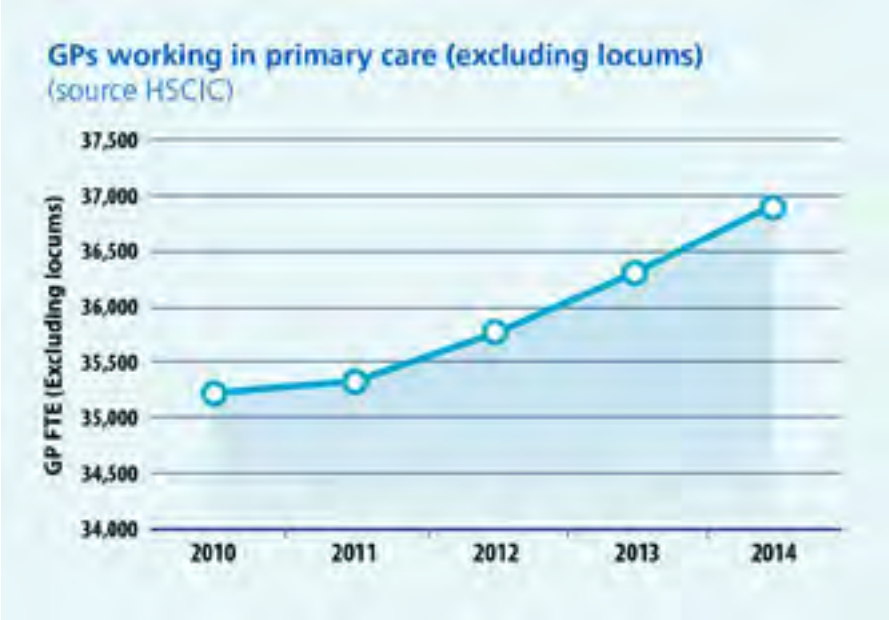
Health and wellbeing

£16 million extra investment in specialist mental health services to support GPs suffering with burn out and stress, and support retention of GPs, in addition to the £3.5 million already announced.

Over the past decade, the number of GPs (full time equivalents) working in general practice has risen by over 5,000.

But we know that many practices now face recruitment issues and are increasingly reliant on temporary staff. Moreover, a higher proportion of older GPs are signalling that they are considering leaving the workforce early.

We aim to double the rate of growth in the primary care medical workforce over the next five years, to create an extra 5,000 doctors working in general practice. This needs to be supported by growth in the non-medical workforce – a minimum of 5,000 extra staff – nurses, pharmacists, physician associates, mental health workers and others.



Work to date

The Primary Care Workforce Commission, set up by HEE and chaired by Professor Martin Roland, called for a broader range of staff to be involved in providing care. Their report, The future of primary care creating teams for tomorrow, set out how we can better deploy the talents of the wider workforce to reduce the workload burden on GPs, meet patients' needs and to free GPs up to do what they do best. The report also set out recommendations to increase the role of nursing, advanced clinical practitioners, medical assistants, practice pharmacists and physician associates along with stronger partnerships with the voluntary sector and better use of technology.

Last year, NHS England, HEE, Royal College of General Practitioners (RCGP) and the General Practitioners Committee (GPC) developed an initial 10 point action plan – Building the Workforce a new Deal for General Practice - to kick start initiatives to improve recruitment, retention and return to practice. Now that there is significant new investment for general practice, we will be working together – and with other professional bodies, such as the RCN, Queen's Nursing Institute, Royal Pharmaceutical Society, National Association of Primary Care and NHS Clinical Commissioners to step up actions to grow the workforce and stimulate a more diverse range of workforce models within primary care.

Through the 10 point action plan, together we have:

- delivered a marketing campaign to encourage foundation year 2 doctors who are applying for specialty training to choose general practice;
- launched a scheme to offer up to £20,000 bursaries for 109 GP trainees to attract doctors to parts of the country where there have been consistent shortages of trainees;
- established new post-CCT fellowships to provide further training opportunities in areas of poorest GP recruitment that encourage new CCT holders to work as GPs in those areas, whilst pursuing special interests and meeting local need such as urgent care and learning disability care;

- committed to invest £3.5 million in 13 new multi-disciplinary training hubs (Community Provider Education Networks) across the country to support the development of the wider workforce within general practice, including placements in general practices, development for current staff and workforce planning;
- created a national induction and refresher (returner) scheme, offering a new £2,300 per month bursary to doctors looking to return to general practice to help with costs and improving entry routes – leading to an increase in the number of applicants and improving coverage, given previous local variation;
- invested an extra £1.75 million nationally to support practice nurse development;
- invested in leadership development and coaching for individual GPs; and
- piloted new ways of working including the development of Primary Care Physician Associates.

For the wider workforce, we agreed a major £31 million scheme to pilot the deployment of over 470 clinical pharmacists in just over 700 practices over the next three years, helping practices with the costs of employment and training. We have published a practice and community nursing education and career framework, and

are developing a strategy for supporting the practice nursing workforce.

Building the workforce for 2020

To double the rate of growth of the medical workforce, and accelerate use of the wider workforce, we set out below the new programmes of work that will be needed. This will be backed by an extra £206 million over the next five years on top of previously announced initiatives.

Recruiting doctors into general practice

HEE has increased GP training capacity and increased recruitment to 3,250 doctors per annum recurrently. In the first round recruitment for 2016, 2,296 posts - 70 percent - have already been filled.

This represents a welcome increase of around 7 percent on last year's first round of recruitment.

HEE will in partnership with the RCGP, and the profession continue refining and developing GP specialty training to provide greater career flexibility while maintaining standards in order to maximise recruitment.

We know we need to improve the number of medical school graduates choosing to join general practice. There is a strong correlation between training placements in general practice and eventually working in general practice. HEE is currently working with the Medical Schools Council, higher education institutions, the RCGP and the GPC to increase the profile of general practice in medical schools and in their curricula.

A working group, chaired by Professor Valerie Wass OBE, will publish recommendations in summer 2016 about recruitment and selection, finance and curriculum and the promotion of general practice as a speciality.

The recommendations will improve the medical school experience of general practice through greater exposure to the diverse and stimulating reality of general practice professionally and personally. More graduates will be encouraged to make a positive choice of general practice as a career.

HEE and the RCGP will continue to develop the current **recruitment campaign** to raise the profile of general practice as a career. The campaign showcases the variety of different opportunities and the flexibility of the specialty, as well as the central role that GPs play in the community and their patients' care. HEE has recruited and trained 35 campaign ambassadors and advocates to support and promote national and regional activities including attendance at recruitment events and through social media.

We will supplement this with a **major international recruitment drive**, to attract up to 500 appropriately trained and qualified doctors – and possibly more - from overseas over the next five years.

Working with HEE we will evaluate its £20,000 bursary scheme to attract trainees into hard to fill areas and identify if more needs to be done.

HEE will roll out a total of **250 post CCT fellowships** by summer 2017 to offer wider and more varied training opportunities in areas of poorest GP recruitment.

Retaining the current medical workforce

One of the strengths of general practice as a career is its flexibility, with the chance to work part-time or combine general practice with work in other settings. We want to make it easier and more attractive for GPs to return to work in English general practice.

Already, the new induction and refresher (returner) scheme has seen:

- the end to multiple different policies, with one single national policy, supported by single website, a consistent set of written guidance to applicants, and a new single point of contact;
- a significant increase in NHS England bursaries for the period of time that the doctor is in a supervised placement - £2,300 per month – up from a range of £0 to £500 per month previously depending on which part of the country you are in;
- the end to requiring doctors working overseas to return to England to start the application process, with the ability to hold interviews now via Skype and sit initial assessments in countries all round the world; and
- a review of the appropriate and relevant content of all assessments, leading to a doubling of pass rates in the last nine months.

As a direct result, we have seen a significant rise in the number of doctors applying to return to work in general practice, with an increase of 40 percent in the number of doctors booking to sit the multiple-choice questions (MCQ), one of the routes for returning to practice, in 2015/16 compared to 2014/15.

We need to accelerate this further so that we can attract at least **an extra 500 doctors** over the next five years back into general practice. The RCGP has sought feedback on some of the main barriers experienced by returning doctors, and this has formed the basis of our action plan for improvement. Our aim is to start measuring the time it takes for a doctor to return to work, and halve the average time.

We will build on the improvements to establish a straightforward route for doctors to return to work in England.

In addition, we will:

- from April 2016, introduce a **new Portfolio Route (2016) for GPs with previous UK experience**, continuing to work in equivalent primary care roles outside the UK, removing the need for them to sit the current exams to return to practice;
- create a central contact point for any doctor wishing to return to work in English general practice, so that doctors are supported in navigating any regulatory issues and to support and guide them through the process;
- address delays in securing Disclosure and Barring Service checks – taking several weeks and sometimes months – and sort out information governance issues to enable checks to be valid across different parts of the system;
- **increase the financial compensation available through the current GP retainer scheme from 1 May 2016**; and introduce a new GP retainer scheme more fit for purpose from 1 April 2017; and
- **offer targeted financial incentives to GPs from May 2016 for returning to work in areas of greatest need.**

We also need to find ways to attract GPs to remain in practice towards the end of their career. The published evidence on retention suggests that the single biggest enabler would be to address concerns over workload, and create a greater sense of 'status' for general practice within society. The totality of the General Practice Forward View is aimed at addressing these fundamental issues.

In addition, we will invest further in leadership development, coaching and mentoring skills for experienced doctors – enabling them to build on their skills and offer the value of their experience to younger doctors. We will take stock of the findings of evidence on retention, and address any further issues identified.

Building the wider workforce

The success of general practice in the future will also rely on the expansion of the wider non-medical workforce – including investment in nurses, pharmacists, practice managers, administrative staff and the introduction of new roles such as physician associates and medical assistants.

Our ambition is to use some of the extra investment going into general practice to support the **employment of a minimum of 5,000 extra staff**.

To achieve this, at a national level, NHS England and HEE, over the next five years, will:

- invest an extra **£15 million nationally in general practice nurse development,** including support for return to work schemes, improving training capacity in general practice for nurses, increases in the number of pre-registration nurse placements and other measures to improve retention;
- extend the clinical pharmacists programme with a **new £112 million offer to enable every practice to access a clinical pharmacist** across a minimum population on average of 30,000 - leading to an extra 1,500 pharmacists in general practice. Appetite for the original pilot scheme was high. We will need to learn more from the evaluation but early indications suggest clinical pharmacists may have a role in streamlining practice prescription processes, medicines optimisation, minor ailments and long term conditions management. We will roll this out further across the country over the next five years, so that every practice can benefit. We will also open up the clinical pharmacist training programme to practices that have directly funded a clinical pharmacist;
- introduce a Pharmacy Integration Fund, worth £20 million in 2016/17 and rising by a further £20 million each year, to help further transform how pharmacists, their teams and **community pharmacy** work as part of wider NHS services in their area. Subject to a separate consultation, our proposals include better support for GP practices, for care homes and for urgent care for the use of the fund;
- invest in an **extra 3000 mental health therapists** to be working in primary care by 2020 to support localities to expand the Improving Access to Psychological Therapies (IAPT) programme;
- provide **£45 million extra funding** nationally over five years so that every practice in the country can help their **reception and clerical staff** play a greater role in **care navigation**, signposting patients and handling clinical paperwork to free up GP time. This builds on successful pilots tested through the Prime Minister's GP Access Fund schemes and vanguard sites where the majority of clinical correspondence can be managed through trained staff;
- pilot new medical assistant roles that help support doctors;
- pilot the role of primary care physiotherapy services;

- invest an extra **£6 million in practice manager development;**
- roll out the recently published HEE Community (District) and General Practice Nursing Service Education and Career Framework and the accompanying HEE Education and Career Framework;
- implement the Queen's Nursing Institute Voluntary Education and Practice Standards for District and General Practice Nursing; and
- work with general practice to ensure general practice nurses have access to mentorship training.

This also needs to be supplemented at a **local level**, and for the first time - through the Planning Guidance – the NHS locally has been asked to produce plans to address workforce issues in general practice. We will review these plans in the summer, and identify any further actions that need to be taken or ideas that can be spread nationally to accelerate the growth, retention and development of the general practice workforce.

The vanguard sites that are testing new integrated models of care and the GP Access Fund schemes are already developing many different ways of using the wider workforce, and proving that this can be better for patients and free up GP time.

A balanced GP workforce

The model of independent contractor status and partnership has proved a valuable foundation for general practice. Partners provide leadership and continuity, and in recent years this has been invaluable as general practice has come under pressure.

We also recognise that a more flexible workforce better enables practices to secure short-term support to cover sick leave, parental leave or transition periods between leavers and joiners. However many practices now report that a shift to reliance on locums is undermining service continuity and stable team working.

It is therefore in the interests of GPs and practices to improve the relative attractiveness of partner and salaried positions versus a shift to a more unstable and short term workforce.

First, **we will work with the profession to introduce new measures entitling GPs who want flexible working but who can commit to working in a practice or an area for a period of time, additional benefits relative to undertaking a rolling series of short term locum roles**. In other words, while continuing to incentivise partnerships and salaried commitments to practices on the one hand, we also want to **create an alternative to day-by-day or week-by-week locuming for those at a point in their career or family life who need more flexibility**.

Second, NHS England will set indicative rates for locums and will ask practices to indicate in the annual e-declaration information where they are having to pay above those rates. This is to understand the scale of the issues practices are facing and help plan how we can target workforce support to areas facing the greatest pressures.

Third, we envisage 'at scale' working in larger practice groupings will create opportunities to embed a more locally focused team based approach which incorporates locums.

Promoting health and wellbeing to combat burnout

A new national service is being established to improve GPs' access to mental health support. Support for GPs suffering mental health problems is part of NHS England's plans to retain a healthy workforce. **NHS England has already committed to spend up to £3.5 million in this new service, and will now increase that investment by a further £16 million**. The procurement will start in June 2016 and the service is expected to be available across England from December 2016. This means all GPs will be able to access free, confidential local support and treatment for mental health issues, supporting GPs who are at risk of suffering stress or burnout.

Implementation

We will establish a new Workforce 2020 oversight advisory group, with representation from national bodies, to steer the delivery of this ambitious programme, and review where further actions need to be taken in light of progress nationally and locally over the next five years.

CASE STUDY

Multidisciplinary workforce - West Wakefield Multispecialty Community Provider (MCP)

West Wakefield Health and Wellbeing Ltd is a GP Federation in West Yorkshire serving a population of 65,000 and is a wave one GP Access Fund site. It is now leading one of the new care models MCP vanguard sites with two other GP networks covering a total population of 152,000 people.

Among a series of initiatives designed to relieve pressure on GPs, they are training care navigators to break down the automatic assumption that a GP appointment is the best first place to go for any problem.

As well as reduce the number of patients needing to access their GP, care navigators are able to 'queue bust' at reception by offering patients who arrive at the practice advice to signpost them to the most appropriate solution for their needs.

Over 70 staff have received training on available resources, services and innovations within the practice and MCP programme, and in the wider voluntary and third sector.

#GPforwardview

Chapter 3: Workload

We will reduce practice burdens and help release time

Support for general practice with the management of demand, diversion of unnecessary work, an overall reduction in bureaucracy and more integration with the wider health and care system including:

- Major £30 million 'Releasing Time for Patients' development programme to help release capacity within general practice (see also Chapter 5).
- New standard contract measures for hospitals to stop work shifting at the hospital/general practice interface.
- New four year £40 million practice resilience programme, starting in 2016.
- Move to maximum interval of five yearly CQC inspections for good and outstanding practices.
- Introduction of a simplified system across NHS England, CQC and GMC.
- Streamlining of payment processes for practices, and automation of common tasks.

Workload was identified by the 2015 BMA survey as the single biggest issue of concern to GPs and their staff. Latest research, published in the Lancet, suggests that there has been an average increase in workload in general practice of around 2.5 percent a year since 2007/8, taking account of both volume and acuity. Whilst some of this rise can be addressed by increasing the workforce, we also want to support practices in moderating demand and reforming how we support and organise services.

The Primary Care Foundation and NHS Alliance have identified the changes that will have the biggest impact in reducing bureaucracy and reshaping demand. Their report, Making Time in General Practice, identified a number of practical, high-impact ways to remove unnecessary pressures on general practice and free up time for patient care.

The report found that the top three sources of bureaucracy experienced in general practice are: the processes used to make and claim payments; keeping up to date with information from commissioners and national bodies, and reporting for contract monitoring or regulation.

The report also estimated that **around 27 percent of appointments could potentially be avoided** if there was more coordinated working between GPs and hospitals, wider use of primary care staff, better use of technology to streamline administrative burdens, and wider system changes.

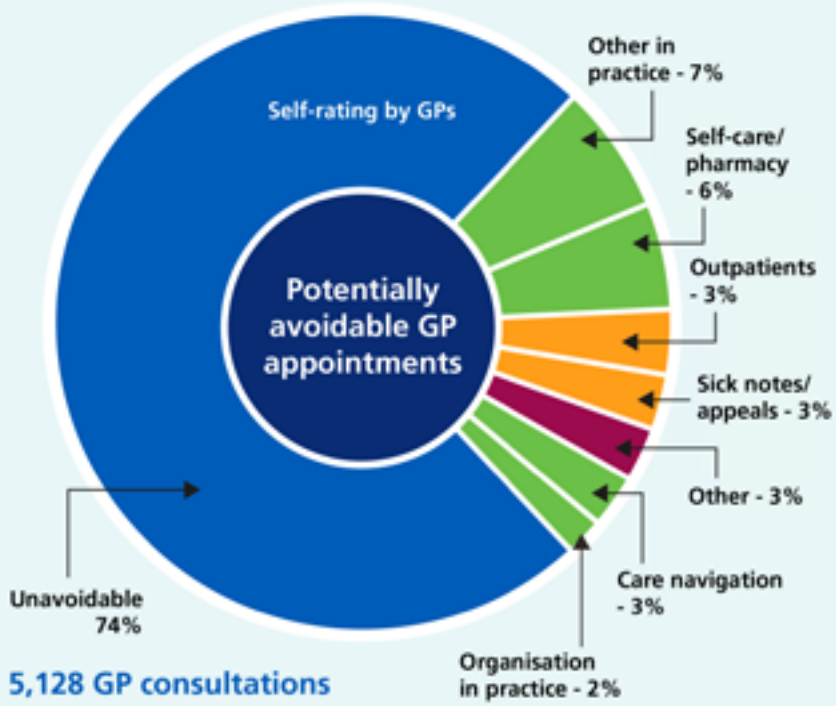
NHS England is therefore taking immediate action in the following areas:

Managing demand more effectively

NHS England is investing in a major new £30 million 'Releasing Time for Patients' development programme to support practices release time (see Chapter 5).

Practices have identified that one way of doing this is to assist patients in managing a greater proportion of their minor self-limiting illnesses for themselves. We will therefore use some of the funding for workforce and technology, outlined elsewhere in this document, to support practices in doing so.

Potentially avoidable GP appointments



In addition, by September 2016, we will have launched a **national programme to help practices support people living with long term conditions to self-care**. Practices will be offered tailored support to offer high quality care planning to patients who have low levels of knowledge, skills and confidence to manage their own health and wellbeing. The aim is to equip the workforce with the tools and skills to do this. This should help improve patient outcomes, and over time, reduce the demand in general practice. We will design this in conjunction with the wider national development programme for general practice.

GPs can also influence the commissioning of local pathways for community pharmacy to help patients with self-care and minor ailments. The developments in digital interoperability and access to a shared primary care record provide practices with an opportunity to harness this potential for reducing demand for urgent appointments.

Alongside a reformed 111 service, we will also work with CCGs to ensure they institute plans to address patient flows in their area using tried and tested ideas such as access hubs, social prescribing and evidence based minor ailment schemes.

Building practice resilience

In 2015, NHS England committed to invest £10 million to support vulnerable practices. Eligible criteria for accessing this additional support was developed with NHS Clinical Commissioners and other national stakeholders, with around 800 practices identified as meeting the criteria.

This support is designed to build resilience in primary care and to support delivery of new models of care. RCGP support for inadequate rated practices will continue as part of this programme. A multi-supplier (call off) framework will be available to commissioners from September 2016 to support the programme. This is likely to include a range of local and national providers and may be expanded over time. In order to maximise the impact of this support, from April 2016, NHS England will offer support to eligible practices that are willing to match fund this additional support, or offer the equivalent resources commitment 'in kind'.

In addition, a further **£40 million** will now be committed to develop a **practice resilience programme**, starting with a **£16 million** boost in 2016/17. We will work with the RCGP and the BMA to develop this programme as quickly as possible, and consider introducing practice resilience teams.

New standards for outpatient appointments and interactions with other providers

We have introduced a number of **new legal requirements in the NHS Standard Contract for hospitals** in relation to the hospital/general practice interface from April 2016. These should relieve some of the administrative burden on practices.

The changes include:

- **Local access policies:** hospitals will not be able to adopt blanket policies under which patients who do not attend an outpatient clinic appointment are automatically discharged back to their GP for re-referral. Also a new requirement on hospitals to publish local access policies and evidence of having taken account of GP feedback when considering service development and redesign.
- **Onward referral:** unless a CCG requests otherwise, for a non-urgent condition related to the original referral, onward referral to another professional within the same hospital is permitted, and there is no requirement to refer back to the GP. Re-referral for GP approval is only required for onward referral of non-urgent, unrelated conditions.
- **Discharge summaries:** hospitals will be required to send discharge summaries by direct electronic or email transmission for inpatient, day case or A&E care within 24 hours, with local standards being set for discharge summaries from other settings. Furthermore, the hospital should provide summaries in the standardised format agreed by the Academy of Medical Royal Colleges, so GPs can find key information in the summary more easily.
- **Outpatient clinic letters:** hospitals to communicate clearly and promptly with GPs following outpatient clinic attendance, where there is information that the GP needs quickly in order to manage a patient's care (certainly no later than 14 days after the appointment). For 2017/18, the intention is to strengthen this by requiring electronic transmission of clinic letters within 24 hours.

- **Results and treatments:** new overarching requirement on hospitals to organise the different steps in a care pathway promptly and to communicate clearly with patients and GPs. This specifically includes a requirement for hospitals to notify patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, for example, telephoning the patient.
- **Medication on discharge:** a new requirement on providers to supply patients with medication following discharge from inpatient or day case care. Medication must be supplied for the period established in local practice or protocols, but must be for a minimum of seven days (unless a shorter period is clinically necessary).

These changes apply to all acute and community providers. GPs should notify their CCG in the event that the contract is not being followed. The CCG is responsible for holding providers to account for the contract changes.

A new NHS England, NHS Improvement, RCGP and GPC Working Group will drive action to improve the current interface between primary and secondary care. The Group's work will include practical steps to enable better communication between GPs and consultants, and how to improve GP access to consultant advice on potential referrals, and managing complex cases in the community.

As part of this, NHS England has established a **Rapid Testing Programme in three sites across the country to review ways of better managing outpatient demand**. This will include assessment of the practical application of consultant hotline and advice services, enabling GPs to get rapid advice rather than referring the patient. In light of the outcome of this programme, the most effective measures will be rolled out for use by CCGs from late summer 2016 onwards. Alongside this, work is underway to make the current functionality of the Choose and Advice system more functional for use by GPs.

New software to automate common tasks

Clinicians are frequently required to undertake a series of tasks on the computer when putting a care plan in place or responding to incoming correspondence. We will work with innovative practices, federations and software suppliers to develop, test and implement the technical requirements for a new task automation solution to reduce workload. It is expected that practices will have access to the new automation function in 2017/18.

Streamlining Care Quality Commission (CQC) practice oversight

In October 2014, the Care Quality Commission (CQC) began to inspect general practice services. CQC ratings have, for the first time, provided a comprehensive assessment of the quality of care provided by practices. By April 2016, they had inspected over a third of practices (35 percent) and found that the vast majority (87 percent) are providing care that is good or outstanding.

The CQC will complete its first round of comprehensive inspections of all practices in 2016/17. CQC is consulting on changes to its regulatory model for its work thereafter.

These proposals will reduce the workload related to inspection for those practices that deliver good or outstanding care, while encouraging improvement and ensuring a proportionate approach that protects patients from the risks of poor care.

Another issue related to CQC has been that of the fees increase for registration. In recognition of this, NHS England agreed with the GPC to reflect these costs in the 2016/17 GP contract settlement to address this cost pressure for practices.

What can practices expect nationally?

- **A reduction in inspections from CQC.** This will apply once all GP practices have been inspected later this year. CQC will tailor its inspection activity, taking a more risk-based approach where it monitors and acts on intelligence and information. It will reduce the frequency of some inspections, so that it targets its resources on those practices where there is a risk of poor care. CQC will agree with NHS England and local CCGs a shared framework to understand and report on quality. **Practices rated good and outstanding - currently the vast majority - will move to a maximum interval between inspections of five years**, subject to the provision of transparent data, available to CQC, NHS England and CCGs; and also to CQC remaining assured that the quality of care has not changed significantly since the previous inspection. Where CQC has concerns, it may revisit sooner.
- **New streamlined approach to inspection for new care models and federated or super-partnerships practices.** CQC will continue to develop the way it inspects to take account of changes to the way the sector is organised and delivered, for example, through new models of care or federated practices – with a focus on the leadership, governance and learning culture of the provider, not necessarily on inspecting every single site.
- **Funding for CQC.** NHS England will discuss with the GPC how best to recognise any further fee increases and will ensure practices are appropriately compensated.
- **Improving and simplifying transparency of information about general practice.** A report from the Health Foundation to the Department of Health made a number of recommendations on valid quality indicators for general practice. A set of key 'sentinel' indicators will therefore be published on My NHS in July 2016.

A successor to the Quality and Outcomes Framework (QOF)

QOF has created a more focussed approach to chronic disease management and provides a structured way of engaging in secondary prevention. However, some argue that it has served its purpose and requires review or even replacement and that it is a barrier to holistic management of health conditions. **NHS England has agreed to undertake a review of QOF with the GPC in the coming year** to address these issues, whilst recognising that it is one of the best public health databases in the world and, done right, can support population-based healthcare.

There are already areas of the country exploring local alternatives to QOF. For practices opting in to the proposed new voluntary MCP contract (see Chapter 5) QOF will be replaced with more holistic team-based funding.

NHS England and GPC have agreed that we will discuss during the next round of negotiations the GPC's wish for the avoiding unplanned admissions enhanced service to be discontinued from April 2017.

Reporting requirements and information, and streamlining the payment system

We will introduce a simplified system for how GP data and information is requested and shared across NHS England, CQC and GMC. This will be backed by a programme of work to cut the bureaucratic burden of oversight.

We are also taking action to simplify the general practice payment system. It is unacceptable for hard-pressed practices to have to waste time chasing or reconciling payments. Where technical issues arise that may delay payments to practices, NHS England has introduced failsafe procedures that allow practices to submit activity data manually into CQRS, therefore ensuring practices cash flow is maintained.

In addition, based on a recent review of the payment processes and systems for general practice, we will now work with the payment providers to focus on:

- improvements in the consistency and accuracy of payments;
- increasing the transparency and availability of information to support them; and
- the feasibility of a single payment vehicle as a single view with an itemised bank statement like reconciliation of claims and payments.

Accelerating paper free at the point of care within general practice

General practice already has the most computerised records in the NHS, and many practices are already considered to be paperless. However, owing to a lack of interoperable systems across the NHS, its dealings with other providers are often on paper, creating risks and inefficiencies that we are committed to reducing.

Examples include tackling the significant workload involved in every practice receiving, checking and processing many prescriptions every day. Rolling out electronic prescriptions is speeding up processes for practices and helping to reduce clinical risk for patients. Work is almost complete which removes the need for practices to print paper copies of records when a patient moves practice. This is already in place for practices using the most up-to-date software, and final testing of updates for the remaining systems is expected to be completed in May 2016.

A major programme is also underway to ensure that by 2020 all incoming clinical correspondence from other NHS providers is electronic and coded. This will reduce practice workload and the risks of errors in data entry, as well as improve the usefulness of incoming information and facilitate more seamless patient care.

Promoting best practice and monitoring improvements

We hosted a series of BMA and NHS England workshops to share evidence and examples with practices of the opportunities to release staff capacity. 95-98 percent of practices that attended reported that these gave them new practical ideas to release staff time.

We will continue to support the spread of good ideas. We will monitor the impact of work to reduce pressure on practices, and we want to empower practices to also do this. We are therefore commissioning a new audit tool to be available for all practices that will allow practices to identify ways they could reduce appointment demand. This will use the same methodology as in the 'Making Time in General Practice' report and allow practices to compare themselves with the national data.

Practices in the GP Access Fund are about to begin testing of an automated appointment-measuring interface to give them detailed information about their activity and how it varies over time. This will help practices match their supply of appointments more closely to demand. We will make it available for every practice from 2017/18.

Mandatory training

Practices have told us that there seems to have been a growth in mandatory training requirements for clinicians and other practice staff. Examples include basic life support, safeguarding, information governance, health and safety, complaints handling, fire safety, fridge procedures etc. Whilst it is easy to see the justification behind each one, the sum of them all creates a significant burden on staff, and crowds out the more targeted training needs of individuals.

NHS England will work with relevant bodies to review and reduce these requirements to ensure a far more proportionate approach is taken. We will also keep in mind the impact of appraisal and revalidation requirements in the analysis.

Support for more integration across the wider health and care system

Social support

Voluntary sector organisations can also play an important role in supporting the work of general practice. For example, local models of social prescribing can enable GPs to access practical, community-based support for their patients, including access to advice on employment, housing and debt. Some areas have developed call-off services for specific groups such as carers.

Local leadership

We want all local Health and Wellbeing Boards (HWBs) to recognise the centrality of primary care in integrating their local health and care systems and the need to ensure access to all relevant support services. The Department of Health will issue guidance to Health and Wellbeing Boards asking them to ensure that joint health and wellbeing strategies (JHWSs) include action across health, social care, public health and wider services to build strong and effective relationships with general practice services. This will ensure that they understand our vision for general practice and how they can and should support it.

Work and health

There is clear evidence that good quality work is good for health and, conversely, being out of work has significant negative impacts on health. The Five Year Forward View set out a vision for the NHS to play a stronger role in prevention, including a focus on helping people at risk of falling out of work. Easier access to health services for people in employment should help individuals to seek help at an early stage, and general practice staff have a role to play in recognising when early referral or treatment may be indicated for someone at risk of falling out of work.

This means that GPs will have greater access to treatment pathways, especially for conditions that have an impact on the ability to work for large numbers of people, such as mental health conditions (IAPT) and musculoskeletal problems.

Over the last year, the Government has set up Fit for Work and will continue to develop this approach. Fit for Work offers a free advice, assessment and case management service for people who are employed and off sick. It is intended to help GPs by improving outcomes and reducing demands on them for fit notes and detailed work-related advice.

In addition, the Government will now consider whether 'early dialogue on work and health' and the resulting sickness certification (fit note) - currently restricted to registered medical practitioners - could be undertaken by other healthcare professionals.

To promote the development of social prescribing, a key measure by which patients can benefit from wider support, NHS England are appointing a new National Champion for Social Prescribing.

CASE STUDIES

General practice and community collaboration managing patient demand and making a difference to people's wellbeing - Robin Lane Medical Centre MCP

Robin Lane Medical Centre in Leeds has nine doctors, employs 50 people, has 13,000 patients and is growing. It also has a wellbeing centre, a cafe and 19 groups run by over 50 volunteer champions every week. By taking a new approach they have seen no increase in demand for primary or secondary care consultations despite patient lists increasing by 4,500 people. The practice has now established a charity to support the wellbeing centre which is run by a board of volunteer champions.

Redirecting administrative tasks away from GPs to release capacity - Brighton and Hove

In Brighton and Hove some practices have developed a robust protocol to allow clerical staff to read, code and where appropriate take action on incoming clinical correspondence, rather than the GP having to deal with every letter. Forty eight practices have now been trained and implemented workflow redirection with substantial changes demonstrated. On average, only 20 percent of letters previously directed to a GP required their direct input. This is saving an average of 40 minutes of each GP's time per day, with no significant events in the first 15,000 letters to be processed. Feedback clearly demonstrates reduced workload pressures and with the time savings generated, increased opportunity for activities related to direct patient care.

Training includes clear mechanisms to provide internal governance and auditing of activity. GPs report being satisfied with the safety of the approach, the improved quality of coding and the release of their time. Clerical staff report that they are confident to run the new process and describe renewed job satisfaction.

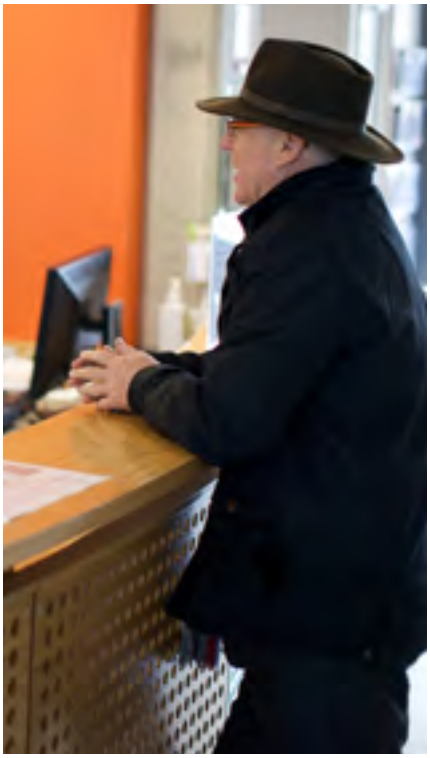
#GPforwardview

Chapter 4: Practice infrastructure

We will develop the primary care estate and invest in better technology

We will go further faster in supporting the development of the primary care estate:

- Investment for general practice estates and infrastructure – supported by continued public sector capital investment, estimated to reach over £900 million over the course of the next five years. This will be backed with measures to speed up delivery of capital projects.
- New rules on premises costs to enable NHS England to fund up to 100 percent of the costs for premises developments, up from a previous cap on NHS England funding of 66 percent (with a proposed date of introduction of September 2016).
- New offer for practices who are tenants of NHS Property Services for NHS England to fund Stamp Duty Land Tax for practices signing leases from May 2016 until the end of October 2017, and compensate VAT where the ultimate landlord has chosen to charge VAT.
- New funding routes for transitional funding support for practices seeing significant rises in facilities management costs in the next 18 months, in leases held with NHS Property Services and Community Health Partnerships.



Greater use of technology to enhance patient care and experience, as well as streamlined practice processes:

- **Over 18 percent increase** in allocations to CCGs for provision of IT services and technology for general practice.
- **£45 million national programme** to stimulate uptake of online consultations systems for every practice.
- Online access for patients to accredited clinical triage systems to help patients when they feel unwell.
- Development of an approved Apps library to support clinicians and patients.
- Actions to support the workload in practices reduce, and achieve a paper-free NHS by 2020.
- Actions to support practices offer patients more online self-care and self-management services.
- Actions to make it easier for practices to work collaboratively, including achievement of full interoperability across IT systems.
- Wi-Fi services in GP practices for staff and patients. Funding will be made available to cover the hardware, implementation and service costs from April 2017.
- A nationally accredited catalogue and buying framework for IT products and services, supported by a network of local procurement hubs offering advice and guidance.
- Work with the supplier market to create a wider and more innovative choice of digital services for general practice.
- Completion of the roll out of access to the summary care record to community pharmacy, by March 2017.

Development of the primary care estate

In 2015/16, NHS England began a multi million investment programme to support primary care and general practice make improvements in premises and in technology, as part of the overall estates strategy for the local NHS. This was backed by both capital and revenue funding, and will continue as the Estates and Technology Transformation Programme. Additional capital investment will also be flowing into general practice beyond this programme, bringing the estimated overall total of capital investment in general practice over the next five years to over £900 million.

NHS England is inviting CCGs to put forward recommendations for investment in primary care infrastructure in future years **by the end of June 2016**. CCGs are developing commissioning plans designed to provide health care services for the future and producing Local Estates Strategies, in conjunction with Community Health Partnerships and NHS Property Services.

Investment in the GP estate is needed not just to improve or extend existing facilities. We also need to increase the flexibility of facilities to accommodate multi-disciplinary teams and their training, innovations in care for patients and the increasing use of technology. And new premises may be needed to cater for significant population growth, and to facilitate primary care at scale or enable patient access to a wider range of services.

Investment in infrastructure can require planning permissions, building regulation approvals, procurements and construction. Given concerns about delays, and the handling of revenue consequences, we have made some changes in response:

- Firstly, the programme of **capital investment will now accommodate schemes that need support over more than one year**.
- Secondly, we will **invest in 'at scale' project support** for schemes to enable them to move quickly through the financial, legal and design processes.
- Thirdly, we have discussed with the GPC changes to the rules governing the funding of premises so that over the next three years NHS England will be able to increase the levels of funding for a wider range of improvements to practices and new facilities. NHS England will work with the Department of Health with the aim of introducing **new rules from September 2016 which will enable NHS England to fund up to 100 percent of the costs of premises developments, rather than the previous cap of 66 percent funding**.

NHS England will agree arrangements to come into place from 1 May 2016 until 31 October 2017 to provide **additional support to practices** in three areas:

- Stamp Duty Land Tax for practices
- VAT on premises, where the ultimate landlord has elected to charge VAT
- Transitional support where practices have seen a significant increase in the costs of facilities management on leases held with NHS Property Services and Community Health Partnerships. We will work quickly to clarify the route by which this new funding support can be provided.

NHS Property Services and Community Health Partnerships are working with CCGs in local areas to agree local estates strategies. CCGs will agree the improvements that will be made so that buildings are used productively and provide the capacity and flexibility that is required. While there are some GP practices that urgently require improvement, there are buildings which are unused or underutilised. Working with their CCGs and estates advisors, general practices will need to help to ensure that buildings are all used productively and effectively.

We will also work more closely with NHS Property Services using existing premises rules to unlock opportunities to transform primary care services, for example, considering wider commissioning gains against underwriting lease arrangements or buying out GP or third party owned premises.

In addition, the Department of Health is working with Community Health Partnerships to mobilise the potential of public and private sector partnerships in the development of the primary care estate, building on the LIFT programme which covers almost half the country.

Investment in better technology

New technology is already playing an important role in improving patient care. Practices round the country are using technology to move from paper to digital records, offering online transactions including online registration, appointment booking, ordering of repeat prescriptions and viewing of medical records. Some practices have gone far beyond these more transactional interactions, and we now need to support much more widespread adoption of their innovations.

A growing number of practices are introducing new apps and web portals that help patients assess and manage their own health risks. These provide information, symptom checkers and sign posting to alternate services, such as community services, expert patient groups and community pharmacies that also have a large role to play in health promotion. They also can include online and telephone consultations.

What does this mean for practices?

Our ambition is to support the adoption and design of technology which:

- enables self-care and self-management for patients;
- helps to reduce workload in practices;
- helps practices who want to work together to operate at scale; and
- supports greater efficiency across the whole system.

We will do this in three ways:

- through **extra investment** – with an increase of over 18 percent going into allocations for CCGs for the provision of IT and technology services for general practice, and a specific **£45 million** multi-year programme to support the uptake on online consultation systems;
- through **setting new core requirements** – making it clear what general practice should be able to expect from IT services, and creating a new framework to assess progress – the Digital Primary Care Maturity Index; and
- through **national enabling work** – to both stimulate the development of the supplier market, and provide certain functions at a national level where that makes sense.

Core GP information technology (IT) services

NHS England is introducing a greater range of core **requirements for technology services to be provided by vendors to general practice** through the CCG-controlled GPIT budget. During 2016/17, services should include:

- the ability to access digital patient records both inside and outside the practice premises, for example, on home visits;
- specialist support including services for information governance, IT and cyber security, data quality, clinical system training and optimisation, clinical (systems) safety and annual practice IT review;
- outbound electronic messaging (for example, SMS) from the practice for direct individual patient clinical communication;
- the ability for patients to transact with the practice through online appointment management, repeat prescription requests and access to their detailed record and test results, with the aim that at least 10 percent of patients will be using one or more online services by the end of this year;

- the ability for electronic discharge letters/summaries from secondary care to be transmitted directly into GP clinical systems – from June 2016; and
- specialist guidance and advice for practices on information sharing agreements and consent based record sharing – from December 2016.

This will be extended further in 2017/18 with:

- funding for Wi-Fi for staff and patients within practice settings;
- the ability to access data and tools that aid GPs (and local commissioners) in understanding and analysing demand, activity and gaps in service provision allowing effective planning, resourcing and delivery of practice services - from June 2017;
- a national framework for the cost-effective purchase of telephone and e-consultation tools - from December 2017;.
- funding to support education and support for patients and practitioners to utilise digital services to best effect and impact - from December 2017; and
- enhancements to the Advice and Guidance platform on the e-referral system to allow two way conversations between GPs and specialists, alerts to let GPs or other practice support staff know when a response (or no response) is received, interoperability with the clinical software system, easier conversion from advice to referral where clinically necessary, and decision support tools to help direct referrals correctly.

Each locality is different with its own mix of demographics, service pressures, commissioning priorities, and local relationships. So, in addition to funding for core GPIT services, CCGs will also have access to funding for subsidiary technology services to support their GP practices. Over time, some of these local investments may become core service offerings once adoption becomes widespread and benefits evaluated. These will include technologies and digital tools:

- to help practices operate collaboratively, such as shared care planning, or telephone and appointment management systems;
- to help practices in becoming more efficient (for example,reduced printing and filing of paper records, online ordering of diagnostic tests); and
- to join up pathways between different healthcare sectors and professional groups, for example, pharmacists.

At a national level, NHS England will continue with its programme of work that supports this direction of travel. This includes:

- the development of online access for patients to clinical triage systems to help patients when they feel unwell;
- the development of an approved Apps library to help GPs to recommend apps that might best suit patients' needs and where there is evidence of clinical efficacy; and
- a range of technology initiatives to drive towards improved practice efficiency and a paper-free NHS by 2020:
  - increase uptake of the electronic prescription system (EPS) and training for batch prescribing;
  - increase electronic transfer of records between practices
  - improve remote data extraction to reduce manual processes;

- access to summary care records in community pharmacies;
- accelerate access to patient records across different services;
- interoperability of different clinical software systems;
- automation of tasks and appointment software to help match appointment supply to demand.

To stimulate the uptake of new technologies, NHS England will be clear that practices can bid for additional technology resource as part of the Estates and Technology Transformation Programme.

In addition, from 2017/18 NHS England will launch a new programme to offer every practice in the country over the coming years support to adopt **online consultation systems.** Depending on uptake, there will be up to **£45 million extra investment** to support this.

Building on the successes of existing procurement approaches, future primary care digital services will be available through a national accredited catalogue with national and regionally negotiated buying frameworks, supported by a network of local procurement hubs offering advice and guidance.

We expect practices and CCGs to work closely together to realise the benefits of this approach and to exploit the opportunities of collaboration through GP federations, locality footprints and local procurement hubs. A new system for measuring the maturity of digital primary care will help CCGs improve commissioning.

NHS England has also published an overarching Interoperability Strategy that enables information sharing, based on Open Application Interfaces (APIs) using open industry standards (HL7 FHIR) and underpinned by key digital standards (the GP Connect project). The standards prioritised will:

- support federated practices by enabling appointments in one practice to be booked from another or an administrative hub using different clinical systems; and
- let healthcare professionals from different settings inform and update a practice through the sending and management of tasks.

NHS England will work with professionals to ensure that these standards on interoperability and control of patient data will become embedded in the minimum standards required for accreditation of future digital primary care systems. NHS England and HSCIC will work with the supplier market to create a wider and more innovative choice of digital services for practices, helping them to improve the way they work and the care they deliver.

The forthcoming publication of the National Data Guardian's review of data security and consent/opt-outs will support GPs by clarifying data security standards, resolving issues around data flows, and proposing a new model for data sharing.

Practices have identified that one way of doing this is to assist patients in managing a greater proportion of their minor self-limiting illnesses for themselves by using online resources. We will therefore use some of the funding for workforce and technology, outlined elsewhere in this document, to support practices in doing so.

CASE STUDY

Redesign of space to enhance capacity for clinical consultation - St Helen's, Merseyside

NHS England has provided a £63,790 contribution to support the development of St Helens Rota, Albion Street. The development, which included an extension to the existing building, will allow the practice to create an additional consulting room plus additional office / meeting room space.

The project will also create an additional Skype triage room within the current patient waiting room. This will allow clinicians to undertake more urgent care such as children's clinics and general clinics especially during the day-time, for example, in hours, particularly during times of increased winter demand, when urgent care services such as A&E are under most pressure.

CASE STUDY

Major expansion to practice buildings offering a wider range of treatment areas and access to care - New Hayesbank Surgery, Kennington

NHS England funding is being used to fund a major extension of the practice building, adding seven clinical rooms, a theatre for minor operations, along with recovery rooms and a larger reception area. The additional treatment areas will enable the practice to offer more appointments and provide more vital local treatment. Building work started in November 2015 and the new premises are to be open to patients later in 2016.

CASE STUDY

Digital services - Modality

Modality MCP, recognising that Birmingham has the highest proportion of smartphone users in the UK and that more than 80 percent of people make transactions on broadband, developed an app through which people can book appointments, send messages to clinicians and provide real-time feedback.

Individuals with long term conditions who previously might have attended A&E at the weekend and been admitted to hospital are often now able to avoid a crisis by 'sending a quick message to their doctor'.

Modality's call centre handles up to 1,300 calls per day, with most patients now given advice or treatment without visiting a surgery. Around 90 percent of both Skype consultations and call-backs by GP partners are closed without a surgery visit. Salaried GPs and advanced nurse practitioners close nearly half of their telephone consultations in the same way.

Modality's work to improve access has seen:

- a 72 percent fall in 'did not attends' (because fewer patients book well in advance as they are confident of speaking to a clinician when they need to)
- the ability to meet increases in demand within existing resources
- average remote consultation times falling to under five minutes
- 70 percent of patients say the new system has improved access
- 100 percent of clinicians agree they would not go back to the old system.

CASE STUDY

'My Healthcare' - Birmingham South and Central

My Healthcare is extending GP opening hours and reshaping how over 120,000 patients, from 23 practices, access health services. The scheme joins up primary care, community based services and urgent care providers, including local walk in centres, via a single point of contact. Services can be accessed and delivered physically and virtually through a hub system, across three sites, seven days a week, from 8am – 8pm by a multi-disciplinary team, including an advanced nurse prescriber, GPs, community nurses, pharmacists, a roving doctor and an out-of-hours doctor.

Using digital technologies (once patient consent is obtained), clinicians working within any hub, have access to patient records from all of the member GP practices. Interoperability, across the system, enables staff to access clinical records and send an electronic summary of the consultation to the patient's registered practice, enabling continuity of a fully informed healthcare record. With a variety of choices for patients, including booking appointments and ordering prescriptions online and telephone or video consultations, the services suit different lifestyles, health needs and personal circumstances.

A roving doctor service, designed to see patients within two hours of contacting their GP, has helped reduce the number of patients needing emergency care. The service, triaged by an on-call GP, is for patients who need a home visit but are not at the point of needing hospital care. This model of service delivery, when in full operation, is expected to create over 90,000 additional appointments per year, with no patient in the area being more than three miles from a hub.

Other future improvements will include a click and collect prescribing service for prescriptions and a lifestyle app to help GPs gain a holistic view of patient health. Patients using the app will benefit from video consultations via the app, instant messaging, a symptom checker, and feedback to/from patients.

Patients and clinicians who have used the service have provided positive feedback. NHS Birmingham South and Central CCG has already commissioned two extra hubs, in response to the success of My Healthcare so far. The CCG is now working to expand the scheme to include all of its 55 member practices.

Chapter 5: Care redesign

We will provide a major programme of improvement support to practices

Support to strengthen and redesign general practice:

- Commissioning and funding of services to provide extra primary care capacity across every part of England, backed by over £500 million of recurrent funding by 2020/21. This forms part of the proposed increase in recurrent funding of £2.4 billion by 2020/21.
- Integration of extended access with out of hours and urgent care services, including reformed 111 and local Clinical Hubs.
- £171 million one-off investment by CCGs starting in 2017/18, for practice transformational support.
- Introduction of a new voluntary Multispeciality Community Provider contract from April 2017 to integrate general practice services with community services and wider healthcare services.

A new national three year 'Releasing Time for Patients' programme to reach every practice in the country to free up to 10 percent of GPs' time.

- Building on recent NHS England and BMA roadshows, spread the best innovations across the country, helping all practices use 10 High Impact Actions to release capacity.
- Learn from the GP Access Fund and vanguard sites to support mainstreaming of proven service improvements across all practices.
- Fund local collaboratives to support practices to implement new ways of working.
- Provide free training and coaching for clinicians and managers to support practice redesign.

Support to strengthen and redesign general practice, including delivering extended access in primary care

Public satisfaction with general practice remains high, but increasingly, we are seeing patients reporting more difficulty in accessing services. We know that many practices report that they would like to offer better access, but that they are experiencing increasing pressure and are having difficulties in offering their patients timely appointments. This is frustrating for practice staff, and for patients alike.

NHS England will provide additional funding, on top of current primary medical care allocations – **over £500 million by 2020/21 - to enable CCGs to commission and fund extra capacity across England to ensure that by 2020, everyone has access to GP services, including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services.**

So how is this achievable at a time of such challenge to general practice?

Of course, good access is not just about getting an appointment when you need it. It is also about access to the right person, providing the right care, in the right place at the right time. Experience from the £175 million investment over the last two years in the GP Access Fund sites covering 18 million patients has demonstrated that enhanced access relies on working across providers and redesigning the way services are delivered, working with patients and making best use of four key elements:

- enabling **self-care and direct access to other services**, for example, online self-management and signposting to other services;
- better use of the talents in the **wider workforce**, such as advanced nurse practitioners, clinical pharmacists, care navigators, physiotherapists and medical assistants;
- greater use of **digital technology**, for example, apps connecting patients to their practice, phone and email consultations, webcams links with care homes.

- **working at scale across practices to provide extended access collectively**, in a similar way to how many GPs currently collaborate within GP co-operatives to provide out of hours care. These services are often called **Primary Care Access Hubs** and offer additional clinical capacity across a group of practices. Patients are referred there by the local practices, often after some degree of triage process to ensure they are suited. They are then seen and managed at the hub, often by a local GP or nurse, with the benefit of access to the patient's medical record.

We will now build on the lessons learned from the GP Access Fund schemes to support CCGs in commissioning additional capacity more consistently across the country, and in developing closer links with urgent care and out-of-hours services. Done well, this can lay the foundations for transforming the way in which other general practice and community services can be delivered collectively too.

We have set out below some of the key questions raised.

Who will be responsible for commissioning and providing these services?
CCGs, working in conjunction with their urgent and emergency care networks, will be responsible for commissioning these services to expand capacity. CCGs will be required to ensure that this extra investment in general practice dovetails with plans to develop a single point of contact to integrated urgent care and GP out of hours services, accessed through a reformed 111 service. In addition, we will be seeking more joined-up services, for instance, hubs hosting GP out of hours bases, community nursing teams and greater access to diagnostic services. CCGs will be required to meet minimum requirements before accessing the additional funding.

Does this mean every practice will have to open at evenings and weekends?
Delivering improved evening and weekend access is **not** about every GP or every practice nurse having to work seven days a week. Nor does it mean that every practice in the country needs to be open seven days a week. It will mean that groups of local practices and other providers will be offered the funding and opportunity to collaborate to staff improved in and out of hours services.

The provider could be a Federation if local GPs decide to express interest. It could also be a mix, for example, a Federation supplying additional capacity on weekdays and Saturdays, with an existing urgent care organisation providing pre-bookable GP appointments on a Sunday.

Who decides what the service looks like?
The balance of pre-bookable and same-day appointments, and the level of capacity required on different days of the week, will be up to individual commissioners and schemes to determine in light of patient demand in their area and to ensure best value for money.

There will be some minimum requirements and these will be published later in the year. They will be tested with the current GP Access Fund sites during 2016/17, ahead of further roll out to more parts of the country in 2017/18 and years beyond.
How will it be rolled out?
Waves of increasing recurrent funding will be made available each year, linked to CCG plans, to support the overall improvements in general practice. This phased increase in investment is designed to match the planned growth in the workforce.

What support will there be?
This document sets out a range of national action to provide support to practices over the coming years, whilst the core funding for general practice increases. In addition, NHS England will ask CCGs to **provide £171 million of practice transformational support**.

This is designed to be used to:

- stimulate development of at scale providers for extended access delivery;
- stimulate implementation of the 10 high impact changes in order to free up GP time to care;
- secure sustainability of general practice to improve in-hours access.

CCGs have a responsibility to ensure a balanced financial position, and will want to target investment in practice support where it can have most impact.

What does this do to my existing workload?
Offering a greater range of evening and weekend appointments, for example, through a local access hub, should improve overall patient flow and help reduce avoidable demand across the system. GP Access Fund areas are already reporting improvements and the intention is that all practices will benefit from this reduction in workload as they are rolled out.

It is vital that alongside extending hours we also strengthen in-hours services. In addition to improving local appointment capacity, there will be investment in online resources that will help patients self-manage, for example, more self-help content on NHS Choices, online consultations and 111 Online, which is currently in development. As part of the review into urgent and emergency care there will also be a step change in the 111 phone service.

A new Multispeciality Community Provider (MCP) contract

Through the actions in this document we aim to sustain, renew and strengthen general practice. The MCP model is a fundamental element of this plan, currently being developed by 14 MCP vanguards across the country.

Today the range of services funded within general practice owes much to history rather than optimal working arrangements for GPs or patients.

The MCP model is about creating a new clinical model and a new business model for the integrated provision of primary and community services, based on the GP registered list, but fully integrating a wider range of services and including relevant specialists wherever that is the best thing to do, irrespective of current institutional arrangements.

At the heart of the MCP model, the provider ultimately holds a single whole population budget for the full breadth of services it provides including primary medical and community services.

Armed with that larger budget and the flexibility to deploy it, the job of the MCP is to focus on better population health management, to suit different groups of the population, and get away from the treadmill of the 'one size fits all' 10 minute consultation followed by outpatient referral or prescription. This means:

- a stronger focus on population health, prevention, and supporting and mobilising patients and communities;
- more integrated urgent care as part of a reformed urgent and emergency care system;
- integrated community based teams of GPs and physicians, nurses, pharmacists, therapists, with access to step up and down beds, in reach into hospitals, for example, redesigning outpatients, geriatric care, and diagnostics as part of extended community based teams.

NHS England will shortly publish the MCP Care Model Framework and contract elements describing the emerging model options in more detail. Six local healthcare systems are working intensively with us to complete the design of the contract, with the aim of going live, on a voluntary basis, in April 2017.

We are working through the legal, contractual and payment options, but anticipate that key features are likely to include:

- the MCP defined as an **integrated provider** not a form of practice based commissioning or total purchasing. Its scope is the services it will itself be providing, not all acute and specialised services;
- **a choice of different organisational forms**, for example, a community interest company, LLP or joint venture with a local trust. Some GP federations, working with partners, may well want to become MCPs and explore this as part of the work CCGs are leading within the STP process;
- a new payment model based on combining all the existing relevant budgets within the MCP service scope;
- a new blended pay for quality and performance scheme that **replaces CQUIN and QOF at MCP level, with the ability for the MCP to flex its own internal arrangements according to local circumstances and the arrangements it makes with its constituent clinicians**;
- depending on the degree of integration of existing practices, there will be an ability for some activities/requirements currently at practice level to be performed at MCP level, including potentially elements of CQC inspections;
- NHS England will develop a model procurement process and criteria for commissioners to let MCP contracts, with a funding model dependent on the number of patients on the registered list of the practices within the MCP; and
- **new employment and independent contractor options** for MCPs to offer clinicians, whether GPs or others, including equity partnership or salaried roles. These could be instead of existing GMS or PMS, with the right for existing GMS or PMS practices either to hold a 'dormant' contract that can be reactivated, or a right to return. **Moving 'off' GMS or PMS contracts to new arrangements within an MCP will be entirely voluntary**.

Working at scale

The majority of GP practices are now working in practice groups or federations. We are seeing that these can have benefits for patients, practices and the wider system:

- **Economies of scale:** practices can create common policies and procedures once, sharing the work between all members. They can also combine their purchasing power to achieve best value.
- **Quality improvement:** some federations are becoming a focus for sharing professional development, clinical governance and service improvement, and are building in-house expertise to benefit all practices.
- **Workforce development:** many are also providing new opportunities to train and support staff, improving resilience and enabling new ways of working.
- **Enhanced care and new services:** the GP Access Fund and vanguard programmes are demonstrating how collaboration at scale makes it possible to improve access, introduce new members of the workforce and provide innovative care in ways that are simply not possible at the level of a single practice.

- **Resilience:** a growing number of federations are helping practices improve their resilience through sharing back office functions, developing business intelligence systems and creating shared pools of staff.
- **System partnerships:** establishing a shared identity across practices makes it easier for primary care to have a larger voice in the local health and care system, and facilitates partnership working with other providers. This is key to creating new models of care for the future.

These are welcome developments we wish to see grow in coming years. We will share these examples more widely to ensure that all emerging groups are able to benefit from opportunities to expand services, stabilise practice income and realise the benefits that working at scale offers.

We will continue to ensure that national investment programmes, such as on access and new care models, support the development of at-scale infrastructure.

National three year 'Releasing Time for Patients' development programme

For many years, the improvement support offered to other parts of the NHS such as the acute sector has not been matched by equivalent support for primary care.

In 2014/15, NHS England established an initial development programme for general practice, offering support to practices that were part of the GP Access Fund schemes – to enable them to work together, and to introduce new ways of delivering care, such as telephone consultations or different use of other professionals in the general practice workforce. The feedback on this programme from GPs has been positive, with 96 percent reporting that it had a large impact on their ability to lead rapid service redesign.

We want to scale up the offer of support to practices to accelerate change. So in 2016/17 we will establish a new national development programme, available to all practices, with an investment of £30 million over three years.

The main components proposed for the programme are:

- **Innovation spread:** a national programme to gather and disseminate successful examples and measure impact. This will include support on implementation of the Ten High Impact Actions, and a specific focus on addressing inequalities in the experience of accessing services, where there are national trends.
- **Service redesign:** locally hosted action learning programmes with expert input, supporting practices and federations to implement high impact innovations which release capacity and improve patient care.
- **Capability building:** investment and practical support to build change leadership capabilities in practices and federations, enabling providers to improve quality, introduce care innovations and establish new arrangements for the future.

Ten High Impact Actions to release capacity

Measuring workload and improvement

Currently it is difficult for practices or commissioners to assess their workload, identify specific priorities for action or track improvements. Creating new tools to measure demand and activity is therefore important to empower practices and monitor progress.

A rapid clinical audit was developed for the 'Making Time in General Practice' report which allowed practices to measure appointment demand. We will commission a simple online version of this for all practices, to allow them to identify ways they could reduce pressure for GP appointments and compare themselves with others.

Practices in the GP Access Fund are about to begin testing of an automated appointment-measuring interface to give them detailed information about their activity and how it varies over time. This will help practices match their supply of appointments more closely to demand. We will make it available for every practice from 2017/18.

Stimulating local support

CCGs have a legal responsibility to improve the quality of care in general practice. A growing number are also focusing on the need for significant provider developments in order to meet the changing needs of their population and address current pressures.

CCGs will need to strengthen arrangements for protected learning time and backfill to enable GPs time and space for development. Many are already providing significant support for practices and federations to redesign care and build more sustainable organisations for the future, but the current provision of support is too patchy. We wish all practices in England to benefit from locally funded development.

CCGs who have already been involved in provider development are finding that three things are most effective: creating space for practices to meet and plan together, through funding backfill; providing expert facilitation to make rapid progress on reviewing options and creating improvement plans; and focusing development on improving care and ways of working before addressing questions of organisational form. CCGs are encouraged to ensure their Sustainability and Transformation Plans contain details of their approach and plans for provider development. NHS England will review these in summer 2016.

Support, consultancy and capability-building for general practices are available from a range of regional and local bodies. We will work with them to ensure that practices and federations have ready access to credible, relevant and high quality support for the full range of their development needs. We will develop frameworks to enable practices to choose the support that is right for them.

This national development programme will be designed in collaboration with practices, professional leaders and improvement experts. Further details, including how federations and practices can join, will be published in the summer.

CASE STUDIES

Same day access - Southern Hampshire

In the Better Local Care (Southern Hampshire) vanguard, four practices have created a Same Day Access Service (SDAS) which pools the same day primary care workload and workforce for the four practices into a single service, operated from a central location at Gosport War Memorial Hospital. The SDAS operates from 8am-7pm, Monday – Friday. Patients call their own surgery and those who require same day advice or care are managed in the SDAS.

Of 5,500 patients referred to the service in its first six weeks of operation, 3,350 (61 percent) were able to have their needs met on the telephone. The remaining 2,150 patients attended a face-to-face SDAS consultation. The face-to-face consultation service is staffed by GPs, emergency nurse practitioners, paediatric nurses and practice nurses.

The initiative has contributed to greater GP availability in the practices; better working conditions for practice staff; longer appointments available for patients with complex needs; and reduced waiting time for routine appointments.

Providing 8am-8pm access to GP services - Morecambe

This involved five pilot practices where patients at all sites have access to a GP triage service between the times of 6.30pm-8pm during the week (above usual offering of until 6.30pm) and 8am-8pm on the weekend.

Both the weekday telephone triage and pre-bookable weekend services are provided at a central site at Morecambe Health Centre, chosen because of its co-location with the same day service (SDS) and the out of hours (OOH) service.

The service is staffed by existing GPs from the participating practices and is supplemented by an Advanced Nurse Practitioner (ANP) at weekends. Since the 8am-8pm service has been operational, an additional 31 hours of non-core GP time has been made available per week to provide both access to GP triage calls or face to face appointments at weekends. Over this period, an additional 16,400 appointments have been made available of which 79 percent were by telephone. Over the Easter bank holiday weekend, over 400 calls were received by the service. Of these, 300 were triaged and resolved and only 5 percent were required to be booked in elsewhere in the system (SDS or their own GP practice for example).

#GPforwardview

Conclusion

General practice is under pressure. This affects patients, and it impacts on the wider NHS. Yet, given the nature of future health needs, never have we as a country needed great general practice services more.

Implementation

This is a substantial package of investment and reform. What matters now is getting on and delivering it so that practices can start to feel the difference. An advisory oversight group with patients and partners (including the GPC and the RCGP) will steer the implementation of the measures outlined in this General Practice Forward View. This is a five year programme of work, and it will be important that we continue to learn and respond to changing circumstances.

Overview of measures

Our priorities will be:

- **investing a further £2.4 billion a year by 2020/21 into supporting and growing general practice services. This represents a 14 percent real terms increase**, reversing the decline in general practice funding, and raising the proportion of investment in general practice to over 10 percent of the NHS England healthcare budget. It is likely to grow even further as CCGs shift care and resources into the community;
- **supplementing this with a one off Sustainability and Transformation package of non-recurrent investments, totalling over half a billion pounds** over the next five years.

The package will include:

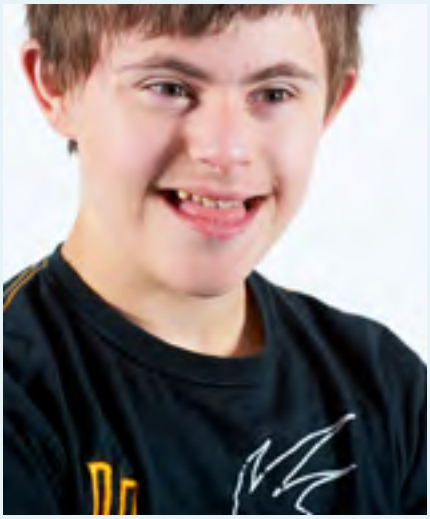
- **£40 million for a new practice resilience programme** starting in 2016/17, and **an extra £16 million to provide services for doctors suffering from burn out;**
- **£206 million for workforce measures** to grow the medical and non-medical workforce, including:
  - Major national and international recruitment campaigns to **double the growth rate of doctors** working in general practice;
  - A new offer to every practice in the country to access a **clinical pharmacist** – leading to an extra 1,500 pharmacists in general practice;
  - Support for every practice to help their reception and clerical staff play a greater role in signposting patients and handling paperwork to free up GP time;
  - Investment in **practice nurse** development and return to work schemes;
  - Investment in practice manager development
  - Piloting medical assistant roles; and
  - Training and investment for **1,000 new physician associates, and 3,000 new mental health workers** to support practices;

All supported by a network of multi-disciplinary training hubs;

- **£246 million to support practices in redesigning services**, including a requirement on CCGs to provide around £171 million of Practice Transformational Support and a new national £30 million **Releasing Time for Patients** development programme for general practice, to help practice **release capacity and work together at scale**, enable self-care, introduce new technologies, and make best use of the wider workforce, so freeing up GP time and improving access to services;

- **Supporting the increased use of technology** backed by both increases in recurrent funding for GP IT, and investment to support the take up of online consultation systems in every practice;
- Adopting an intelligent approach to introducing extended access through flexibilities in delivery of the Government's access commitment, enabling **integration** with out of hours provision, the ability for extended access to boost overall capacity and reduce demand in normal working hours, and an understanding that no GP will be forced to open seven days or work seven days;
- **Supporting new models of care** in vanguard sites, to spread innovative solutions, and the development of a voluntary MCP contract for larger GP groups and community health services;
- **Improving the interface between hospitals and general practice**, beginning with changes to the NHS Standard Contract from April 2016;
- Continuing to make **capital investments**, with the estimated likely capital investment over the next five years to reach over £900 million;
- Bringing forward proposals to tackle **indemnity costs;** and
- Reducing the frequency of CQC inspection for good and outstanding general practices, whilst continuing to protect patients and drive up quality.

Taken together, these measures represent the most far-reaching support offered to general practice in a decade.



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Report of the Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6 October 2016

Subject: Clinical Commissioning Groups' annual update

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Summary statement:

This report provides an update on Clinical Commissioning Group achievements and challenges for 2015/16.

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Portfolio:

Health and Wellbeing

1. **Summary**

This report provides an update on Clinical Commissioning Group achievements and challenges for 2015/16.

2. **Background**

Clinical commissioning groups (CCGs) are clinically-led statutory NHS bodies responsible for planning, buying (commissioning) and monitoring health care services in their local area.

Commissioning is about getting the best possible health outcomes for the local population, by assessing local health needs, deciding priorities and strategies, and then buying services on behalf of the population from a range of organisations including hospitals, clinics and community health bodies. CCGs are responsible for the health of their entire population and their performance is measured by how much they improve outcomes.

CCGs are:

- membership bodies, whose members are constituent local GP practices;
- led by an elected governing body made up of GPs, a nurse and a hospital consultant, and lay members;
- responsible for about 60% of the NHS budget;
- responsible for healthcare commissioning, including mental health services, urgent and emergency care, planned hospital care, and community care;
- independent and accountable to the Secretary of State for Health through NHS England.

NHS England directly commissions highly specialised services (such as bariatric surgery) and primary care (services provided by family doctors, pharmacists, opticians and opticians). CCGs work with NHS England's local area teams to ensure joined-up care. Some CCGs – including Bradford City and Bradford Districts CCGs - also jointly commission services from local GP practices.

Through health and wellbeing boards, CCGs work closely with local authority public health teams to achieve the best possible health outcomes for the local community. Together they develop a joint needs assessment and strategy for improving the health of local people.

3. **Report issues**

UPDATE ON HOW WE ARE PERFORMING

Working with local people

We want to deliver high quality and safe services for the people of Bradford, Airedale, Wharfedale and Craven. Engaging local people in a meaningful way is central to the way we work and to understanding the needs and experiences of people who use the health services we commission.

Our vision for engagement is to involve the people and communities in all of our work so they can help shape our decision-making and priority setting. Effective engagement will help us to improve patient experience, improve health outcomes, as well as make the best use of public resources.

There are a number of ways in which we do this across the three CCGs by working with local patient groups, the voluntary and community sector, and organising or attending engagement events and activities.

Grass Roots insight report and quality walk rounds

Grass Roots insight is the monthly insight to patient experience which captures intelligence from a variety of sources (including, for example, Patient Opinion, NHS Choices, Healthwatch, complaints, MP and public feedback, communities and voluntary sector services). Through collaboration, *Grass Roots* continues to increase its reach.

In the Bradford CCGs there is a proactive approach to insight which includes the joint quality committee regularly undertaking in-depth reviews into key areas of our commissioning and ensuring that patient, carer and community perspectives are shaping them. In the past year, deep dives, service engagement and surveys that have informed *Grass Roots* have included the urgent care strategy, access to psychological therapy services, children's experience of hospital services, and maternity services.

In Airedale Wharfedale and Craven (AWC) CCG, alongside *Grass Roots*, members of the governing body do regular walk rounds of services to listen first hand to patient's recent and ongoing experiences of their care. These visits allow the CCG to work with the providers in developing actions plans for improvement.

People's Board

The *People's Board* champions patient and public participation across the two Bradford CCGs, providing assurance, support and advice on the delivery of programmes of work. It ensures that patients and the public have a voice and - through challenge, support and co-production - are able to work with, and influence how, the CCGs delivers their vision. The idea grew from the CCGs' involvement with patients, carers and the public, via our patient networks and community engagement, right from the creation of the CCGs in 2013, and became operational in January 2016.

The *People's Board* works with the CCGs on policy and service design. Key areas of work include:

- influencing (creating two-way dialogue to inform the CCGs' decisions);
- greater transparency (holding to account and improving feedback);
- involvement and reach (ensuring we hear and involve all Bradford communities);
- effective activity (building trust to have effective discussions and actions).

Through the *People's Board* we hope to 'hard wire' the patient and public voice into our key decision-making processes. However our patients experience of primary medical care remains an area requiring improvement, particularly in relation to

access, and we are trying to find new and innovative ways of meeting the rising demand for services with limited resources.

Key Issues

Improving access to psychological therapies (IAPT) – Bradford District Care NHS Foundation Trust

Traditionally, medicines have been the only type of treatment available for people suffering from depression and anxiety disorders. The IAPT service – which involves a programme of talking therapy treatments - was created to offer them a realistic and routine first-line of treatment combined, where appropriate, with medicines. First targeted at people of working age, IAPT was opened to adults of all ages in 2010. For monitoring purposes, national targets for IAPT are based on an estimated number of patients who would benefit from access to the service and an expectation that 15% of this group will be seen each year. The Bradford CCGs fell slightly below the 15% target by 31 March 2016, with Bradford City CCG treating 1420 (14.8%) and Bradford Districts CCG treating 6135 (14.8%). AWC CCG achieved the target at 15.9%. There is a further expectation that, after using this service, at least one in every two people (50%) who receive therapy are expected to recover. Again, for patients who have received psychological therapies, those who moved to recovery fell short in Bradford CCGs with just one in three patients moving to recovery, and AWC performing below the target at 47.2%.

With the move to the lead provider model from 1 April 2016 both the implementation of the new **patient case management information system** (PCMIS) data system and the development of a full training plan will provide assurance that recovery rates will improve through 2016/17.

Constitutional measures

The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of the Constitution in their decisions and actions. The CCGs measure the performance for the services they commission against the standards in the NHS Constitution; performance for 2015/16 is shown in the table below:

	Target	AWC	City	Districts
Methicillin-resistant Staphylococcus Aureus (MRSA) (a type of bacteria resistant to a number of widely used antibiotics)	0	2	1	2
Clostridium difficile (C-Diff) (a bacterium that can be found in people's intestines)		45	14	116
Cancer two week wait (time taken to see a specialist after urgent referral for suspected cancer)	93%	96.3 %	94.6 %	95.3%
Cancer 31-day (time taken from receiving diagnosis to first definitive treatment)	96%	98.5 %	98.3 %	98.3%
Cancer 62-day (beginning first definitive treatment following urgent GP referral)	85%	89.8 %	86%	87.4%
Mixed sex accommodation (CCGs are required to eliminate unjustified mixing in relation to sleeping accommodation)	0	0	0	3
Referral to treatment (RTT) incomplete pathways (Patients yet to start treatment who have waited no more than 18 weeks from their referral)	92%	93.1 %	93.3 %	93.8%
A&E four hour wait (how long it is expected you wait at an A&E department to be treated and discharged)	95%	95.68 %	93.49 %	93.49 %
Diagnostic test waiting times (patients waiting over 6 weeks for a diagnostic test)	99%	99.7 %	98.7 %	98.4%
999 calls – Red Category A in 8 minutes (for the most serious cases, ambulances are required to arrive in 8 minutes)	75%	56.1 %	79.1 %	69.4%
999 calls – **Red Category A in 19 minutes**	95%	88.5 %	97.5 %	97.2%
A&E Handovers from crew to hospital staff	95%	82.1 %	85.1 %	85.1%

There were 133,590 attendances at Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) accident and emergency (A&E) during 2015/16 with 124,867 (93.5%) achieving the emergency care standard. At Airedale NHS Foundation Trust's A&E there were 54,744 attendances in the same period, of which 52,390 attendances met the 95.7% target. Nationally only 46 out of 165 trusts achieved the emergency care standard during October to December 2015.

While we have not seen an overall increase in attendance at BTHFT A&E through the winter period, there have been times of peak attendances, which have proved challenging. We have seen a decline in assessments through the ambulatory care unit with half as many patients going via ambulatory care. This is in spite of an increased focus by BTHFT. This implies that we have seen a greater number of people attending A&E rather than being admitted to a hospital bed (an increase of over 10% when compared to quarter 4 of the previous year), leading to an increase

in bed occupancy for patients with urgent care needs. This has resulted in high levels of high dependency unit resuscitation bed occupancy and some paediatric patients being admitted to beds outside of Bradford. In summary, the acuity of patients has proved the main challenge throughout the winter.

Although for AWC the emergency four hour standard was achieved for 2015/16, continued pressures for urgent care within the health system mean that this standard continues to be a challenge to deliver.

Attendances at Airedale Hospital's A&E department have increased over the past year. Patients who are ready to be discharged to another care provider - such as a nursing or residential home, or with a home care package - are experiencing delays for a number of reasons such as the capacity in these areas or due to a patient choosing a specific home that does not have availability.

During times of pressure through 2015/16 regular operational update meetings are held with providers and oversight is provided by our system resilience group. The emergency care intensive support team (ECIST) has been working with BTHFT to agree a phased physical redesign of A&E. The intermediate care hub and expansion of our virtual ward are key to reducing acute admissions.

Non-achievement of the A&E standard both locally and nationally is being reviewed by NHS Improvement.

The CCGs are working with partners across the health and care system to reduce unnecessary hospital admissions, transform care for people with learning disabilities, create sustainable urgent and emergency care services and to create a better environment to promote self-care and prevention.

In recent months, partners from our system resilience group (SRG) have participated in a patient flow review to look at areas of improvement across BTHFT and Airedale NHS Foundation Trust (AFT) facilitated by the Academic Health Science Network. We have also participated in a national pilot of urgent and emergency care by the Care Quality Commission (CQC) and we await feedback from the CQC on the findings of this review.

The intention of the Better Care Fund (BCF) is for health and social care to work together to ensure that a range of outcomes are met for the local population. This is explored later in the report. It should be noted that a requirement of this fund is to develop an action plan to address delayed transfers of care. This will support the providers in the delivery of the A&E standard and will enable more beds to be made available.

Ambulance response times (AWC CCG, Bradford City and Districts CCGs) – Yorkshire Ambulance Service

The ambulance waiting times standards continue not to be met by the Yorkshire Ambulance Service at the provider level overall. They are also not being achieved for Bradford Districts CCG or AWC CCG populations. The standards are being met for the population Bradford City CCG.

NHS England is piloting giving ambulance call handlers extra assessment time to improve clinical outcomes. At present, ambulance services are allowed 60 seconds before the clock starts to decide what the right course of action before dispatching an ambulance or initiating another response. Two pilots have been announced where call handlers will be allowed up to a maximum of an additional 120 seconds for assessment, before the clock starts, for all 999 calls except immediately life threatening calls (Red 1). Yorkshire Ambulance Service joined the national pilot in mid-April 2016. We expect the outcome of this pilot will change the construct of the national standard.

To support improvement of ambulance response times in areas where it is a challenge to meet them, AWC CCG has invested in a number of defibrillators to provide 24-hour access for the communities in which they are sited. These have been placed where there is high footfall from local residents, in rural areas and in other places that can be hard to reach during rush hour. If this improves response times and outcomes for patients, it can be considered across other areas in the Bradford district.

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Whilst also encouraging providers to improve, its role is to ensure that health and social care services provide people with safe, effective, compassionate and high-quality care.

Airedale NHS Foundation Trust

At the time of writing this report, Airedale NHS Foundation Trust had only just received their CQC report which had given them an overall rating of “requires improvement”. The CQC carried out its inspection from 15 -18 March 2016 and undertook two further unannounced inspections on 31 March 2016 and 11 May 2016. The report was published on 10 August 2016 and the Quality Summit was scheduled for a week later (17 August 2016). The CQC reported that services were caring, effective and responsive but needed improvement to be safe and well led. An action plan is required by 19 September 2016.

Bradford District Care Foundation Trust

In June 2014 Bradford District Care Foundation Trust (BDCFT) received an overall rating of “requires improvement” following a CQC inspection which focused on patient safety and the trust was required to implement actions to improve. The trust was subsequently re-inspected on 11-13 January 2016 as part of the new inspection regime and has subsequently received a rating of ‘good’. The CQC found that the actions to address the improvements required had all been achieved. The health-based places of safety (HBPoS) environments have been refurbished and now meet the Royal College of Psychiatrists’ guidance. The trust has also made improvements relating to the availability of medical staff to review patients on the acute wards.

Bradford Teaching Hospitals NHS Foundation Trust

In October 2014 Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) received an overall rating of "requires improvement" following a CQC inspection. The trust was required to improve in the domains of effective, responsive and well-led, was rated as inadequate for safety and 'good' for the domain of caring. The improvement focused on a number of clinical areas and governance structures including addressing a backlog of referral to treatment waiting list, infection control and cleanliness, availability and suitability of equipment and premises and involvement of staff and service users and governance systems. A total of 36 areas of improvement were required. BTHFT developed a detailed improvement programme to action the required improvements. On 11- 13 January 2016 and 26 January 2016 the CQC again undertook a focused inspection of the trust, reviewing areas that required improvement from the 2014 inspection. The inspection report was published on the 24 June 2016 and the trust has received an overall rating of 'requires improvement' with the domains of safe, responsiveness and well-led rated as 'requires improvement' and effectiveness and caring rated as 'good'. The good progress made by BTHFT was noted by the CQC. The CQC also noted several areas of outstanding practice, including collaboration with neighbouring trusts to recruit and retain a workforce that reflects the black, Asian, minority ethnic population of Bradford; leadership in the 'well-North' programme aimed at improving the health of the poorest communities and achievements in hip fracture and palliative care services.

Key messages from the 2014 inspection and noted improvements in the 2016 inspection include:

- A high volume of patients were waiting for a review of their outpatient care pathway after previously having been seen by a consultant at the 2014 inspection. The CQC in the 2016 inspection noted some real improvements in some of the core services and noted that the trust is "making significant improvements" overall in this area. The total number of patients waiting for an outpatient appointment has reduced from 205,000 to 11,790 by December 2015. In July 2016 this figure was less than 3,000.
- The stabilisation of children - the skills and experience of some staff in the stabilisation room - required improvement in 2014 and has now been fully addressed by the trust. Changes have also been made to the workforce model. The trust commissioned an external review of the service and a children and young people's board has been established.
- Improvements to non-invasive ventilation - level two high dependency unit (HDU) standards which were not being met in 2014 have now been fully addressed.
- Staffing issues, including a shortage of suitably skilled, qualified and experienced staff in line with best practice and lack of a system to triangulate staffing levels against other information remains an ongoing issue since the 2014 inspection. The CQC acknowledged the Trust's actions to address workforce issues through its approval of £2.5m of additional staffing in December 2015.
- Improvements were noted in governance and decision-making but more work is needed to ensure that this is properly embedded at ward level.

The trust has developed an 'accountability and responsibility' framework and has revised its governance structure to address ongoing improvements.

GP practice ratings

The CQC also inspects GP practices. By August 2016, 21 Bradford City CCG GP practices had been inspected, one of which was rated as "outstanding" whilst 19 were rated as "good" and one was rated as "requires improvement". Thirty-three practices in Bradford Districts CCG have been inspected - 31 were rated as "good" and two as "outstanding". Ten practices in AWC CCG have been inspected – one was rated as "outstanding", eight were rated as "good" and one as "requires improvement". GP practices rated as "outstanding" are among the top 3% of all GP practices in the country.

Bevan Healthcare CIC, a practice which provides health and social care to homeless people, asylum seekers and refugees, was one of the practices rated as "outstanding" by the CQC for the standard of care it provides to its patients, who are some of the most disadvantaged in Bradford. Professor Steve Field, Chief Inspector of General Practice, made the following statement following their recent CQC inspection; *"This is one of the best practices CQC has inspected. Bevan House was outstanding in each of the categories we inspect against and outstanding in every one of the six population groups – a remarkable achievement. The work that this practice was doing in the wider community is exemplary and deserves recognition. It is very clear that the practice is providing outstanding, personalised, patient-centred care very often connecting with traditionally difficult-to-reach patient groups."*

Where GP practices have required improvement a practice action plan has been submitted to the CQC. Progress against these plans is monitored by the CCGs.

Care home ratings

The CQC has inspected 94 out of 124 care homes across Bradford and Airedale CCGs under the new CQC inspection regime of which currently 14 (11.3%) homes are rated as inadequate, 33 (26.6%) homes require improvement and 47 (37.9%) good, leaving 30 (24.2%) still to be inspected by the CQC.

CCG KEY ACHIEVEMENTS

Mental health

Working closely with BDCFT as our main provider of services, as well as other services and organisations across Bradford, Airedale, Wharfedale and Craven, we have developed a joint action plan for improving the care for people in a mental health crisis, the crisis care concordat. As a result of the concordat, we implemented a 24-hour, seven-day, joint health and social care First Response service. The service has open access and responds to calls from anyone experiencing or encountering someone in mental health crisis. It also works closely with the police to provide 'street triage' for anyone they come into contact with who may require mental health intervention or require a place of safety. First Response has access to both the Safe Haven during the day (opened from August 2016) and The Sanctuary in the evening to avoid people having to attend A&E when they are experiencing a crisis. Both these services are provided in partnership with the voluntary sector.

This year BDCFT has worked closely with GP services to provide physical checks for over 5,000 people who have serious mental illness, and this has been highlighted as a model of best practice by the King's Fund. We have also developed the primary care wellbeing service, so we can evaluate the clinical and cost effectiveness of using a liaison psychiatry approach to treating people with medically unexplained symptoms in a non-stigmatising way in primary care. Early evaluation shows a strong case for further development and the importance of this approach has also been recognised by the King's Fund.

Our children and young people's mental health transformation plan 2015-2020, *Future in Mind*, aims to promote resilience, prevention and early intervention; improve access to effective support; provide care for the most vulnerable; develop the workforce; and be accountable and transparent. This has resulted in a clear action plan to take forward with our partners.

We are currently reviewing mental health in Bradford District and Craven to develop a vision and strategy for the mental health and wellbeing of the district to underpin a five-year transformation plan.

Self-care and prevention

Self-care is a key component of work being undertaken by the CCGs and public health which requires a mind-set change for both staff and members of the public. The 2015 theme for the Bradford district self-care week was 'self-care for life' which raised awareness about to safely treat minor ailments such as colds or fever. It also highlighted how people can live healthily and prevent avoidable, but serious, long-term conditions such as type 2 diabetes or heart disease.

A number of events took place over the week which offered tips on living healthily and well – ranging from a conga in Bradford's City Park, to wellbeing café events and more. There was also advice on hand throughout the week at community venues, GP surgeries, schools and libraries.

The Self-Care Forum announced the self-care and prevention programme as joint winners of the first National Self Care Week award. Alongside Bracknell and Ascot, Bradford and Airedale were praised for their activities during 2015.

Workforce

The integrated workforce programme (IWP) is an overarching and enabling programme that aims to work collaboratively to identify, and work towards, a system-wide integrated health and social care workforce that is fit for the future.

A successful workforce event was held in November 2015 where challenges, key priorities, good practice and potential workforce solutions were identified and brought together from a wide range of health and care, voluntary and education partners. The vision, created and developed from the event was:
"*The best people, providing seamless care, the Bradford District and Craven way*".

A number of 'big ideas' were also identified, including developing a system-wide integrated workforce strategy. The strategy was given priority during the remainder

of 2015 and was co-designed, co-created, shaped, tested and refined by partners within and across the health and care system. Work also commenced during 2015 on the shaping of the other 'big ideas' that would support delivery of the strategy and also in identifying system wide leaders to take them forward.

The strategy's success will be measured on its ability to promote health and care as the sector of choice to work for; to attract and recruit people to the Bradford District and Craven and to engage, develop and retain people within the wider health and care system in order to maximise workforce resilience and sustainability in the longer term. The underlying principles are, as far as possible, to grow and develop our own both across the system and the district as well as influencing the wider determinants of health by supporting routes into work and healthy living.

In 2016 the way people and organisations will need to work together seamlessly, in an integrated and system-wide way, will be clearly defined, communicated, measured and jointly owned through a series of milestones. There will be an expected cultural and mind-set shift to working for and with 'the system' with a shared commitment to the development and ownership of a common set of values, behaviours and core competences. The underpinning philosophy will be one of promoting prevention, self-care/self-management through the empowerment of others and, delivering direct care in a seamless and integrated way through the implementation of new models of care, to those that have more complex care needs.

The common identified priorities include:

- Co-creating and co-designing a district/system wide workforce strategy for health and social care;
- Inspiring and attracting young people to work in health and social care (11-18 years old);
- Promoting and encouraging new entrants and re-entrants to work in health and social care and in the Bradford District and Craven;
- Working with education partners to develop shared apprenticeship schemes;
- Developing a wide range volunteering opportunities;
- Developing system-wide joint leadership programmes;
- Creating and providing the conditions to attract and retain staff across a system, for example, by engaging, listening and involving; providing benefits and rewards; promoting mental and physical health, work and well-being and supporting employees to live healthier lifestyles;
- Promoting and ensuring diversity and inclusion is a common thread throughout.

Continuing healthcare (CHC)

The package of ongoing care that is arranged and funded solely by the NHS for people who are not in hospital, and have been assessed as having a 'primary health need', is an extremely busy area for us. In the last year we dealt with over 3,000 requests for assessments for CHC or funded nursing care in the Bradford

district, as well as reviewing many historic cases for funding eligibility. The CCGs' approach has been commended by NHS England.

Flagging patient records

In the first pilot of its kind in the country, five local GP practices have trialed a new way of flagging patients' access needs. This includes, for example, visually impaired people getting GP and hospital letters in alternative formats - such as large print, audio or via a phone call - so that receptionists and healthcare staff are aware of any individual requirements people may have.

Bradford CCGs

***Bradford Beating Diabetes* (Bradford City CCG and Bradford Districts CCG)**

The aim of the *Bradford Beating Diabetes (BBD)* programme is to reduce the risk, by postponing or delaying the onset of developing type 2 diabetes and to provide sufficient information and advice so patients can understand what being at risk means and about the complications associated with diabetes. The programme is supported by NHS England, Public Health England and Diabetes UK. Bradford has been chosen as one of seven national demonstrator sites for the national diabetes prevention programme.

The programme has two phases: firstly, to identify patients who, from a previous blood test, are known to be at risk; and, secondly, to identify all other eligible adults (for example, people over 40 years old, from high risk black and minority ethnic groups, and adults with conditions that increase the risk of type 2 diabetes).

Finding patients who are at risk

In Bradford City, where phase one has now finished, over 17,000 people (out of around 42,000 people invited) have taken up the invitation to have a repeat blood test. Just over 1,900 people have declined to take part. The test identifies people who are at high, moderate or low risk of developing diabetes. Those who are at high risk have received a referral into a programme to support them make small, achievable changes in their life. Phase two of the campaign is now the priority.

In Bradford Districts CCG phase one delivery began in October 2015 and almost 3,000 people (out of around 9,000 people invited) have taken up the invitation to have a repeat blood test. Just over 200 people have declined to take part. Those who are at high risk have received a referral into a programme to support them make small, achievable changes in their life.

Bradford's diabetes prevention programme

In Bradford City CCG more than 1,200 people have accepted a referral to a structured education programme - known as *Bradford's* Diabetes Prevention Programme - with over 50% starting and more than 40% attending five or more sessions. Around 2,100 people who were offered a referral declined it. People who have attended have seen changes in weight, their blood pressure and other clinical measures, all of which have reduced their risk of developing type 2 diabetes.

Leeds Beckett University has evaluated the structured education and results have shown improvements in blood sugar readings (HbA1c), weight and waist circumference. It has also shown an improvement in the individual's knowledge of diabetes and has been a "wake-up call" to the seriousness of the condition. The report also shows an improvement in the consumption of fruit and vegetables, as well as increased levels of activity.

New cases of type 2 diabetes found

In Bradford City CCG our data shows that, across the CCG's area - for the duration of the project (November 2013 to March 2016) - 1,545 patients have been added to the diabetic register. This shows that *BBD* not only raises awareness, but also identifies people with diabetes at an early stage, thus reducing the risk of associated complications.

In Bradford Districts CCG our data similarly shows that 442 patients have been added to the diabetic register since 1 October 2015.

Bradford's Healthy Hearts **(Bradford Districts CCG)**

Bradford has one of the worst death rates from heart disease in England. That's why one of our main priorities – through *Bradford's Healthy Hearts (BHH)* – is to reduce the risk of heart attack and stroke.

Through our workstreams, clinicians working with the *BHH* programme, have:

- used the QRISK2 assessment (a calculator to work out the risk of heart attack and stroke) to identify people with more than a 10% risk of having a stroke and to start them on statin medication. This has resulted in more than 6,000 patients starting to take a statin to reduce their cholesterol levels.
- worked to prevent strokes for people with atrial fibrillation (an abnormal heart rhythm that increases the risk of stroke). This programme has assisted almost 1,000 people to start oral anticoagulation (blood thinning) therapy to reduce the risk of stroke.
- developed a workstream which aims to improve blood pressure control for 38,000 patients who have high blood pressure, around 13,000 of whom are currently above target.

Based on assumptions from clinical trials, *BHH* has potentially prevented or postponed over 100 cardiovascular events. This has been done in a variety of ways, using innovative ways to encourage patients to understand how to reduce their blood pressure and cholesterol levels along with commencing therapies to help them do this. A website has been also been developed and our patients have reported positively about how they have been able to take responsibility for their condition and the medication they take.

We have started a series of monthly patient education events to help people learn more about cardiovascular disease (CVD), how to reduce their risk, and how to look after their health when they have the disease. Again the sessions have proved a huge success with 100% reporting that their knowledge of CVD had improved following the session.

During the year the *BHH* team was honoured to win a number of national awards, including:

- General Practice Awards 2015 – clinical team of the year (winner)
- General Practice Awards 2015 - general practice team of the year (winner)
- Association of Healthcare Communications and Marketing – best website (runner-up)
- BMJ Awards 2016 – clinical leadership team of the year (winner)

and was shortlisted for the HSJ Valuing Healthcare Awards 2016 – use of IT to drive value in clinical services.

A summary of some of our other successes:

- Our new integrated intermediate care hub, based at St Luke's Hospital, is now up and running and helping to provide health and social care closer to home for elderly patients. It provides a single point of access for GPs, staff in the community and other health and social care professionals to refer patients into all intermediate care.

- One particular highlight has been the creation of our *People's Board* (see page 3).

Delegated function – Co-commissioning primary care

From 1 April 2015 Bradford City CCG and Bradford Districts CCGs also became responsible for the co-commissioning of local GP services. We were one of only 64 CCGs in the country that had been given this responsibility, delegated by NHS England. The ability to commission these services means that local people will have a greater say in deciding how services are developed. Part of the reason for our success in gaining full delegation is that we are committed to improving the quality of services in general practice in Bradford and that we are able to make decisions that are sensitive to local needs. We are already working with our GP practice members to improve standards and we will extend this work further.

During 2016 we finalised our primary care commissioning strategy with our members enabling our commissioning decisions not to be taken in isolation.

We are responsible for helping our GP practices improve the quality of services provided for patients. We have reviewed a number of key themes including patients' perceptions of GP access, unwanted variation between practices, for example prescribing patterns and customer care training for GP practice staff.

Airedale, Wharfedale and Craven CCG

Integrated care pioneer programme

In 2013, a nationwide programme was launched and national bodies asked local areas (NHS and local government) to express an interest in working together to develop ambitious and innovative approaches to efficiently deliver integrated health and social care. The aim is that individuals have an improved experience, there is less waste and people's lives improve. In becoming 'national pioneers' there is a requirement to act as exemplar sites, and to share with others the use of unique approaches to efficiently deliver integrated care. AWC CCG was successful in its application and the subsequent selection process and is one of 25 sites in the

country who receive national support to progress integration programmes of change. The programme is known as new models of care (NMoC). Support is in the form of programme funding, shared learning and shared best practice from other national sites that will help inform our models of care and increase the pace of change and rapid delivery of our new models of care programme. The programme within AWC is made up of four areas on which the CCG is currently working with partners. Examples of two of the areas of progress in preventing hospital attendances, hospital admissions and in ensuring people receive the care most appropriate for their needs are:

Complex care

AWC CCG, together with health and social care partners and patient representatives, developed a new service for people with complex care needs as part of our NMoC work. A new complex care team – funded by the CCG – started work in April 2016 to provide dedicated and co-ordinated support to people with complex needs. It has a strong focus on proactive, rather than reactive, care and the team from Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Yordales (a federation of local GPs), are working to understand people's needs fully and, where there is a risk of increased use of health and care services, to act before this happens. They work closely with individuals and provide support and treatment wrapped around patients' needs in, or closer to, their homes to reduce their need for emergency hospital care. A unique addition to this team is the personal support navigator (PSN). This new and unique role is delivered in partnership with the local authorities and voluntary and community services (Age UK and Carers Resource). The PSN is a dedicated point of contact for these people and an integral part of the team supporting individuals to help them make more informed decisions and live more independently. Some early case studies demonstrate the impact this new approach to care is having on people's lives, in particular the PSN role is helping individuals and their carers to achieve their own goals, reduce isolation, improve self-care and self-management. The roles allow for flexibility in approach and one to one contact and support for individuals, backed up with clinical experts and social care services.

Enhanced care

Enhanced care is focused on looking at the issues faced by patients who see their GP on a regular basis or who frequently end up in hospital. The enhanced primary care schemes commenced in 2015 and have provided more proactive care and support to address patients' needs. The support varies and is tailored to an individual by addressing their overall needs (physical, mental health and broader needs which may not be health-related). GP practices across the area have been trialling different ways of delivering enhanced care based on their knowledge of their practice population. Some practices have employed advanced nurse practitioners or care co-ordinators (who may not be clinical) to find suitable patients and co-ordinate their care, offering one-to-one support. Others are contacting patients after an unplanned admission to hospital to review their needs and the reason for admission. They ensure support is in place upon discharge to help rehabilitation and help prevent re-admission. Another example is employing people with different skills such as physiotherapists and pharmacists to work in practices to better respond to people's needs. The schemes have nurtured innovation and creativity among practice staff but most of all have made real improvements to

people's health and wellbeing. The results and stories shared by those receiving this new approach to care have been far-reaching with patients becoming more confident to manage their own health and care needs reducing use of services, have more knowledge, and the ability to access services in the community making better use of other professionals' skills instead of reliance on their own GP.

A summary of some of our other successes:

Falls pathway

This pathway has been established in 2015/16 with partners to help identify people who are at risk of falling and reduce fall-related injuries. The pathway will be introduced in 2016/17 to identify people at risk of falling earlier so that preventative measures can be taken. Staff from health, social care, fire and voluntary and community services will work in partnership to offer people more support to maintain their independence

Care home quality improvement scheme

This scheme runs across a number of care homes in the AWC locality providing proactive care for elderly and vulnerable patients. Care plans are developed with GPs, and the patient and their families to ensure the patient's wishes and needs are taken into account, staff in the home receive education and support from the GPs on an ongoing basis, and the homes have a named GP or nurse providing continuity of care. GPs and nurses attend the homes on a regular basis and review people to prevent issues rather than wait until someone becomes ill. This has improved quality and people's experience. The service has resulted in a reduction in 999 and A&E activity, and in emergency admissions to hospital.

Diabetes

Towards the end of 2015/16 the CCG commenced procurement of an innovative service which will provide enhanced care to people with diabetes and also meet people's specialist podiatry needs. The CCG has worked with clinical experts and patients to determine what outcomes the service would need to deliver to ensure the optimum diabetes care. This will improve the lives of individuals and reduce the risks of complications. On award of the contract the contract provider will be held to account for delivering these improved outcomes which include better disease control, reduced complications, reduced kidney disease and amputations, people knowing more about the disease and being more in control of their care through self-care and self-management, with an improved approach to prevention so less people get diabetes.

CCG Assurance 2015/16

NHS England's overall assessment on the performance of AWC CCG for 2015-16 is 'good'; they reported their full assurance on all aspects of governance, finance, quality and performance:

One of the five components in the 2015/16 CCG Assurance Framework is "planning"; importantly this looks at the wider set of plans that the CCG is responsible for developing and implementing across the short and long-term. There

was recognition that the CCG had experienced some financial challenges in 2015/16, and although the CCG had developed a financial recovery plan and subsequently met its financial targets for 2015/16. NHS England felt the CCG did not currently have a financial plan that met their planning rules in 2016/17 and therefore decided to record “limited assurance” in the planning component.

This resulted in the CCG receiving an overall rating of “requires improvement”.

NHS England’s assessment of Bradford City CCG and Bradford Districts CCG rated as “good” across all domains with an overall rating of “good” for 2015/16.

PROGRESS TOWARDS INTEGRATION OF HEALTH AND SOCIAL CARE

The Bradford and Airedale health and wellbeing board brings together key people from the health and care system to provide a single place to work together to shape and improve the health and wellbeing of the local population.

During the year the health and wellbeing board has overseen work on jointly managed (between the local authority and CCGs) aftercare arrangements under Section 117 of the Mental Health Act 1983. Linked to approval of the *Better Care Fund*, the board has considered progress towards integration of health and social care. This focussed on enhancing health and wellbeing and accelerating an improvement in outcomes for the local population through integrated commissioning. It includes building on the *Better Care Fund*, expanding joint commissioning particularly for mental health and learning disabilities services and delivering new models of care. All this work moves us closer to delivering our vision for 2020 of a sustainable health and care system.

Pooled budget – the Better Care fund

The *Better Care Fund* (BCF) is a Government initiative to drive more integrated working and at a faster pace. The Bradford CCGs and AWC CCG, along with Bradford Council, have aligned agreed budget lines. BCF monies will be deployed to help services work closer together more effectively to improve integrated working and health and care of our local population.

Together, the CCGs want to improve the outcomes and experiences of people, families and carers by doing things differently: getting organisations, people and communities working together and thinking creatively so that health and social care are fit for now and for future generations. The BCF will support us to achieve greater integration and to deliver our vision of integrated health and social care and support. An important point to note is that the BCF is made up from existing CCG and council money – it is not new or additional. Across the Bradford district and Craven the fund is being used to to focus on:

- capital funding including disabled facilities grants;
- carers’ break funding;
- expansion of intermediate care services, including the Bradford virtual ward, early supported discharge schemes, community equipment, Airedale Collaborative Care Team (ACCT), intermediate care beds, intermediate care support in the community, mental health and palliative care – community support, reablement services in social care and NHS;

- Care Bill implementation;
- protecting social services.

Non-elective admissions

During 2015/16 a total 15,047 patients had a non-elective admission to hospital. A rate of 2,780 non-elective admissions per 100,000 (in Quarter 4), this was below the health and wellbeing board target of 2,843 admissions per 100,000 populations. Work plans to support the Integrated Care Programme include:

- Testing of new models of pro-active care
- Intermediate care service
- Community step-up and step-down service
- Intermediate care in the patient's own home (via the virtual ward and collaborative care teams)
- Use of intelligence to identify those at risk of admission, predictive risk stratification, frailty index, clinical judgement
- Integrated health and social care communities

Throughout 2015/16 BCF partners reported a risk regarding non-elective activity. A reduction in such admissions is linked to the expanded virtual ward. Recruitment challenges for the virtual ward resulted in a delay in the opening of this facility. This subsequently led to an overtrade position in non-elective admissions. As such BCF partners agreed the performance fund would fund this increase in activity.

Delayed transfers of care - achieved

Our excellent performance on delayed transfers of care, both overall health and social care, has been maintained. This has been highlighted as best practice in regional sector-led improvement and in December 2015 we delivered a 'Masterclass' session at a joint local authority and NHS regional event chaired by Sandy Keene (National ADASS.). We are not complacent and will continue to work in 2016/17 on maintaining this position.

Admissions to residential and care homes - achieved

We are on track to meet the agreed target of no more than 750 admissions to residential and care homes. Current year end out-turn value is expected to be around 735 which is based on approximately 415 permanent admissions to residential or nursing care during the year. This figure has yet to be validated by the Health and Social Care Information Centre (HSCIC).

Effectiveness of reablement - full target not achieved

There is good evidence that reablement improves service outcomes (that is, it prolongs people's ability to live at home, and removes or reduces the need for standard home care). Measured by its capacity to enhance the chances of staying at home, reablement also contributes to user independence and wellbeing. There is moderately good evidence that reablement improves outcomes for users, in terms of restoring the ability to perform activities of daily living (ADL) or improving morale. Reablement comprises 'services for people with poor physical or mental health to

help them accommodate their illness by learning or re-learning the skills necessary for daily living'. The focus is on helping people to do things for themselves rather than the traditional home care approach of doing things for people that they cannot do for themselves. Reablement is usually a 6–12 week intervention, focused on dressing, using the stairs, washing and preparing meals, although there is growing recognition of the need for reablement also to address social and psychological needs. Although reablement overlaps with intermediate care, its focus on assisting people to regain their abilities is distinctive.

We are not on track to meet the agreed target with a current year end estimate of around 88%. We are exploring care pathway data on short-term reablement type support to supplement this metric, which will inform and influence more effective local monitoring of integrated short-term support services such as the Bradford and Airedale integrated intermediate care services at the districts' hospitals. The hubs are contributing to improving reablement particularly in ensuring individuals receive the appropriate care within their home or a step up facility, all of which supports admission avoidance, early supported discharge and delayed transfers of care. The original target of 95% was recognised by the health and wellbeing board and Bradford Health Care Commissioners as unrealistic given the enablement model and the England average of 82%. Admissions to residential and care homes saw a significant increase in April 2015 but have been declining since then, this could be attributed to changes realised via the better care fund. Locally there is a view that no-one should be admitted to long-term care without all opportunity for reablement being exhausted first.

Local indicator – dementia case finding

The local indicator selected for Bradford BCF relates to the proportion of people diagnosed with dementia compared to the estimated prevalence rate. The local target is set at 75% of those expected to have dementia to have a diagnosis recorded. The national target is set at lower at 67% of those expected to have dementia to have a diagnosis recorded. In 2015/16 the England average for finding all cases of dementia is 67.6% with the best five achieving CCGs averaging 86.5% of patients who are expected to have dementia, having a diagnosis. Across Bradford and Airedale in the last quarter of 2015/16 we achieved 81.6% of our population who were expected to have dementia, with a diagnosis. (note: this result is based on the footprint of the three CCGs – we are currently unable to split out Craven GP practices' population)

FINANCIAL PERFORMANCE

Airedale, Wharfedale and Craven CCG

In 2015/16, revenue resources of £202.7m were available to the CCG, compromising £199.2m for the commissioning of healthcare services (programme allocation) and £3.5m for administration costs (running cost allocation). The programme resource allocation included a national growth uplift of 1.4% on the 2014/15 resource baseline, whilst the running cost allocation was 10% lower than last year (in line with the national policy on reducing administration costs).

2015/16 was financially challenging but we are pleased to report that the CCG successfully achieved its statutory financial duties and reported a surplus position

of £2.019m. As part of its financial planning process, AWC CCG recognised a number of risks in achieving its financial plan and to achieve its targets it would need to generate cash-releasing savings of approximately £4m. In September 2015, as a result of the risk of increasing healthcare activity and costs, and lower than expected savings, AWC CCG was formally placed into financial recovery with NHS England. A comprehensive financial recovery plan has been developed to ensure targets were met by the end of the financial year, and that AWC continues to achieve financial stability in future years.

Bradford City CCG

In 2015/16, revenue resources of £146.1m were available to the CCG, comprising £143.5m for the commissioning of healthcare services (programme allocation) and £2.6m for administration costs (running cost allocation). The programme resource allocation included a national growth uplift of £4.4m (3.78%) on the 2014/15 resource baseline, whilst the running cost allocation was 10% lower than last year (in line with the national policy on reducing administration costs).

New areas of expenditure incurred by the CCG related to primary medical services (£17.5m) following the delegation of commissioning responsibility from NHS England, and also the *Better Care Fund* (£2.6m of additional investment) which is a national policy initiative designed to promote integrated working between health and social care.

Overall, the CCG continued to manage its resources effectively and met its statutory financial duties to keep revenue expenditure within available revenue resources, and to keep administration costs within the CCG's running cost allocation. Also, cumulative surplus funds carried forward to 2016/17 decreased by £0.2m to £3.5m as a result of using some funding to progress the *Bradford's Healthy Hearts* initiative.

Bradford Districts CCG

In 2015/16, revenue resources of £484.3m were available to the CCG, comprising £477.2m for the commissioning of healthcare services (programme allocation) and £7.1m for administration costs (running cost allocation). The programme resource allocation included a national growth uplift of £13.6m (3.42%) on the 2014/15 resource baseline, whilst the running cost allocation was 10% lower than last year (in line with the national policy on reducing administration costs).

New areas of expenditure incurred by the CCG related to primary medical services (£48.4m) following the delegation of commissioning responsibility from NHS England, and also the Better Care Fund (£10.5m of additional investment) which is a national policy initiative designed to promote integrated working between health and social care.

Overall, the CCG continued to manage its resources effectively and met its statutory financial duties to keep revenue expenditure within available revenue resources, and to keep administration costs within the CCG's running cost allocation. Also, cumulative surplus funds carried forward to 2016/17 increased by £0.9m to £7.3m as a result of non-recurrent transformation spend being less than planned.

Using the *NHS Right Care* approach to inform CCG priorities

The *Right Care* commissioning for value work programme originated during 2013/14 in response to requests from CCGs that they would like support to help them identify the opportunities for change with most impact. It is a partnership between NHS England, Public Health England and *NHS Right Care* and the initial work was an integral part of the planning approach for CCGs.

Right Care is about identifying priority programmes that offer the best opportunities to improve healthcare for populations; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system. By providing the commissioning system with data, evidence, tools and practical support around spend, outcomes and quality, the programme can help clinicians and commissioners transform the way care is delivered for their patients and populations and reduce variation in health inequalities.

Commissioning for value is not intended to be a prescriptive approach for commissioners, but rather a source of insight which supports local discussions about prioritisation and utilisation of resources. It is a starting point for CCGs and partners, providing suggestions on where to look to help them deliver improvement and the best value to their populations. It also supports CCGs to meet their legal duties to have regard to reduce health inequalities.

Many of the themes from the *Five Year Forward View* (FYFV) are reflected in the principles of the *Right Care* programme. The focus on value, health outcomes, empowering the patient, transforming through systems and networks of care, and the need to drive down variation in quality and health outcomes are all key themes of both *Right Care* and the FYFV.

The *NHS Right Care* programme has one key objective and three key phases. Its key objective is to maximise value at population and individual level. The key phases are ‘where to look’, ‘what to change’ and ‘how to change’.

‘Where to look’ helps health economies to identify where they need to prioritise their transformation and health care improvement effort, based on where they can most improve. Each CCG has been compared to its ten most similar CCGS based on deprivation, population size and density, highlighting where any variation occurs. This data allows CCG to focus their efforts on areas where they can improve patient outcomes and reduce costs.

The second phase, ‘what to change’, helps CCGs to work out what is optimal and what changes are needed to move from where they are to where they want to be. The third phase ‘how to change’ comes when evidence has been gathered, and a case has been made

AWC CCG is part of wave one which commenced in 2015, and the Bradford CCGs are part of wave two which will commence in September 2016. The three priority areas which are being focused on in AWC CCG are respiratory, cardiovascular disease and cancer. Work has started with clinicians to improve pathways and outcomes for specific patient groups. This focus on outcomes has highlighted a variation in the effectiveness of certain medical procedures and those identified

with limited clinical effectiveness may be removed or replaced. The Bradford CCGs have used the *Right Care* approach when developing *Bradford Beating Diabetes* and *Bradford's Healthy Hearts* and will continue this as part of their *Right Care* programme in 2016.

NATIONAL PROGRAMMES

Care home vanguard

This new care model, which aims to enhance health for residents in care homes, brings together more than a dozen organisations – including the CCGs - from health and social care services, care home providers, technology specialists and academics working across Airedale, Bradford, Craven, East Lancashire and Wharfedale.

Chosen from 269 applications from across the country, the local partnership has been named as one of the first 29 vanguard areas that have won a share of a £200m transformation fund.

Vanguard sites pilot plans to significantly improve patients' experiences of local healthcare by bringing home care, mental health, community nursing, GP services and hospitals together for the first time since 1948.

The local scheme will use technology, such as telemedicine, to integrate services and provide immediate access to expert opinion and diagnosis, where appropriate, as well as supporting individual independence and improving the quality of life of residents by focusing on proactive rather than responsive care and delivering more specialist services into the care home.

- Across the three CCGs there are 131 homes signed up for telemedicine, these include 49 homes across NHS Airedale, Wharfedale & Craven CCG and 82 homes across in NHS Bradford City CCG and NHS Bradford Districts CCG.

Urgent and emergency care vanguard

Established in 2014, the West Yorkshire urgent and emergency care network vanguard covers Leeds, Bradford, Calderdale, Kirklees, Wakefield and Harrogate. It serves a population of around three million people.

The vanguard works with partners, including five local system resilience groups, to build on progress already made in transforming primary, community and acute care services. Work on the vanguard includes:

- Yorkshire Ambulance Service developing a stronger focus on becoming a mobile treatment service delivering care at patients' homes with conveyance to hospital for those who really need to go
- three mental health service providers working with West Yorkshire Police to deliver major service change which will see rapid crisis response through emergency response control centres and 'street triage'
- creating an integrated West Yorkshire care record and a system-wide information dashboard which reports in 'real-time'.

4. **Options**

Not Applicable

5. **Contribution to corporate priorities**

A number of metrics relate to joint working across the Bradford District and contribute to corporate priorities.

6. **Recommendations**

6.1 That the Health and Social Care Overview & Scrutiny Committee note the content of the report

7. **Background documents**

None

8. **Not for publication documents**

Not Applicable

9. **Appendices**

None

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Report of the Strategic Director Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on the 6th October 2016.

P

Subject: Adult and Community Services Annual Performance Report 2015/16

Summary statement: The following report sets out a summary of the Adult and Community Services Department for the financial year 2015/16 across a range of national performance indicators.

Bernard Lanigan
Assistant Director Integration and Transitions

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Portfolio:

Cllr Val Slater – Health and Wellbeing

Overview & Scrutiny Area:

Health and Social Care

1. **SUMMARY**

The following report provides an overview of the Department of Adult and Community Services performance across the Adult Social Care Outcomes Framework in 2015/16.

2. **BACKGROUND**

2.1 The Adult Social Care Outcomes Framework (ASCOF) is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.

The key roles of the ASCOF are:

• It provides councils with robust information that enables us to monitor the success of local interventions in improving outcomes, and to identify our priorities for making improvements. We can also use ASCOF to inform outcome-based commissioning models

• It is a useful resource for our Health and Wellbeing board who can use the information to inform their strategic planning and leadership role for local commissioning

• It strengthens accountability to local people. By fostering greater transparency on the outcomes delivered by care and support services, it enables local people to hold councils to account for the quality of the services that they provide, commission or arrange.
We also use the ASCOF to develop and publish our local account to communicate directly with local communities on the outcomes that are being achieved, and their priorities for developing local services

• Regionally, the data supports sector led improvement; bringing councils together to understand and benchmark their performance. This, in turn, stimulates discussions between councils on priorities for improvement, and promotes the sharing of learning and best practice. In Bradford we are fully engaged in the Y&H Sector Led Improvement programme and the ASCOF measures are monitored on a quarterly basis together with Risk Awareness via the regional Performance and Standards network.

• At the national level, the ASCOF demonstrates the performance of the adult social care system as a whole, and its success in delivering high-quality, personalised care and support. Meanwhile, the framework supports Ministers in discharging their accountability to the public and Parliament for the adult social care system, and continues to inform, and support, national policy development.

The Government does not seek to performance manage councils in relation to any of the measures set out in this framework. Instead, the ASCOF will inform and support improvement led by the sector itself, underpinned by strengthened transparency and local accountability.

2015-16 ASCOF measures are currently being validated by NHS Digital (formerly the Health and Social Care Information Centre) and so should be used for internal benchmarking only until publication in Oct 2016.

The 27 ASCOF measures are derived from the following data collections are co-ordinated nationally by NHS Digital and managed locally in Bradford by Performance and Intelligence staff working to the Chief Executive's Office but linked to the Dept. of Adult and Community Services:

ASCS Adult Social Care Survey (Annual) *7 ASCOF measures*
SALT Short and Long Term Support Data Collection (Annual) *11 ASCOF measures*
SACE Survey of Adult Carers Experience (Biennial) *5 ASCOF measures*
NHS England Situation Report (Monthly) *2 ASCOF measures*
Mental Health Minimum Dataset (Monthly) *2 ASCOF measures*

The Adult Social Care Survey is carried out annually to help ensure that services are helping adults to live safely and independently, experience better outcomes and that essential needs are being met. The aim of the survey is to measure the extent to which the lives of adult users have improved as a result of a care package.

2.4 The survey was carried out during February 2016, based on a standard questionnaire provided by the Department of Health. Questionnaires were sent to a random sample of residents who were receiving long term adult social care services provided or commissioned by Bradford Council. The sample of people was split into four distinct groups:

- Adults with learning disabilities in the community
- Adults with learning disabilities in residential care
- Residents in their own home
- Residents in care homes

2.5 In total 1,500 questionnaires were sent to residents chosen at random using a stratified sample process to ensure representation from the four main user groups.
We had a questionnaire response rate of 37%. This was the fifth year that a survey of this kind had been sent out to residents in Bradford.

3. REPORT ISSUES

3.1 The data reported is currently subject to validation from NHS Digital and is due to be published nationally in October 2016. The data is currently restricted and therefore this report will not provide any comparator information with named other authorities. The report does however draw comparison with our 2014/15 performance.

3.2 In 2015/16 there were a total of 22 ASCOF measures reported, all comparable with 2014/15. Table 1 below sets out these measures detailing the direction of travel for each:

Table 1

		2015-16		2014-15	2014-15	
	ASCOF		*Direction of Travel*			
		Bradford		Bradford	Y&H	England
1A	Social Care Quality Of Life	**19.5**	↑	**19.4**	19.1	19.1
1B	Control Over Daily Life	**79.2%**	↑	**77.8%**	78.5%	77.3%
1C(1a)	Self-Directed Support (Cared For)	**86.8%**	↑	**79.4%**	82.5%	83.7%
1C(1b)	Self-Directed Support (Carers)	**82.5%**	↑	**81.8%**	71.7%	77.4%
1C(2a)	Direct Payments (Cared For)	**17.5%**	↑	**14.8%**	25.0%	26.3%
1C(2b)	Direct Payments (Carers)	**81.9%**	↑	**81.8%**	60.4%	66.9%
1E	LD Employment	**5.5%**	↑	**5.1%**	6.4%	6.0%
1F	MH Employment	**6.1%**	↓	**7.0%**	8.1%	6.8%
1G	LD Independence	**86.3%**	↑	**84.4%**	80.4%	73.3%
1H	MH Independence	**69.1%**	↑	**66.5%**	68.6%	59.7%
1L(i)	Social Contact	**51.4%**	↓	**52.2%**	45.7%	44.8%
2A(i)	Perm Admissions To Care 18-64	**14**	□□	**14**	11.8	14.2
2A(ii)	Perm Admissions To Care 65+	**513**	↑	**572**	720.3	668.8
2B(i)	Re-ablement (effectiveness)	**88.2%**	↓	**88.5%**	84.4%	82.1%
2B(ii)	Re-ablement (offered)	**2.8%**	↑	**2.1**	2.2	3.1
2C(i)	Delayed Transfers of Care (ALL)	**3.38**	↑	**3.7**	9.3	11.1
2C(ii)	Delayed Transfers of Care (Soc. Care)	**0.19**	↑	**0.60**	2.7	3.7
2D	Outcomes from Short Term Support	**64.8%**	↑	**54.4%**	67.6%	74.6%
3A	Satisfaction	**63.1%**	↑	**62.5%**	66.6%	64.7%
3D(i)	Information and Advice	**70.8%**	↓	**73.3%**	75.6%	74.5%
4A	Feeling Safe	**73.2%**	↑	**70.7%**	68.2%	68.5%
4B	Feeling Safe As A Result of Services	**84.8%**	↑	**82.3%**	83.2%	84.5%

3.3 Performance in 17 measures have shown an improvement over 2014/15, with 1 measure remaining the same. The following 4 measures are showing deterioration on 2014/15:

ASCOF 1F Proportion of adults in contact with secondary mental health services in paid employment
ASCOF 1I Proportion of people who use services who reported that they had as much social contact as they would like

ASCOF 2B pt1 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
ASCOF 3D pt1 The proportion of people who use services who find it easy to find information about support.

Feedback from the HSCOSC following our 2014-15 Annual Performance report has also prompted us to provide additional information on each of the ASCOF measures. The next section of this report includes the rationale for each measure, clarification on the definition and data sources.

ASCOF Domain 1: Enhancing Quality of Life for People with Care and Support Needs

ASCOF 1A Social Care Related Quality of Life

ASCOF 1A is a patient reported experience measure giving an overarching view of the quality of life of users of social care. This measure is an average quality of life score based on responses to the annual Adult Social Care Survey and covering the eight domains; control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation.

Continuous improvement over the last 3 years is significant as the survey is sent to a random sample of people receiving long term adult social care and support in community or residential/nursing settings provided or commissioned by BMDC Adult & Community Services. Both the England and Regional average in 14-15 was 19.1 and at 19.4 Bradford was the 3rd highest performing LA in Y&H. Initial analysis for 15-16 shows the Regional average to have improved to around 19.2 with Bradford also improved to 19.5 and currently placed 5th out of the 15 LAs in the Y&H Region.

ASCOF 1A		2013-14	2014-15	2015-16
Social Care Related Quality of Life	Numerator: The sum of the scores for all respondents who answered Q3a to 9a and 11. Higher scores are assigned to better outcomes.	109,965	107,975	112,105
	Denominator: The number of respondents who answered questions 3a to 9a and 11 in the ASC Survey	5,770	5,550	5,738
	Outcome	**19.1**	**19.4**	**19.5**

ASCOF 1B Control over Daily Life

A key objective of the drive to make care and support more personalised is that support more closely matches the needs and wishes of the individual, putting users of services in control of their care and support. Therefore, asking users of care and support about the extent to which they feel in control of their daily lives is one means of measuring whether this outcome is being achieved.

Performance improvement on ASCOF 1B is indicative of the progress made on Personalisation and Self Directed Support within Adult Services Access, Assessment and Support and Community Services. In 2014-15 78% of people surveyed said they had as much/adequate control over their daily lives, above the England average of 77% and in line with the Regional average of 78%. Initial analysis for 15-16 shows Bradford improving to 79% and placed 6th out of the 15 LAs in the Y&H Region.

ASCOF 1B		2013-14	2014-15	2015-16
Control over Daily Life	Numerator: Of the respondents those who answered 'I have as much control over my daily life as I want" and "I have adequate control over my daily life'. (*weighted*)	5,400	4,320	4,544
	Denominator: Total number of people responding to Q3a in the ASC Survey, "Which of the following statements best describes how much control you have over your daily life?"", (*weighted*)	6,915	5,550	5,738
	Outcome	**78.1%**	**77.8%**	**79.2%**

ASCOF 1C pt1a Proportion of adults aged over 18 using social care and receiving self-directed support

Research has indicated that personal budgets impact positively on well-being, increasing choice and control, reducing cost implications and improving outcomes. The Care Act places personal budgets on a statutory footing as part of the care and support plan.
Performance in 15-16 has improved as more people in receipt of long term community based support have been assessed via a self-directed support Care Act Assessment resulting in a personal budget.

We have also improved our reporting processes following Regional ADASS Sector Led Improvement work on data consistency, resulting in a planned improved resubmission of our Short and Long Term Support Data Collection to NHS Digital. Although the National average in 14-15 was 83.7% initial analysis for 15-16 shows Bradford to be just below the Regional average of 88%. Our implementation of Integrated Digital Care Records should have a positive impact on the allocation and throughput of re-assessments and reviews which will benefit the data contributing to this measure.

ASCOF 1C pt1a		2013-14	2014-15	2015-16
Proportion of adults aged over 18 using social care and receiving self-directed support	Numerator: The number of clients receiving either a Direct Payment or council managed Personal Budget at the year-end 31st March.	n/a	3,040	3,266
	Denominator: The number of clients (aged 18+) accessing long term community support at the year-end 31st March.	n/a	3,825	3,761
	Outcome	**n/a**	**79.5%**	**86.8%**

ASCOF 1C pt1b Proportion of carers receiving self-directed support

The same narrative above also applies for Carers. The National average in 14-15 was 77.4%, well above the Regional average of 63%. Initial analysis of the 15-16 provisional ASCOF measures indicate that Bradford remain above the Regional average although there still appears to be a high variation between councils indicating either different models of operations and possibly reporting methodology in place.

In Bradford we have revised our methodology on this measure in line with ADASS Sector Led Improvement work on data consistency, resulting in a resubmitted HSCIC Short and Long Term Support data collection for 2014-15. We expect our implementation of Integrated Digital Care Records to facilitate improved recording and reporting of Carers Self Directed Support data. A key feature of IDCR is a joined up Care Management and Finance system that will enable better quality data flows, help improve links between Performance and Commissioning and prove and enabler in future Health and Social Care Integration.

ASCOF 1C pt1b		2013-14	2014-15	2015-16
Proportion of carers receiving self-directed support	Numerator: The number of carers receiving either a Direct Payment or Council managed Personal Budget in the year to 31st March	n/a	2,670	2,728
	Denominator: The number of carers (caring for someone aged 18 or over) receiving carer-specific services in the year to 31st March.	n/a	3,264	3,308
	Outcome	**n/a**	**81.8%**	**82.5%**

ASCOF 1C pt2a Proportion of adults using social care receiving Direct Payments

Studies have shown that direct payments increase satisfaction with services and are the purest form of personalisation. The Care Act requires that all local authorities inform those using services and their carers of their personal budget, which will set out the cost to the Local Authority of meeting their needs. They will have the right, in most circumstances, to request this as a direct payment. There is likely to be a significant impact on this measure and work is being

taken forward to assess, in light of the Care Act, how best personalisation of services can be reflected in the ASCOF.

In Bradford, despite improving performance in 15-16, we remain one of the bottom 3 performing councils in the Region on this measure. In 14-15 the Regional average was 25%, and initial analysis of provisional 15-16 ASCOF data shows only a slight increase to around 26%.

ASCOF 1C pt2a		2013-14	2014-15	2015-16
Proportion of adults using social care receiving Direct Payments	Numerator: The number of clients receiving direct-payments and part-direct payments at the year end 31st March	n/a	565	660
	Denominator: The number of clients (aged 18+) accessing long term community support at the year-end 31st March.	n/a	3,825	3,761
	Outcome	**n/a**	**14.8%**	**17.5%**

ASCOF 1C pt2b Proportion of Carers using Direct Payments for support direct to the carer

The narrative above also applies to Carers Direct Payments. The England average for this measure in 14-15 was 66.9% so despite little movement on last year we appear to remain a top performer on this measure in 15-16 with initial figures from the Y&H Region indicating an average of around 70%.

The Integrated Carers Service in Bradford builds on local and national best practice in relation to supporting carers and recognises the critical role carers play in supporting people with health and care needs at home. A central hub delivers services locally ensure carers are identified, recognised and supported to continue their caring role while having an opportunity for a life outside of caring in work, education and leisure. We are looking to strengthen internal links between Commissioning and Performance teams in the council to improve our business intelligence in this area and to ensure our information contributes to all the Carers measures in the Adult Social Care Outcomes Framework.

ASCOF 1C pt2b		2013-14	2014-15	2015-16
Proportion of Carers using Direct Payments for support direct to the carer	Numerator: The number of carers receiving direct-payments and part-direct payments at the year end 31st March	n/a	2,670	2,709
	Denominator: The number of carers (caring for someone aged 18 or over) receiving carer-specific services in the year to 31st March.	n/a	3,264	3,308
	Outcome	**n/a**	**81.8%**	**81.9%**

ASCOF 1E Proportion of adults with a learning disability in paid employment

The measure is intended to improve the employment outcomes for adults with a learning disability, reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits. This measure is complementary with other measures in the Public Health and NHS Outcomes Frameworks.

The England average in 14-15 was 6% and so although we've improved on last year we look to be below this and the provisional 15-16 Regional average of 6.4%. Service Improvement work has been identified by Commissioning Leads and Assessment and Support Service Managers to better understand how we can improve on this measure and promote those organisations whom we commission to provide an employment support service. Our implementation of Integrated Digital Care Records in 2016 will help improve the data quality for this measure and will enable more accurate real time reporting for monitoring performance and personal outcomes for individuals.

ASCOF 1E		2013-14	2014-15	2015-16
Proportion of adults with a learning disability in paid employment	Numerator: All people within the denominator, who are in paid employment	70	70	82
	Denominator: The number of eligible adults (aged 18-64), who have received long term support for learning disability during the year	1,275	1,385	1,491
	Outcome	**5.5%**	**5.1%**	**5.5%**

ASCOF 1F Proportion of adults in contact with secondary mental health services in paid employment

The measure is of improved employment outcomes for adults with mental health problems, reducing their risk of social exclusion and discrimination. Supporting someone to become and remain employed is a key part of the recovery process. Employment outcomes are a predictor of quality of life, and are indicative of whether care and support is personalised. Employment is a wider determinant of health and social inequalities.

The measure shows the percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Adults 'in contact with secondary mental health services' is defined as those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA). The Regional average in 14-15 was 8.1% and Bradford were ranked 9th out of the 15 councils.

ASCOF 1F		2013-14	2014-15	2015-16
Proportion of adults in contact with secondary mental health services in paid employment	Numerator: All people within the denominator, who are in paid employment	n/a	n/a	150
	Denominator: Number of working age adults (18-69 years) who have received secondary mental health services and who were on the Care Programme Approach at the end of the month.	n/a	n/a	2,360
	Outcome	**6.5%**	**7.0%**	**6.1%**

ASCOF 1G Proportion of adults with a learning disability who live in their own home or with their family

The measure is intended to improve outcomes for adults with a learning disability by demonstrating the proportion in stable and appropriate accommodation. The nature of accommodation for people with a learning disability has a strong impact on their safety and overall quality of life and the risk of social exclusion.

The England average for ASCOF 1G in 14-15 was 73% and we have continued to improve year on year to 86.3% in 2015-16, which on early indication of provisional ASCOF data would put Bradford in the top 3 performing councils in the Region and above the 79% average.
As above the implementation of Integrated Digital Care Records in 2016 will help improve the data quality for both the numerator and denominator and will enable more accurate real time reporting on this measure.

ASCOF 1G		2013-14	2014-15	2015-16
Proportion of adults with a learning disability who live in their own home or with their family	Numerator: All people within the denominator who are "living on their own or with their family" as per the DoH definition	1,060	1,170	1,286
	Denominator: The number of eligible adults (aged 18-64), who have received long term support for learning disability during the year	1,275	1,385	1,491
	Outcome	**83.1%**	**84.5%**	**86.3%**

ASCOF 1H Proportion of adults in contact with secondary mental health services living independently, with or without support

The measure is intended to improve outcomes for adults with mental health problems by demonstrating the proportion in stable and appropriate accommodation. This is closely linked to improving their safety and reducing their risk of social exclusion.

Interpretation of the measure should take into account the point above regarding scope, and the likelihood that some people in contact with mental health services are being supported in accommodation by the council, but are not captured within the current definition because they are not on the CPA. The England average for ASCOF 1G in 14-15 was 59.7% and we have continued to improve year on year to 69.1% in 2015-16.

ASCOF 1H		2013-14	2014-15	2015-16
Proportion of adults in contact with secondary mental health services living independently, with or without support	Numerator: All people within the denominator, who are in paid employment	n/a	n/a	1,610
	Denominator: Number of working age adults (18-69 years) who have received secondary mental health services and who were on the Care Programme Approach at the end of the month.	n/a	n/a	2,360
	Outcome	**64.3%**	**66.5%**	**69.1%**

ASCOF 1I pt1 Proportion of people who use services who reported that they had as much social contact as they would like

There is a clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. This measure will draw on self-reported levels of social contact as an indicator of social isolation for both users of social care.

Although performance on this measure has dipped slightly on 14-15 Bradford were in the Top 3 performing councils in 14-15 and so the 15-16 outcome remains positive in comparison to neighbouring LAs, and we're likely to be in the top 3 performers once again in 15-16. The England average in 14-15 was 45%, Y&H Region 46%. Our implementation of Integrated Digital Care Records in 2016 will enable real time reporting of this measure for people long term and short term adult social care support.

ASCOF 1I pt1		2013-14	2014-15	2015-16
Proportion of people who use services who reported that they had as much social contact as they would like	Numerator: In response to Q8a of the ASC Survey, those who selected the response "I have as much social contact as I want with people I like" (*weighted*)	3,155	2,895	2,949
	Denominator: All respondents to Q8a "Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?" (*weighted*)	6,445	5,550	5,738
	Outcome	**49.0%**	**52.2%**	**51.4%**

ASCOF Domain 2: Delaying and reducing the need for care and support

ASCOF 2A Pt1 Long-term support needs for people aged 18-64 met by admission to residential and nursing care homes, per 100,000 population

Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.

Performance on ASCOF 2A pt1, which represents those aged 18-64, has remained stable and in line with the Y&H Regional average which was 11.8 in 14-15 and looks to be around the 14 mark in 15-16. We have improved our reporting processes in this area and aligned to ADASS led Sector Led Improvement work on data consistency, resulting in a re-submission of our data to NHS Digital for both 14-15 and 15-16 ASCOF.

ASCOF 2A Pt1		2013-14	2014-15	2015-16
Long-term support needs for people aged 18-64 met by admission to res/nurs care homes, per 100,000 pop	Numerator: The number of council-supported younger adults (aged 18-64) whose long-term support needs were met by a change of setting to residential and nursing care during the year	n/a	44	44
	Denominator: The population of younger adults in the area (then *100,000)	n/a	314,250	314,300
	Outcome	**n/a**	**14.0**	**14.0**

ASCOF 2A Pt2 Long-term support needs for people aged 65+ met by admission to residential and nursing care homes, per 100,000 population

Performance on ASCOF 2A pt2, which represents those aged 65+, has improved year on year and above the Y&H Regional average which was 720 in 14-15. Provisional 15-16 ASCOF data suggests Bradford are the best performing council in the Region on this measure in 15-16.

ASCOF 2A Pt2		2013-14	2014-15	2015-16
Long-term support needs for people aged 65+ met by admission to res/nurs care homes, per 100,000 pop	Numerator: The number of council-supported older people (aged 65+) whose long-term support needs were met by a change of setting to residential and nursing care during the year	n/a	421	385
	Denominator: The population of older people in the area (then *100,000)	n/a	73,570	75,000
	Outcome	**n/a**	**572**	**513**

ASCOF 2B Pt1 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for on-going support and dependence on public services. ASCOF 2B measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – a key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.

Performance on ASCOF 2B pt1, has deteriorated slightly year on year but at 88% Bradford remain above the England and Regional averages which were 82% and 84% respectively in 14-15. Provisional 15-16 ASCOF data puts Bradford 7th out of the 15 LAs. The volume of people receiving short term support to maximise independence has increased year on year and our Bradford Enablement Support Team now provide an enablement and rapid response service as part of an integrated intermediate care service at our hospitals.

ASCOF 2B Pt1		2013-14	2014-15	2015-16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Numerator: Of those in the denominator those who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital	165	230	328
	Denominator: No. of older people discharged from hospital to their own home or to a res/nurs home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home	175	260	372
	Outcome	**94.3%**	**88.5%**	**88.2%**

ASCOF 2B Pt2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

The rationale for a two-part measure is to capture the volume of reablement offered as well as the success of the reablement service offered. This will prevent areas scoring well on the measure while offering reablement services to only a very small number of people.
Again the volume of people receiving short term support to maximise independence has increased year on year which has had a positive impact on this particular measure when compared to the denominator of the total number of people discharged from hospital. The England average in 14-15 was 3.1, significantly higher than the Regional average of 2.2 which we have exceeded in 15-16.

Improved joint business intelligence between the NHS and BMDC Adult Social Care would improve the reporting of this measure and implementation of IDCR in Adult and Community Services including the adoption of the NHS Number as the unique patient identifier is also a positive step.

ASCOF 2B Pt2		2013-14	2014-15	2015-16
Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Numerator: No. of older people discharged from hospital to their own home or to a res/nurs home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home	175	260	372
	Denominator: Total number of people, aged 65+, discharged alive from hospitals in England between 1 Oct 2015 and 31 Dec 2015. This includes all specialities and zero-length stays.	12,075	12,575	13,132
	Outcome	**1.4%**	**2.1%**	**2.8%**

ASCOF 2C Pt1 Delayed transfers of care from hospital per 100,000 population

This measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population. It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

Bradford are one of the best performers in the country on DToCs and in 15-16 have improved further on this measure. Effective joint working between health and social care in hospital setting s is central to this and the detailed analysis on DToCs provided by the LGA provides us with the business intelligence to monitor this as part of our Better Care Fund arrangements with the NHS Clinical Commissioning Groups. In Oct 2015 Bradford presented an ADASS 'masterclass' in this area to local and national Adult Social Care senior managers.

ASCOF 2C Pt1		2013-14	2014-15	2015-16
Delayed transfers of care from hospital per 100,000 population	Numerator: The average number of delayed transfers of care (aged 18+) on a particular day taken over the year. This is the average of the 12 monthly snapshots collected in the monthly NHS England Report	14	14	13
	Denominator: Size of adult population in area (aged 18+) *100,000	388,065	389,210	389,300
	Outcome	**3.61**	**3.60**	**3.38**

ASCOF 2C Pt2 Delayed transfers of care from hospital per 100,000 population attributable to Adult Social Care

Part 2 of the Delayed Transfers of Care measure reports those delays that are attributable to Adult Social Care or jointly to Adult Social Care and the NHS. Again Bradford are one of the best performers in the country on DToCs and in 15-16 have improved further on this measure. Initial analysis of the 15-16 ASCOF data shows we are the top performing council in the Region on this (we were second best in 14-15 to Barnsley).

ASCOF 2C Pt2		2013-14	2014-15	2015-16
Delayed transfers of care from hospital per 100,000 population attributable to Adult Social Care	Numerator: The average no. of delayed transfers of care (aged 18+) on a particular day taken over the year, attributable to social care or jointly to social care and the NHS. This is the average of the 12 monthly snapshots.	5	2	1
	Denominator: Size of adult population in area (aged 18+) *100,000	388,065	389,210	389,300
	Outcome	**1.29**	**0.51**	**0.19**

ASCOF 2D Outcome of short-term services: sequel to service

This measure will reflect the proportion of those new clients who received short-term services during the year, where no further request was made for on-going support. Since the aim of short-term services is to reable people and promote their independence, this measure will provide evidence of a good outcome in delaying dependency or supporting recovery – short-term support that results in no further need for services. The measure is the percentage of those that received a short term service during the year where the sequel was either no ongoing support or support of a lower level .

The figures are indicative of the enablement model in place in Bradford and which was subject to a service review in 2015-16. Personal outcome measures from our BEST service are positive for those who complete the period short term support to maximise independence.

ASCOF 2D		2013-14	2014-15	2015-16
Outcome of short-term services: sequel to service	Numerator: Number of new clients where the sequel to "Short Term Support to maximise independence" was on-going low level or other short term support, or no services provided.	n/a	855	1,877
	Denominator: No. of new clients who had short-term support to maximise independence. Those with a sequel of either early cessation of service, or those who have had needs identified but have either declined support or are self-funding are excluded.	n/a	1,570	2,896
	Outcome	**n/a**	**54.5%**	**64.8%**

ASCOF Domain 3: Ensuring that people have a positive experience of care and support

ASCOF 3A Overall satisfaction of people who use services with their care and support

This measures the satisfaction with services of people using adult social care, which is directly linked to a positive experience of care and support. Analysis of surveys suggests that reported satisfaction with services is a good predictor of people's overall experience of services. The relevant question drawn from the ASC Survey is Q 1: "Overall, how satisfied or dissatisfied are you with the care and support services you receive?".

This measure has improved slightly year on year from a relatively poor outcome of 61.9% in 2013-14 to 63.1% in 2015-16. The England average in 14-15 was 64.7% and the Y&H Regional average 65.9% where Bradford were placed 13th out of 15 councils. Although initial analysis of 15-16 ASCOF suggests we may have climbed out of the bottom 3 we still remain below the Regional average and we will be producing further analysis of 15-16 survey results by Service Type, Primary Support Reason etc. to inform Service Improvement and Commissioning.

ASCOF 3A		2013-14	2014-15	2015-16
Overall satisfaction of people who use services with their care and support	Numerator: In response to Q1 in the ASC Survey, those individuals who selected the response "I am extremely satisfied" or "I am very satisfied" (*weighted*)	4,240	3,470	3,622
	Denominator: All those that responded to the question 1 in the ASC Survey (*weighted*)	6,845	5,550	5,738
	Outcome	**61.9%**	**62.5%**	**63.1%**

ASCOF 3D pt1 The proportion of people who use services who find it easy to find information about support

This measure reflects social services users' experience of access to information and advice about social care in the past year. Information is a core universal service and a key factor in early intervention and reducing dependency. Improved and/or more information benefits carers and the people they support by helping them to have greater choice and control over their lives. This may help to sustain caring relationships through, for example, reduction in stress, improved welfare and physical health improvements. These benefits accrue only where information is accessed that would not otherwise have been accessed, or in those cases where the same information is obtained more easily.

A 2 part measure with the Carers survey this is one of the areas where we need to improve and the disappointing outcomes in this area are mirrored by our poor results in 2015-16 Regional mystery shopping (both Face to Face and Reception rated as 'Unsatisfactory' and only the Website rated 'Excellent'). The England average in 14-15 was 75% and provisional ASCOF 15-16 results show Bradford to be in the bottom 3 regionally.

ASCOF 3D pt1		2013-14	2014-15	2015-16
The proportion of people who use services who find it easy to find information about support	Numerator: Those responding to Q12 in the ASC Survey, by choosing the answer "very easy to find" and "fairly easy to find" (*weighted*)	3,205	4,070	4,065
	Denominator: All respondents to Q12 in the ASC Survey "In the past year, have you generally found it easy or difficult to find information and advice about support, services or benefits?" (*weighted*)	4,475	5,550	5,738
	Outcome	**71.6%**	**73.3%**	**70.8%**

ASCOF Domain 4: Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

ASCOF 4A Proportion of people who use services who feel safe

Safety is fundamental to the wellbeing and independence of people using social care, and the wider population. Feeling safe is a vital part of users' experience and their care and support. There are legal requirements about safety in the context of service quality, including CQC essential standards for registered services.

This measure has improved from 70.7% in 14-15 to 73.2% in 15-16, the best outcome over the last 3 years.

ASCOF 4A		2013-14	2014-15	2015-16
Proportion of people who use services who feel safe	Numerator: Those who responded to Q7a in the ASC Survey with "I feel as safe as I want" (*weighted*)	4,865	3,930	4,198
	Denominator: The number of respondents to Q7a in the ASC Survey: "Which of the following statements best describes how safe you feel?" (*weighted*)	6,805	5,550	5,738
	Outcome	**71.5%**	**70.7%**	**73.2%**

ASCOF 4B Proportion of people who use services who say that those services have made them feel safe and secure

This measure supports ASCOF measure 4A by reflecting the extent to which users of care services feel that their care and support has contributed to making them feel safe and secure.

As such, it goes some way to separate the role of care and support in helping people to feel safe from the influence of other factors, such as crime levels and socio-economic factors. This measure has improved significantly year on year from 73% in 13-14 to 84.8% in 15-16 proving that Adult and Community Services provided or commissioned by BMDC are having a more positive impact on individuals' safety. The England average in 14-15 was 84.5% and the Regional average 83.2%.

Initial analysis of provisional 15-16 ASCOF data places Bradford still below the Regional average of 87% and just out of the bottom 3 performing councils. Adult and Community Services have managed the development of the care market, including working closely with CQC to ensure the supply of all care provision is maintained safely. This has required adult services staff going into support care homes to support them to improve quality and safety on several occasions this year, and has included the management of the closure of nursing homes.

ASCOF 4B		2013-14	2014-15	2015-16
Proportion of people who use services who say that those services have made them feel safe and secure	Numerator: Those who responded to Q7b in the ASC Survey with "Yes".	4,940	4,570	4,864
	Denominator: The number of respondents to Q7b in the ASC Survey : "Do care and support services help you in feeling safe?" (*weighted*)	6,740	5,550	5,738
	Outcome	**73%**	**82.3%**	**84.8%**

Short Term Adult Social Care Support

Requests for support and sequels to request

In 2015–16 there were 31,500 requests for adult social care support from new people of which 6,800 or 22% of whom were under 65 years, 24,700 or 78% over 65 years. Year on year there has been a 7.5% increase in the number of new requests for support. Of the total requests for support from new clients 3,000 resulted in some form of short term re-ablement or rehabilitation support to maximise independence, predominantly provided by the BMDC Adult and Community Services BEST (Bradford Enablement Support Team).

4,100 requests resulted in long term eligible support services. 9,600 requests for support met with on-going short term support or low level services for example equipment or assistive technology.14,500 requests for support resulted in referrals to universal services or signposting to other services.

52% of all requests for support received at the Adult Services Access Point were signposted or dealt with at point of contact.

Short Term Support to Maximise Independence

Of the 3,000 new requests for short term support to maximise independence, 1,000 or 33% went on to receive some kind of long term support. The most common reason for people needing this type of support was in relation to physical personal care support, 81% of people under 65 years and 86% for people over 65 years.

Long Term Adult Social Care Support

Long Term Support in the Community

5,030 people received long term support in the community in 2015/16 of which 2,080 (42%) were aged 18-64 and 2,950 (58%) over 65 years.

3,765 were in receipt of community based services as at the 31st March 2016; of which 1,935 were aged 18-64 and 1,830 over 65 years. In total 3,600 people were in receipt of services for more than twelve months.

Long Term Support in Residential and Nursing Care

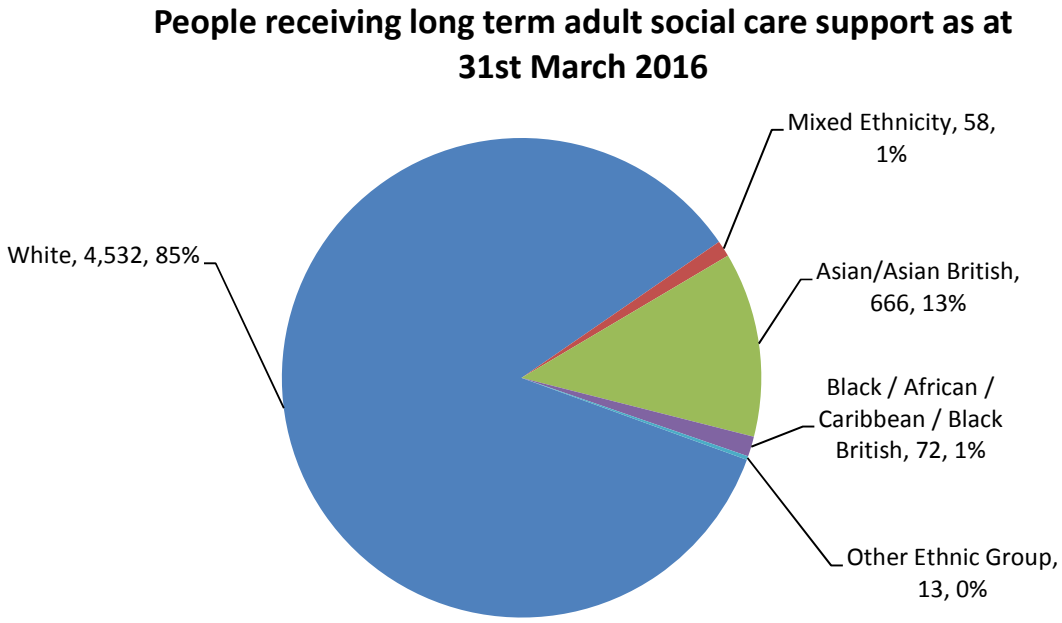
There were **44** admissions to long term residential or nursing care placements for people aged 18-64. In the case of older people there were **385** admissions, a 9% reduction on 2014-15.

In total there are **1,980** people living in long stay residential or nursing care, **430** aged 18-64 and **1,550** over 65 years.

Table 2 shows the ethnicity of those people in receipt of long term adult social care support as at 31st March 2016:

Table 2

	Male	Female	Total
White	1,795	2,737	4,532
Mixed Ethnicity	30	28	58
Asian/Asian British	328	338	666
Black / African / Caribbean / Black British	34	38	72
Other Ethnic Group	6	7	13



Carers
In 2015/16 3,580 carers received carer specific support provided or commissioned by the council of which 2,700 carers received a direct payment.

Overall the Council's Performance on Adult Social Care remains good and the information set out in the report is used within the Adult and Community Services Department to identify specific actions for officers in order to improve performance in all areas.

The Department remains committed and active to the Yorkshire and Humber Sector Led Improvement Approach to driving up performance.

4. FINANCIAL & RESOURCE APPRAISAL

There are no financial issues arising from this report.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

N/A

6. LEGAL APPRAISAL

There are no legal implications at this time.

7. RECOMMENDATIONS

Members are invited to comment on the report.

8. APPENDICES

None

9. BACKGROUND DOCUMENTS

None