City of Bradford MDC
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Agenda for a meeting of the Bradford and Airedale Health and Wellbeing Board to be held on Tuesday, 31 January 2017 at 10.00 am in Committee Room 1 - City Hall, Bradford

Dear Member

You are requested to attend this meeting of the Bradford and Airedale Health and Wellbeing Board.

The membership of the Board and the agenda for the meeting is set out overleaf.

Yours sincerely

P Akhtar

City Solicitor

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: Fatima Butt
Phone: 01274 432227
E-Mail: fatima.butt@bradford.gov.uk

To:

MEMBER	REPRESENTING
Councillor Susan Hinchcliffe	Leader of Bradford Metropolitan District Council (Chair)
Councillor Val Slater	Portfolio Holder for Health and Wellbeing
Councillor Simon Cooke	Bradford Metropolitan District Council
Kersten England	Chief Executive of Bradford Metropolitan District Council
Dr Andy Withers	Bradford District Clinical Commissioning Group
Helen Hirst	Bradford Districts and City Clinical Commissioning Group
Dr James Thomas	Airedale, Wharfedale and Craven Clinical Commissioning Group
Dr Akram Khan	Bradford City Clinical Commissioning Group (Deputy Chair)
Brian Hughes	Locality Director, West Yorkshire NHS England - North (Yorkshire and Humber)
Anita Parkin	Director of Public Health
Michael Jameson	Strategic Director of Children's Services
Javed Khan	HealthWatch Bradford and District
Sam Keighley	Bradford Assembly Representing the Voluntary, Community and Faith Sector
Bev Maybury	Strategic Director Health and Wellbeing Board
Bridget Fletcher/Clive Kay/Nicola Lees	One Representative of the main NHS Provider

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 29 November 2016 be signed as a correct record (previously circulated).

(Fatima Butt – 01274 432227)

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.

(Fatima Butt - 01274 432227)

B. BUSINESS ITEMS

5. WORKING BETTER TOGETHER: A WHOLE SYSTEM APPROACH TO HEALTH AND WELLBEING: ENSURING SUSTAINABLE, HIGH QUALITY PRIMARY MEDICAL CARE SERVICES

In April 2016 NHS England published the General Practice Forward View and through it committed to an additional £2.4billion additional investment by 2020/21 to improve patient care and access and develop new ways of providing primary care.

The Chief Officer of Bradford and Craven Clinical Commissioning Groups will submit **Document "P"** which sets out the challenges facing general practice and asks Clinical Commissioning Groups to submit plans to address those challenges.

The three CCGs have strategies in place to secure sustainable, high quality primary medical care. Airedale, Wharfedale and Craven CCG has concentrated its approach on the role of general practice within new models of care, particularly the enhanced primary care approach. Bradford City and Districts have developed a stand alone strategy which is appended to the report.

The Director of Public Health in Wakefield will give a presentation on their approach to accountable care.

Recommended-

That the Board notes and supports the actions being taken to ensure sustainable, high quality provision of GP services as being key to the delivery of the Board's Joint Health and Wellbeing Strategy.

(Helen Hirst – 01274 237788)

6. THE 2017-19 BUDGET PROPOSALS OF CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL

At the September 2016 Health and Wellbeing Board meeting, members received a presentation from the Directors of Finance Group (Finance Directors from the Clinical Commissioning Groups, the main health providers and the Local Authority) that outlined a four year financial forecast for the Health and Wellbeing sector and placed the forecast in the context of high and growing demand for services as a result of demographic changes, for example an ageing population.

On the 6th December 2016 Council budget proposals for 2017-19 were approved for public consultation.

The Strategic Director Health and Wellbeing will submit **Document "Q"** which asks the Board to consider the Council's 2017-19 budget proposals.

Recommended-

That the Board provides feedback on the 2017-19 Council Budget proposals.

(Sarah Muckle – 01274 437345)

7. CHAIRS HIGHLIGHT REPORT: BETTER CARE FUND QUARTER 2 PERFORMANCE: UPDATES FROM BRADFORD HEALTH AND CARE COMMISSIONERS AND THE INTEGRATION AND CHANGE BOARD: HEALTHY WEIGHT DELIVERY BOARD UPDATE

The Health and Wellbeing Chair's highlight report **(Document "R")** summarises business conducted between meetings: where for example reporting or bid deadlines fall between Board meetings or business conducted at any meetings not held in public where these are necessary to consider material that is not yet in the public domain.

Reporting through a highlight report means that any such business is discussed and formally minuted in a public Board meeting.

The report covers:

- Better Care Fund - Quarter 2 Performance
- Business conducted at the November and December meetings of the Bradford Health and Care Commissioners Group and the Integration and Change Board.
- A further update on establishing a whole system approach to Healthy Weight from the Healthy Weight Delivery Board.

Recommended-

(1) That the Board approves the Terms of Reference for the Integration and Change Board.

(2) That the Board notes the 2016-17 Quarter 2 Performance of the Better Care Fund and the preparation of the Better Care Fund Plan 2017-18.

(Angela Hutton – 01274 437345)

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Report of the Chief Officer of Bradford & Craven Clinical Commissioning Groups to the meeting of the Bradford and Airedale Health and Wellbeing Board to be held on 31st January 2017.

Subject: **P**

Working Better Together: A Whole System approach to Health and Wellbeing: Ensuring sustainable, high quality primary medical care services

Summary statement:

In April 2016 NHS England published the General Practice Forward View and through it committed to an additional £2.4billion additional investment by 2020/21 to improve patient care and access and develop new ways of providing primary care. This document set out the challenges facing general practice and asked Clinical Commissioning Groups to submit plans to address those challenges.

The three CCGs have strategies in place to secure sustainable, high quality primary medical care. Airedale, Wharfedale and Craven CCG has concentrated its approach on the role of general practice within new models of care, particularly the enhanced primary care approach. Bradford City and Districts have developed a stand alone strategy which is appended to this report.

Helen Hirst
Chief Officer. Airedale, Wharfedale and Craven CCG, Bradford City CCG and Bradford Districts CCG

Report Contact: Helen Hirst
Phone: (01274) 237788
E-mail: helen.hirst@bradford.nhs.uk

Portfolio:

Health and Wellbeing

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

In April 2016 NHS England published the General Practice Forward View (GPFV) and through it committed to an additional £2.4billion additional investment by 2020/21 to improve patient care and access and develop new ways of providing primary care. This document set out the challenges facing general practice and asked Clinical Commissioning Groups (CCGs) to submit plans to address those challenges. The draft GPFV plans for Airedale, Wharfedale and Craven CCG and Bradford City & Bradford Districts CCGs are appended to this report.

The three CCGs have strategies in place to secure sustainable, high quality primary medical care. Airedale, Wharfedale and Craven CCG has concentrated its approach on the role of general practice within new models of care, particularly the enhanced primary care approach. Bradford City and Districts have developed a stand alone strategy which is appended to this report.

A summary of the CCGs' overall plans is attached.

2. BACKGROUND

2.1 Local context

In October 2014 Simon Stevens, Chief Executive of NHS England, published the 'Five Year Forward View' (FYFV) for the future of the NHS. He put patient experience, care closer to home and moving care out of hospital settings at the heart of plans for transforming the NHS. In the Bradford District and Craven health and care economy we have interpreted this challenge in our own Five Year Forward View and more recently our Sustainability and Transformation Plan (STP), to enable the transformation required to deliver our shared vision: *"To create a sustainable health and care economy that supports people to be well, healthy and independent".*

Since April 2015, both Bradford City CCG and Bradford Districts CCG have held delegated responsibility to commission primary medical services on behalf of NHS England. This provides the opportunity for the CCGs as local commissioners to have greater influence in the use of resources and shape services for the future. It is a key enabler in developing seamless integrated out of hospital services around the diverse needs of our populations and in delivering the aspirations of both the local and national five year forward views as well as those described in the 'General Practice Forward View' published by NHS England in April 2016. Airedale Wharfedale and Craven CCG has made a formal expression of interest to take delegated responsibility to commission primary medical services from 1 April 2017 but in the meantime the principal commissioner for primary medical care in the AWC area is NHS England.

Delivery of our system wide vision is led by the Integration and Change Board (ICB) which is collectively accountable to the Bradford Health and Wellbeing Board. Its role is to provide system wide leadership and accountability for securing the delivery of a sustainable health and social care system within the Bradford health and care economy,

implementing the vision and direction for delivering the best outcomes for the population as set out in the Five Year Forward View and Sustainability and Transformation Plan, as required by the Bradford Health and Wellbeing Board.

Within the wider Bradford district and Craven health and social care system there is an ambition to move towards an Accountable Care System (ACS) to achieve the triple aim of improved population health outcomes, high quality experience of care and at a good value per capita cost. We expect to be operating within an ACS by 2018/19 in Airedale and by 2020/21 in Bradford and we are planning major steps in the design of this in 2016 and 2017. We believe that by establishing an accountable care approach, we will be able to commission holistic care for our population, taking into account the care they will need for their whole life, and for the whole person, rather than commissioning separate services. We will commission services that 'wrap around' them, to provide co-ordinated consistent and high quality services across organisational boundaries.

This approach will be outcome based. We are not interested in merely counting activity and inputs, rather, we want to know that the care received by our population is of high quality, safe and of best value and that we commission interventions that improve the population's overall health outcome. We believe, for this to succeed, primary medical care services must be the bedrock of our system. It is clear that without total primary medical care involvement, a fully functioning ACS would not be possible. Therefore this strategy clearly sets out our ambition to ensure primary medical care services play a full part in the development and move towards accountable care

The scope of our plans includes the entire service element of primary medical care. This includes all services deliverable under core General Medical Services and Personal Medical Services. It also includes enhanced services, the quality and outcomes framework, vaccinations and immunisations and locally commissioned services. The scope includes services delivered at both individual practice level and delivery at scale. The delivery of our plans relies on all elements of the primary medical care workforce, not just General Practitioners. This includes, but is not limited to, Advanced Nurse Practitioners; Practice Nurses; Practice Managers; Receptionists; Health Care Assistants, practice-based Pharmacists and practice volunteers.

The term 'general practice' is often used interchangeably when describing three related yet different concepts:

- The current model of delivery (including, but not limited to, independent contractor status)
- The wider members of the primary health care team who work in and/or for the practices
- The skills of GPs that are unique to the profession

It is important that our plans address all of the above. It is also important to note that throughout our plans where we refer to patients we are referring to both patients and their carers as we recognise that not all patients are able to access care or manage their

conditions independently. We recognise the importance of engaging with carers as part of our service transformation. It is also imperative to acknowledge that the primary medical care services relate to both physical and mental health needs. Our plans recognise the need to ensure that mental health illnesses are treated with the same parity of esteem as physical health needs and will support the delivery of the mental health strategy to guarantee this occurs in Bradford district and Craven.

2.2 National context

NHS England's Five Year Forward View (2014) sets out a vision for the NHS, based on new models of care. Primary medical care is recognised as *"one of the great strengths of the NHS"* and further investment is planned, specifically relating to:

- stabilising core funding;
- greater influence over the NHS budget for CCGs;
- increased numbers of GPs;
- increased funding for infrastructure development;
- initiatives to tackle health inequalities; and
- awareness of roles and resources to support self-care.

The environment for further investment and development is challenging, complicated by recruitment and retention issues; transformation shifting care closer to home; lower relative funding; increased activity in acute services (e.g. A&E); the development of new primary medical care models e.g. federations; increasing demand and financial pressures; and pressures from increasing performance targets.

Government policy continues to move services into the community, placing yet more pressure on overstretched GP services struggling to provide enough appointments, with consequential delays to see a GP.

In April 2016, NHS England (NHSE) in partnership with The Royal College of General Practitioners (RCGP) and Health Education England (HEE) published the General Practice Forward View. This document can be seen as primary medical care services' own FYFV – highlighting the key challenges which face primary medical care currently and the changes and developments which NHSE, RCGP and HEE identify as being key priorities in ensuring a high quality and sustainable primary medical care service is in place in the future.

The General Practice Forward View (GPFV) focuses on five main areas:

1) Investment
2) Workforce
3) Workload
4) Practice infrastructure

5) Care redesign

Against each area, the GPFV outlines what NHSE plans to implement to support those areas, and the detail set out in the CCGs' plans outlines what we will be doing locally to interpret and implement the GPFV in order to make it real for Bradford district and Craven people.

Some of the plans and concepts outlined in the GPFV have also been evidenced in earlier documents which have informed local thinking. The Royal College of General Practitioners previously set out a vision suggesting that primary medical care in 2022 should be based on shared decision making; increased community self-sufficiency; coordinated care; collaboration across boundaries; and greater use of information and technology. The NHS Alliance has also prepared a vision for primary medical care , focused on developing a "community of care" using a restructured workforce; improved premises; increased coordination; social prescribing; effective use of technology; a review of funding; and increased self-care and prevention.

The BMA's discussion paper "General practice and Integration" states that initiatives to reduce service fragmentation and align organisational interests for the benefits of patients through the development of collaborative working should be welcomed. The current arrangements of competing providers and at times, rigid separation between primary medical care, community providers and social care are having a detrimental effect on patients, with disjointed service delivery, duplication, increased transaction costs and flows of funding which create perverse incentives that do not reflect patient needs. Our CCGs agree with this, and the work we are doing on ensuring primary medical care is the bedrock to the accountable care system is our main approach in eliminating these issues in the future.

3. OTHER CONSIDERATIONS

None

4. FINANCIAL & RESOURCE APPRAISAL

The GPFV talks of an additional £2.4bn investment. It is unclear how much of this investment we can expect to see through direct allocation. CCGs have to plan for an additional £3/head of population (£1.8m) over 2017 to 2019 and this resource has to come from existing allocations.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

None specific to this paper

6. LEGAL APPRAISAL

None specific to this paper

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

The Equality Act 2010 unifies and extends previous equality legislation and we have also taken this Act into account when developing our plans.

To ensure that the CCGs are meeting their equality duties, improving health and reducing health inequalities we will:

- Adhere to the 'Brown principles'[9]
- Ensure any changes to services will include local engagement with patients, public, carers and wider stakeholders and ensure that this includes involvement of protected characteristic groups and that equality monitoring is undertaken for all engagement activity.
- All service reviews undertaken will undertake an equality analysis.
- Service contracts and service specifications will reflect the need for equality monitoring and ensure that providers demonstrate and report on how they are meeting their public sector equality duty.
- Any decision making resulting from these plans will give consideration to any identified 'impact' on protected characteristic groups and where appropriate identify and implement mitigating actions.
- Adhere to the accessible information standard by ensuring that patients and service users, and their carers, can access and understand the information they are given. This includes making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email. We will also ensure that people get any support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or an advocate.

7.2 SUSTAINABILITY IMPLICATIONS

None specific to this paper

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None specific to this paper

7.4 COMMUNITY SAFETY IMPLICATIONS

None specific to this paper

7.5 HUMAN RIGHTS ACT

None specific to this paper

7.6 TRADE UNION

None specific to this paper

7.7 WARD IMPLICATIONS

None specific to this paper

8. NOT FOR PUBLICATION DOCUMENTS

None

9. RECOMMENDATIONS

9.1 The Board notes and supports the actions being taken to ensure sustainable, high quality provision of GP services as being key to the delivery of the Board's Joint Health and Wellbeing Strategy.

11. APPENDICES

1 Summary of each Clinical Commissioning Group's key aims and objectives for primary medical care

2 Airedale, Wharfedale and Craven CCG General Practice Forward View Draft Plan submitted to NHS England 23/12/16

3 Bradford City and Bradford Districts CCGs Primary Medical Care Commissioning Strategy approved by the CCGs in December 2016

12. BACKGROUND DOCUMENTS

General Practice Forward View, April 2016, NHS England
https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

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Summary of Airedale, Wharfedale and Craven's Plans

General Practice will operate as equal partners in an Accountable System of Care, using a resilient workforce to deliver innovative and proactive healthcare improving the wellbeing for all our population

Aims and Intended Outcome

- General Practice operates as equal partners in the (future) delivery of healthcare for our population in the AWC CCG area.
- Our approach to care is innovative, integrated, proactive and holistic.
- We promote and increase uptake of self-care and self-management
- General Practice understands the health care needs and lifestyle factors of our patients and communities within AWC and tailors care delivery accordingly.
- Where appropriate general practice is delivered at scale in locality hubs, maintaining continuity of care with equitable distribution of services through smaller 'spoke/satellite' services,
- General Practice works in collaboration with partners as part of an accountable system of care.

Summary of Bradford City and Districts CCGs Plans

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

The primary medical care commissioning strategy for NHS Bradford City Clinical Commissioning Group and NHS Bradford Districts Clinical Commissioning Group sets out the commissioning aspirations for the next five years to enable primary medical care services within Bradford to:

- Be delivered via primary medical care at scale by a mixture of independent practices, networks and federations as part of an accountable care system operating out of hubs, co-located and collaborating with other relevant services 7 days a week. As well as NHS and social care providers this will also include VCS organisations.
- Regularly use technology for all elements of patient care including access, consultations, telehealth and telemedicine.
- Have established new roles and new ways of working, including 'virtual primary medical care', shifts in traditional roles and responsibilities and that Bradford is 'The place to be'.
- Have better demand management, as patients are empowered and experienced in self-care and preventative services are embedded within the accountable care system.
- Have strong embedded relationships with education, paving the way for increased levels of self-care and a workforce who choose to work and live in Bradford.
- Have equality of care for the whole population. Wherever people live or are registered within Bradford, they can access the same services.

To attain our end state we will focus on the following key areas of action: improve access; high quality; workforce; self care and prevention; collaboration; and, estates, finance and contracting.

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NHS
Airedale, Wharfedale and Craven
Clinical Commissioning Group

Delivering the Forward View for General Practice (GPFV)

Airedale, Wharfedale and Craven CCG

Contact: Lynne Scrutton. Head of Design and Delivery

Clinical Lead: Dr James Thomas AWC CCG Clinical Chair

CONTENTS:

Introduction:

The following plan is intended to provide assurance to NHS England of the CCGs approach to delivering the Forward View for General Practice.

The content is set in the context of our local and West Yorkshire Sustainability and Transformation Plans (STP), our Operational Plan and the National Forward View for General Practice. It is aligned to the agreed ***system wide vision*** for Airedale, Wharfedale and Craven which has been agreed with strategic partners:

Our Vision:

To deliver the *system vision*:
Our aim is to establish a place based 'system of care' in which provider organisations collaborate to manage the common pool of limited resources available and work together as one system to improve the health and care for the whole population, through this delivering 'Accountable Care Airedale'.

Commission one system of high quality care, through a single outcomes based contract focused on improving the whole populations' health and well-being and is financially and clinically sustainable

Our Plan for delivering the GP Forward View:

Sustainability and Transformation Plan (STP) and Operational Plan:

Our plan for delivering the GPFV is aligned to our local and the West Yorkshire Sustainability and Transformation Plan (STP) and our 2017/19 Operational Plan. Through this approach we will continue to focus on ensuring delivery of the NHS Constitution Standards, the triple aims identified in the STP, and on commissioning safe, high quality and effective care.

Example indicators in the 2017/19 Operational Plan which support delivery of the STP triple aim and the GPFV:

- Train 10% of the health and social care workforce to support people to better self-care
- Improved population outcomes through the implementation of new contracting models
- Commission new models of primary medical care that ensures 7 day access is achieved for 100% of our population by 2021
- 90% of people who access Psychological Therapies will engage through direct self-referral
- By 2018/19 we will have modelled additional schemes to shift transfer of resources equivalent to £1.8m to primary care

Area of GPFV plan	Description
Vision Narrative	A clear narrative on the vision for and delivery of sustainable general practice that reflects the ambition set out in the General Practice Forward View

The 2020 ***vision for general practice*** in Airedale, Wharfedale and Craven is:

General Practice will operate as equal partners in an Accountable System of Care, using a resilient workforce to deliver innovative and proactive healthcare improving the wellbeing for all our population

Aims and Intended Outcome

- General Practice operates as equal partners in the (future) delivery of healthcare for our population in the AWC CCG area
- Our approach to care is innovative, integrated, proactive and holistic
- We promote and increase uptake of self-care and self-management
- General Practice understands the health care needs and lifestyle factors of our patients and communities within AWC and tailors care delivery accordingly
- Where appropriate General Practice is delivered at scale in locality hubs, maintaining continuity of care with equitable distribution of services through smaller 'spoke/satellite' services
- The locality hub and smaller spoke/satellite service model will facilitate meaningful collaborative partnership working in an Accountable System of Care

This vision has been co-produced by the CCG in partnership with representatives from General Practice, Yordales Health Federation and YOR LMC.

An accountable care system will not succeed without general practice at its heart. A strong sustainable accountable care system needs strong sustainable primary medical care.

At Pace and Innovation:
Airedale, Wharfedale and Craven is a National Pioneer site and is one of few national Accelerator sites. Through our programmes of work we are designing, developing and testing New Models of Care and progressing at pace towards an Accountable Care System. Our ambition is to run an Accountable Care System in shadow form in 17/18, live in 18/19.

General Practice is the cornerstone of care and an integral and critical stakeholder within any such system; General Practice has been a key stakeholder in designing and testing the New Models of Care which have been commissioned, in particular Enhanced Primary Care. 2016/17 is the second year of delivering Enhanced Primary Care, through these arrangements we have made available up to £5 per head additional investment in General Practice. Up to 2017/18 this funding has been non recurrent (during the pilot phase). In November 2016 the Governing Body accepted a recommendation that this funding is confirmed for two years to enable longer term planning and evaluation. Please see Investment Plan section for more detail. For different reasons (changes in partnership, missed deadline and non-engagement), 3 of our 16 practices did not participate in 16/17.

Building on progress to date and incentivising engagement through utilisation of available PMS Premium funding we anticipate that all practices will engage in enhanced care in 2017/18 and 2018/19. The investment will also encourage pro-active care and through this the opportunity to test and expand a range of new roles which will support delivery of the overall vision.

Accountable Care Airedale:
We will also continue on our journey as an Integrated Care Pioneer and use this as a vehicle to accelerate delivery of Accountable Care Airedale. Through this programme we will develop, commission and test New Models of Care such as complex care, enhanced primary care, community based 'wrap around' services, and we will promote and embed approaches to self-care and self-management. We have also established brief task and finish groups to develop and deliver improvements in services and pathways where Commissioning for Value packs have provided us with information on an opportunity to reduce variation and improve outcomes for our population.

The Accountable Care Airedale Programme and Programme Board have been established and through this mechanism we will ensure a joined up approach to delivery of the STP, Operational Plan and GPFV Plan.

Accountable Care Airedale: Degree of integration and primary care contractual arrangements:
As expressed earlier in this document our aim is to commission one system of high quality care, through a single outcomes based contract focused on improving the whole populations' health and well-being - which is financially and clinically sustainable.

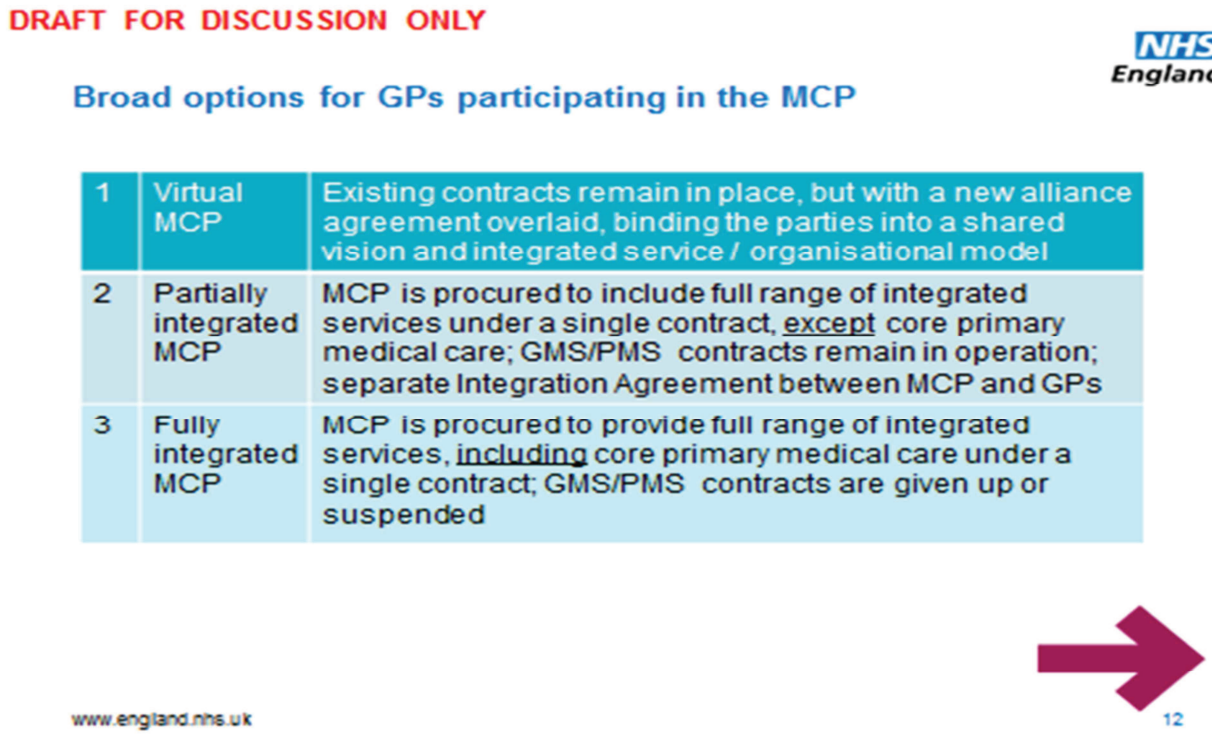
An accountable care system will not succeed without general practice at its heart. A strong sustainable accountable care system needs strong sustainable primary medical care.

As equal partners in an accountable care system there is currently no opportunity for general practice to genuinely commit to being part of the accountable care system and deliver care through one single outcomes based contract. Currently practices within Airedale, Wharfedale and Craven hold GMS, PMS or APMS contracts which, with the exception of the one APMS contract, have no end date. It would be a radical move to review and implement different contractual arrangements for general practice and would require NHS regulatory change. In view of this it is more likely that general practice will integrate as part of the system through an integration agreement. However the National Pioneer team are working with

regulatory bodies to explore how general practice might fully integrate in future and there may be an option to suspend GMS/PMS contracts (with right of return) allowing general practice to deliver care through the one single contract. This would allow general practitioners to operate as salaried doctors as part of a larger system of care with less personal accountability than a general practitioner with a GMS/PMS contract has. This may be attractive to some who are experiencing significant resilience issues.

In recognition that there are a range of options and degrees of integration for general practice as part of the accountable care system dialogue has commenced regarding the future ambition of General Practice.

Example options are set out in the diagram below, this refers to a MCP however it could equally apply to a PACS or Accountable Care model



Locally we need to explore general practices preferences. We expect the outcome to be partial integration unless there is a desire to test full integration. We believe this to be unlikely however there could be a mixed economy with some choosing to integrate and agree an Integration Memorandum of Understanding which will join them as part of the Accountable Care System (ACS) and some may be interested in pursuing the option to suspend GMS/PMS contract and be a fully integrated part of the ACS. There will be no attempt to impose any model on practices this must be driven by General Practice as an integral and key partner in 'Accountable Care Airedale'.

This work will be progressed through the Accountable Care Airedale Programme Board and the National Pioneer Programme.

It is important to note that the CCG is level one co-commissioner so it is not currently responsible for commissioning general medical care hence any agreements, as suggested above, would need to be supported by NHS England, or full delegation of commissioning responsibilities agreed. An expression of interest in delegated commissioning was submitted 5th December 2016 so it may be that the CCG becomes

responsible with effect from April 2017.

General Practice 'Stabilisation, Sustainability and Transformation' Plan:
The CCG in partnership with General Practice and YOR LMC have co-produced a vision for General Practice and are developing a General Practice Stabilisation, Sustainability and Transformation Plan which aligns to the Five Year Forward View. Delivery of the vision will be through this plan.

To deliver our 2020 vision for General Practice within Airedale, Wharfedale and Craven and our vision for the system we must have strong, high quality, accessible, resilient and sustainable general practice. General practice is the foundation of care and the bedrock of any health and care system. An accountable care system will not succeed without general practice at its heart. A strong sustainable accountable care system needs strong sustainable primary medical care.

A critical component is culture and engagement so alongside supporting general practice stabilisation and sustainability we must also encourage and nurture a culture of innovation and ambition which in itself will engender transformational change. The establishment and renewed interest in Yordales Federation provides a mutually beneficial opportunity and a vehicle through which we can achieve greater involvement and engagement of general practice, in turn strengthening its ability and opportunity to operate as an equal and integral partner in the accountable care system. Yordales Federation now has 7 clinical directors and 2 managerial directors representing all three CCG localities, along with YOR LMC involvement in the Accountable Care Programme and joint CCG/Federation working our ability to deliver the ambition within he GPFV is optimised.

The plan also supports delivery of AWC CCG strategic objectives and principles:

STRATEGIC OBJECTIVES:
Reduce reliance on reactive emergency and urgent care through more planned and proactive model of services
Change the mind-set of professionals to promote active participation in health and wellbeing of the individual
Change the mind-set of the public so they become an active participant in their health and care
Deliver the pledges as set out in the NHS constitution
PRINCIPLES:
No one in hospital unless their care cannot be delivered safely in the community 24/7
No one discharged to long term care without the opportunity for a period of enablement
24/7 access to and delivery of co-ordinated care, which is needs driven and not about age, condition or location

The plan has been co-produced with representatives from General Practice, Yordales Health Federation, YOR LMC and the CCG. It is informed by the outputs of a joint development session which was held on 23rd September 2016. There are four themes within the action plan which align to the General Practice Forward View

- Workforce
- Access
- Infrastructure (Technology and Estates)
- Care Redesign and Workload

Please refer to pages 33 and 34 for the Plan on a Page and our Initial Roadmap to progress this work

Further development will be undertaken in partnership with member practices and YOR LMC through the new general practice engagement network as an iterative process as the Accountable Care System within Airedale is developed and implemented.

Investment in primary care	The investment plan (revenue and capital) in primary care to deliver all aspects of the General Practice Forward View, locally. Including: 1. High level modelling that provides evidence of: - The shift of activity from hospital to out of hospital care - Total spend trajectories for the shift to primary care 2. Clarity on the resource shift so the STP can be clear on the new out of hospital /primary care expenditure plan –per capita shift to primary care and total spend reflecting the direction of travel for increased investment in primary care 3. The CCG's proposed on-going investment plans and timescales for making this investment in-line with delivery of the service offer above (including where CCGs require access to supporting additional non-recurrent transformation resources)?

The General Practice Forward View and associated planning requirements set out additional investment from CCG allocations into primary care over the period to 2018/19 along with additional funding allocations to CCGs or NHS England teams. Taken together with increases in allocation for primary care and central investment in general practice, it is expected that the overall share of the NHS budget going to primary care will increase over the period to over 10%.

Future investment plans for AWC:

	17/18	**18/19**	**19/20**
Transformational Support	£785k. £5 per head of population to commission enhanced primary care and establish and test extended access through a hub model Requirement is circa £471k over 2 years (£3 per head)	£1m. £6.50 per head of population to commission enhanced primary care Requirement is £471k over 2 years (£3 per head)	**TBD as part of an accountable care system**
Access Improvement	Part of £5 per head to test extended access through a hub model	£539k (£3.34 per head) to roll out locality hub model	£ 965k possibly £1.5m (£6 per head extra ? plus the £3.34)

	Enquiry made re whether any additional funding available through WYAZ for General Practice extended access £100k NR in 2016/17 to support infrastructure change to establish hub through WYAZ	This may be incorporated with enhanced primary care funding, to be determined by patient engagement regarding 'local need'	
General Practice Consultation Software	£41k New CCG allocation	£55k New CCG allocation	New CCG allocation
Training Care Navigators & Medical Assistants	£27.5k Devolved to NHSE AT or CCG	£27.5k Devolved to NHSE AT or CCG	
General Practice Resilience Programme	Held centrally do not factor into plan	Held centrally do not factor into plan	Held centrally do not factor into plan
Reception & Clerical Staff training	£14k in 16/17 Plan will be agreed with practice managers		
Funding for new roles and functions to support general practice resilience and integration			
Physician Associates in General Practice (Utilising Quality Premium Funding)	£45k		
Quality Improvement in Care Home Services (Practice provided)	£105k plus £64k	£105k plus £64k	TBD as part of an Accountable Care System
Personal Support Navigators in Complex Care (Age UK provided) CCG & Local Authority Funded.	£90k CCG Funding	£90k CCG Funding	TBD as part of an accountable care system
Personal Support Navigators in Enhanced Primary Care (Age UK provided. Funding request submitted to National Pioneer	TBC		
Wellbeing Pilot (Primary Care part of provider partnership)	£100k	£100k	
Complex Care (Primary Care part of provider partnership)	£690k	£690k	TBD as part of an accountable care system
Integrated Diabetes and Specialist Podiatry Service (Primary Care part of provider	£1.39m	£1.39m	£1.39m

partnership)			
Local Enhanced Service	£828k (includes £425k non-rec PMS premium allocation transfer from NHSE)	£971k (includes £567k non-rec PMS premium allocation transfer from NHSE)	
Estates and Technology Transformation Fund	Bid for options appraisal and business case leading to capital funding bid for Keighley submitted, categorised as Phase 3. Alternative funding sources being explored		

Investment Plan:
In 17/18 and 18/19 we intend continuing to invest in Enhanced Primary Care (EPC) and giving practices more certainty of funding so they can plan and deliver transformational change. The value will increase by a further £1.50 per head of population in 2018/19. This will require annual review of schemes in the context of the forward view, New Models of Care and the developing Accountable Care System. This includes ensuring integration with the complex care model, cultural change, changes in clinical practice and ways of working building on the move from a purely medical model of care, ensuring continuation of outcomes focus delivering pro-active care for those at risk.

We recognise that to deliver a change in culture and mind set, self-care, self-management, prevention and a new model of pro-active care it will be necessary to invest in general practice. Enhanced primary care presents an opportunity to 'pump prime' and allow time for benefits to be realised following which there is the ability to move funding around the system and invest more in the 'front end' of care i.e. general practice. The financial envelope to support accountable care is the financial envelope, in time the system will determine where the funds are best invested until then commissioners are committed to supporting investment in general practice wherever possible without destabilising or having a detrimental impact on other areas of the system of care..

As party to the West Yorkshire Acceleration Zone (WYAZ) the CCG is working with practices to determine 'local need' and ensure patient participation in the design of extended access for our population. This work will be undertaken in Q4 2016/17 to inform rapid establishment of a hub model of extended access to test in 2017/18, funded as part of the £5 per head investment. We will utilise the PMS Premium funding made available in 2017/18 to secure general practice engagement in a range of activities, bringing forward engagement activities to Q4 2016/17 to ensure we are prepared to implement schemes from 2017.

The CCG requires robust engagement and general practice leadership in areas such as :

- Development of a General Practice strategy which includes broader primary care (Co-design)
- Development of New Models of Care for General Practice
- Development of New Models of Care within Accountable Care Airedale
- Engagement in Accountable Care and delivery of the Forward View for General Practice
- In particular the model for delivery of accelerated extended access in 2017/18
- Patient engagement to determine 'local need' for weekend extended access
- Clinical engagement in all communications & engagement activities associated with New Models of Care, GPFV & Accountable Care Airedale

Options appraisal to determine the optimum method of securing this engagement has been undertaken and we are consulting with general practices regarding their preferences. This robust approach to engagement will ensure true co-design and involvement in delivery of the GPFV, most likely through a new general practice engagement network.

Working at scale and Enhanced Primary Care (EPC):
For avoidance of doubt our ambition is that where it is appropriate General Practice is delivered at scale in locality hubs, maintaining continuity of care with equitable distribution of services through smaller 'spoke/satellite' services. This includes 'core' general practice, enhanced services, enhanced primary care all building to a new model of general practice with self –care and self-management embedded as a new offer to individuals – as part of an accountable system of care. This approach will create efficiencies and will support resilience and sustainability of general practice.

The locality hub and smaller spoke/satellite service model will facilitate meaningful collaborative partnership working in an Accountable System of Care. General practice at scale and operating as a federation through Yordales Health also strengthens the ability of general practice to operate as an equal partner, speaking and contributing with one voice influencing new models of care. Without this approach 16 separate independent voices would inevitably dilute general practices ability to influence the accountable care system.

Working at scale and through hubs is a relatively new concept locally however over the last two years models of working at scale and delivering a new model of care have been tested through enhanced primary care. For instance in 16/17 one scheme covered the whole of Craven, a population of 50k involving 4 practices located within a large rural geographic footprint.

Learning from the 'at scale' schemes delivered through enhanced primary care demonstrates that bringing together disparate practices with different cultures and systems over a new footprint is not an easy task. We recognise that to deliver general practice 'at scale' through locality hubs the CCG will need to offer support and facilitation by way of clinical and managerial leadership and dedicated time. We have also submitted bids to the National Pioneer Programme and are considering a bid to the GP Resilience Scheme to support this approach financially. If successful funding will be used to secure an expert change agent and backfill for practice clinical leadership time, to accelerate a 'proof of concept' within Keighley and establishment of Keighley Medical Group, bringing together 5 practices working as one locality hub. The learning from this is intended to encourage others and build confidence in the ability of general practice to operate 'at scale' and also realise significant benefits from this approach. .

To progress these new models of 'at scale' locality hub working will also require significant consultation with a range of stakeholders, not least GPs, practices and the public.

EPC:
The development of EPC schemes in 16/17 for delivery 17/18 will focus on delivering pro-active care, new roles, working at scale, improving access (through reducing demand & churn) and as part of the WYAZ. When agreeing the approach for 17/18 we will work with our enhanced care reference group to evaluate what has worked well and realised benefits and adopt as best practice in 17/18.

Members are reviewing the 10 high impact change areas and targeting efforts at those most likely to realise benefits. It will be necessary to secure commitment to free up GP time to engage in change programmes which stabilise and sustain general practice - whilst also testing innovation and transformation. The approach to utilising PMS premium funding will support this work being undertaken.

EPC Evaluation:
As part of the national pioneer programme we have engaged with the Policy, Innovation, Research Unit (PIRU) in order that independent evaluation of the impact of New Models of Care is undertaken. This includes benchmarking with other national pioneer sites the impact of new care models on a range of health and social care indicators. This will support review over a longer term of the impact of additional

investment in general practice on the system and support and build an evidence base.

Engagement and dialogue with general practice representatives has commenced through the enhanced care reference group (ECRG) and the Operational Development and Delivery Group which includes provider representatives from Accountable Care Airedale.

Reduce Bureaucracy:
Our approach to outcomes based commissioning has enabled a move away from activity based reporting, counting, and payment. For example our Local Enhanced Service specification has three domains, diagnosis, shared care and treatment. Practices are paid based on a population and are not required to report activity numbers but are assessed on outcomes delivered. This principle has also been applied to Enhanced Primary Care (EPC)

Activity Modelling:
An exercise to undertake modelling and calculate the impact of investment in pro-active enhanced primary care (EPC) could have on the system has been undertaken and has been used as a basis for calculating impact. This has informed contract negotiation in 16/17 for 2017 - 2019 contracts. To invest £5 per head in general practice it will be necessary to adjust contract activity and values and this presents some risks to the CCG:

a) In year one 14/15 despite £5 per head investment into general practice to delivery enhanced primary care the impact required to demonstrate return on investment through a reduction in A&E, Non Elective admissions and ambulance activity at a population level has not been achieved
b) The preliminary findings for year 2 do not suggest that return on investment will be realised in year 2 either
c) In view of this it is important to recognise the potential destabilising effect a reduction in contract value could have elsewhere within our local system as indications are that investment in schemes such as enhanced primary care may not actually reduce overall activity levels ***in the short term***
d) In order to robustly quantify the impact of investment in enhanced primary care schemes we need to be able to evaluate at cohort level (the target population receiving pro-active care through these schemes and whether ROI is demonstrated at cohort level). We are currently experiencing difficulty with information governance issues which are preventing analysis of anonymised data, we are working with our CSU provider to resolve these issues and are taking advice from the national Accelerate team to unblock these barriers to evaluating the impact
e) We have also received support from PIRU and hope to have independent evaluation of these new models of care
f) It is this level of evaluation that will give confidence that investment realises system benefits
g) To deliver pro-active care which in turn delivers the anticipated outcomes **takes time**; it requires a significant culture change both from a system, professional and patient engagement perspective

Example Modelling

2015-09-10-B AWC NMoC EPC.pptx

Approach to Funding Formulas:
Recognising the increasing demographic growth (see Population Projections Table), variation in deprivation indices and as a result different health inequalities and associated opportunities it is critical that we progress and develop innovative initiatives to meet increasing demand and reduce health inequalities within finite resources. This is likely to mean taking into account deprivation and health inequalities when

designing and implementing funding formulas. This approach has already been tested with our methodology to redistributing the PMS Premium funding.

With regard investment we will:

1. Agree with member practices and NHSE an approach to justify investment and redistribution of PMS premium by way of securing meaningful engagement and clinical leadership to support co-design and delivery of extended access, the GPFV and Accountable Care Airedale

2. Agree a plan with practice managers and support them to commission training to the value of the £14k allocation for signposting and document management

3. Review and implement national specifications and additional requirements relating to investment made available; such as training care navigators and medical assistants

4. Consider taking into account health inequalities when designing funding formulas

Support and grow the primary care workforce	A baseline assessment of workload, demand and supply side numbers. A plan to: - Develop initiatives to attract and retain GPs and other practice staff, and - Develop expanded multi-disciplinary primary care teams

Workforce Strategy:
A Bradford and Craven Integrated Workforce Strategy has been developed and agreed. Work streams to support delivery have been established, these are key enablers to the Accountable Care Airedale and Accountable Care Bradford Programmes. A summary of the strategy is embedded.

IWP Workforce Strategy.pptx

Predicted Population Growth:
An analysis of expected population growth within AWC over 5, 10 and 15 years has been undertaken by Public Health Analysts in the City of Bradford Metropolitan District Council.

Calculation method - applying ONS CCG resident population projections 2014 to registered practice populations (April 2016). Please see table below

The predicted population growth overall in the next 15 years is not significant, rising from 158,000 to 168,000, this equates to a 6.6% growth in the next 15 years. However the majority of this expected growth is in the over 65's hence the models of care and workforce model needs to meets the needs of older people, particularly frail elderly.

The impact of broader determinants of health, social care circumstance and levels of social care service provision is also a contributing factor to be taken into account. Local Authorities are planning and preparing for more people to have access to assisted living facilities and for packages of care to support people to remain at home. This will in turn increase demand on health services as less people move to long term nursing care and remain in local communities. Models of Care and workforce make up needs to reflect changing population demographics and offer different response through enhanced skill mix and new roles, including generic roles which take account of individuals physical, psychological and social care

needs, through this reducing reliance on GPs.
The predicted population age profile has been used to inform future workforce requirements. By breaking down further into localities we can also plan for hub working. Through the accountable care system there will be the ability to flex the workforce to target areas of most need, through this contributing to addressing health inequalities. Interestingly, whilst the Airedale locality has the largest population, over the next 15 years the predicted growth in population is fairly equally distributed within each locality. This is due to the younger makeup of the Airedale locality and predicted reduction in growth in up to 65's in the next 15 years. So, whilst currently the largest proportion of our population resides in Airedale, the growth rate is proportionately less than predicted in the other localities. This doesn't however take into account health inequalities so whilst the growth in population may be predicted to be proportionately less in Airedale, the need for services is likely to remain constant or increase as people in deprived areas are known to become sicker sooner and so demands on local practices are likely to continue to grow.

When determining workforce needs, in particular the GP workforce, we fully recognise that practices in AWC will be competing not only locally but regionally and nationally to secure the limited emerging GP workforce. In view of this we have taken as innovative an approach as we are able to, at this time, to predict our future workforce model. We are already testing the effectiveness of different skill mix and roles, for example extensivist roles, personal support navigators, physicians associates, as well as more tested roles such as psychologists, physiotherapists and nurse practitioner. We are assessing receptiveness of patients to alternative professionals being the first point of contact and will build on public and patient engagement activities, linked to self-care and self-management initiatives to support mind-set change so people understand that the GP isn't always the best or right professional to meet their needs. We will use feedback and learning to adjust plans as outcomes and benefits of these new approaches are realised.

Practice Population Projections - 2016-2031

		0-19 yrs				20-64yrs				65+ yrs			
Practice code	Practice Name	2016	2021	2026	2031	2016	2021	2026	2031	2016	2021	2026	2031
Craven													
B82007	Townhead	1,799	1,815	1,846	1,821	4,977	5,005	4,965	4,912	2,687	2,958	3,270	3,608
B82020	Crosshills	2,618	2,633	2,657	2,624	6,798	6,807	6,748	6,698	2,705	2,968	3,282	3,634
B82028	Fisher MC	2,731	2,747	2,767	2,734	7,810	7,839	7,772	7,704	3,556	3,912	4,335	4,810
B82053	Dyneley	2,397	2,411	2,433	2,403	7,024	7,048	6,989	6,931	2,438	2,682	2,963	3,290
Wharfedale													
B83002	I&W	834	841	848	838	2,343	2,355	2,337	2,317	1,191	1,308	1,451	1,615
B83620	Addingham	472	473	475	470	1,423	1,436	1,425	1,408	1,006	1,108	1,234	1,365
B83008	Ling House	3,226	3,241	3,260	3,221	6,625	6,618	6,558	6,523	1,617	1,774	1,976	2,192
B83019	Grange Park	1,586	1,598	1,607	1,587	3,644	3,653	3,628	3,594	1,414	1,555	1,719	1,910
B83624	IG Medical	3,699	3,729	3,764	3,717	9,619	9,627	9,527	9,450	4,844	5,355	5,990	6,680
Airedale													
B83023	Holycroft	2,647	2,657	2,675	2,643	5,694	5,690	5,628	5,597	1,755	1,923	2,134	2,369
B83027	Haworth	1,868	1,878	1,890	1,866	5,473	5,485	5,436	5,387	1,964	2,138	2,369	2,609
B83033	Kilmeny	3,455	3,469	3,493	3,451	7,813	7,797	7,713	7,673	2,056	2,253	2,499	2,760
B83061	Oakworth	704	707	711	703	2,107	2,108	2,088	2,070	692	760	841	923
B83602	North Street	2,710	2,729	2,746	2,713	3,609	3,601	3,578	3,579	391	426	479	533
B83006	Silsden	2,278	2,285	2,303	2,276	6,491	6,512	6,457	6,405	2,552	2,802	3,108	3,428
B83021	Farfield	3,181	3,196	3,219	3,180	7,367	7,377	7,304	7,255	2,249	2,465	2,731	3,021
	Total	**36,205**	**36,408**	**36,696**	**36,244**	**88,817**	**88,959**	**88,153**	**87,503**	**33,117**	**36,387**	**40,380**	**44,747**

Workforce Plan – understanding the current situation:
HEE report Q2 2016/17 (15 out of 17 practices input to HEE tool) shows that there is much variation across practices in AWC in terms of number of patients per GP, age of GP partners and the spread of other roles in general practice. It highlights that AWC faces challenge in years to come with a significant proportion of workforce roles currently undertaken by staff that are nearing retirement age. 15% of GPs are aged 55 and over and 28% of practice nurse over 55 and 37% of practice management staff over the age of 55.

GP workforce in AWC is consists of 67% GP partners, 30% salaried GPs and 3% GP registrars.

Based on current GP & Nurse establishment as reported through HEE GP Workforce Q2 July - September 2016 (NB tool has only been completed by 12 out of our 16 practices and therefore only includes data relating to these) as demonstrated in the tables below which show Full Time Equivalent (FTE) per 1,000 patients per practice, there is considerable variation across AWC both in types and number of health care professionals within practices.

Three Graphs have been extracted from the most recent HEEE Workforce Report for AWC CCG (Q2 2016/17)

Graph 1 demonstrates that overall there is a healthy ratio of clinical input per 000 patients when combining GP, ANP, Nurses and Direct Patient Care. It also demonstrates a move towards using more nursing input to complement GP care with one particular practice operating on a mainly ANP model of care.

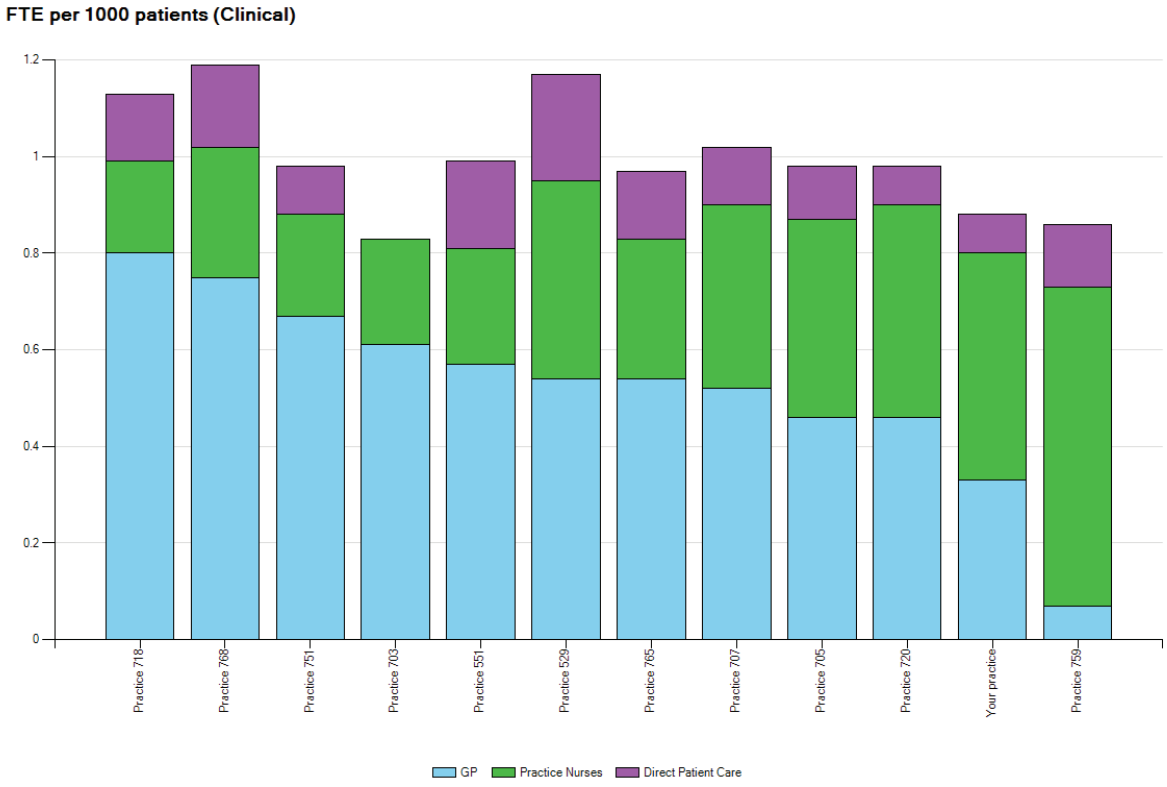
Graph 2 shows that 7 practices are providing more GP clinical sessions per 000 patients than the Yorkshire & Humber (Y&H) average, the CCG average being in line with Y&H average.

Graph 3 compares CCG practices favourably with all bar 2 practices having a higher ratio of clinicians per 000 patients than the Yorkshire and Humber average.

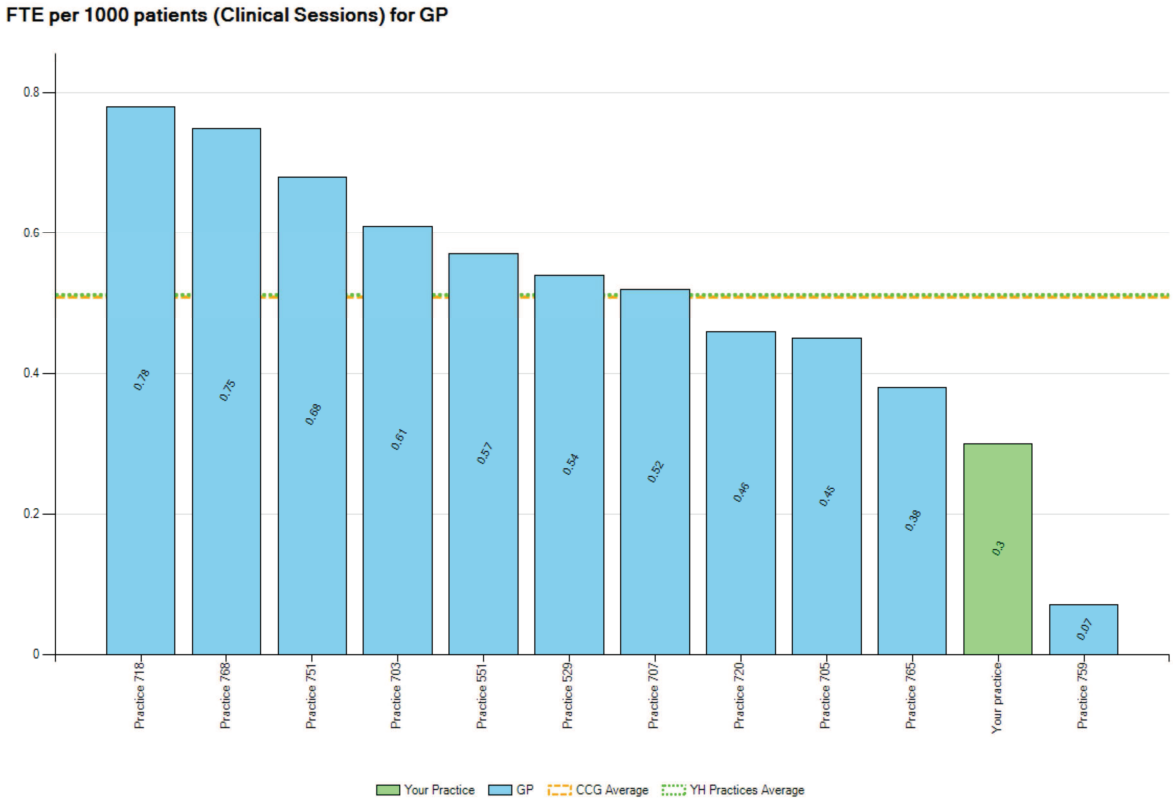
However please note the anomaly in the third graph which reports practice 759 as having 4865 patients per GP/ANP. We believe this to be inaccurate and have queried this with HEEE. This does pose some question about the quality of the data analysis in the HEEE report or practice inputting, for example the practice with an ANP model may be reporting ANP time as nursing time which may explain the anomaly.

To sense check the accuracy of the GP/patient ratio assumed from the HEEE data (excluding practice 759 as a significant anomaly) a report published by GP Online in December 2014 portrayed AWC CCG area favourably as one of the highest GP to patient ratio (1426 patient per GP) the worst in the country being 2237 patient per GP

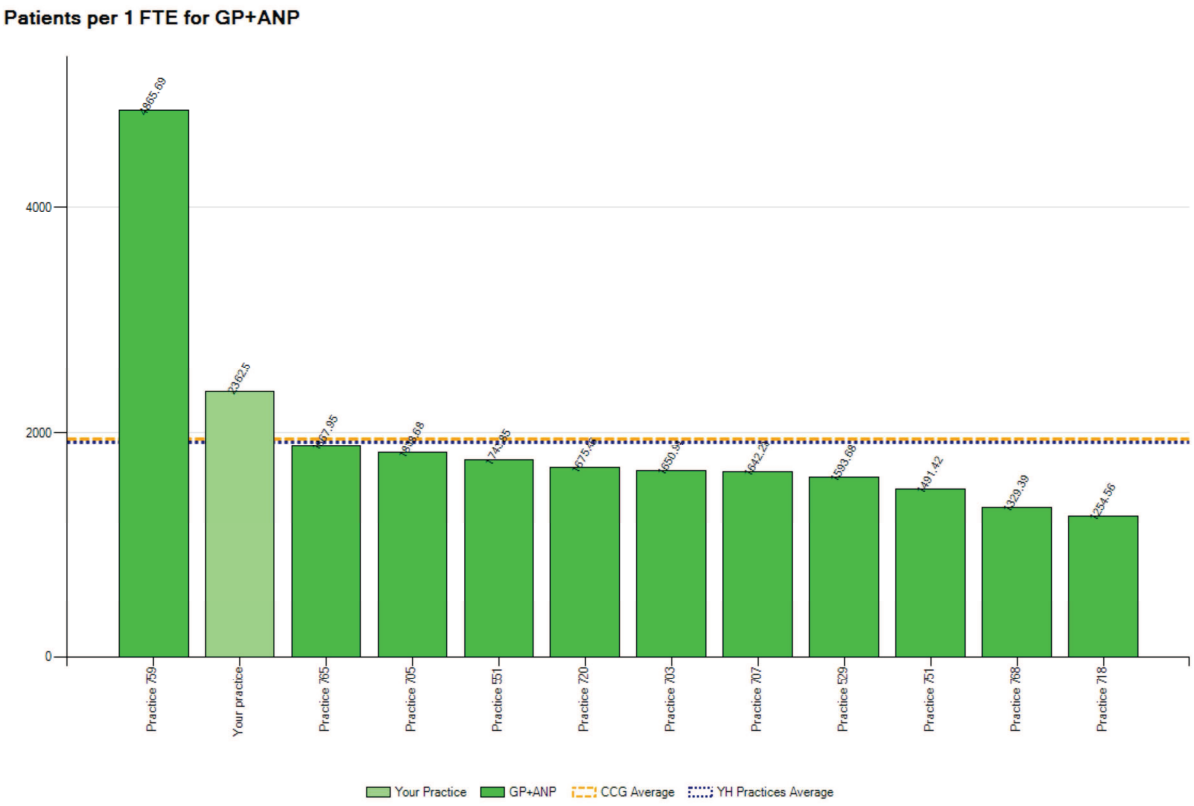
Graph 1



Graph 2



Graph 3



Future Workforce:
To deliver a system of accountable care with General Practice at the forefront the workforce strategy for primary medical care will be developed in the context of the wider health and social care system and in light of expectations of a greater use of community assets, workforce and role re-design to ensure the most effective use of the skills within the primary medical care team.

With regard other practice staff and expanding multi-disciplinary primary care teams, the CCG has funded a clinical lead for practice nurse development on a sessional basis and has encouraged uptake locally of student nurse training placements. This experience will help encourage nurses, once qualified, to choose practice nursing as a vocation

15 of the 16 member practices are also training practices and dialogue has taken place with GP trainers who have affirmed that they and are amenable and in fact positive in contributing to support delivery of the GPFV through identifying efficiencies and opportunities to review and change the way training is delivered by them as a collaborative rather than individual practices. These individuals are potential future leaders within an ACS

Nursing Workforce:
With over 28% of practice nurses over the age of 55 the balance of recruiting new Nursing staff to be ready to fill this gap is essential. We provide training facilities/placements for pre-registered nurses to allow them to gain an interest in developing a career in Primary Care, also places for postgraduate nursing staff in Masters level Practice Nursing courses in Primary care. Funding is available within each GP practice to

recruit General Nurses to develop skills in Primary Care by career development through the HEE modular courses which are run over a 2 year period, with further funding streams being explored to encourage this investment.

The expansion of the Practice Nurse role will be undertaken using the AWC Framework for Practice Nurses which provides them with a detailed picture of the role of the General Practice Nurse. As already stated this role is wide ranging and it may take time to acquire all the competencies, but the framework will ensure a flexible, gold standard workforce that integrates into the wider MDT.

Recruitment of Health Care Assistants (HCA)by using an apprenticeship scheme to ensure extended roles, using HEE approved training courses and development of educationally robust HCA; also the development of Assistant Practitioners, sometimes known as Associate Practitioners who are a growing part of the healthcare workforce. They would take on more responsibilities than the Health Care Assistant and be under the supervision of registered colleagues.

Multi-disciplinary primary care teams:
A range of new roles such as health promotion manager (range of health promoting activities), health navigators (signposting to VCS), personal support navigators (first point of contact addressing lower level health & social care needs) and care navigators (coaching/buddying) roles are being tested locally to inform future workforce requirements. These will continue to be assessed and tested through New Models of Care. When the specification relating to the care navigators and medical assistants referred to in the GPFV is made available we will review and commit to utilising the CCG allocation to build on the roles which are working locally where this fits and deliver the requirements of the specification.
Given the predicted population growth, impending retirement of GPs and nurses and national shortage in availability of GPs and Nurses we recognise the changing workforce will require a range of roles and professionals with less dependency on GPs. In view of this we continue to design and test a range of roles to complement to general practice workforce

Examples of range of new roles being tested:

	2016/17	**2017/18**
Extensivist	2 In complex care service	Expand to 3 or 4 as role develops
Physicians Associates	In 2 practices	Expand to 5
Physiotherapy First	In 3 practices	Share learning and expand via EPC
Personal Support Navigators	5 in complex care service	Expand to EPC & Primary Care Wellbeing (subject to Pioneer Funding)
Care Co-Ordinators	In 2 practices	Expand via EPC
Wellbeing Practitioners	In 1 pilot practice	Expand via EPC
Community Pharmacy practice based	In a range of practices	Expand funded via EPC

Possible Future Workforce Model, in practice and locality hubs as part of an Accountable Care System:

The expected population growth equates to 6.6% over the next 15 years, mainly in the over 65 age range. This has been used to estimate the future workforce model and numbers; this takes account of those who may retire over the next 15 years, gaps addressed through succession planning. This model does not constitute a definitive workforce plan, it is an estimate based on the data and information available at the time of writing.

Role	2016	2021	2026	2031
GP	66.52	68	70	71
Nursing	41.92	42	43	44
Extensivist	**2**	**4**	**5**	**6**
Physicians Associate	**2**	**5**	**8**	**12**
Therapists (Physio/OT)	**2**	**3**	**4**	**6**
Personal Support Navigators / Care Co-ordinators	**5**	**10**	**12**	**15**
Wellbeing Practitioners/psychologists/MH therapists	**2**	**4**	**5**	**6**
Clinical Pharmacists	**2**	**3**	**4**	**5**
Generic Health & Social Care	**0**	**3**	**6**	**9**

A baseline assessment of workload, demand and supply side numbers:
AWC CCG and member practices do not routinely hold or collect this type of information. An assessment of patient satisfaction with access, availability of next appointment, activity levels at GP OOH, GP centre co-located with A&E and A&E attendances all give an indication of workload, demand and supply. Until there is a consistent approach across West Yorkshire and a toolkit to support collection, collation and analysis of data local approaches to ascertain this are unlikely to be meaningful or comparable.

We acknowledge that the Centre for Workforce Intelligence has said that there is likely to be a significant undersupply of GPs by 2020 unless immediate actions are taken to redress the imbalance between supply and demand, as well as increasing training numbers for longer-term sustainability. That over the longer term, the rate of increase in the number of GPs has also been dramatically outstripped by increases in the medical workforce in secondary care. An indicator of this locally has been anecdotal reporting by GPs and reliance on locum GPs because substantive vacancies have not been filled. There are several local examples of this within Airedale, Wharfedale and Craven, although some practices are reporting being successful in recruiting and retaining GPs.

Examples of practical actions were articulated in the output from the recent joint CCG, practice, LMC workshop: The plan requires further refinement. However we will:

1. Support General Practice so that is has an equal voice and is recognised as an equal partner in the developing accountable care system, This in itself will present more opportunities for development

and establishment of an innovative workforce with the right skills and expertise in place to support GPs. The GP role may become a consultative role using their expertise in the most appropriate place for the most appropriate people utilising colleagues within the primary care team as an alternative initial point of contact thereby reducing pressure on GPs

2. Work as an active member of the Integrated Workforce Programme for Bradford District and Craven, taking a long term strategic view of workforce planning to ensure a primary medical care workforce that is fit for purpose for the future.

3. Continue to develop new roles as explain previously, and take account of the care navigator and medical assistant specification and implement

4. In partnership with Bradford take a long term view to raise the aspirational levels of young people to both want to train to work in the health and social care system, including primary medical care and to want to work in the Bradford and Craven District through schemes such as work experience, training placements and apprenticeships

5. Through the Bradford and Craven Digital 2020 programme ensure staff and patients have the right skills to maximise and enable the use of digital technology to ensure the most effective use of time, people and finances

6. In partnership with Bradford link with NHS England and Health Education England to benefit as much as possible from the national resources which are to be deployed on the back for the General Practice Forward View

7. Where resources, both financial and people, permit, commission and/or facilitate training and development to support the primary medical care workforce to develop their skills and knowledge in order to promote safe, effective, high quality service delivery

8. Progress at pace our self-care and prevention programme and continue to build into specifications provider requirements to promote and implement interventions which promote self-management interventions to empower patients to become active in the management of their own care to reduce the need to see a health care professional

9. Review and promote the new GP Retainer Scheme

10. Tap into GP trainers as potential advocates and future leaders within the ACS, support collaborative approach to training delivery

11. Commit to developing and delivering different roles and approaches to skill mix of primary care teams. The vision is to have multi-disciplinary practice teams working across larger population areas (see super practices/ hub and spoke model) delivering a wide range of primary care services

12. Build on work to date and support practices to work together and expand and develop a range of different roles to become part of practice MDT's. These will include use of care navigators, health promotion, Physicians Associates, physio therapists and ANP's as well as GP's and GPwSI's

13. Review the range of roles being tested in the CCG through New Models of Care and build on learning, delivering the requirements of the care navigator and medical assistant specifications when made available

14. Support practices to enable additional commitment to training and development programmes, this will include development of new roles, and expansion of existing roles and will consider the role of pharmacist and physio therapist working in different ways – embedded and becoming part of general practice teams

15. Address difficulties in recruiting GP partners and heavy reliance on locums through a pro-active recruitment campaign, shared approaches to recruitment, development and promotion of local website advertising opportunities, reducing reliance on recruitment companies and associated costs of recruitment. The intention is that Yordales Federation will take an active role in this. We recognise that this may require practices contributing to the cost albeit overall reducing cost of recruitment. Through the Bradford & Craven workforce programme we will support practices, the federation and LMC to work in partnership to develop robust recruitment and retention policies which extend beyond individual practices. Advertise and plan recruitment as a system

16. Encourage practices to complete the Health Education England Workforce toolkit to provide reliable workforce data

17. Explore wider issues and reduction in number of medical students choosing general practice as a career. To be progressed through the Bradford and Airedale Workforce programme

18. Utilise 17/18 PMS premium funding to secure clinical leadership and engagement in consulting, and designing care models and access improvements through hub approach - to be delivered through partnership working and care model design group.

19. Build consensus around direction of travel for development of super practices (also see above). Progress has been made with recent mergers and we anticipate further local changes over next 12-18 months with smaller practices working more collaboratively and merging some functions with other practices

20. Support further development of a super practice approach and establishment of Keighley Medical Group. There is an appetite for this within Keighley with a likely timescale of 2 years. The intention would be to have one super Keighley practice – from one purpose built site in Keighley. A proposal has been submitted to ETTF and full business case will be worked up based on outcomes of specialised options appraisal. It may be necessary to consider progressing this without support from ETTF

21. Support the federation in developing more shared back office functions and efficient use of primary care estate

22. Evaluate and utilise learning from the Primary Care wellbeing service – Kilmeny Surgery in Keighley has established this service for their patients with long-term illnesses or chronic diseases; and who frequently visit their doctor with physical and mental health problems. The team, working in partnership with Bradford District Care NHS Foundation Trust, includes a consultant clinical psychologist, occupational therapist, physiotherapist, advanced nurse practitioner and a consultant psychiatrist. Staff work with patients to better support the patient's long-term condition or illness and improve the quality of care

23. Extend the Complex Care – Funding has been secured for a further 2 years to 2019. This service alleviates pressure on general practice through addressing complex care needs as part of our new models of care work. . The team, from Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Yordales (a federation of local GPs), will provide 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 will be the personal support navigators (PSN) role delivered in partnership with the local authorities and voluntary and community services. The PSN will be a dedicated point of contact for these people and an integral part of the team

24. A funding request has been submitted to the National Pioneer team to secure addition Personal Support Navigator roles to expand the workforce associated with the enhanced primary care and primary care wellbeing service. Testing the added value of this role will inform future workforce requirements

25. Intermediate care hub – This was launched at the end of 2014 and has continued to be supported and developed during 2015/16 and 2016/17. The hub provides a single point of access for GPs, hospital staff, community staff and other health and social care professionals to refer patients to intermediate care services. This includes short-term hospital beds, respite care and services that give patients support in their own homes

26. We work closely with our local authority colleagues through a range of forums such as health and wellbeing boards and Accountable Care Programme Board to ensure joint strategic need assessment and to ensure plans are aligned

Improve access to General Practice in and out of hours	A baseline assessment covering local variation in access, in-hours and out of hours plus an assessment of current extended hours practices A plan to implement enhanced primary care in evenings and weekends – with a clear trajectory for delivery by 2020 A description of how wider primary care (dental, optometry, community pharmacy) will contribute to this plan A description of how the plan for access to general practice is linked into the wider integrated urgent care system including 111

In Airedale, Wharfedale and Craven through the national patient experience survey (CCG July 2016 slide pack) local people report satisfaction level in line with or indeed exceeding national levels. So we have a strong foundation upon which to improve. Satisfaction levels vary by practice and the CCG uses a quality dashboard to monitor and support quality improvement. We will continue to develop this approach.

Core hours are Monday to Friday, 8am to 6.30pm; additional capacity is available during extended opening hours and GP services co-located with the local emergency department out of hours. This includes additional GP capacity commissioned by the local acute provider as part of system resilience.

The CCG is not currently responsible for commissioning core services in core hours but it is responsible for commissioning extended services and services beyond core hours (apart from the national DES). The CCG is committed to commissioning pro-active care which is expected to reduce demand and care which meets the needs of the population through core and enhanced primary care and an effective extended hour's service. This will support the implementation of the 7 day services agenda. As part of the West Yorkshire Accelerator Zone we will design and test extended access through a locality hub approach in 2017/18 and use the learning from this to inform trajectories for 100% coverage - expanding to further locality hub models. Likely locality hubs are: Keighley Health Centre; Coronation Hospital/Springs Medical Centre & Skipton Hospital as these sites have the necessary infrastructure and access to SystemOne.

Experience from previous extended general practices service provision over weekends suggests less interest locally in weekend appointments with uptake less than expected. We therefore need to ensure public engagement and that the model of care, location and timing of future weekend provision meets need and is an efficient and sustainable model to run.

Further work will be carried out in Q4 16/17 to ascertain the needs of our patient population and to offer choice of appointments both in terms of times and skill mix on offer as part of care redesign work. We will explore delivery through locality hub/s rather than individual practices; this will offer choice to patients which is in line with the direction set out in the GPFV. General Practice is a key partner in any future accountable care system and as part of this the development of more super practices such as Keighley Medical practice across our patch will support a hub type approach, partners in accountable care delivery will contribute to the design and development of extended access to general practice through the care model design group so the scope of service may be further enhanced through this approach. At the centre of this will be commitment to deliver high quality sustainable general practice services that meet the needs of our patients.

In order to support wider access to primary medical care, adoption of digital ways of working will be supported. This will include digital access to prescription ordering, appointment booking, digital consultations (e.g. video consultations) and text messaging. The use of technologies will also improve access to services via the use of Wi-Fi to promote agile working of partner agencies and the use of telehealth and telemedicine to allow patients to better self-manage their own conditions.

Self-Care and Prevention continue to be a key programme of work. This includes social prescribing; workforce awareness and training in motivational interviewing techniques to support a culture change in the mind-set of staff and individuals; use of Community Health maps to signpost to supporting VCS services and resources; Self-Care digital solutions and personal support navigators.

What we will do:

1. Engage with our population through the New Models of Care communication and engagement programme and ascertain views and desires regarding extended general medical practice provision including extended hours over 7 days

2. Utilise 17/18 PMS premium funding to secure clinical leadership and engagement in consulting, and designing care models and access improvements through hub approach - to be delivered through partnership working and care model design group

3. Through the Accountable Care System care model design group develop an effective and efficient approach to extended GP access through collaborative hub working

4. Build on the pro-active outcomes focussed enhanced primary care and complex care models to support reduction in demand for GP appointments

5. Engage in the West Yorkshire Acceleration Zone and deliver an extended access hub using this to inform trajectories for 100% coverage

6. Work with NHS 111 and Local Care Direct to improve integrated working with the GPs co-located within A&E and primary care streaming from A&E

7. Market test and prepare for procurement of extended GP services should this be necessary

8. Establish the future of the out of hours service model post March 2018

9. Ensure that the necessary estate in AWC has access to Wi-Fi to enable agile working from partner agencies

10. Promote use of technology to support people to manage their own conditions and maintain independence

11. Increase complex care and enhanced primary care caseloads and accelerate delivery of outcomes through robust contract management

12. Ensure our providers maintain the Directory of Services to enable patients to be signposted to the right service at the right time

13. Commit to continue to reduce transactional bureaucracy to increase time available for patient care; examples of this are our outcomes focussed approach to our local enhanced service bundle

14. Access national funding which will facilitate the adoption and spread of technologies

15. Continue with the Self-Care and Prevention programme of work

Transform the way technology is deployed and infrastructure utilised	A map of current estates and technology initiatives A plan to deliver the requirements set out in the GP IT Operating Model 2016/18 A clear primary care estates and infrastructure strategy linked to the wider strategy for integrated out of hospital care Confirmation that primary care requirements have been included in Local Digital Roadmaps

There are no current estate initiatives although Keighley has been agreed as the foremost estate priority and a bid has been submitted to the ETTF for an options appraisal, business and leading to a capital finding bid. We recognise that it may be necessary for the CCG to consider funding the first 2 elements of this. We will definitely require support to progress our estate strategy and deliver locality hubs and to ensure 'fit for purpose' estate as the CCG does not have capital or recurrent funding to invest. The CCG is level one co-commissioner.

The exploitation of IT in support of General Practice has remained a constant within the district for many years now. We enjoy a unique position where all of our GP practices are using the same Clinical System (SystmOne), share the same modern central infrastructure and Community of Interest Network (COIN). Records are shared extensively across the district in Healthcare as all of our local Community Services (e.g. District Nursing, Health Visiting and School Nursing) also utilise SystmOne.

Our Local Authority has recently implemented the SystmOne Social Care Module, for Adult Social Care, and whilst this information is not shared at present we are currently undertaking a series of activities that will see the safe and appropriate two way sharing of health and social care data. This will be a huge step for the district and there is a great deal of national interest in this element of our transformational journey.

We are confident that our vision and desires will deliver the 4 key digital proposals for the NHS as laid out by Martha Lane Fox:

Reaching the 'furthest first' – making sure those with the most health and social care needs who are often the least likely to be online, are included first in any new digital tools being used across the NHS

Free Wi-fi in every NHS building

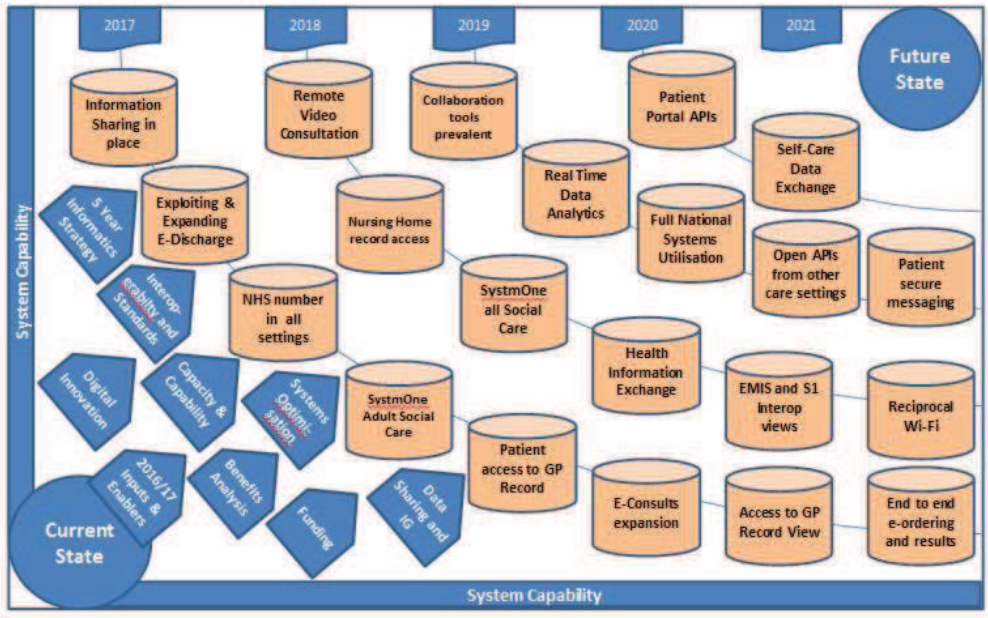
Building the basic digital skills of the NHS workforce to ensure that everyone has the digital skills needed to support people's health needs.

An ambitious target that at least 10% of registered patients in each GP practice should be using a digital service such as online appointment booking, repeat prescriptions and access to records by 2017.

Looking further ahead as our Sustainability and Transformation Plans mature they will detail an ambitious journey, alongside our primary care estates and infrastructure strategy, supporting all organisations that are key in delivering our transformation activities including the delivery of integrated out of hospital care.

Specifically in terms of IT, our Local Digital Roadmap describes our journey to an improved digital future and a paper free record by 2020/21 for all. This roadmap also reflects the requirements of the GPIT Operating Model 16-18 and highlights a plan for achieving a number of exciting transformational capabilities:

Informatics System Capability Schematic 2016-2021



We will continue to work with our GPIT Delivery Partners, eMBED Consortium, to ensure we maintain and deliver all of the core requirements set out in the GP IT Operating Model 2016/18. We have already made significant progress in a number of areas and some of these are highlighted below:

GPIT Requirement	Comment / Progress	Status / Delivered by
SMS Text Messaging	Programme already completed. Period of optimisation to follow to reduce spend via message length rationalisation.	Complete. To schedule. To complete by end 31-03-17.
Wi-Fi in GP Practices	Project request initiated with a 4 Phase approach:	

	Phase 1 – Physical installation of Wi-Fi kit in agreed strategic areas Phase 2 – Enablement of Staff and Guest (Guests will typically be from other Care Provider organisations) Phase 3 – Reciprocal Wi-Fi with ANHST, BHTFT, BDCFT and CBMDC as a minimum (others to be defined) Phase 4 – Enhanced Guest Wi-Fi services to enable Patient access including landing pages, registration, and access to health apps including Patient Online.	To complete by 31st January 2017 To complete By 28th February 2017 To complete by end 2nd quarter 2017 To complete by end 3rd quarter 2017
Patient Online	Support from NHSE continues to optimise utilisation across the district	>10% registered patients using Patient Online by 2017 Desires to achieve 25% in 17/18 and 50% in 18/19
Electronic Prescription Service (2)	Ongoing Programme of enablement supported by our IT Delivery Partner	>60% utilisation already achieved across the district. Desires to achieve at least 90% in 17/18 and 95% in 18/19
GP2GP	Ongoing Programme of enablement supported by our IT Delivery Partner	>60% utilisation by the end of 16/17. Desires to achieve 90% in 17/18 and 95% in 18/19
Electronic Referrals (ERS)	Programme of optimisation yet to be initiated with our IT Delivery Partner	>60% utilisation by the end of 16/17. Desires to achieve 80% in 17/18 and 90% in 18/19

Alongside our West Yorkshire colleagues, in support of the West Yorkshire Urgent Care (Record) Vanguard, we are undertaking an assessment of the Enhanced Summary Care Record with a view to commencing enablement in Q4 16/17 and into 17/18.

The CCGs submitted one bid against the Estates and Technology Transformation Fund (ETTF) as this is the key priority to enable delivery of Keighley Medical Group and hub working in Keighley. The bid was to undertake options appraisal, develop a business case leading to a bid for capital funding. We understand that that the CCG may now be required to fund options appraisal and business case.

The Bradford Craven and District Interim Estate Strategy in its first iteration focuses purely on primary and

community care estate as we recognise the importance of getting these core services right to enable them to be a platform for service transformation. The proposals that we put forward as part of our ETTF submission highlight this, as there is a key focus on primary care estate.

Through all of our New Models of Care programmes and participation in the National Accelerate and Pioneer work we recognise the need for core primary care to deliver safe, high quality services for our programmes to be successful. In the absence of this transformation change through an accountable care system which includes general practice will not be realised. Without strong primary care we will not be able to transform services, nor give patients the confidence and ability to self-care. To allow primary care and an accountable system to do this it must have estates that are fit for purpose and allows for different ways of working within the community. Therefore the main focus of our ETTF proposals is the strengthening of this primary care base.

We will:

1. Work with strategic partners CHP & NHS Property services to explore the possibilities and plan an alternative approach to ETTF to secure capital funding to deliver a premise solution and hub for Keighley (general practice plus at scale) and reconfiguration of existing estate to deliver locality hubs in Craven and Wharfedale

2. Work with NHS England on short to medium term plan for the provision of service to patients registered at North Street Surgery should this be required. The future for these patients will be know at the time of submitting the final plan (Now resolved)

3. Engage in delivery of the Digital Road Map through the Digital 2020 Programme (which has taken account of primary care requirements)

Better manage workload and redesign how care is provided	A plan to improve the capacity in general practice through redesign (e.g. LEAN / Releasing Time to Care) and collaboration (such as shared clinical services and back-office functions)

Practices in Airedale, Wharfedale and Craven have a track record of participating in improvement initiatives having been involved in Health Improvement Foundation programmes (formally National Primary Care Development Team) and other such initiatives. The national and international learning and experiences shared through involvement in the Pioneer programme enabled new approaches of care to be designed, developed and delivered with the aim of pro-active care reducing demand and releasing capacity. This includes through involvement of new types of workers and roles within the practices such as care navigators and physiotherapists. We have some powerful case studies which endorse this approach. This required review and redesign of ways of working, promoting services, signposting and care delivery. Initiatives such as the care home quality improvement schemes have had a significant impact on requests for GP home visits from participating care homes. AWC practices are always looking for areas to change and improve and share learning and experience through their networks, this includes our local commissioning forums. We feel we can clearly demonstrate a quality improvement culture within AWC.

The action plan to support delivery of the vision for general practice included a commitment for practices through the federation to explore opportunities for shared back office functions and use of primary care estate, for instance co-locating staff from different practices to fulfil these functions more efficiently. There is already evidence of joint working with recent practice mergers/sharing of staff roles (for example Kilmeny Surgery and Oakworth Medical Centre.

Practices have attended workshops held in Leeds which introduced the LEAN/Time to Care Initiatives. They are currently exploring the high impact change areas and those which they feel will have most impact locally and those they feel they have already undertaken. They have considered and reviewed an offer from www.gpip.co.uk to participate in a programme this year and have indicated their desire to participate in this or similar in 2017/18.

We will:

1. Support our practices to access the new national development programme (as outlined in the GPFV) to allow them to make changes which should impact on releasing capacity within the system. Opportunities will be put in place to allow practices to benefit from the Ten High Impact Actions.

2. We propose that we utilise 2017/18 PMS premium funding to support practices to participate

3. Support practices through the Yordales Federation to identify where they can access strategic workforce planning support as they have asked for this

Organisational form	A description of the current organisational form of general practice within the CCG The ambition for primary care at scale underpinned by a delivery plan A description of how the "future state" is linked to the wider strategy for integrated out of hospital care

In Airedale, Wharfedale and Craven there are 17 practices and 16 contracts, this is likely to reduce as talks are underway regarding mergers and development of large practice bases.

Practices are naturally located within three distinct localities:

Airedale:
The majority of services provided by 5 practices in Keighley which are exploring possibilities of developing a super practice - Keighley Medical Group. The remaining Airedale practices being located on the periphery of Keighley serving villages on the outskirts.

Craven:
This covers a large rural district served by 4 practices which are well suited to a hub (2 Skipton practices) and spoke arrangements (spoke being Settle, Grassington and Crosshills).

Wharfedale:
There is an appetite from some to consider the possibility of developing one super practice, less so from others.

The vision for general practice is based around hub and spoke arrangements however the degree of ambition with regard involvement in an accountable care system will determine configuration of services and organisational form. Through the accountable care system development and the Accelerate programme the appetite for the degree of integration will be determined through discussions in 2016/17. As mentioned in previous sections there is the possibility of:

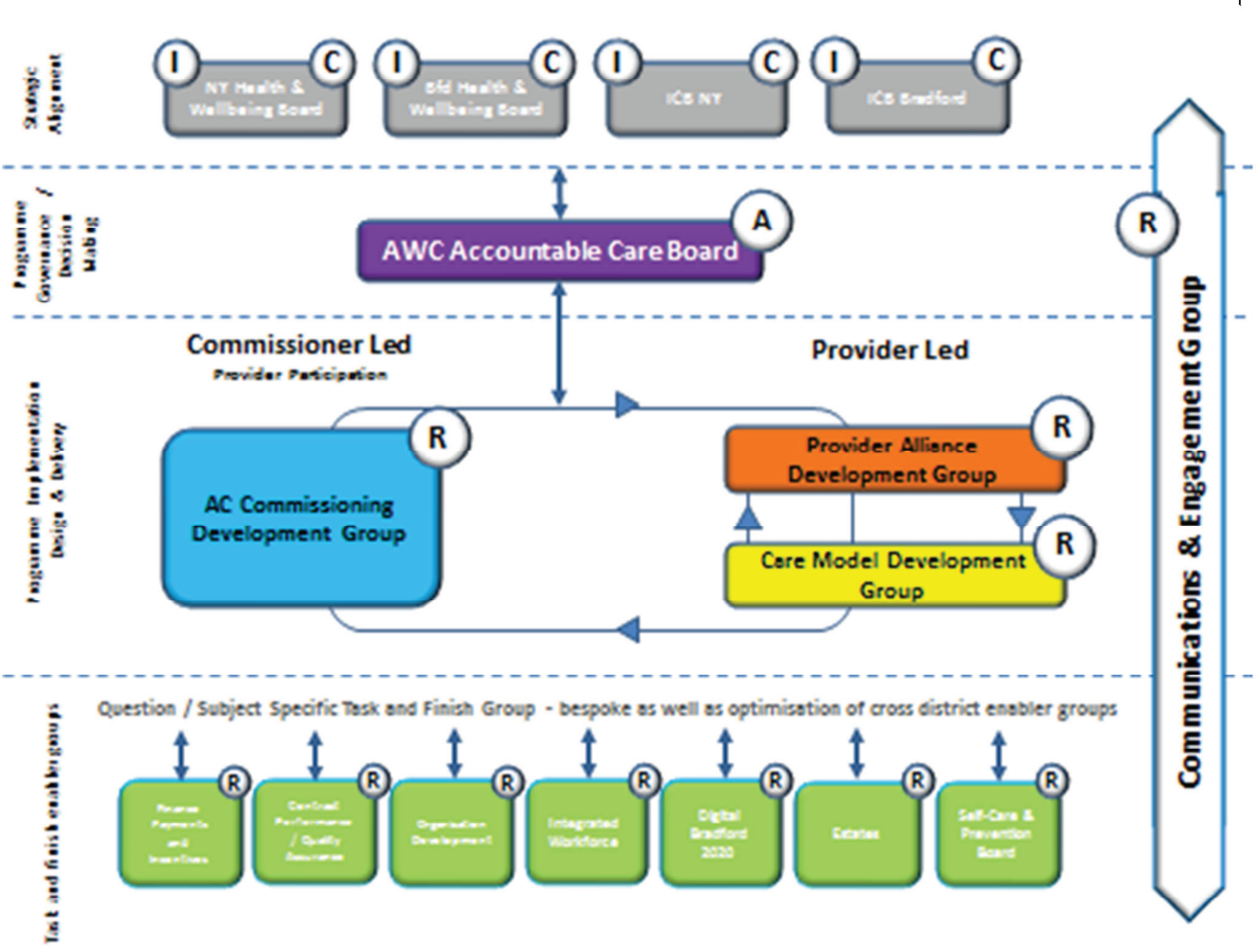
- Virtual Integration - where general practice integrates as part of the accountable care system

through retaining their GMS/PMS contracts and agreeing to an overarching integration agreement;

- A Mixed Economy/Partial Integration - where some practices suspend their GMS/PMS agreement and become an integral part of the accountable care organisation (with right of return to GMS/PMS); and
- Full Integration - where all practices suspend contracts and become part of the ACO

Through the National Accelerate programme we are exploring these options with general practice and the local system leaders and discussions will take place at the Accountable Care Board which includes the federation and YORLMC representing general practice, the provider alliance and care model design group. Exploration is in early stages and requires changes to regulations in order to progress. No clear intent has been agreed however there is involvement of key parties in exploring possibilities.

Accountable Care Governance Framework



Potential Organisational Forms for General Practice as Part of an ACS
An example for illustration purposes only follows

DRAFT FOR DISCUSSION ONLY

NHS England

Broad options for GPs participating in the MCP

1	Virtual MCP	Existing contracts remain in place, but with a new alliance agreement overlaid, binding the parties into a shared vision and integrated service / organisational model
2	Partially integrated MCP	MCP is procured to include full range of integrated services under a single contract, except core primary medical care; GMS/PMS contracts remain in operation; separate Integration Agreement between MCP and GPs
3	Fully integrated MCP	MCP is procured to provide full range of integrated services, including core primary medical care under a single contract; GMS/PMS contracts are given up or suspended

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An accountable care system will not succeed without general practice at its heart. A strong sustainable accountable care system needs strong sustainable primary medical care.

What we will do:

1. Conduct an options appraisal to identify the most appropriate model and subsequent form for primary medical services
2. Increase the level of general practice involvement in Accountable Care Airedale (ACA) discussions
3. Ensure robust involvement through Federation & LMC as general practice representatives
4. Increase the level of patient engagement in service design
5. Put in place processes to actively support the delivery of primary medical care at scale
6. Ensure general practice is key in C&E activities as part of ACA programme
7. Where procurement rules allow, have commissioning strategies that positively encourage networks of practices and stakeholders as providers
8. Ensure primary medical care services are the foundation of an accountable care system
9. Support the development of the Voluntary and Community sector to engage as one voice across the system to support improvement
10. Working with the Local Authority and Public Health, establish formal links with education providers and others to bring health messages and health education into schools and colleges to encourage children and young people to consider future working in the health and social care sector of Bradford

Engagement	A description of the CCG is engaging local primary care professionals (GPs, dentists, pharmacists, optometrists) and the local population and patients in the development and delivery of the Transformation Plan.

There has been continuous engagement with our stakeholders throughout the development of the Accountable Care System Programme

This includes:

- Enhanced Care Reference Group
- Integrated Service Development Group
- Practice Nurse network
- Healthwatch/Patient Networks/Practice Participation Groups
- YORLMC Ltd
- Provider Alliance
- Health and Social Care Overview and Scrutiny Committee
- Integration and Change Board
- Health and Wellbeing Board
- CCG Clinical Boards
- CCG Governing Bodies
- Specific GP engagement events
- Public Governing Body meetings

However we recognise that as discussions and the approach to the accountable care system progresses we need to establish and implement a robust and comprehensive communications and engagement plan which takes account of a broad range of stakeholders not least the public and other local primary care professionals. This will be undertaken with partners through the Communication &Engagement work stream of the Accountable Care Programme and will include representative committees for DOPs

Risks and mitigation	A GPFV project risk register will be developed with risks escalated to the corporate risk register and / or Governing Body Assurance Framework as appropriate. A description of the key risks and mitigation follows

Key risk	**Mitigation**
Finance: There is a risk that the planned transformational change does not realise expected benefits (both financial and outcomes) due to failure in planning and / or evidence base resulting in increased financial pressure and system instability	Robust planning informed by available evidence and national and international learning, modelling applied to inform realistic contract values, regular monitoring and adjustment of schemes if evidence not delivering
Access: There is a risk that GPs will not 'buy in' to rationale for 7 day services/extended hours due to existing general practice pressures, current culture, custom and practice, burn out and impact on work life balance resulting in an inability to commission	Work with Yordales Federation & YOR LMC to ascertain interest and undertake market engagement. Include LCD in discussions and model for 24/7 care. Plan for external procurement if necessary

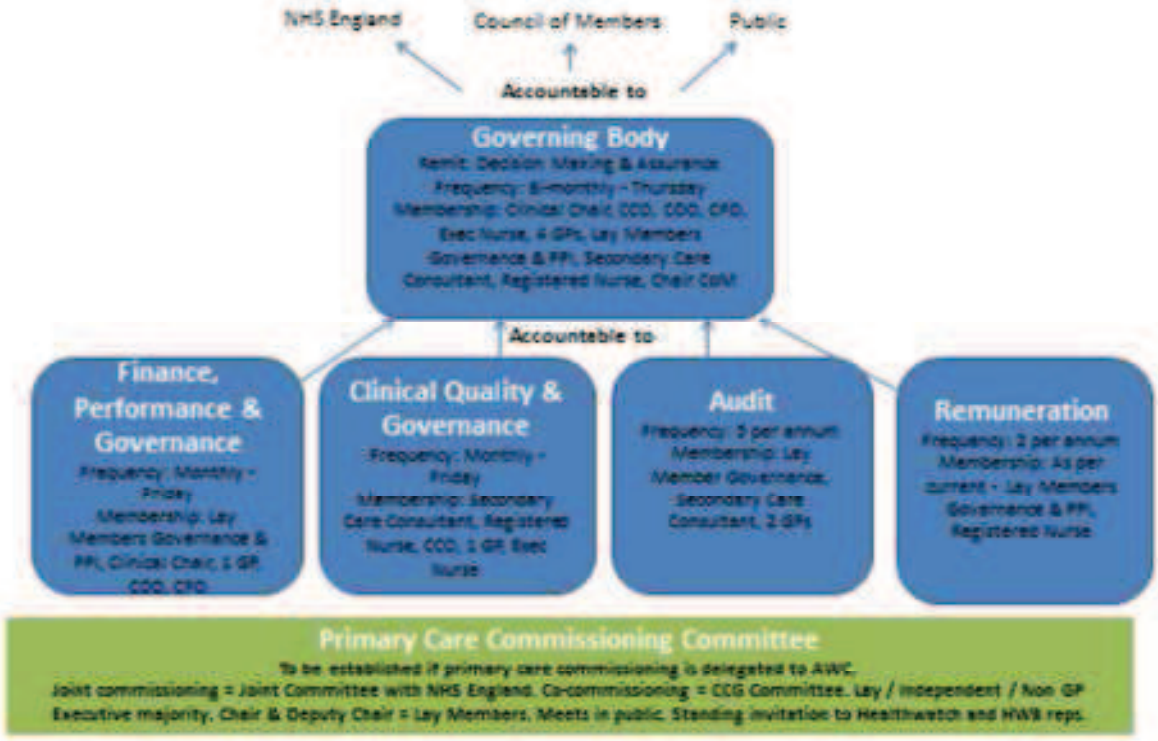
extended access locally	
Baseline information: There is a risk that the baseline information being requested as part of this plan will not be available and / or sufficiently robust due to no established system in place locally to collect or analyse such data. This may result in non-compliance with GPFV requirements and plans being designed from a flawed evidence base	Source tools and advice from NHSE or develop local approach, recognising that local approaches will not be suitable for benchmarking due to inconsistencies. This will require incentives for practices to record, collect and provide data and CCG resource to receive analyse and interpret
Access to national resources: There is a risk that national resources to support delivery of the FYFV will be insufficient due to unrecognised patient need / demand / expectations resulting in gaps and pressures for CCGs	Maintain links with NHSE Regional Team to ensure communication and information channels in place to access resources and highlight need
Workforce: There is a risk that the capacity of the future workforce will be insufficient to deliver the FYFV aspirations due to national workforce pressures and a competitive staffing environment resulting in non-delivery of services or sub optimal services within AWC	Full engagement in district and local workforce planning and establishment and delivery of robust action plan locally (including recruitment and retention). Approach NHSE & HEEE for support with strategic planning and access to expertise. AWC is a relatively attractive area in which to live and work
Delivery timeline of ACS: There is a risk that the planned timeline for ACS in 18/19 is not realistic due to optimistic planning and governance/regulatory barriers resulting in additional system pressures and an increasingly competitive provider environment	ACS programme management and commitment from senior leaders, access to expertise and support through national Pioneer and Accelerate Programme
OOH: There is a risk that GP OOH services standalone out with the planned ACS due to the contract end date of March 19 and time-line for re-procurement resulting in system and care pathway fragmentation	Task and finish group established locally and CCGs to engage in WY wide conversations
CCG resources to deliver: There is a risk that AWC CCG has insufficient staff and financial resource to deliver the FYFV aspirations and associated plan due to budgetary constraints and running costs restrictions resulting in non-compliance with GPFV requirements and weakened delivery of services	Review management structure in partnership with Bradford and identify opportunities for joint working, factor into financial plans. Utilise system resource through ACS programme and utilise PMS premium to support GP engagement
Limited evidence base: There is a risk that the plan and the ACS will not be realised or deliver the required efficiencies and improvements due to insufficient evidence base outputs resulting in non-compliance with GPFV requirements and system pressures	Utilise Pioneer and Accelerate resource and share learning adjusting approach where necessary. Utilise system resource through ACS programme and utilise PMS premium to support GP engagement
LMC challenge: There is a risk that the representative committee does not support the action plan due to	Engage via Liaison meeting, include LMC in strategy discussions, Accountable Care

perceived increase in unremunerated work for general practice and / or workload pressures resulting in non-compliance with GOFV requirements	Programme Board and Local groups such as the care model development group and enhanced care reference group
Public and Patients: There is a risk that the public do not accept new ways of working, self-care, self-management and alternatives to seeing their GP due to perceived 'drop' in standards/access to expert advice and / or unwillingness to change resulting in adverse publicity and repeated churn as people try to get access to what they perceive they need – GP appointments	Consistent messages and communications and engagement plan, consultation. Self-Care and Prevention programme and ACS programme

Governance	A description of the governance arrangements to provide the CCG with assurance that the plan is being delivered fully and on time.

Governance will be through the CCG Governance Structure with assurance and decision making at Governing Body level (please see diagram below for current arrangements)

Governance structures are currently being reviewed in light of the development of a shared senior management team and increased partnership working between NHS AWC CCG, NHS Bradford Districts CCG & NHS Bradford City CCG. This work and any revised governance structures will take account of the requirements of the GPFV.



CORPORATE GOVERNANCE OF AWC CCG

MANAGEMENT OF AWC CCG

Airedale, Wharfedale and Craven (AWC) Vision:

General Practice will operate as equal partners in an Accountable System of Care, using a resilient workforce to deliver innovative and proactive healthcare improving the wellbeing for all our population

What we will do

- Develop a sustainable and highly motivated collaborative workforce
- Promote and increase uptake of self- care and self-management
- Ensure General Practice is an equal partner in an Accountable Care System (ACS) delivering place based population healthcare for AWC
- Tailor high quality care to the needs and lifestyle factors of our patients and communities
- Continue to implement, refine and expand our New Models of Care (NMoC)

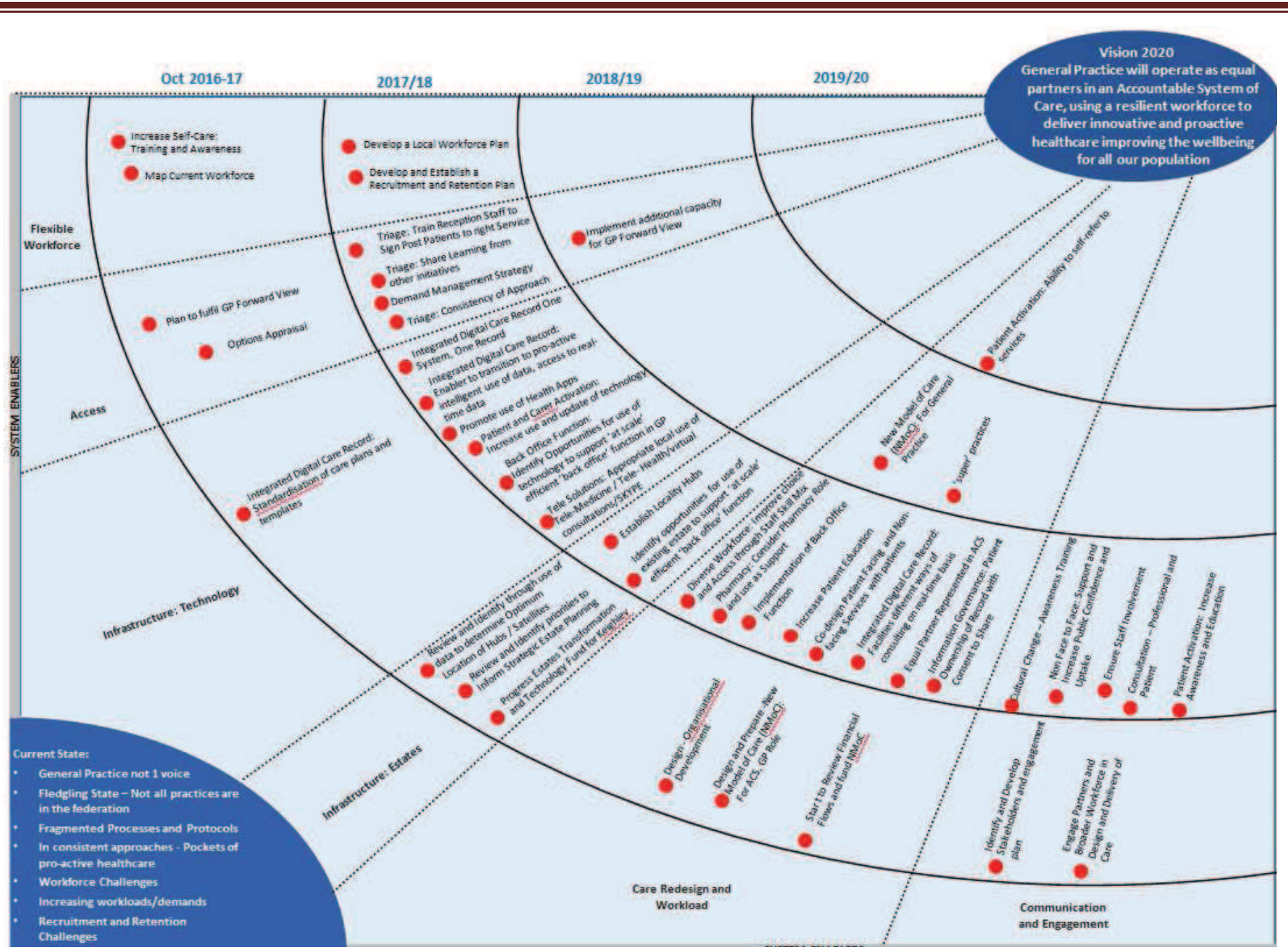
How will we do it?

The following key work streams have been identified:

- **Workforce** – Review skill mix, expand existing roles and develop new ones, pool resources, increase training and support for new workforce and fully implement recruitment and retention policies
- **Technology –** Use digital technology to support new ways of working, enable collaborative working for health care professionals, to improve access to care and ensure patients have a choice of how they access care including virtual consultations and non-face to face access. Establish a single integrated care record and sharing of care plans across providers
- **Estates –** establish hub and spoke model to deliver extended access and develop 'super' practices to pool resources, work more efficiently and promote resilience
- **Improve Access –** Support practices to work collaboratively to deliver equitable services for all, increase public awareness and confidence about range of roles and support available from primary and community services, increase choice of appointment times and types
- **Care Redesign –** Continue to develop and refine our enhanced and complex new models of care, share best practice and learning across the system, promote consistency and collaboration, co-design with service users and general practice workforce to develop new ways of working with focus on role redesign, development of 'super' practices and to promote prevention, self-care and self-management and support implementation of 10 high impact changes
- **Culture & Engagement –** Support general practice to fully engage and be an equal partner in the single place based system of care for AWC. Support workforce with change management and promote awareness and engagement with public to support progression at pace towards an accountable system of care and implementation of new models of care

What we will achieve

- Patients receive the right care in the right place from the right person the first time
- Improved outcomes for patients, people are supported to stay healthy, well and independent and have access to care and support when they need it
- An efficient and integrated place based system of care for AWC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2018/19
2019/20
Vision 2020
General Practice will operate as equal partners in an Accountable System of Care, using a resilient workforce to deliver innovative and proactive healthcare improving the wellbeing for all our population
SYSTEM ENABLERS
Flexible Workforce
Access
Infrastructure: Technology
Infrastructure: Estates
Care Redesign and Workload
Communication and Engagement
Increase Self-Care: Training and Awareness
Map Current Workforce
Develop a Local Workforce Plan
Develop and Establish a Recruitment and Retention Plan
Implement additional capacity for GP Forward View
Plan to fulfil GP Forward View
Options Appraisal
Triage: Train Reception Staff to Sign Post Patients to right Service
Triage: Share Learning from other initiatives
Demand Management Strategy
Triage: Consistency of Approach
Integrated Digital Care Record: Standardisation of care plans and templates
Integrated Digital Care Record: System, One Record
Integrated Digital Care Record: Enabler to transition to pro-active
Integrated Digital Care Record One
Promote use of Health Apps
Patient and Carer Activation: Increase use and update of technology
Back Office Function: Identify Opportunities for use of technology to support 'at scale' efficient 'back office' function in GP
Tele Solutions: Appropriate local use of Tele-Medicine / Tele- Health/virtual consultations/SKYPE
Establish Locality Hubs
Identify opportunities for use of existing estate to support 'at scale' efficient 'back office' function
Diverse Workforce: Improve choice and Access through Staff Skill Mix
Pharmacy: Consider Pharmacy Role and use as Support
Implementation of Back Office Function
Review and Identify through use of data to determine Optimum Location of Hubs / Satellites
Review and Identify priorities to Inform Strategic Estate Planning
Progress Estates Transformation and Technology Fund for Keighley
Design - Organisational Development
Design and Prepare 'New Model of Care (NMoC)' For ACS, GP Role
Start to Review Financial Flows and fund NMoC
New Model of Care (NMoC) For General Practice
'super' practices
Patient Activation: Ability to self-refer to services
Increase Patient Education
Co-design Patient Facing and Non-facing Services with patients
Integrated Digital Care Record: Facilities different ways of consulting on real-time basis
Equal Partner Represented in ACS
Information Governance: Patient Ownership of Record with Consent to Share
Cultural Change – Awareness Training
Non Face to Face: Support and Increase Public Confidence and Uptake
Ensure Staff Involvement
Consultation – Professional and Patient
Patient Activation: Increase Awareness and Education
Identify and Develop Stakeholders and engagement plan
Engage Partners and Broader Workforce in Design and Delivery of Care
Current State:
General Practice not 1 voice
Fledgling State – Not all practices are in the federation
Fragmented Processes and Protocols
In consistent approaches - Pockets of pro-active healthcare
Workforce Challenges
Increasing workloads/demands
Recruitment and Retention Challenges

High Level Action Plan:

In addition to the Roadmap on the previous page a summary of actions set out in this Assurance Plan follow:

Action	Forum to progress	Do once with Bradford	Timescale
Investment Plan			
1. Agree with member practices and NHSE an approach to justify investment and redistribution of PMS premium by way of securing meaningful engagement and clinical leadership to support co-design and delivery of extended access, the GPFV and Accountable Care Airedale	Council of Members & NHS England Establish new general practice engagement network		Q 4 2016/17
2. Agree a plan with practice managers and support them to commission training to the value of the £14k allocation for signposting and document management	New general practice engagement network		Q 4 2016/17
3. Review and implement national specifications and additional requirements relating to investment made available; such as training care navigators and medical assistants	New general practice engagement network		When made available. Expected Q 4 2016/17
4. Consider taking into account health inequalities when designing funding formulas	Primary Care Commissioning Committee (when established) SMT & Governing Body Accountable Care Programme 'Engine Room'		2017/18
Workforce			
5. Support General Practice so that is has an equal voice and is recognised as an equal partner in the developing accountable care system,	Accountable Care Programme and CCG support to Yordale Federation		Ongoing 2016 to 2019

6. Work as an active member of the Integrated Workforce Programme for Bradford District and Craven, taking a long term strategic view of workforce planning to ensure a primary medical care workforce that is fit for purpose for the future.	Integrated Workforce Programme	Yes	Ongoing 2016 to 2019
7. Continue to develop new roles as explain previously, and take account of the care navigator and medical assistant specification and implement	Accountable Care Programme, Care Model Development Group – inform Integrated Workforce Programme		Ongoing 2016 to 2019
8. Take a long term view to raise the aspirational levels of young people to both want to train to work in the health and social care system, including primary medical care and to want to work in the Bradford and Craven District through schemes such as work experience, training placements and apprenticeships	Integrated Workforce Programme	Yes	Ongoing 2016 to 2019
9. Ensure staff and patients have the right skills to maximise and enable the use of digital technology to ensure the most effective use of time, people and finances	Bradford and Craven Digital 2020 programme	Yes	Ongoing 2016 to 2019
10. Link with NHS England and Health Education England to benefit as much as possible from the national resources which are to be deployed on the back for the General Practice Forward View	Integrated Workforce Programme	Yes	Ongoing 2016 to 2019
11. Where resources, both financial and people, permit, commission and/or facilitate training and development to support the primary medical care workforce to develop their skills and knowledge in order to promote safe, effective, high quality service delivery	Integrated Workforce Programme	Yes	Ongoing 2016 to 2019
12. Progress at pace our self-care and prevention programme and continue to build into specifications provider requirements to promote and implement interventions which promote self-management interventions to empower patients to become active in the management of their own care to reduce the need to see a	Self-care and Prevention Programme Care Model Development Group	Yes	Ongoing 2016 to 2019

health care professional			
13. Review and promote the new GP Retainer Scheme	Integrated Workforce Programme	Yes	Ongoing
14. Tap into GP trainers as potential advocates and future leaders within the ACS, support collaborative approach to training delivery	New general practice engagement network Clinical Leadership Programme		Ongoing
15. Commit to developing and delivering different roles and approaches to skill mix of primary care teams.	New general practice engagement network Integrated Workforce Programme	Yes	2017/18
16. Build on work to date and support practices to work together and expand and develop a range of different roles to become part of practice MDT's. These will include use of care navigators, health promotion, Physicians Associates, physio therapists and ANP's as well as GP's and GPwSI's	New general practice engagement network Care Model Development Group Integrated Workforce Programme	 Yes	2017/18
17. Review the range of roles being tested in the CCG through New Models of Care and build on learning, delivering the requirements of the care navigator and medical assistant specifications when made available	New general practice engagement network		Q4 2016/17 into 2017/18
18. Support practices to enable additional commitment to training and development programmes, this will include development of new roles, and expansion of existing roles and will consider the role of pharmacist and physio therapist working in different ways – embedded and becoming part of general practice teams	Integrated Workforce Programme	Yes	Q4 2016/17 into 2017/18
19. Address difficulties in recruiting GP partners and heavy reliance on locums through a pro-active recruitment campaign, shared approaches to recruitment, development and promotion of local website advertising opportunities, reducing reliance on recruitment companies and associated costs of recruitment.	New general practice engagement network Consider application to GP resilience Fund		Q4 2016/17 into 2017/18

20. Through the Bradford & Craven workforce programme we will support practices, the federation and LMC to work in partnership to develop robust recruitment and retention policies which extend beyond individual practices. Advertise and plan recruitment as a system	Integrated Workforce Programme	Yes	Q4 2016/17 into 2017/18
21. Encourage practices to complete the Health Education England Workforce toolkit to provide reliable workforce data	New general practice engagement network		Q4 2016/17
22. Explore wider issues and reduction in number of medical students choosing general practice as a career.	Integrated Workforce Programme	Yes	2017/18
23. Utilise 17/18 PMS premium funding to secure clinical leadership and engagement in consulting, and designing care models and access improvements through hub approach	New general practice engagement network		2017/18
24. Build consensus around direction of travel for development of super practices	New general practice engagement network		2017/18
25. Support further development of a super practice approach and establishment of Keighley Medical Group.	New general practice engagement network		Q4 2016/17 & 2017/18
26. Support the federation in developing more shared back office functions and efficient use of primary care estate	New general practice engagement network		Q4 2016/17
27. Evaluate and utilise learning from the Primary Care wellbeing service	New general practice engagement network		
28. Extend the Complex Care	Completed		
29. A funding request has been submitted to the National Pioneer team to secure addition Personal Support Navigator roles to expand the workforce associated with the enhanced primary care	New general practice engagement network		

and primary care wellbeing service. Testing the added value of this role will inform future workforce requirements			
30. We work closely with our local authority colleagues through a range of forums such as health and wellbeing boards and Accountable Care Programme Board to ensure joint strategic need assessment and to ensure plans are aligned	Accountable Care Programme Board		Ongoing
Improve Access			
31. Engage with our population through the New Models of Care communication and engagement programme and ascertain views and desires regarding extended general medical practice provision including extended hours over 7 days	Accountable Care Programme Board New practice engagement network & PPRGs		Q4 2016/17 and ongoing
32. Utilise 17/18 PMS premium funding to secure clinical leadership and engagement in consulting, and designing care models and access improvements through hub approach	New general practice engagement network Care Model Development Group		Q4 2016/17 and ongoing
33. Build on the pro-active outcomes focussed enhanced primary care and complex care models to support reduction in demand for GP appointments	New general practice engagement network Care Model Development Group		Q4 2016/17 and ongoing
34. Engage in the West Yorkshire Acceleration Zone and deliver an extended access hub using this to inform trajectories for 100% coverage	New general practice engagement network Care Model Development Group		2016/17
35. Work with NHS 111 and Local Care Direct to improve integrated working with the GPs co-located within A&E and primary care streaming from A&E	Care Model Development Group		2016/17
36. Market test and prepare for procurement of extended GP services			

should this be necessary	CCG SMT		Q4 2016/17
37. Establish the future of the out of hours service model post March 2019	Accountable Care Programme Board		2018/19
38. Ensure that the necessary estate in AWC has access to Wi-Fi to enable agile working from partner agencies	Digital 2020 Programme	Yes	2017/18
39. Promote use of technology to support people to manage their own conditions and maintain independence	Digital 2020 Programme supported by: Accountable Care Programme Board Self -Care and Prevention programme	Yes	2017/18
40. Increase complex care and enhanced primary care caseloads and accelerate delivery of outcomes through robust contract management	Operational Development and Delivery Group		2017/18
41. Ensure our providers maintain the Directory of Services to enable patients to be signposted to the right service at the right time	Contract Management Boards	Yes	Ongoing
42. Commit to continue to reduce transactional bureaucracy to increase time available for patient care; examples of this are our outcomes focussed approach to our local enhanced service bundle	New general practice engagement network		Ongoing
43. Access national funding which will facilitate the adoption and spread of technologies	Digital 2020 Programme	Yes	Ongoing
Technology & Infrastructure			
44. Work with strategic partners CHP & NHS Property services to explore the possibilities and plan an alternative approach to ETTF to secure capital funding to deliver a premise solution and hub for Keighley (general practice plus at scale) and reconfiguration of existing estate to deliver locality hubs in Craven and Wharfedale	Strategic Estates Group		Ongoing

45. Work with NHS England on short to medium term plan for the provision of service to patients registered at North Street Surgery should this be required. The future for these patients will be know at the time of submitting the final plan	Resolved/Completed		Complete
46. Engage in delivery of the Digital Road Map through the Digital 2020 Programme (which has taken account of primary care requirements)	Digital 2020 Programme	Yes	Ongoing
Workload and Redesign			
47. Support our practices to access the new national development programme (as outlined in the GPFV) to allow them to make changes which should impact on releasing capacity within the system. Opportunities will be put in place to allow practices to benefit from the Ten High Impact Actions.	New general practice engagement network		2017/18
48. Support practices through the Yordales Federation to identify where they can access strategic workforce planning support as they have asked for this	New general practice engagement network		2017/18
49. See also Workforce section			
Organisational Form			
50. Conduct an options appraisal to identify the most appropriate model and subsequent form for primary medical services	New general practice engagement network National Pioneer Programme		2017/18
51. Increase the level of general practice involvement in Accountable Care Airedale (ACA) discussions	New general practice engagement network and, Accountable Care Programme - Ditto –		Ongoing
52. Ensure robust involvement through Federation & LMC as general practice representatives			
53. Increase the level of patient engagement in service design	Care Model Design Group		Ongoing

54. Put in place processes to actively support the delivery of primary medical care at scale	New general practice engagement network		Ongoing
55. Ensure general practice is key in C&E activities as part of ACA programme	New general practice engagement network and, Accountable Care Programme		Ongoing
56. Where procurement rules allow, have commissioning strategies that positively encourage networks of practices and stakeholders as providers	CCG SMT		Ongoing
57. Ensure primary medical care services are the foundation of an accountable care system	New general practice engagement network and, Accountable Care Programme		Ongoing
58. Support the development of the Voluntary and Community sector to engage as one voice across the system to support improvement	Accountable Care Programme		Ongoing
59. Working with the Local Authority and Public Health, establish formal links with education providers and others to bring health messages and health education into schools and colleges to encourage children and young people to consider future working in the health and social care sector of Bradford	Accountable Care Programme	Yes	

NHS
Bradford City
Clinical Commissioning Group

NHS
Bradford Districts
Clinical Commissioning Group

Primary Medical Care Commissioning Strategy

2016 – 2021

Version Control

Version Number	Date	Editor	Purpose/Change
v1	**20th May 2015**	**Karen Stothers**	
v2	**8th June 2015**	**Karen Stothers**	Comments from LP, HH and AH.
v3	**23rd July 2015**	**Karen Stothers**	Comments from AW and joint GB/CB chatter
v4	**15th September 2015**	**Karen Stothers**	Comments from VW, GT
v5	**15th September 2015**	**Karen Stothers**	Clean copy removing GT comments – requirement to revisit comments in v4. CC comments – new self-care section, amendments to Access, LTC, Workforce and IT GF comments. Inclusion of commissioning for quality primary care section (MT comments)
v6	**20th October 2015**	**Lisa Pope**	Textual revisions
v7	**5th November 2015**	**Karen Stothers**	Clean copy following LP revisions
v8	**26th May 2016**	**Liz Allen**	Districts v7 and City v6 combined and updated to reflect publication of GP Forward View (NHSE, April 2016), formation of the Bradford Care Alliance, steps towards an accountable care system and the development of the Bradford District and Craven Sustainability and Transformation Plan
v9	**5th July 2016**	**Vicki Wallace**	Further additions regarding STP, GPFV, removal of out of date information, altered layout and included feedback from general practice engagement event on 30th June and email comments
v10	**20th July 2016**	**Vicki Wallace**	Additions following joint (BC and BD CCGs) Governing Bodies and Clinical Boards strategy session on 13th July
v11	**8th August 2016**	**Liz Allen**	Revisions and additions following meeting of CCG Clinical Chairs, Directors of Strategy, Head of Commissioning and Contracting (Primary Care) and senior representatives of YORLMC Ltd.
V12	**7th December 2016**	**Vicki Wallace**	Revisions and additions following engagement process with stakeholders

Record of Stakeholder Engagement

Stakeholder Group	Version number	Date
Bradford Districts Governing Body	Districts - v3	11th August 2015
Bradford City Governing Body & Clinical Board	City – v6	9th December 2015
City and Districts member practices and YORLMC Ltd	v8	30th June 2016
Bradford City and Bradford Districts Joint Governing Body and Clinical Board session	v9	13th July 2016
Bradford City and Districts CCGs and YORLMC Ltd	v9	29th July 2016
People's Board	v11	18th August 2016
Public and Stakeholder engagement (included Governing Bodies, Joint Clinical Board, YORLMC)	v11	5th September 2016 – 14th October 2016
Integration and Change Board	v11	28th October 2016

Contents (To update once complete)

Foreword (Still to be drafted for/written by Helen, Andy and Akram)

Executive Summary

This document sets out the primary medical care commissioning strategy for NHS Bradford City Clinical Commissioning Group and NHS Bradford Districts Clinical Commissioning Group. It sets out the commissioning aspirations for the next five years to enable primary medical care services within Bradford to:

- Be delivered via primary medical care at scale by a mixture of independent practices, networks and federations as part of an accountable care system operating out of hubs, co-located and collaborating with other relevant services 7 days a week. As well as NHS and social care providers this will also include VCS organisations.
- Regularly use technology for all elements of patient care including access, consultations, telehealth and telemedicine.
- Have established new roles and new ways of working, including 'virtual primary medical care', shifts in traditional roles and responsibilities and that Bradford is 'The place to be'.
- Have better demand management, as patients are empowered and experienced in self-care and preventative services are embedded within the accountable care system.
- Have strong embedded relationships with education, paving the way for increased levels of self-care and a workforce who choose to work and live in Bradford.
- Have equality of care for the whole population. Wherever people live or are registered within Bradford, they can access the same services.

To attain our end state we will focus on the following 6 key areas and deliver our 'We will' statements:

1. Improve access
2. High quality
3. Workforce
4. Self care and prevention
5. Collaboration
6. Estates, finance and contracting

To enable the Clinical Commissioning Groups to facilitate this we will change the way we commission, contract and pay for services as part of our move to accountable care. This will include funding federations of primary medical care providers, rather than the traditional route of individual primary medical care providers.

1. Introduction

The health and care delivery system of Bradford District & Craven comprises of three Clinical Commissioning Groups (CCGs), two local authorities and four main NHS providers. Although each are statutory organisations in their own right, the three CCGs have a strong commitment to working collaboratively. This primary medical care commissioning strategy relates only to Bradford City and Bradford Districts CCGs. We will continue to work closely with our partners to secure the best possible integrated and efficient health and care services for people in the Bradford District and Craven area.

In October 2014 Simon Stevens, Chief Executive of NHS England, published the 'Five Year Forward View' (FYFV)[1] for the future of the NHS. He put patient experience, care closer to home and moving care out of hospital settings at the heart of plans for transforming the NHS. In the Bradford District and Craven health and care economy we have interpreted this challenge in our own Five Year Forward View[2] and more recently our Sustainability and Transformation Plan (STP), to enable the transformation required to deliver our shared vision: *"To create a sustainable health and care economy that supports people to be well, healthy and independent".*

Since April 2015, both Bradford City CCG and Bradford Districts CCG have held delegated responsibility to commission primary medical services on behalf of NHS England. This provides the opportunity for the CCGs as local commissioners to have greater influence in the use of resources and shape services for the future. It is a key enabler in developing seamless integrated out of hospital services around the diverse needs of our populations and in delivering the aspirations of both the local and national five year forward views as well as those described in the 'General Practice Forward View'[3] published by NHS England in April 2016.

Delivery of our system wide vision is led by the Integration and Change Board (ICB) which is collectively accountable to the Bradford Health and Wellbeing Board. Its role is to provide system wide leadership and accountability for securing the delivery of a sustainable health and social care system within the Bradford health and care economy, implementing the vision and direction for delivering the best outcomes for the population as set out in the Five Year Forward View and Sustainability and Transformation Plan, as required by the Bradford Health and Wellbeing Board.

Within the wider Bradford health and social care system there is an ambition to move towards an Accountable Care System (ACS) to achieve the triple aim of improved population health outcomes, high quality experience of care and at a good value per capita cost. We expect to be operating within an ACS by 2020/21 and we are planning major steps in the design of this in 2016/17. We believe that by establishing an accountable care approach, we will be able to commission holistic care for our population, taking into account the care they will need for their whole life, and for the whole person, rather than commissioning separate services. We will commission services that 'wrap around' them, to provide co-ordinated consistent and high quality services across organisational boundaries.

This approach will be outcome based. We are not interested in merely counting activity and inputs, rather, we want to know that the care received by our population is of high quality, safe and of best value and that we commission interventions that improve the population's overall health outcome. We believe, for this to succeed, primary medical care services must be the bedrock of our system. It is clear that without total primary medical care involvement, a fully functioning ACS would not be

possible. Therefore this strategy clearly sets out our ambition to ensure primary medical care services play a full part in the development and move towards an ACS.

Primary medical care services are the underpinning bedrock of the whole health and social care system and this strategy is a key driver of the delivery of the Out of Hospital Programme. The Out of Hospital Programme has interdependencies with other ICB programmes, and achievement of our system wide vision is dependent upon all programmes delivering.

The scope of this strategy covers the entire service element of primary medical care. This includes all services deliverable under core General Medical Services[4] and Personal Medical Services[4]. It also includes Enhanced Services, the Quality and Outcomes Framework, vaccinations and immunisations and locally commissioned services. The scope includes services delivered at both individual practice level and delivery at scale. The scope does not include services delivered by community providers e.g. district nursing. This does not mean that there will be no interaction or influence over the commissioning of community services and this interaction with be managed by the Out of Hospital Programme Board. The delivery of the strategy relies on all elements of the primary medical care workforce, not just General Practitioners. This includes, but is not limited to, Advanced Nurse Practitioners; Practice Nurses; Practice Managers; Receptionists; Health Care Assistants, practice-based Pharmacists and practice volunteers.

It is unlikely that the future model of primary medical care will look exactly like the service that exists today. Over the next 5-10 years the service must transform, adopting new ways of working and of delivering care to the population of Bradford. To do this we will learn from what we have done well, look to local, national and international examples of best practice, and will establish a culture that facilitates innovation, to enable new ideas to be tried and tested.

The term 'general practice' is often used interchangeably when describing three related yet different concepts:

- The current model of delivery (including, but not limited to, independent contractor status)
- The wider members of the primary health care team who work in and/or for the practices
- The skills of GPs that are unique to the profession

It is important that our strategy addresses all of the above. It is also important to note that throughout this strategy, where we refer to patients we are referring to both patients and their carers as we recognise that not all patients are able to access care or manage their conditions independently. We recognise the importance of engaging with carers as part of our service transformation. It is also imperative to acknowledge that the primary medical care services included in this strategy relate to both physical and mental health needs. This strategy recognises the need to ensure that mental health illnesses are treated with the same parity of esteem as physical health needs and will support the delivery of the mental health strategy to guarantee this occurs in Bradford.

1.1 National context

NHS England's Five Year Forward View (2014)[1] sets out a vision for the NHS, based on new models of care. Primary medical care is recognised as *"one of the great strengths of the NHS"* and further investment is planned, specifically relating to:

- stabilising core funding;
- greater influence over the NHS budget for CCGs;
- increased numbers of GPs;

- increased funding for infrastructure development;
- initiatives to tackle health inequalities; and
- awareness of roles and resources to support self-care.

The environment for further investment and development is challenging, complicated by recruitment and retention issues; transformation shifting care closer to home; lower relative funding; increased activity in acute services (e.g. A&E); the development of new primary medical care models e.g. federations; increasing demand and financial pressures; and pressures from increasing performance targets.

Government policy continues to move services into the community, placing yet more pressure on overstretched GP services struggling to provide enough appointments, with consequential delays to see a GP.

In April 2016, NHS England (NHSE) in partnership with The Royal College of General Practitioners (RCGP) and Health Education England (HEE) published the General Practice Forward View[3]. This document can be seen as primary medical care services' own FYFV – highlighting the key challenges which face primary medical care currently and the changes and developments which NHSE, RCGP and HEE identify as being key priorities in ensuring a high quality and sustainable primary medical care service is in place in the future.

The General Practice Forward View[3] (GPFV) focuses on five main areas:

1) Investment
2) Workforce
3) Workload
4) Practice infrastructure
5) Care redesign

Against each area, the GPFV outlines what NHSE plans to implement to support those areas, and the detail set out in this strategy outlines what Bradford CCGs will also be doing locally to interpret and implement the GPFV in order to make it real for Bradford people.

Some of the plans and concepts outlined in the GPFV have also been evidenced in earlier documents which inform this strategy. The Royal College of General Practitioners previously set out a vision suggesting that primary medical care in 2022[5] should be based on shared decision making; increased community self-sufficiency; coordinated care; collaboration across boundaries; and greater use of information and technology. The NHS Alliance[6] has also prepared a vision for primary medical care , focused on developing a "community of care" using a restructured workforce; improved premises; increased coordination; social prescribing; effective use of technology; a review of funding; and increased self-care and prevention.

The BMA's discussion paper "General practice and Integration"[7] states that initiatives to reduce service fragmentation and align organisational interests for the benefits of patients through the development of collaborative working should be welcomed. The current arrangements of competing providers and at times, rigid separation between primary medical care, community providers and social care are having a detrimental effect on patients, with disjointed service delivery, duplication, increased transaction costs and flows of funding which create perverse incentives that do not reflect patient needs. Our CCGs agree with this, and the work we are doing on ensuring

primary medical care is the bedrock to the accountable care system is our main approach in eliminating these issues in the future.

The Equality Act 2010[8] unifies and extends previous equality legislation and we have also taken this Act into account when developing this strategy. Nine characteristics are protected by the Act; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

To ensure that NHS Bradford City and NHS Bradford Districts are meeting their equality duties, improving health and reducing health inequalities we will:

- Adhere to the 'Brown principles'[9]
- Ensure any changes to services will include local engagement with patients, public, carers and wider stakeholders and ensure that this includes involvement of protected characteristic groups and that equality monitoring is undertaken for all engagement activity.
- All service reviews undertaken as part of this strategy, will undertake an equality analysis.
- Service contracts and service specifications will reflect the need for equality monitoring and ensure that providers demonstrate and report on how they are meeting their public sector equality duty.
- Any decision making resulting from this strategy will give consideration to any identified 'impact' on protected characteristic groups and where appropriate identify and implement mitigating actions.
- Adhere to the accessible information standard by ensuring that patients and service users, and their carers, can access and understand the information they are given. This includes making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email. We will also ensure that people get any support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or an advocate.

1.2 Sustainability and Transformation Plan

The national FYFV[1] also sets out the aim of closing three gaps in health care:

- The health and wellbeing gap
- The care and quality gap
- The funding and efficiency gap

The NHS planning guidance for 2016/17[10] outlined the importance of closing these gaps, and locally this would be enacted via each area producing and delivering a Sustainability and Transformation Plan (STP). The planning guidance made it clear that a STP is not just about writing a document, nor is it a job to be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting.

In common with the other CCGs across West Yorkshire, it has been agreed that our footprint for local delivery of the STP is to remain as the Bradford District and Craven locality, embracing the understanding of a place-based and population-based plan, whilst being a sub-set of the West Yorkshire STP. Along with the other West Yorkshire CCGs we fully recognise and have included in our plan the need to work across our footprint boundaries in order to create sustainable services.

The Healthy Futures group has identified that there is still a substantial financial and efficiency gap that must be closed if health and care services are to be sustainable in the future. The financial efficiencies that have to be achieved are extremely challenging and need to be met at both a local (CCG) and sub-regional (West Yorkshire) level. Five areas are being targeted across the whole of the West Yorkshire footprint. These are: Mental Health; Urgent and Emergency Care; Cancer; Stroke; Specialised services. This work will take into consideration the impact on protected groups regarding access, experience and outcomes.

Primary medical care services in Bradford play an important role in delivering the STP as the majority of care is delivered in primary or community settings. In Bradford we recognise the importance of primary medical care, it is the bedrock of our whole system, the foundation on which the rest of the health and social care system is built. This is because the majority of care delivered in the NHS is delivered by primary medical care teams. They are often the first port of call for patients and are the gateway in many instances to acute care via the referral system. Unless high quality safe care is delivered by primary medical care, the number of patients presenting acutely within secondary care increases, access issues result in high A&E attendances and early diagnosis of conditions is reduced.

This strategy outlines the main steps that will be taken to improve the quality, reduce the variability in care, and deliver long term sustainability of services in primary medical care, thereby contributing to the closure of the three gaps outlined above.

1.3 Local context

Primary medical care services in Bradford are in a different position currently to many other areas nationally. The concept of a GP with Special Interest (GPwSI) was established in Bradford, and there has been a long history of investment within primary medical care. Developments and investment have meant that there has been an acute care to primary medical care shift taking place over the last 20 years, so many of the changes taking place elsewhere in the country have already happened in Bradford. These changes did not take place systematically over Bradford, for example, the practices in the city centre area were more focussed on attracting new GPs to this under-doctored area, while the specialisation took place in areas which now predominantly fall under the remit of Districts CCG. Once more, we need to look to new and innovative ways of working to guarantee the benefit of our long history of investment in primary medical care is felt by all patients.

Here in Bradford there are significant transformational and enabling programmes in place. The primary medical care commissioning strategy will sit alongside and will support, drive and respond to other Bradford initiatives including (but not limited to):

It is important to note that not all of the actions and intentions outlined in this strategy will be the responsibility of the Out of Hospital Programme to deliver. Some aspects will be delivered by other programmes of work, e.g. self-care and prevention programme, Bradford Digital 2020. This strategy is about the role of primary medical care in the whole system – it is just one element of the health and care system in Bradford, albeit a very crucial element. This strategy outlines the primary medical care transformation which will support the wider transformation of health and social care services in Bradford.

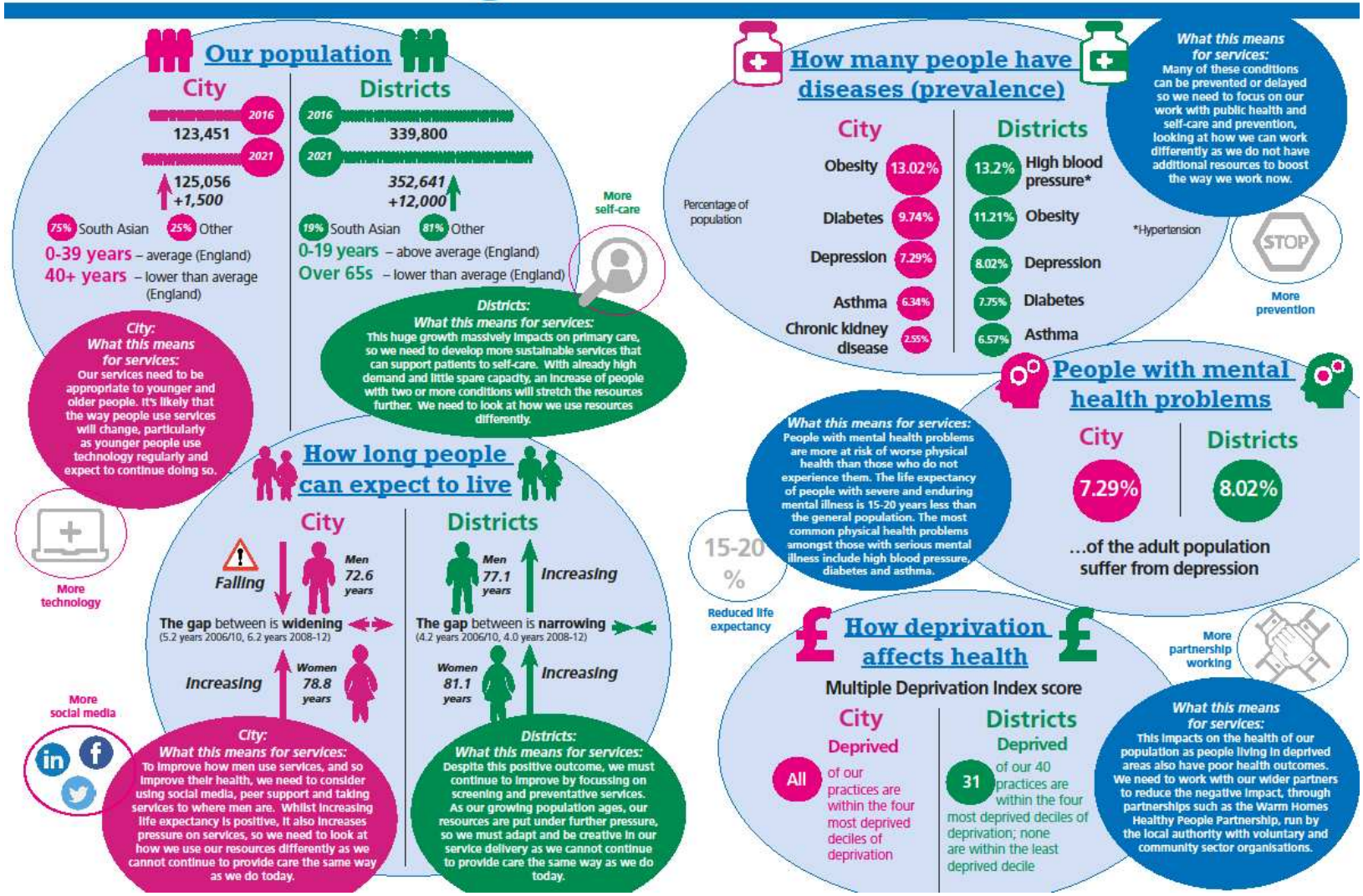
1.3.1 Health Challenges in Bradford

The health needs of the population of Bradford are challenging. The different profiles of our two CCG's are outlined below.

TO NOTE – IMAGE ON NEXT PAGE WILL BE BIGGER IN FINAL DOC

Health challenges

NHS
Bradford City Clinical Commissioning Group
Bradford Districts Clinical Commissioning Group



1.3.2 The primary medical care provider landscape in Bradford

The two CCGs in Bradford have two differing provider landscapes. In Bradford City CCG there are 27 separate primary medical contract holders providing care for 124,000 patients, of whom 75% are of South East Asian origin with an average list size of 4571. The majority of the population live in the 20% most deprived areas of England.

While in Bradford Districts CCG, 43 separate primary medical contract holders provide care for 328,000 patients, of whom 19% are of South East Asian origin. 41% of the population live in the 20% most deprived areas of England with an average list size of 8288.

Bradford City CCG, with the agreement of the Council of Members, and Bradford Districts CCG, with agreement of the Council of Representatives, became delegated commissioners of primary medical care services in April 2015. We believe that by accepting these delegated responsibilities we are now enabling local commissioners to have greater influence in the use of resources and the shaping of services in the future. One of our key objectives is to manage the provider landscape in primary medical care in order to enable the development of seamless integrated out of hospital services around the diverse needs of the population. Eventually this will progress into fully local and responsive place based commissioning via the ACS.

Contract types and values:

There are 7 GMS contracts (4 City, 3 Districts), 56 PMS contracts (19 City, 37 Districts) and 7 APMS contracts in place (4 City, 3 Districts). These contracts currently provide services to patients during core hours (8.00am to 6.30pm Monday to Friday) providing services over 86 sites (17 branch surgeries). APMS contracts are time-limited contracts, when contract terms end national guidance dictates that these are fully evaluated against key criteria for value for money, needs assessment, impact assessment and consultation proposals.

The majority of these contracts outlined above are held by individual practices. However, we have a number of practices who hold multiple contracts across the district (e.g. one partnership holds 5 contracts) and often in these situations patients are able to access services at any of those sites. The list size across our practices also varies, in Bradford City CCG they range from 1573 to 9360, while in Bradford Districts CCG the numbers are 2933 to 25,110.

Since becoming delegated commissioners, both CCGs have undertaken negotiations with PMS practices and the Local Medical Committee around the equitable funding review. The implementation of the PMS equitable funding review (EFR) came under the terms of the national policy for PMS reviews set by NHS England. In summary the amount of PMS funding classed as a 'premium' i.e. anything over £79.99 per weighted head of population is being redistributed to practices within the CCG area in a way that demonstrates the principles of equity, fairness and value for money. Locally we have agreed to an offer of equitable distribution. The national requirement was for the review to be completed by 1 April 2016 and implemented within four years and the CCGs are on track with achieving this.

Practices that are likely to suffer hardship as a result in the changes can make a request for further transitional support funding. The decision to grant further transitional funding will be one for each Governing Body to make and will be done in an open and transparent way, with YORLMC oversight to ensure fairness and equity. Practices will have to demonstrate why the change in policy has resulted in hardship. All practices with a high premium should have been planning to manage a reduction so it will be necessary to demonstrate why the shortening of the premium recovery period

cannot be managed without threatening the viability of the practice. Each Governing Body was clear that it did not want to see any practice's viability threatened as a result of the change of pace arrangements. To support this, the CCGs have provided financial support to practices to allow them to manage the changes.

Our approach to APMS contracts and practice mergers is becoming established, both of which will have an eye to sustainability and quality. The move to 7 day service provision will include a review of the existing extended hours Directed Enhanced Service, with the aim to enable practices to work flexibly to meet the needs of our population, especially in regards to the needs of children, which is especially pertinent in Bradford City CCG. The work behind the EFR supports the CCG to improve the offer of services to patients by ensuring that all patients have access to enhanced services and local diagnostics via local arrangements even if their own GP practice is not directly able to provide these. Bradford City CCG, through the EFR, has an opportunity to work with practices to develop new models of delivery, encouraging practices to look at innovative ways of managing demand within primary medical care. This will benefit practices by giving them the opportunity for meaningful community engagement and the development of members of the practice team to make links deep in to the community, using appropriate language and cultural norms, promoting health and wellbeing.

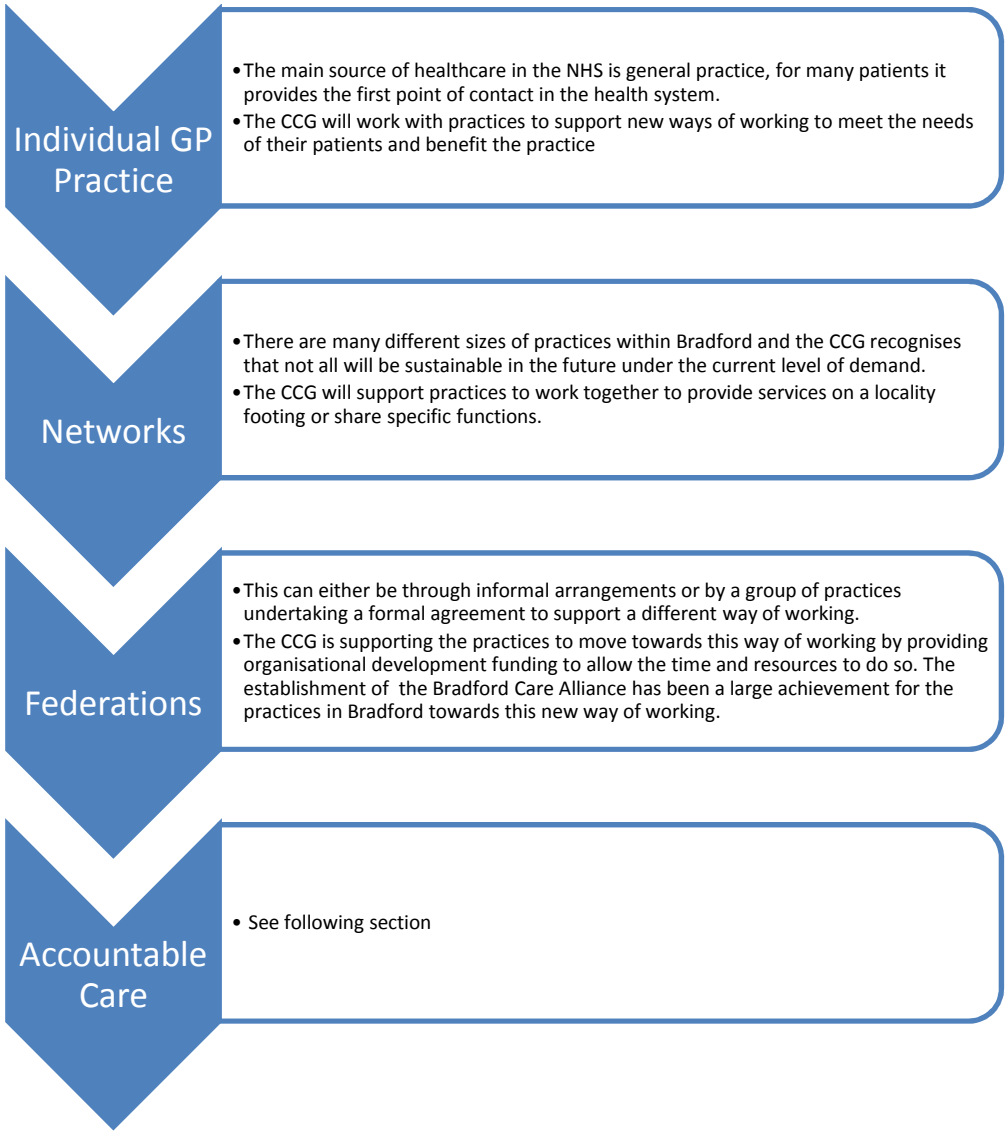
As well as core provision which is set out within the contract, primary medical care services also deliver enhanced service provision as we have deliberately chosen to increase the primary medical care offer across both CCGs in Bradford. Enhanced services can be seen to be 'over and above' day to day services, including:

- A directed enhanced service for extended hours provides an opportunity for practices to offer extended hours opening to patients. This service is delivered by 90% of Bradford practices, offering a range of early morning, late evening and Saturday morning appointments.
- A local enhanced service on a list basis for diagnostic testing for ECG, spirometry, and 24 hour BP monitoring. This is offered by all practices.
- The local community enhanced dermatology service went out to Any Qualified Provider (AQP) at the beginning of 2015 and contracts were awarded in July 2015. There are currently 9 practices delivering this service.
- Using a process of 'structured collaboration', commissioners and providers are working with the public, patients and service users to co-design a transformed end-to-end integrated diabetes pathway that incorporates primary prevention of the condition as well as better management for those who have diabetes and secondary prevention of related complications. The current diabetes services delivered in primary and community settings (described as Levels 2 and 3) are part of this redesign work, all of which serves as the first part of our journey towards an accountable care system. The structured collaboration process is implemented through a series of workshops, with the objective of agreeing a service specification before the end of 2016 and the two Bradford CCGs offering a single accountable contract for implementation from April 2017.

1.3.3 The emerging primary medical care landscape in Bradford:

Nationally there is growing consensus for primary medical care to be delivered at greater scale. New models of working are emerging within primary medical care in Bradford and developing a strong, sustainable and continuously improving primary medical care infrastructure is a key priority for the Bradford CCGs. We have acknowledged that there is work still to do to establish primary medical care as the strong foundation upon which the new models of care delivery for the future can be built and see one of the enablers as being the development of a new model of primary medical care.

This new model includes practices working as an individual organisation, collaboratively with each other, within the wider primary medical care arena and within the overall health system with services being commissioned across bigger footprints. There is no 'one size fits all' rule in Bradford, we believe that each of the elements below will be needed in the future system and practices are likely to play a role in all elements:



The Bradford Care Alliance (BCA), a community interest company, was established in June 2016. This represents the provider voice of the vast majority of member practices across Bradford. This will facilitate engagement in service redesign and service delivery, as the individual voices of primary medical care are channelled through the BCA. This is a definitive step for primary medical care

services in Bradford which the CCGs recognise and therefore will work with the BCA to deliver this strategy as well as with YORLMC Ltd, the statutory body that represents general practice providers.

1.3.4 Accountable Care System (ACS)

As outlined in the introduction, our wider Bradford health and social care system wishes to commission an ACS by 2020/21. A future with a functioning ACS should enable:

- Care to be delivered seamlessly that is personalised to meet individuals' goals, taking into consideration their cultural needs.
- Person centeredness at the core of all solutions – embracing the tenet that the patient is a valuable member of the care team.
- Individuals to be engaged in a way that is appropriate and accessible to them (care is co-designed) and jointly accountable – that care happens with them not to them.
- Primary medical care to operate at scale with sufficient infrastructure to support delivery of the ACS.
- The population to be segmented by the type of care that they need as well as the level and frequency of care provision so that it is clearly identifiable to all stakeholders, including the relevant providers and the individuals comprising of the population. This will contribute towards reducing health inequalities.
- Risk stratification and predictive modelling tool is embedded in operations as a core enabler to ongoing planning, targeting interventions and monitoring impact. This work will also help to identify protected groups who may not access health care.

As part of our journey towards establishing an accountable care system across Bradford by 2020/21, during 2016/17 the CCGs are testing the capability of our health and care system (commissioners and providers) to work collaboratively to achieve a common purpose. We are undertaking a *structured collaboration* approach to procure transformed diabetes services and the prevention of diabetes. Structured collaboration is a process where CCGs as commissioners work with existing providers, patients/service users and the public to establish a new approach to the delivery of transformed services. This means that we expect the providers to work together collaboratively, rather than in competition with each other. Such collaboration between commissioners, providers and patients/service users and the public is being conducted with the aim that, over time, the emphasis can shift away from secondary prevention of disease and delivering services to meet acute care needs towards primary prevention and self-care We want to enable and empower our population to make decisions around their illnesses and, where possible, to support them to prevent or delay the onset of some diseases altogether.

This work is being taken forward via the CCGs and the Bradford Provider Alliance. The Bradford Provider Alliance (working title) is a partnership of all of the main stakeholders across Bradford and includes: Bradford Teaching Hospitals NHS Foundation Trust; Bradford Care Alliance; Bradford District Care Foundation Trust, and Bradford Metropolitan District Council. They in turn are working with wider partners, including the independent sector (e.g. care homes) and Voluntary and Community Sector organisations as well as the public, patients, service users and carers.

The CCGs have recognised that it would be extremely difficult to go from the current commissioner and provider arrangements to a whole accountable care system in one step, which is why in 2016/17 we are concentrating on diabetes. We believe this will support the overall aim to achieve an ACS by 2020/21. Using the same structured collaboration process, we are also progressing the work of the Out of Hospital Programme in order to transform services for a much broader population – starting with those with multiple long term conditions and/or complex care needs. The services will be redesigned to provide proactive care and/or a reactive response to the changing needs of these

patients and service users. This will range from people who are able to self-care to those who are in a stable condition managed in primary and community services to those who have escalating needs, are unstable or have acute care requirements.

New care models such as these will promote the development of the provider landscape and the embedding and progression of a new commissioning approach over the next 5 years to facilitate the realisation of an ACS across Bradford.

Given the vital role that primary medical services play in out of hospital care, it makes sense for the implementation of this strategy to be a key part of the Out of Hospital Programme – recognising the interdependencies with other transformational and enabling programmes (e.g. Urgent and Emergency Care, Self-care and Prevention).

2. Case for change

The case for change covers both the need to change the way care is delivered and factors which impact on the future sustainability of the service.

Wider system changes
As already discussed, the development of an ACS within Bradford will focus the need for change within primary medical care services to facilitate the sector in continuing to play a major role in the delivery of care. As commissioner of the services, we want primary medical care together with the voluntary and community sector to be the foundation to the accountable care system. Therefore we are undertaking investment and actions to facilitate this.

Planning – homes and workplaces
Bradford Metropolitan District Council is preparing a new Local Plan for the District (2015-2030). The Plan will shape the decisions such as where new homes, jobs and infrastructure are located and which areas such as greenspaces are protected. The strategy of the new Local Plan is contained within the Core Strategy while the details of which sites will be identified to deliver that strategy will be contained in several separate plans – Area Actions Plans for the City Centre and Canal Road Corridor areas and the Allocations Development Plan Document (DPD) for the rest of the district.

The Core Strategy sets out the strategic policy for the District and the targets for new development, including the amount of land which will be required for new employment development and the number of new homes which different parts of the District will be expected to accommodate. Four key geographical areas have been defined and three of these relate to our CCGs geography:

- Regional city – 27750 new homes
- Airedale – 8450 new homes (includes Bingley and Baildon)
- Pennine Towns – 3400 new homes (includes Queensbury, Thornton, Denholme and Wilsden).

The CCGs will need to work closely with the Council to understand where new developments will potentially put pressure on existing primary medical care resources.

Demand and variation
There is a large and increasing gap between the workload demands on practices and their capacity to deliver essential services to their registered patients. GPs and their teams report feeling overwhelmed by rising workload, particularly from a growing and ageing population with complex health needs, increasing patient expectations and rapid shifts in work from secondary to primary medical care. It is also generally recognised that there is unwarranted variation in the quality of primary medical care. We have developed systems and processes where these variations can be highlighted and we need primary medical care providers to come together to understand these and work to pathways and policies to ensure care is more equitable and efficient across the district. As well as increasing the efficiency of services, we aim for this work to increase the quality of services delivered across Bradford and reduce health inequalities relating to these.

Workforce challenges
At the same time, there is an emerging workforce crisis with shortages of GPs leaving, many practices unable to recruit doctors, and evidence that some experienced GPs are considering leaving primary medical care altogether. Bradford is not always seen as a positive place to work – not all GP

training places are filled and people choose to work elsewhere. There are different levels of GP shortages across Bradford, with the most significant problems in the City area. The CCGs also have a significant number of practice staff approaching retirement age which will put further pressure on the system over the next few years. The accuracy of the information that we have on our workforce also creates problems, as not all practices complete the workforce returns which creates problems for future succession planning. Through the district wide workforce programme, as well as a local CCG approach, we need to undertake staff development and succession planning, taking a joined up approach with local partners to reduce the number of staff moving around the system. This must be supported by NHS England and Health Education England. We need to show that Bradford is an exciting place to work, with lots of opportunities for work satisfaction and professional and personal development.

Finances

In addition to the quality and safety drivers for change there is a strong financial case for change as the current funding model is not affordable in the long term. Without change we will not be able to deliver a financially stable health economy or provide sufficient resource to deliver the essential improvement in clinical standards that is required to deliver sustainable high quality care primary care consistently.

> "There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS."[11]

The national planning guidance outlines the need to shift resources from secondary to primary care through transformational working to enable sustainability of the system and the CCGs will continue to focus on this as a key part of this strategy[10]. We have seen a higher level of investment in primary medical care in Bradford than in other areas nationally as many of the services traditionally delivered in secondary care has already shifted to primary medical care. This puts increased pressure on us to change as many of the service developments that are taking place in other CCGs have already taken place in Bradford.

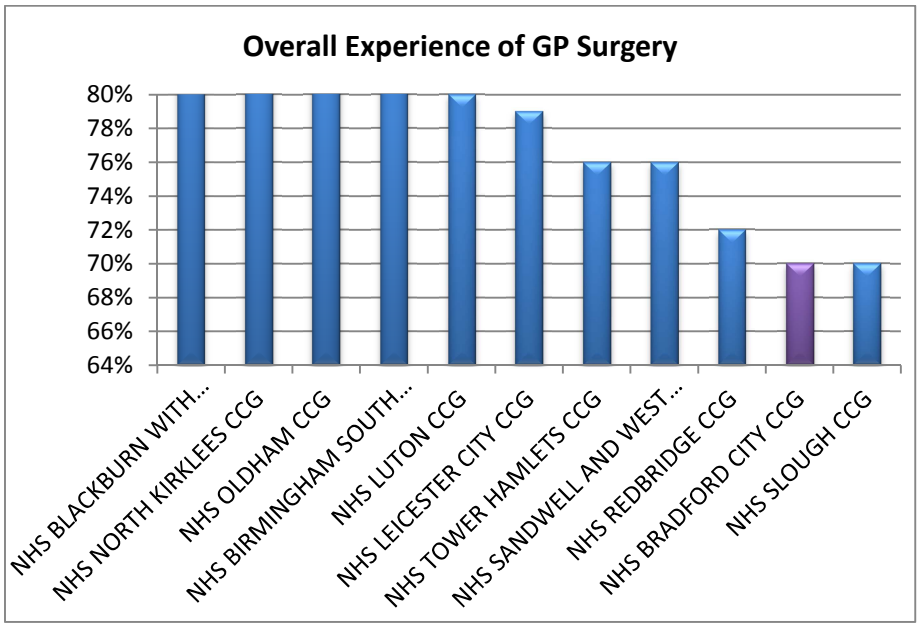
Patient experience

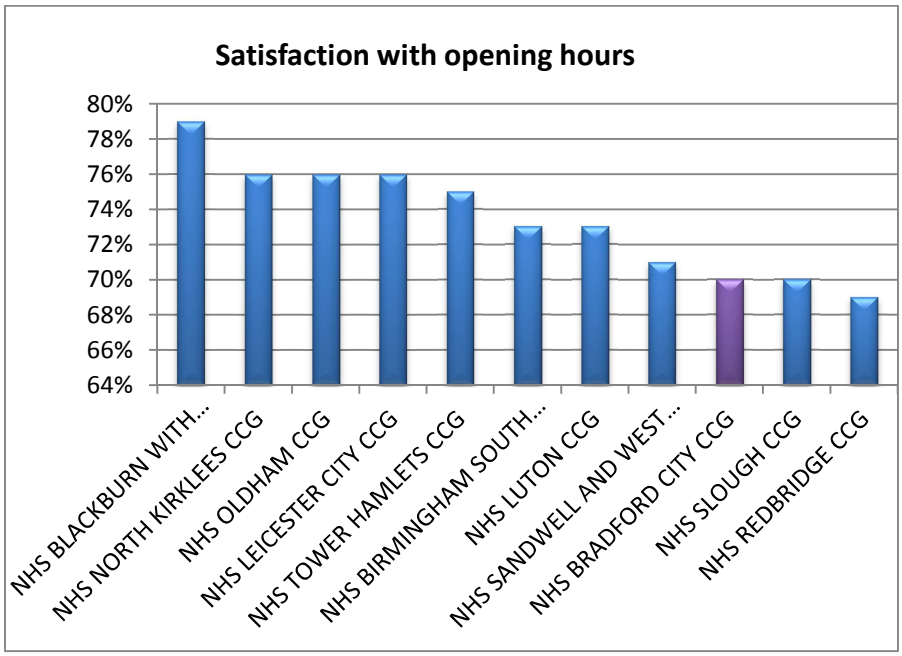
The way in which primary medical care is measured in relation to patient satisfaction and experience is through a national GP survey. The survey has its limitations in terms of the demographic and cultural mix of respondents compared with people registered at individual practices but it is a nationally recognised measure against which some conclusions can be drawn and benchmarked. The two main areas commonly used to understand how patients are feeling in regards to their practice are;

- Overall experience of their GP practice and
- Satisfaction about opening hours.

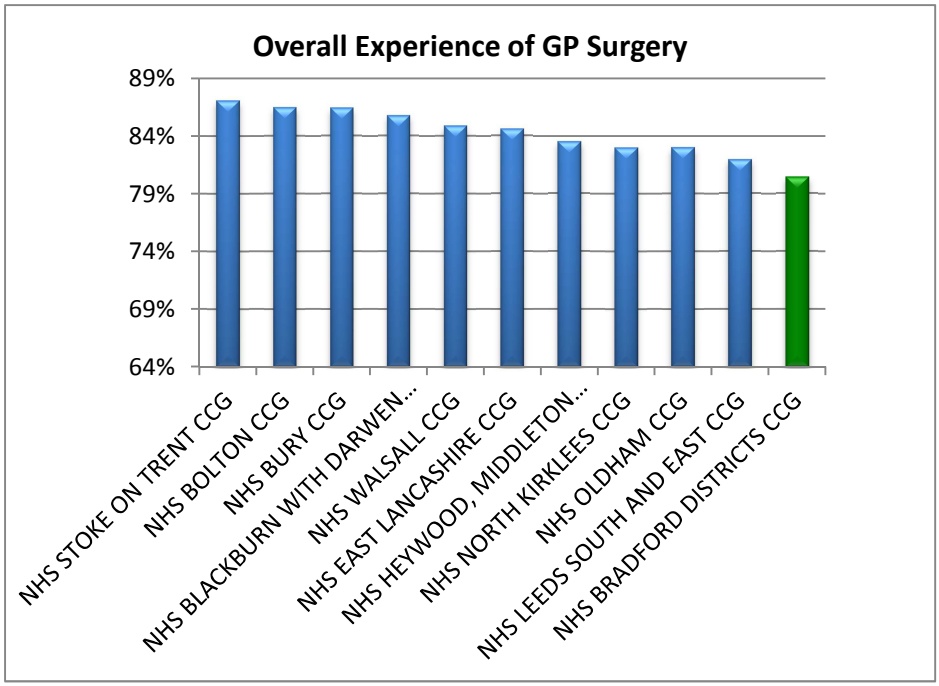
Each CCG is benchmarked against comparator CCGs, i.e. other CCGs that have similar populations so comparisons can be drawn. As seen in the graphs below, both CCGs in Bradford have improvements to make and improving patient experience is a key challenge for us.

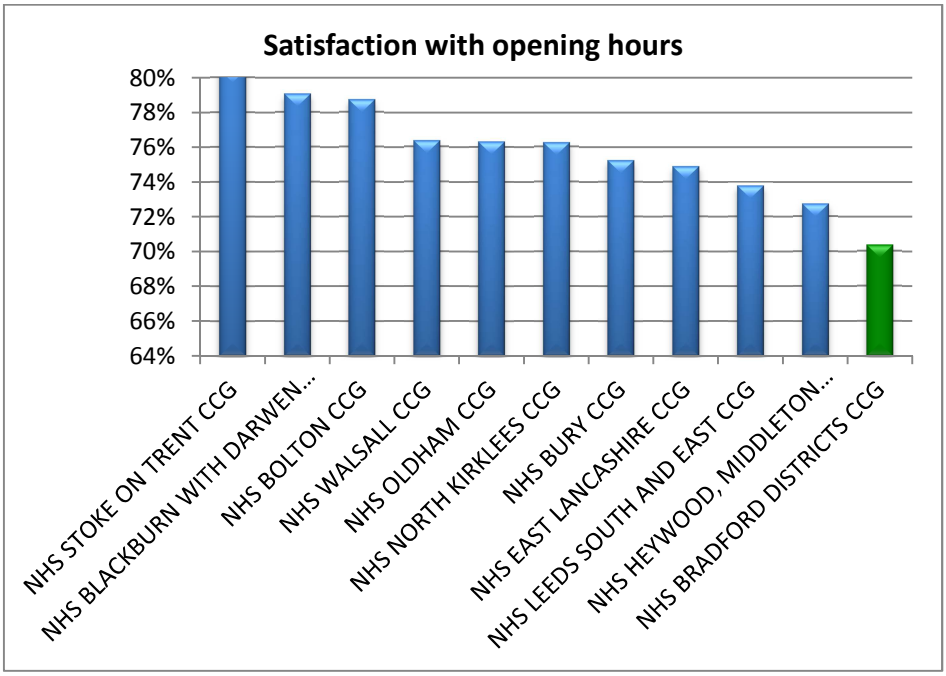
Bradford City CCG:





Bradford Districts CCG:





This focus on patient experience is key, as this is what will allow our system to change and adapt. Until patients experience a positive change in the way they use and experience services they will not

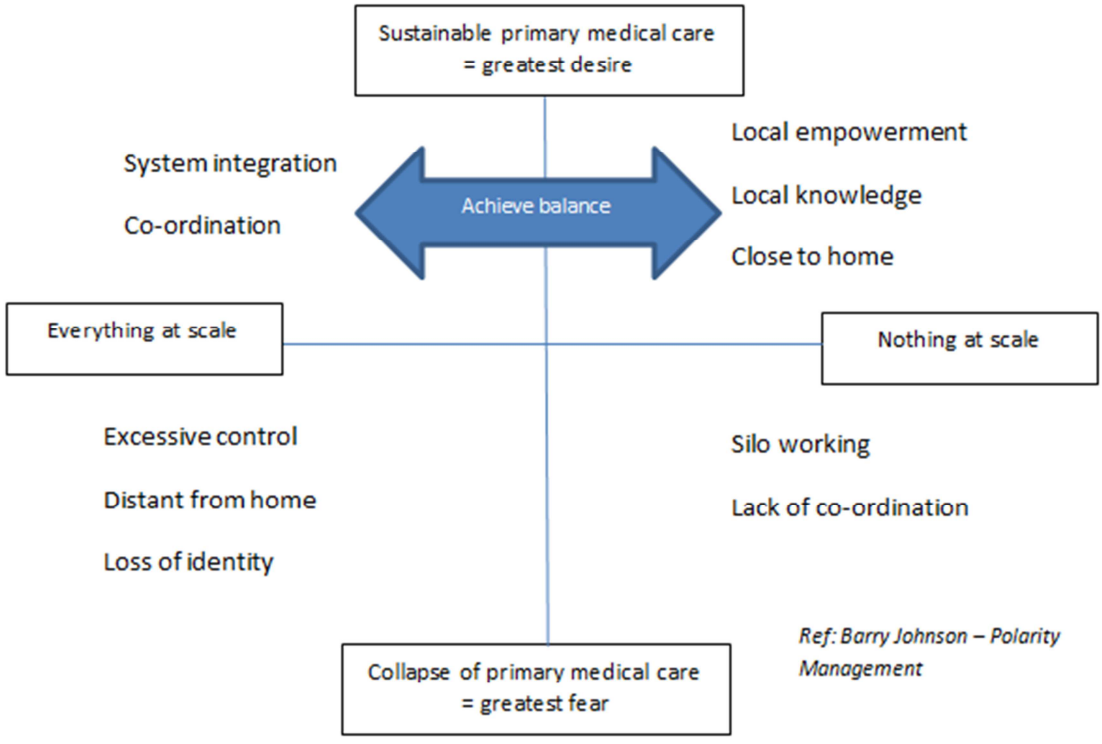
make any changes to the way they access and utilise services. We need to ensure that their experiences of the changes we are embedding are positive, so they continue to use them as they were commissioned, this experiential behaviour will be what facilitates a lot of the transformational change within the system.

3. End state

All of the information above highlights that we need to change our current system. If we do not, there is a very real risk that primary medical care will not exist in 2021 – that it will have collapsed. This is currently a possible future state due to increasing levels of demand, reducing numbers of professionals wishing to work in Bradford, unsuitable estate, financial pressures and an increasing number of complex patients all putting stress on a system that was designed over half a century ago.

Although this has not yet been seen across the full spectrum of primary medical care, there have been pockets of failure within the NHS where quality of service has severely deteriorated and systems fail. National examples include large acute trusts and although these are not primary medical care examples they are large systems of care and it is possible that similar failures could occur in Bradford if changes are not enacted.

To ensure future sustainability of primary medical care and therefore the wider health and social care system, we need to develop a model that will better meet the needs of the population of Bradford whilst at the same time be efficient and able to deliver high quality care. We need to do this via shared learning and use of best practice evidence, using both comparator sites nationally and local experience. As shown in the diagram below, there is a fine balance to be found between sustainability and failure and how healthcare is both delivered and received.



The CCGs want to establish a system that is efficient and has a collaboration of services, whilst keeping people at the centre with holistic care wrapped around them and a population that feels empowered. There is more work to be done in exploring the future model of primary medical care, in partnership with Bradford Care Alliance and YORLMC as the representative organisations of our

local providers. As commissioners, the CCGs wish to see by 2021 a delivery model of primary medical care that will:

- Build on the strengths of current services and deliver primary medical care at scale from individual and/or networks of practices so all patients have equity of service. Care delivery will continue to be based around the practice list but services delivered across aggregated list sizes of a minimum of 7500 will enable depth and sustainability to the workforce delivering the care. Networks will vary depending upon the service delivered, with some working across footprints of 30,000 – 50,000 while other, more specialised services being delivered across wider population numbers. For example, individual practices will continue to deliver long term condition management, while 7 day services and complex care services may be delivered across networks of 50,000.
- Be the bedrock of the ACS as we increase the breadth of primary medical care. Learning from American models[12] stress that primary care is the lynchpin of the model, with a focus on prevention and ability to manage long term conditions effectively.
- Include workforce roles that are not currently in place via local and national initiatives, including physician associates and medical assistant roles. This will be enabled through the establishment of a Bradford Primary Medical Care Academy (or similar). This will be supported by strong retention and skill development of all staff roles including increasing the number of professionals working in Bradford by providing a positive working environment.
- Deliver care from a reduced number of sites across Bradford as services will only be delivered from fit-for-purpose estate that also enables hub working. Hub working will be embedded and this will involve primary medical care delivering services together as well as working with other providers, e.g. community services, so seamless and holistic care is provided to the patient.
- Transform the role of GP as the sole referrer to other services. Many services will be commissioned so other health care professionals can refer patients and, where appropriate, patients will be able to refer themselves.
- Deliver care and enable access via technology which will be part of our core offer. This will be widespread across the system and will not just be operated in silos. All patients will be able to communicate with a member of the primary medical care team either face to face, over the phone, via video conferencing or via text messaging. This will offer patients the choice of how they wish to interact with primary medical care and create a flexible and adaptive service. The use of technology for self-care will also be the norm, as tools and telemedicine will be widely available.
- Be commissioned for outcomes, not for activity.
- Be sustainable via local and where appropriate national investment via a shift in resources to primary care.

Our end state has to include an improved experience for patients. Using direct patient feedback from a variety of sources (patient networks, complaints, People's Board, Survey Monkey) we want to move from the current patient experience to the future position, both outlined below.

Patient perspectives – current		
I need to call at 8am to make an appointment on the day	When you have family, caring responsibilities or young children, trying to make a morning call for an appointment is impossible	I don't feel I can plan ahead and get good advice so I wait till I am really ill
I'm not sure what the role of other practitioners are so I prefer to see the GP	I see a different person each time so I don't build a relationship or trust – this means I always opt to see a GP or even go straight to A&E	I will see a different doctor or nurse each time and have to explain my long term condition again or go through different treatment options because they don't understand my condition, my history and my circumstances and what support I really need.
I feel like I call NHS111 and then still need to go to my doctor for reassurance	The pharmacist is usually my last port of call	My GP practice does not feel welcoming
I second guess advice given by health professionals	If I can't see a GP, my only option feels like it is to go to A&E and wait	I don't think the professionals have time to communicate
I don't feel like the GP practice treats me with respect	I don't really understand why I receive the medication I receive	

Patient perspectives – future		
I can have the information and resources to understand my own health needs	I can manage my own appointments	I can see a practitioner who is familiar with my long term condition treatment and care plan
My family and carers are recognised as being key to my good health	I understand my treatment, condition and care options.	I feel confident and assured in the advice and care offered by my GP practice
I know in advance where I am going, what support and treatment I will be provided with and who will be my main point of contact	There will be friendly and welcoming people within the practice who can guide me to the best place to receive information and care	There will be more peer support options available

I will feel confident about the treatment and care given to me	My local pharmacist can offer more care and treatment options	The help, care and treatment I receive is given to me in a timely way
The service I receive is consistent and of high quality	There are wider choices to access help when I need it	My GP practice is linked to other health and social care services that I interact with – e.g. hospital care, school nurse and care homes.
There are opportunities for me to share my experiences and help other people at my practice through volunteering and getting involved	I can have access to the best person to help treat a minor or acute illness	When I move between practitioners for my care, the service can respond in a joined up way
I can access activities and services that support my well-being and good health		

We have tried to capture the varied and diverse nature of our population but we recognise that we will always need to check our engagement processes reflects our diversity as our population is always changing with new migrants, asylum seekers and moving population groups.

4. Vision, outcomes and key themes

To meet the case for change outlined above the **vision** for the Bradford CCGs' Primary Medical Care Commissioning Strategy is:

We will commission and deliver excellent primary medical care for all of the people of Bradford

The intended **outcome** of the strategy is:

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

The vision will be realised through the following key themes:

Improve access	• Accessible and appropriate primary medical care services for all patients both in and out of hours
High quality	• Consistent, high quality and safe care delivered to all patients
Workforce	• Sustainable, motivated, integrated and with the right skills
Self-care and prevention	• Empower and support people to take responsibility and control of their health and wellbeing
Collaboration	• Collaboration, across practices, with patients and with partners
Estates, finance and contracting	• Effective estates, finance and contracting models to enable integration and positive health outcomes

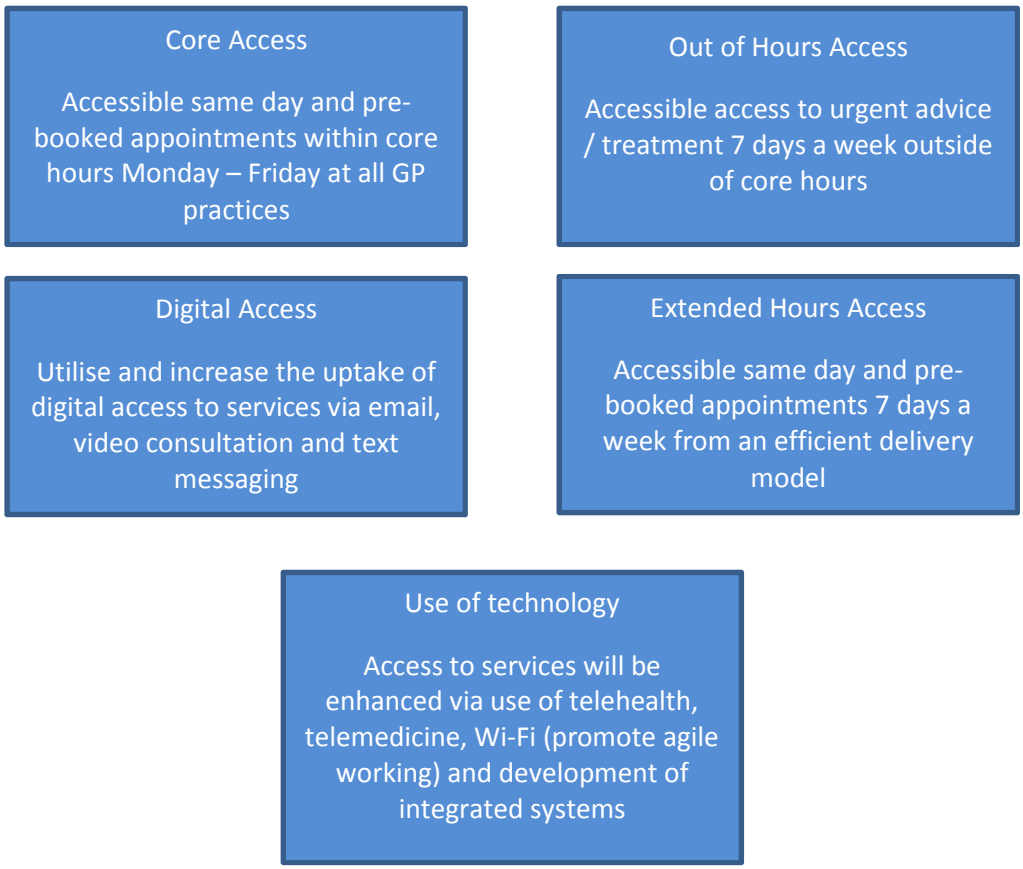
The challenge for primary medical care in the future years will be to work in collaboration with each other and also with other sectors to lay the foundation for total service transformation and the move to accountable care. We will need to break down existing boundaries and service models to deliver patient centred care regardless of the provider. We will need to explore new and innovative ways of delivering services whilst having a relentless focus on improving the quality of care for patients via reviewing, supporting, implementing performance management and shared learning, with the ultimate aim of continuous improvement.

5. Priority themes and key elements

This section describes the priority themes which will need to be addressed if the primary medical care elements of the out of hospital care system are to be transformed. Under each theme there are a number of key elements that will be addressed to deliver the vision of this strategy. Each theme will address how we will transform primary medical care services in the Bradford CCGs. It will aim to deliver this against a range of challenges from: unwarranted variation in quality, an ageing population, increase in co-morbidities, funding constraints, workforce changes, declining patient satisfaction and variation in the utilisation of secondary care. It is apparent that there are areas of overlap between the priority themes, so we need to implement the totality of the strategy to achieve our goals.

5.1 Priority Theme One: Improve access to primary medical services

Accessible and appropriate primary medical care services for all patients both in and out of hours



People should be able to easily access appointments both in and outside of core hours. (Core hours are Monday to Friday, 8am to 6.30pm). They should not notice the difference in quality or access to care depending upon the time or day that they need it. There should also be equity of access. In the future it will not matter where our population live or are registered within Bradford, they will have access to all of the same services. We will support this by working differently with our partners, especially the voluntary and community sector, that can provide relevant and needed services to patients outside of the medical model, thereby improving access to primary medical care services. This has become clearer in Bradford following the work undertaken on the Community Assets approach and published report. Work is ongoing to allow us to better realise the benefits and outcomes from this way of working. Improving access is seen as a key enabler to deliver other parts of service transformation such as the Keogh recommendations around urgent care[13]. To support this we will look at the additional elements of funding beyond core GMS/PMS to see whether this can be used differently to support access.

The current contract for our GP out-of-hours service will end in March 2019. Currently this is jointly commissioned across West Yorkshire, led by Greater Huddersfield CCG. Yorkshire Ambulance Service provides the service and sub-contracts the GP face-to-face element to Local Care Direct. The CCGs need to decide whether we will continue to work with the other CCGs in West Yorkshire to develop a sustainable commissioning model for future provision of the service or whether the development of an accountable care system will include this service for Bradford alone.

The CCGs want to ensure that an effective extended hours service is put in place which will support the implementation of the 7 day services agenda and meet the needs of patients, while at the same time it must be an efficient and sustainable model to run. Therefore we will explore the development of a collaborative hub model which will add resilience to smaller practices in the district while offering choice to patients which is in line with the direction set out in the GPFV[3]. This is not all about more GP appointments, but other healthcare professionals or partners, including nurses, mental health workers, clinical pharmacists, voluntary and community sector organisations. However, as well as offering patients choice and ensuring access is improved, we also need to work with patients around expectations as we are measured on how patients view services. We need to maintain high quality and accessible services, whilst sharing with patients what is possible within our resources. This may mean that patients may not always get what they want so we need to work with our populations regarding community and individual responses to health.

In order to support wider access to primary medical care, adoption of digital ways of working will be supported and will become part of our core offer. This will include digital access to prescription ordering, appointment booking, telephone and digital consultations (e.g. video consultations), and text messaging. We have already started this journey as all Bradford primary medical care practices have Patient Online enabled for use. This allows repeat prescriptions to be ordered online, online access to detailed information in patient records and appointments online. We will also access the national funding which is going to be made available from 2017/18 to support the adoption of online consultation systems.

Currently there is a discord between access and being seen (face-to-face). Through the use of technology the CCGs will embed a culture that doesn't equate access to being seen. Access can also be met virtually, by navigation, or the provision of information. This will take into account the accessible information standard, ensuring what we use is appropriate to the wide ranging needs of our population. The use of technologies will also improve access to services via the use of Wi-Fi to promote agile working of partner agencies and the use of telehealth and telemedicine to allow patients to better self manage their own conditions. This will not evolve without changes to the way we commission services, so we will explore the necessary models needed to commission 'virtual primary medical care services' and implement these over the next 5 years. The adoption of technology will allow flexibility to be built into the system as at the moment in many cases it is 'one size fits all'. In the future we will have a range of choices for our population, for example, a reminder text to take medication, a 2 minute phone call, or a 15 minute face-to-face appointment.

We also need to work with our primary medical care providers to reduce any unnecessary bureaucracy within services to increase the amount of time spent delivering patient care. For example, with the move to outcome based commissioning we could reduce some of the activity counting which currently takes place. This will not be easy, but we must establish what we can stop to enable more effective use of time.

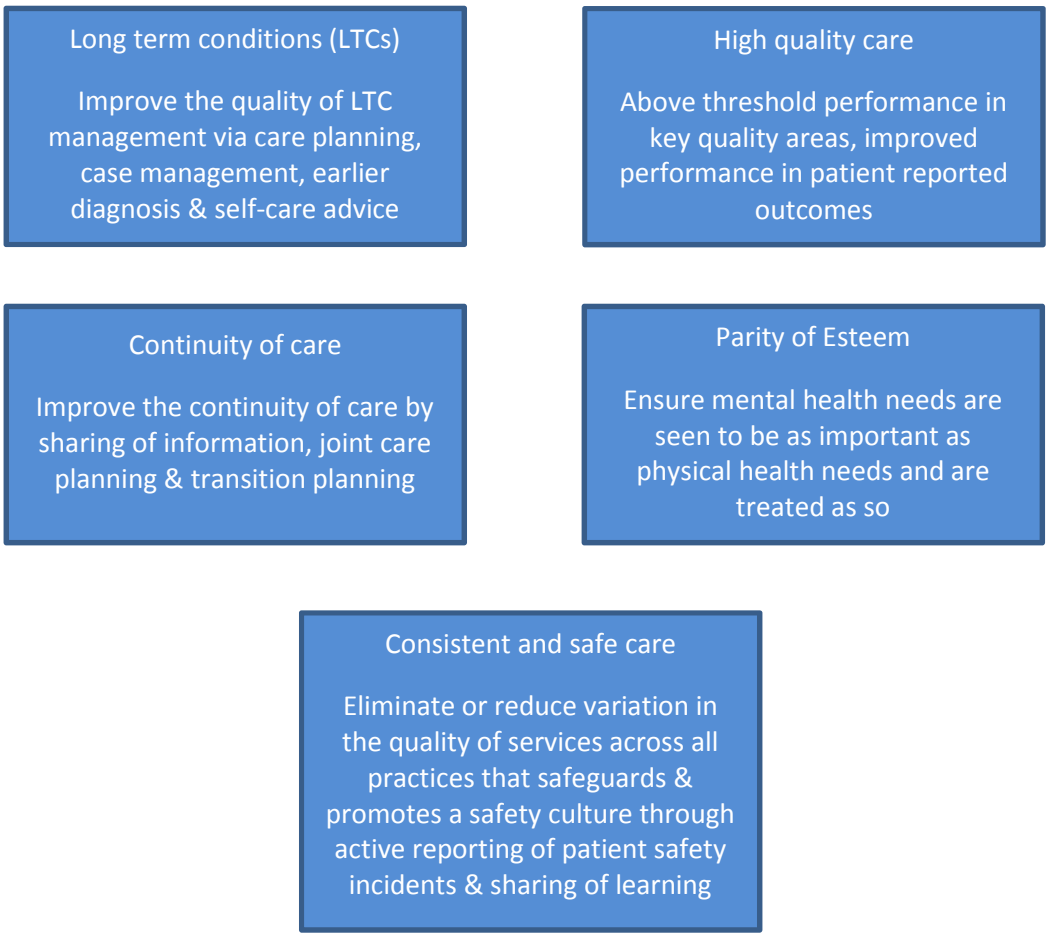
What we will do:

- **Develop an effective and efficient approach to extended access through collaborative hub working**
- **Increase the number of practices offering online booking of appointments and repeat prescriptions**
- **Support the roll out of email and video consultations by exploring and commissioning the concept of 'virtual primary medical care '**

- **Work with NHS 111 and Local Care Direct to improve access to GP out of hours in the short term, exploring direct booking into GP practices in hours and extended access appointments**
- **Establish the future of the out-of-hours service model post March 2019**
- **Ensure all patients have access to the same services, even if their own practice does not offer them**
- **Ensure that the primary medical care estate in Bradford has access to Wi-Fi to enable agile working from partner agencies**
- **Utilise technology to support people to manage their own conditions and maintain independence**
- **Ensure our providers maintain the Directory of Services to enable patients to be signposted to the right service at the right time**
- **Review the extended hours directed enhanced service and use of other funds (e.g. primary medical care element of system resilience funding) to support access to practices.**
- **Commit to reduce transactional bureaucracy to increase time available for patient care.**
- **Access national funding which will facilitate the adoption and spread of technologies.**

5.2 Priority Theme Two: High quality primary medical care

Consistent, high quality and safe care delivered to all patients



We want primary medical care providers to consistently provide high quality and safe care to the whole of our population. There have been huge improvements made in regards to improving quality over the last 10 years and this needs to continue. This will include ensuring the continuity of this care, especially in relation to working with other providers; patients who are transitioning between services and end of life care, ensuring patients' wishes are actioned whenever possible. We expect practices to participate in incident reporting to improve patient safety outcomes and be engaged in peer review to support a culture of continuous improvement.

Primary medical care is seen to be the cornerstone of health support for people with long term conditions (LTC). Not only in terms of its role in supporting people to manage their conditions, through personalised care planning, but also earlier diagnosis of LTCs; identifying health needs of their community ('risk stratification'); and ensuring that there are services in place to manage those needs (the commissioning role). The CCGs will work with practices and other providers to ensure appropriate pathways are in place which are commissioned based on outcomes and take into account our diverse populations and their cultural needs, care planning is embedded and training and development needs are met to reduce variation in delivery across Bradford.

High quality primary medical care requires medicines optimisation. This is a robust plan to integrate safe, cost effective medicines use into the commissioning of all services from development to

monitoring of outcomes in order to secure best possible benefits for patients from finite NHS resources. Medicines optimisation is defined as 'a person centred approach to safe and effective medicines use, enabling people to obtain the best possible outcomes from their medicines.'[14]

Medicines optimisation differs from medicines management in a number of ways but most importantly it focuses on outcomes and patients rather than processes and systems. This focus on improved outcomes for patients should help ensure that patients and the NHS get better value from the investment in medicines. It relies on a multidisciplinary team to work with the person to deliver the best possible outcomes.

Within Bradford this will require a shift in responsibility from the paternalistic approach of the former PCTs to a more interactive approach of the CCGs, working with all key stakeholders to develop and deliver the strategy.

From research it is clear that:

- Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need
- 30-50% of medicines are not taken as intended and that ten days after starting a new medicine 30% of patients will be non-adherent
- Sub-optimal use of medicines leads to extensive waste in the system and lost opportunities in improving health and morbidity
- Medication errors occur in up to 11 per cent of prescriptions, mainly due to errors in dosage
- Around 6.5% of all hospital admissions have been attributed to, or associated with, adverse drug reactions, with up to two thirds of these being preventable
- Adverse reactions are particularly common among vulnerable groups, such as, frail older patients in nursing homes
- In hospitals, the General Medical Council's EQUIP study demonstrated a prescribing error rate of almost nine per cent.
- Over half a million medication incidents were reported to the NPSA between 2005 and 2010. 16% of them involved actual patient harm.

High quality care for all means that we must close the health gap between people with mental health problems and those with physical health needs. Addressing mental health and psychological needs will improve the quality of life for the individual, and may also reduce the impact and costs related to 'physical' long term conditions, e.g. from chest pain, chronic obstructive pulmonary disease and diabetes. The cost of managing a patient with diabetes and co-morbid depression is 4.5 times higher than the cost of managing a patient with diabetes alone[15]. People must be assessed and treated holistically for their health problems, rather than providing separate services for physical and mental disorders. Psychological therapies are crucial to this. Contemporary western medicine is based on a tradition of treating mental health separately from physical health – a tendency to assume that diseases occur independently of social context. When mental health is treated as separate from physical health, the healthcare experience is often stigmatized and the care process is fragmented. Depression, the most common mental health condition seen in general practice, often occurs with, and compromises, care of other chronic illnesses; yet stigma and secrecy often cause depression to go undetected, undiagnosed, or under-treated. We will ensure that the outcomes defined as part of an ACS take account of individuals physical, psychological and care needs and mental health is equally as important as physical health. Through the delivery of the GPFV[3] we will take advantage of the extra 3000 mental health therapists which the document outlines will be in

place by 2020. The aim of these is to support localities to expand the Improving Access to Psychological Therapies programme.

Throughout our work to deliver the primary medical care strategy we will maintain close linkages with the mental health strategy for the district, as many of the actions taking place under its remit impacts on primary care. For example, the mental health strategy outlines that they will improve the knowledge and awareness of mental health within the primary care workforce to enable a more holistic approach to patient management. They also plan to develop a model of integrated physical and mental health services whereby people can have their care needs met at the same location as part of an agreed pathway of care, which will involve primary medical care services.

The CCGs will work with the Care Quality Commission to ensure that our primary medical care service providers meet their contractual and regulatory requirements. An open approach will be taken from the learning from this process and through the CCG's GP Joint Quality Group we will develop work plans for improving the quality of care delivered by primary medical care.

High quality care can only be delivered if the right information regarding patients is available to the right people. The need for a summary care record is imperative to this, providers either using the same system or ensuring interoperability between patient systems has to happen to enable this to occur. The Bradford Digital Roadmap outlines the key elements to this and this strategy will support the roll out.

The move towards an ACS will focus attention on high quality safe care, as this will be the most efficient and effective model. Primary medical care services are essential to this development and must engage to ensure the right outcomes for their patients are met through the new delivery model.

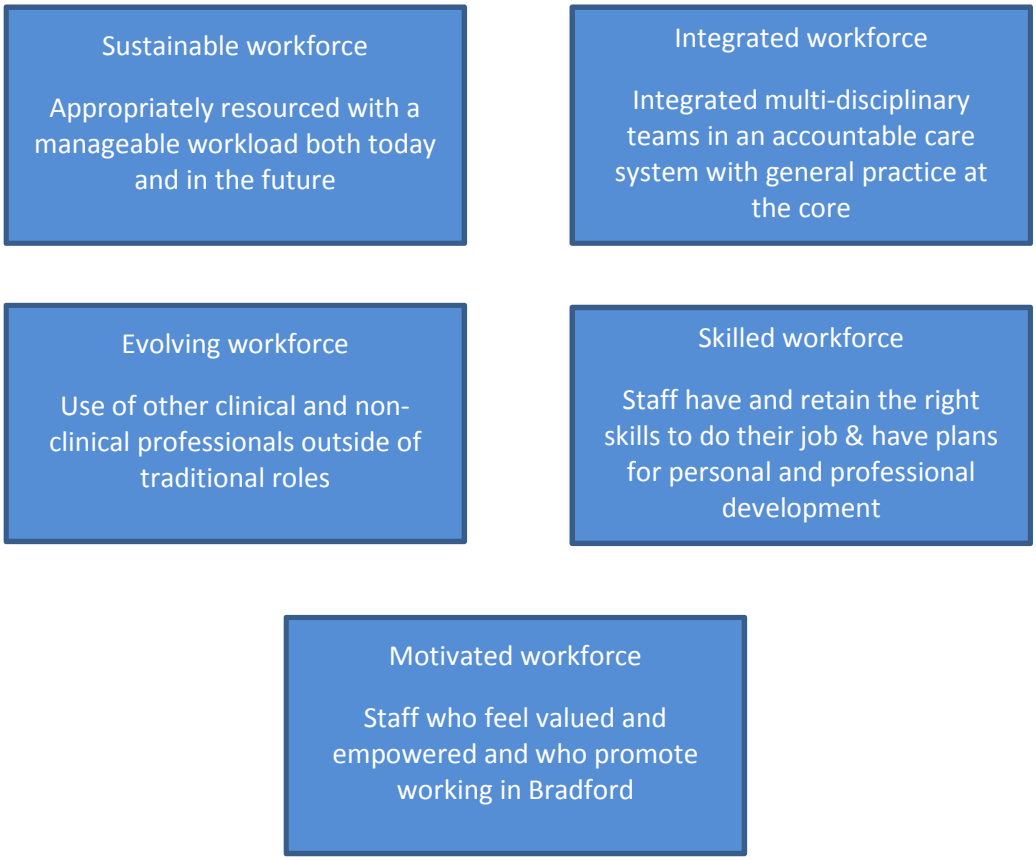
What we will do:

- **Provide opportunities for peer review and learning from other services**
- **Provide medicines optimisation opportunities within primary care, focussing on LTC**
- **Ensure all patients with an identified need for a care plan have one**
- **Commission pathways which support system approaches to the management of and early diagnosis of conditions and self-care management strategies**
- **Support the delivery of Parity of Esteem by commissioning services which ensure people are treated holistically for their health problems, linking closely with the delivery of the Mental Health Strategy**
- **Commission services which are outcomes based on evidence-based clinical guidelines/best practice**
- **Through the GP Joint Quality Group, develop a work plan to deliver against areas which need greatest improvement and/or have the highest unwarranted variation**
- **Use the contract assurance process to support reductions in variation and quality improvements, ensuring equality monitoring data informs this work**
- **Use the contract assurance process to support reductions in variation and quality improvements within prescribing**
- **Promote and establish a patient safety culture to ensure all practices report patient safety incidents and learning from incidents is transparently shared, including those of medicines safety**

- **Commission evidence-based support tools to use in primary medical care (e.g. Map of Medicine) to drive and support consistent, high quality care to deliver the best outcome for patients using the service.**
- **Maintain strong links with the mental health strategy and embed the actions relevant to primary medical care services.**

5.3 Priority Theme Three: Develop the primary medical care workforce

Sustainable, motivated, integrated and with the right skills



Workforce planning in the NHS states[16] that there are large data gaps on key areas of the workforce, particularly in primary and community care. This is in part due to the reluctance of many GPs to share workforce data with commissioners and workforce planners but, through our GP Joint Quality Group, we will encourage more practices to complete this tool to allow for more accurate succession planning in the future.

The total number of GPs in England has increased by 2.3 per cent, from 31,356 in 2010 to 32,075 FTEs in 2013, but modelling by NHS England and the Royal College of General Practitioners (RCGP) has demonstrated that this rate of increase will not even come close to meeting future demand (Health Education England 2015). To ensure a comprehensive picture is developed and to plan effectively for the longer term, the anticipated impact of retirements from service also needs to be taken into account. As part of our contract management, we will encourage all member practices to submit a full suite of workforce indicators so that we can plan more effectively for the future.

The Centre for Workforce Intelligence[3] has said that there is likely to be a significant undersupply of GPs by 2020 unless immediate actions are taken to redress the imbalance between supply and demand, as well as increasing training numbers for longer-term sustainability. Over the longer term, the rate of increase in the number of GPs has also been dramatically outstripped by increases in the medical workforce in secondary care. An indicator of this locally has been heavy reliance on locum GPs because substantive vacancies have not been filled which is especially the case with Bradford City CCG. Bradford Districts CCG has above the national average (England) of GPs per 100,000

population (53.21 compared to 51.20). However, Bradford City CCG is much lower with 43.81 GPs per 100,000 population. We have to make sure that our processes and pathways recognise the high locum use within Bradford. Often implementation of new pathways can be negatively impacted upon as we do not communicate these changes appropriately to locums. We need to work with our primary medical care providers to understand how we mitigate the risks around this. We need to understand how we improve our communication links from both the CCG and also internal mechanisms within primary medical care providers to ensure all staff groups are aware of our pathways and processes.

At face value, these workforce trends outlined above are at odds with the ambition of future care models to deliver more care in the community. To meet the CCGs' ambitions outlined in this document, the workforce strategy for primary medical care needs to be developed in the context of the wider health and social care system and in light of expectations of a greater use of community assets, workforce and role re-design to ensure the most effective use of the skills within the primary medical care team. This work also needs to take into consideration how we attract a workforce which reflects the diversity of our population.

One key challenge is to identify the best person to do the job, and this will not always be a GP. This can go against the expectations of patients, which is why the CCGs and the wider system need to work on the messages shared with our populations. We need to be clear that it is the right care that counts, not who is delivering it. This will be facilitated by some of the national initiatives outlined in the GPFV[3] including the mental health therapists and clinical pharmacists. The CCGs need to ensure that any relevant processes that are necessary for this are in place to take full advantage for Bradford.

The current way of working has been partly established as the GP is often the sole referrer to other forms of care e.g. outpatients. To facilitate better use of resources the CCGs will commission services in a way which unblocks this, for example via patients directly referring themselves, or for services to accept referrals from other health care professionals when appropriate.

We need to recognise that our workforce is the best resource we have available to us in Bradford and look to pioneering ways to attract, retain and develop it. This may need to be innovative, for example the establishment of a Bradford Primary Medical Care Academy and through apprenticeships, as Bradford is not always perceived as a positive place to work. The CCGs will explore the recruitment and retention opportunities outlined in the GPFV[3] including the NHS GP Health Service to support GPs and GP trainees who have mental health issues. We will also include bursaries to attract GP trainees and financial incentives for areas of greatest need. Skill development of new and existing staff is also key. The CCGs will continue to offer existing opportunities whilst utilising the national resources for reception and clerical staff, practice managers and practice nurses.

Our children and young people need to be aware of the variety of roles available to them, within primary medical care and the wider health and social care economy that are not only medical or nursing. We will also need to support and where necessary drive forward new models of primary medical care provision, beyond the list-based, practice-centred model which has predominated in the NHS since 1948. This is explored further under Priority Theme Five: Collaborative Working.

To achieve this, the CCGs and wider system will need to put more emphasis on leadership development and succession planning. The delivery of the strategy needs strong leadership to break down the silo working between organisations and inspire people to make the necessary changes to get the best out of our workforce.

What we will do:

- **Work as an active member of the Integrated Workforce Programme for Bradford District and Craven, taking a long term strategic view of workforce planning to ensure a primary medical care workforce that is fit for purpose for the future.**
- **Be ambitious and challenging about what the future primary medical care workforce should look like; developing a population centric model where the workforce is planned around the needs of the population and predicted demographic and disease management changes**
- **Take a long term view to raise the aspirational levels of young people to both want to train to work in the health and social care system, including primary medical care and to want to work in the Bradford District through schemes such as work experience and apprenticeships**
- **Develop the existing workforce to work in a system wide integrated way, across organisational boundaries**
- **Enable greater flexibility within primary medical care through recognising the unique skillsets of each profession within primary medical care whilst developing people to take on roles/tasks that can be carried out by others with the appropriate training. This may include working with our local training establishments to introduce new roles in primary medical care or the establishment of a Bradford Primary Care Academy**
- **Ensure staff and patients have the right skills to maximise and enable the use of digital technology to ensure the most effective use of time, people and finances**
- **Link with NHS England and Health Education England to benefit as much as possible from the national resources which are to be deployed on the back for the General Practice Forward View**
- **Where resources permit, commission and/or facilitate training and development to support the primary medical care workforce to develop their skills and knowledge in order to promote safe, effective, high quality service delivery**
- **Commission services and interventions which promote self management interventions to empower patients to become active in the management of their own care to reduce the need to see a health care professional**
- **Promote existing schemes that support recruitment e.g. training practices and retainer schemes**
- **Promote Bradford as a positive place to work, live and stay**
- **Encourage/incentivise practices to complete the Health Education England Workforce toolkit to provide reliable workforce data**
- **Commission services which unblock the role of GP as sole referrer to other services where appropriate.**
- **Put resources into leadership development for current leaders and succession planning**
- **Work with our primary medical care providers to establish better links with our locums to ensure pathways and processes are enacted fully across Bradford.**

5.4 Priority Theme Four: Promote self-care and prevention

Empower and support people to take responsibility and control of their health and wellbeing

Prevention System wide leadership and collaboration to drive healthy lifestyles, with a particular focus on children and young people	**Skill development** Ensure our workforce have the skills to educate and inform patients about self-care
People power Our population have the tools, techniques and confidence to aspire to live well	**New models** We commission new ways of providing and promoting prevention and self-care services to our communities

Self care and prevention is about people doing more for themselves, either with support or individually. The Self Care and Prevention programme works across all health and social care partners to promote the health, wellbeing and independence of people in Bradford using an asset based approach. To make this happen we plan to:

- Give people the right tools and resources to self care and live a healthy life
- Support health and social care staff with the skills to empower people they work with
- Make self care and prevention a priority across organisations and programmes

General Practice is overstretched and demand is growing with high numbers of patients seeking advice on social and emotional issues rather than medical problems. The Citizens Advice Bureau survey of 1000 GPs in February 2016[18] estimated that the financial cost to the NHS from non-health demand on GPs is at least £395m representing more than 5% of the NHS England budget for general practice and equivalent to the salaries of 3,750 full-time GPs and 19% of GPs consultation time. The report also shows that three-quarters of GPs say that the proportion of time they spend dealing with non-health issues as part of consultations has increased over the past year and this affects their workload and quality of life. Self Care and Prevention work can support General Practice to deal with some of this demand with solutions like social prescribing.

Bradford City and Districts CCGs have a number of innovative projects listed below which will transform how we deliver the self care and prevention agenda in Bradford:

1. **Social Prescribing** – a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'- so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector (VCS). We plan to

commission a new service in General Practice to support people with their social and emotional needs which will reduce pressure on General Practice.

2. **Workforce** – to deliver a range of learning opportunities to support staff to empower patients to self care. For example, motivational interviewing training and new training for reception staff and health care assistants on self care and active signposting.
3. **Self Care Hubs** – we plan to co-design and transform underutilised health and community centres to offer a wider range of holistic health and wellbeing activities and services. The Hubs will work with the voluntary and community sector, local people and self care initiatives such as social prescribing to connect health and care services together.
4. **Self Care Digital Solution** – develop a new tool to provide the public, patients and the health and care workforce with a simple and accessible online digital platform (app and website) to promote self-care and support people to manage their own health and wellbeing.
5. **Practice Health Champions** – creating a 'community centred practice' through volunteering and patient involvement. We have commissioned a further ten practices to implement the practice health champion model, which means we have a total of 21 practices delivering community centred practice and now Bradford is the largest City in the UK to deliver the practice health champion model.

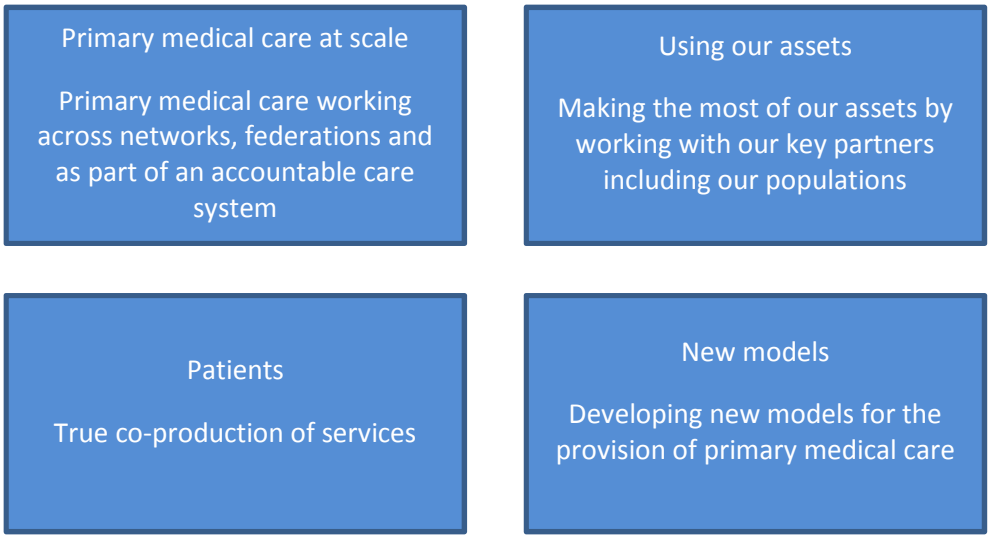
The full responsibility for self-care, health promotion and disease prevention does not solely rest with primary medical care, but it does have a key role to play. Every contact made by a member of the primary medical care team could include self-care advice and health promotion messages and appropriate risk assessments. Self-care empowers patients and allows them to take an active role in their own decision making, make informed choices, able to challenge and ask questions of health professionals supporting them with their care and to take responsibility for their health. The CCGs will also link in with the national programme to help practices support people living with long term conditions to self-care, as outlined in the GPFV[3].

What we will do:

- **Work with the Self-care and Prevention Programme to ensure that we align to the wider work happening across health and social care and to provide consistent messages about self-care to local people.**
- **Provide our workforce with the tools needed to promote self-care and accelerate positive behaviour change towards prevention and self-care in the population. This will include E-learning, self-care and active signposting and intensive motivational interviewing and behaviour change techniques.**
- **Ensure that self-care is embedded within care pathways which are delivered in primary medical care.**
- **Support the self-care and prevention elements that are driven from our strategic priorities and programmes.**
- **Support the development of primary medical care staff being advocates for well-being by providing key healthy lifestyle choices, including smoking cessation, weight management and reduction in alcohol consumption.**
- **Promote screening programmes – cancer and general health checks, to encourage earlier presentation and earlier diagnosis**
- **Commission preventative services**
- **Review the delivery of immunisation programmes, looking for gaps in provision and promoting centres of excellence.**
- **Promote self-care principles and techniques as the first choice of action for many health care concerns.**

5.5 Priority Theme Five: Collaborative working

Collaboration, across practices, with patients and with partners



Despite the strong worldwide reputation of UK primary medical care we need to support and where necessary drive forward new models of primary medical care provision, beyond the list-based, practice-centred model which has predominated in the NHS since 1948. This is because we – and many other NHS partners in England – do not believe that the traditional model is sustainable in the long term. We recognise that the future for primary medical care needs to be about collaboration, be that formally working together, or more informally, for example, sharing specific functions and reducing silo working. This is often described as primary medical care at scale.

This strategy is not promoting one single model for this, but is promoting a move away from the current establishment of small independent businesses working out of multiple sites, so we will work with our practices to support the evolution of a new primary medical care model. This does not mean that there will one model for primary medical care in Bradford in the future, but we have to ensure the sustainability of primary medical care. We will retain the list based model but we will commission services from single or aggregated lists of 7500 and above, to allow for depth and sustainability of practice. Practices will also work within networks and federations. Federations and other collaborative networks are an important way of enabling primary medical care organisations such as GP practices to provide a wider range of services, while at the same time offering the benefits of a smaller organisation, such as convenient location and continuity of care. For example, we will commission locality services across networks of 30,000 – 50,000 patients and more specialised services will be commissioned over wider footprints of 100,000 and above. Services such as extended access and GPs with specialist interest services will be commissioned at scale.

The above principle will be considered in relation to the CCGs' use of APMS contracts. In the past, when a provider has ceased working (for a variety of reasons) the CCGs have often re-contracted the service via APMS, but in the future the strategic aim of primary medical care at scale will be considered when the CCGs are considering the procurement of an APMS contract. This may include different contracting arrangements.

To ensure a model that is better placed to meet the needs of our local populations, both now and into the future, we will explore options for delivering primary medical care services in the most

effective and efficient way that best addresses the current and predicted workforce and demographic challenges we face. This needs to take into consideration the role of primary medical care in the development of an ACS in Bradford. We need to ensure that primary medical care is the bedrock to the ACS otherwise the system will not work. Primary medical care has to be able to collaborate to fulfil this. An ACS would not work if practices were disengaged or insisted on being represented as sixty plus separate voices as through accountable care the CCGs will be awarding single contracts through alliance agreements. We know that work is already underway in Bradford in regards to working differently with each other within primary medical care. Federations of practices are already providing services to their populations of patients, and the development of Bradford Care Alliance allows our federations to come together as 'one voice' when appropriate. This is happening as primary medical care providers are aware of the need to make their service sustainable in the long term and the CCGs need to support this as part of the move to accountable care.

A step within this will involve delegating resources to primary medical care providers operating at scale, therefore we will continue to work with our primary medical care providers in the development of the 'at scale' model. The CCGs believe the development of Bradford Care Alliance will support this and want to ensure that this is sustainable in the future. To support this primary medical care funding flows will change. For example, some of the national funding pots outlined in the next section could be delegated to either Bradford Care Alliance or federations rather than individual practices. This will change relationships with how providers of NHS services work together. It will reduce the need for competition and will allow an increasing focus on prevention and self-care, providing patients with the choice of how they manage and receive their care. This should also impact on workforce and demand, as the GPFV[3] states that 27% of appointments could potentially be avoided if there was more co-ordinated working between primary medical care and hospitals.

The CCGs have already invested resources into the development of the federated model within Bradford and to ensure that this model embeds into the system, resources will still need to be targeted towards supporting collaborative working. This will involve staff resource, as the CCGs move towards the ACS model, the way our staff work will also change, taking up provider facing roles as we take on tactical commissioning. There is also a need to support leadership development within the community, enabling grassroots development and change.

To support collaboration we will need to explore the issue of indemnity which has held back developments in the past. We will gain a legal understanding and solution to ensure any future service provision is not hampered by increasing indemnity costs of professionals seeing patients either out of hours or from other practices, whilst developing new contract models to support this process. The CCGs anticipate that the work being undertaken nationally to look at indemnity will support this but recognise that it may not cover all of the areas that we need as part of new models of delivery.

Primary medical care practitioners do not only need to collaborate with each other, they also need to collaborate with patients and patient representatives. We want to establish a true culture of co-production with patients and patient participation groups. We do not want to blame patients for living in high levels of deprivation, or having lower levels of educational attainment. Our populations are strong, cohesive and resilient and we want to build on this with the development of our health services. Getting true patient buy-in will be one solution to our issues and building the relationship between the practice and patients is key to this.

Our steps towards this have already commenced, but we have a long way to go. The CCGs have established The People's Board, an 18 member group of people with varied and significant experience and representation of our CCGs' populations who have a strategic and quality remit. This group has real influence over the CCGs' plans and proposals, which we aim to strengthen over time.

We want to move to a model where patients are involved in large decisions (e.g. service redesign), but also smaller scale change (e.g. practice appointment changes). This happens in pockets across Bradford currently, with some practices heavily bought into co-production involving their patients in all elements, even the colour of their walls. However, others have yet to arrive at this point. We want to support practices and patients to get the most out of their Patient Participation Groups (PPGs), we want them to see them as something they want to do, rather than have to do. (They are a contractual requirement).

As well as the individual patient voice which is represented well through PPGs and other sources of patient feedback (e.g. NHS Choices, complaints and compliments) we need to better engage our populations and communities. A strong way to approach this is for primary medical care and the CCGs to work more collaboratively with our voluntary and community sector (VCS) providers. VCS organisations have a great and in-depth understanding of the communities and populations that they work with. They are able to represent the 'whole' of these groups, rather than individual voices which often come through our other channels which has become more apparent through the recent community assets work. This is a significant asset and over the next few years we need to establish new ways of working to ensure that we hear these voices and engage with VCS organisations as we change. This will be aided by the funding provided to the VCS sector by the CCGs to support their organisational development towards an entity that can offer one voice across the sector.

Another relationship we need to develop and collaborate with in the future was highlighted clearly by our member practices at engagement events – that of schools and education. As well as encouraging our youth to become the future workforce of health and social care in Bradford, we need to work with our children and young people to promote self-care, resilience and prevention. We believe that starting this education at an early age would be one of the most effective ways to reduce pressure on our services in the future and result in the most appropriate use of our resources. We will work with our Local Authority and Public Health partners on this.

It is important to note that collaboration itself is not an end state – it is an enabler to allow transformation to happen.

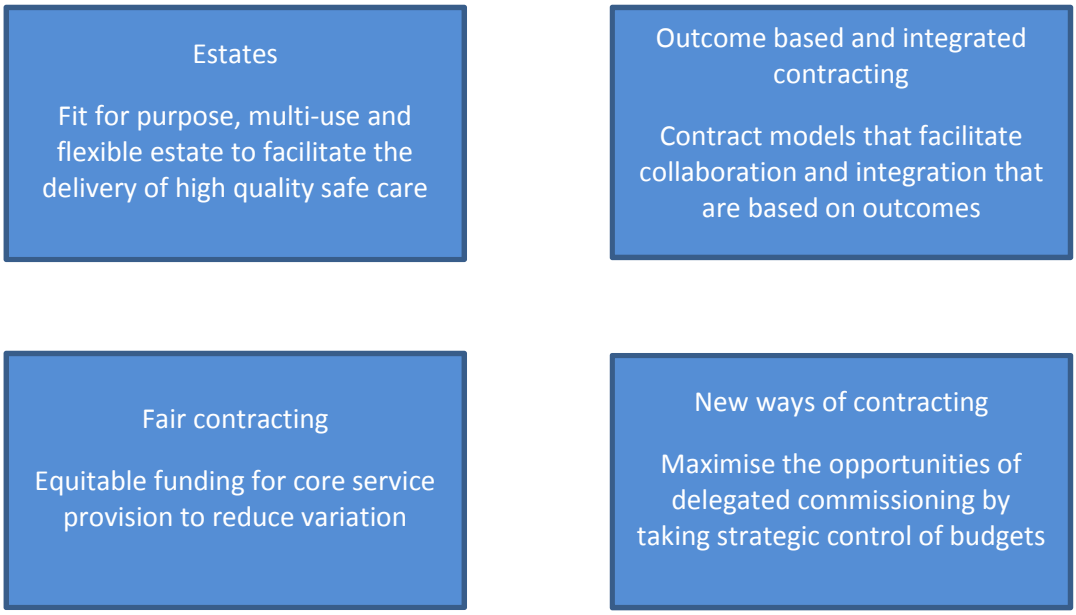
What we will do:

- **Through our commissioning processes we will increase the level of patient engagement in service design and primary medical care decision making which is inclusive and reflects our local population**
- **Put in place processes (including funding) to actively support the delivery of primary medical care at scale**
- **Have commissioning strategies that positively encourage networks of practices and stakeholders as providers**
- **Consider this strategy in the future of primary medical care contracts**
- **Ensure primary medical care services are the foundation of an accountable care system**
- **Support the development of the Voluntary and Community sector to engage as one voice across the system to support improvement**

- **Through a thorough understanding of relevant regulatory and legal frameworks, provide solutions relating to indemnity in respect of working outside of core hours and providing care for patients registered at other practice**
- **Working with the Local Authority and Public Health, establish formal links with education providers and others to bring health messages and health education into schools and colleges to encourage children and young people to consider future working in the health and social care sector of Bradford**

5.6 Priority Theme Six: Estates, finance and contracting

Effective estates, finance and contracting models to enable integration and positive health outcomes



To enable primary medical care services to deliver high quality safe care now and in the future, the infrastructure supporting these services needs to be right and fair. Having fit for purpose estate is key to this, and this strategy sits alongside the Bradford District and Craven Interim Estates Strategy which highlights the importance of ensuring primary and community care estate meets the needs of the population. We must stop investing funding in estate which is no longer fit for purpose or provides identical services within a very small geographic area, but instead we will look to rationalise our estate, investing in buildings and infrastructure that can support high quality service delivered at scale. This will involve reducing void and underutilised space, and will see the closure of some of our estate, either as services change or we move services into more suitable estate. This will not just be limited to primary medical care services. We will look to closer working through hub development with other services through better use of our estate. We recognise that this may go against the wishes of our population, as many people look for convenience in regards to accessing primary medical care. However, the CCGs believe in the importance of having estate that has the facilities to enable the delivery of high quality care and will continue to follow processes to access national funding as it becomes available.

This will be further facilitated by the widespread adoption of technology. As outlined in Priority Theme One, the use of technology will alter the way our populations access services and the way staff across the health and social care system deliver care. For example, installation of Wi-Fi in practices will enable patient access to their own records and staff to work flexibly across sites. These changes will benefit both our populations and our staff, improving the experience of both the delivery and receipt of primary medical care.

To undertake real transformational change we will look to different ways of contracting and commissioning. We will maximise the opportunities placed before us via delegated commissioning, with primary medical care leading the way and shaping the new models of care that we plan to deliver. This will be key in the accountable care system, where a new contracting model can provide

the opportunity to work collaboratively around workforce, service delivery and the holistic care of patients. Through delegated commissioning we can use primary medical care resources differently, focussing on the delivery of our strategic priorities and to build in the sustainability of primary medical care. We will use our delegated responsibilities to ensure that practices are treated fairly in regards to contracting discussions. We will follow agreed policies regarding list closures, list reassignments and boundary changes. We will make sure no patient or patient group is disadvantaged, ensuring patients always have a choice of where they register to receive primary medical care services.

As well as primary medical care contracts, we need to ensure that benefits from other contracts are being utilised. For example, the changes to the NHS Standard Contract for hospitals will reduce workload within primary medical care. This will be seen via reduced referrals back to GPs when hospitals undertake internal referrals or 'do not attends' and ensuring patients have a minimum of 7 days medication (unless a shorter period is clinically appropriate). Primary medical care providers should inform the CCGs if they feel these processes are not being followed.

The CCGs will stop commissioning short term projects which cease when the funding runs out. Instead we will commission with conviction, building exit strategies into contracts in case they are needed, but have contracts that will allow time for new services to embed and deliver. We need to have the confidence to invest where we believe the greatest improvement in outcomes for our population will be and put in place the systems to show the impact and outcomes of the services.

We will continue the drive towards outcome based commissioning. This is an important aspect of improving the quality of care delivered to our patients. We need to know what the impact is on the services we deliver and, if they are substandard, we must either build in service improvements or decommission and re-procure a service that will deliver the outcomes we need. Gone are the days of activity counting in primary medical care. The CCGs expect high quality outcomes from our services and our future contracting approach will be a vehicle to deliver this. We will also use our delegated commissioning powers to ensure high quality and safe core primary medical care services are delivered. Where resources permit, we will work with practices to support the delivery of great care through commissioning and/or facilitating education and training, but if there are quality or contractual concerns these will be managed via the Contract Assurance Group. Practices will be supported to improve, but if it is found that this is not possible then contractual levers (e.g. breach notices) will be utilised as high quality care for our patients is paramount.

We will implement the outcomes of the equitable funding review without destabilising primary medical care, whilst improving the service offer. We will ensure that the resources we have are fairly distributed to reduce unwarranted variation and health inequalities. To further support practice sustainability, the General Practice Forward View assumes additional investment from CCG allocations into primary care over the period to 2020/21. Taken together with increases in allocation for primary care and central investment in general practice, it is expected that the overall share of the NHS budget going to primary care will increase over the period to over 10%.

As outlined in the GPFV we are planning to spend approximately £3 per head (totalling £1.4m non recurrently locally) across 2017/18 and 2018/19 for practice transformational support, set out in the General Practice Forward View. The investment will be used to support the roll out of extended access across both of the Bradford CCGs. As part of the West Yorkshire Urgent and Emergency Care Acceleration Zone the roll out will be accelerated and the £1.50 in 2017/18 will be used to commission services (likely via hubs) across the patch. Initial delivery will be from April 2017 and this will be expanded in 2018/19 with the use of the £3.34 from national funding, plus the £1.50 from

the CCGs. Both CCGs have already provided financial resources to support the development and maturing of the federated approach being taken forward by practices in Bradford.

The detail behind these plans has yet to be established, as this is not new funding so the CCGs need to identify the service areas that this money will be taken from. It is anticipated that some of this may come from reducing activity in the acute care sector, but final plans have not yet been established and this work is underway. It must be recognised that this will not be easy in Bradford, as primary medical care services in Bradford are in a different position currently to many other areas nationally. The concept of a GP with Special Interest (GPwSI) was established in Bradford, and there has been a long history of investment within primary medical care. Developments and investment have meant that there has been an acute care to primary medical care shift taking place over the last 20 years, so many of the changes taking place elsewhere in the country have already happened in locally which will make further change more difficult.

The CCGs also plan to access and utilise national funding streams:

- Vulnerable practice scheme: We are in discussions with NHS England in regards to 5 practices which we feel would benefit from access to the vulnerable practice funding currently. We recognise that this funding allocation has now been committed so there will be no further opportunities to access this.
- Online general practice consultation software systems: Bradford Districts CCG expects to receive £88,661 in 2017/18 and £118,104 in 2018/19 to support the role out of this work. Bradford City CCG expects to receive £32,025 in 2017/18 and £42,618 in 2018/19. The CCGs will be clearer on the detail of the work to be done on publication of the national specification and monitoring arrangements but expect this to be non-recurrent.
- Training care navigators and medical assistants: Bradford Districts CCG expects to receive £59,107 in 2017/18 and £59,052 in 2018/19 to support the role out of this work. Bradford City CCG expects to receive £21,350 in 2017/18 and £21,309 in 2018/19. The CCGs will be clearer on the detail of the work to be done on publication of the national specification and monitoring arrangements but expect this to be non-recurrent.
- General practice resilience programme: We recognise that this funding will be delegated to local teams. A number of our practices have self referred against this funding pot and we will work with NHS England to identify those who will receive support as we believe there is a great need for this investment within Bradford. We would like to see West Yorkshire wide work being taken forward around workforce, including baseline information collection. On a local footprint we would be keen to utilise this funding to support the development of local sustainability initiatives, such as a local locum bank which all practices could utilise.
- Estates and Technology Transformation Fund (ETTF): Bradford Districts CCG submitted 8 schemes against the ETTF, 7 of these are being taken forward into the next stage. All 7 of these relate to improving GP premises to allow for better patient experience and improving patient access. The technology bid aims to provide the public, patients and the health and care workforce with a simple and accessible online digital platform to promote self-care, support people to remain independent and to manage their own health and wellbeing. Bradford City CCG submitted 6 schemes, 3 of which have been taken through to the next stage. These are a mix of estate and technology proposals, and go beyond improvements to GP estate. These include the establishment of self care hubs and the roll out of WIFI in GP

practices to support both patients and flexible working for community staff. We will work with the national team to undertake the work needed to further all of these proposals.

- Reception and clerical staff training and online consultation systems: The CCGs have received the first allocation of this funding and we have plans are in place to roll out training from January 2017. The plans for the existing and future allocation have been developed in conjunction with general practice and in the first instance are looking at 'signposting with confidence' training for receptionists.
- International recruitments: Bradford City CCG looks forward to receiving further information this year regarding international recruitment as the CCG would benefit from the recruitment of new doctors. The national average (England) of GPs per 100,000 population is 51.20, while this is much lower in Bradford City with 43.81. Therefore, the CCG will look to work with NHS England to benefit from the international recruitment that they lead.
- Additional roles in general practice: Both CCGs will work with NHS England in regards to establishing additional clinical pharmacists and mental health practitioners in general practice and will await the production of further information.

What we will do:

- **Reduce the amount of void and underutilised primary medical care estate across Bradford.**
- **Stop investing funding in primary medical care estate that is no longer fit for purpose and facilitate the relocation of these services to underutilised estate elsewhere in Bradford.**
- **Explore and adopt new contracting approaches to support the integration of services**
- **Adopt outcome based commissioning to ensure our patients receive high quality services**
- **Manage any primary medical care contract concerns via the Contract Assurance Group, supporting practices to meet the terms of their contract.**
- **Use contract levers where required to ensure high quality care for their patients, ensuring primary medical care providers are aware of how they can feedback to the CCGs if the changes to the NHS Standard Contract are not being delivered.**
- **Implement the outcomes of the PMS equitable funding review and ensure that the extra contractual service offer is made to all patients**
- **Access national funding where possible to support primary medical care sustainability**
- **Identify £3 per head investment over 2016/17 and/or 2017/18 to support practice transformation**

6. Expected benefits and local metrics

It is anticipated that the strategy will deliver the following benefits:

- improved patient experience and outcomes;
- improved access to primary medical care;
- equality of service;
- improved quality of services;
- better health outcomes within a sustainable workforce and financial envelope;
- improved ability to meet and sustain nationally and locally agreed targets;
- reduced health inequalities; and
- enhanced patient engagement.

To determine whether the strategy is delivering the expected benefits a number of local metrics will be used as key indicators of success, they are the 'measures that matter'. The proposed key metrics to monitor the achievement of the strategy can be seen in Appendix 2.

We also need to understand the impact of the changes implemented through this strategy on the wider health and social care system. Work is underway across all of the CCGs' transformational programmes to explore how this can be done. The CCGs need to be sure that the impact of, for example, any workforce decisions, is not to the detriment of another service area. The development of the accountable care system should support this, as any changes elsewhere should be easier to identify when working as one system.

The delivery of this strategy will also support the achievement of our STP and the local delivery of the GPFV[3]. The different areas of focus outlined in this strategy all align with elements of the GPFV[3] and support the closure of the health and wellbeing gap, care and quality gap and the finance and efficiency gap, as seen in Appendix 3.

7. Enablers

To ensure the roll out and success of this strategy there are a number of enabling factors which are outlined below.

Enabler	Expected strategic benefit
Whole system commissioning	Contracting decisions that support integrated working and delivery of services across networks and promotion of outcome based provision Local incentive schemes that promote economies of scale Assessment of APMS contracts , outcomes to support delivery at scale and flexible workforce models Local enhanced service provision that improves the offer to patients, that are list based and reduce the variability of offer.
Better use of IT	Widespread adoption of modern technology to make health and care services more convenient, accessible and efficient. For example increasing the uptake of telehealth, telecare and telemedicine.
Engagement and co-production	Making the most of our community and population assets by involving them in decision making
Optimal use of medicines	A strategic shift from medicines management towards medicines optimisation with the patient at the centre of all discussions. Reduction of waste within the system, and focus on high quality cost effective prescribing.
Quality and assurance	To ensure the delivery or safe, effective cost effective care, the setting and monitoring of quality standards in healthcare must be underpinned by an effective partnership between CCG and providers.
Leadership	To ensure delivery of this strategy we will need strong leadership to drive it forward. This is not only strategic leadership at CCG level, but leads within primary medical care and within other partner agencies. There has to be a drive and desire to want to change.

8. Governance and Engagement

Governance

This Primary Medical Care Commissioning Strategy will be owned by the Clinical Boards of Bradford City CCG and Bradford Districts CCG respectively. The Out of Hospital Programme Board will oversee the delivery and the Out of Hospital Engine Room will be responsible for its implementation.

Engagement

There has been continuous engagement with our stakeholders throughout the development of the Primary Medical Care Commissioning Strategy via the:

- Governing Body (City and Districts)
- Practice Quality Improvement Group (City)
- GP Performance and Quality Improvement Group (Districts)
- Primary Care Commissioning Committees (City and Districts)
- Out of Hospital Programme Engine Room/Programme Board
- Learning and Development Groups (City and Districts)
- The People's Board
- Healthwatch/Patient Networks/Practice Participation Groups
- YORLMC Ltd
- Bradford Care Alliance (CIC)
- Health and Social Care Overview and Scrutiny Committee
- Integration and Change Board
- 4 week public consultation and engagement exercise

GP Practice Engagement

As providers of primary medical care and members of the CCG, it was vital to get good engagement from all GP practices in Bradford City and Bradford Districts. A number of approaches were taken to ensure that GP practices in both CCG's had opportunity to have their say, including: -

- Clinical Board discussions
- Chatter Group discussions
- Council of Representative discussions
- Council of Member discussions
- Joint Clinical Board and Governing Body discussions
- GP engagement events
- Clinical Commissioning Forums

This engagement with member practices will continue through the implementation of the programmes of work that are defined within this strategy predominantly through the Out of Hospital Programme, but also via other programmes, including Self-care and Prevention, Planned Care and Urgent and Emergency Care.

Patient and Public Engagement

The Bradford CCGs have fully committed to engaging patients and the public in all aspects of our work priorities. This has been embedded within our various engagement programmes so that patients, service users, carers and the public are involved in developing future service models through a range of engagement activities, from individual patient stories to patient networks and events. We will focus on ensuring that this engagement continues and is representative of our local populations and is provided in a variety of formats to ensure we meet the accessible information standards.

A variety of different approaches to engaging patients and the public have been taken. These included:

- Using existing patient networks and groups, using feedback from previous events
- Healthwatch Report – Invisible at the desk[19]
- Patient participation groups
- Grassroots process

As with member practices, engagement with patients and public will continue through the future implementation phases and structured collaboration. Where there are potential service changes patients will be engaged in the process and be involved in co-production of key work priorities. Consideration will be given to the impact on patients and our populations in regards to any changes made, especially relating to protected groups.

9. Summary

By 2020/21 via the delivery of this primary medical care strategy we envisage the primary medical care services in Bradford will:

- Be delivered via primary medical care at scale by a mixture of independent practices, networks and federations as part of an accountable care system operating out of hubs, co-located and collaborating with other relevant services 7 days a week. As well as NHS and social care providers this will also include VCS organisations.
- Regularly use technology for all elements of patient care including access, consultations, telehealth and telemedicine.
- Have established new roles and new ways of working, including 'virtual primary medical care', shifts in traditional roles and responsibilities and that Bradford is 'The place to be'.
- Have better demand management, as patients are empowered and experienced in self-care and preventative services are embedded within the accountable care system.
- Have strong embedded relationships with education, paving the way for increased levels of self-care and a workforce who choose to work and live in Bradford.
- Have equality of care for the whole population. Wherever people live or are registered within Bradford, they can access the same services.

10. Appendices

Appendix 1 – Glossary

ACS	Accountable Care System	Care system to improve health of a whole population across community and hospital care, physical and mental health. Focus is on outcomes and joined up health & social care services that simple, accessible and responsive to needs. Care is personalised using community assets and agreed payment schemes to support joint commissioning.
ADPD	Allocations Development Plan Document	The ADPD supports the delivery of the Core Strategy. It allocates specific sites to meet needs for housing, employment, education, shopping and open spaces in Bradford District.
ANP	Advanced Nurse Practitioners	An ANP makes autonomous decisions for which they are accountable and receive patients with undifferentiated and undiagnosed problems, make an assessment of health care needs and prescribes accordingly.
APMS	Alternative Provider Medical Services	A contracting route available to enable CCGs to commission or provide primary medical services within their area to the extent that they consider it necessary to meet all reasonable requirements.
AQP	Any Qualified Provider	CCGs determine the services to be commissioned as AQP; the intention is to increase patient choice. All providers must meet the qualification criteria set for a particular service and once qualified their service will appear on choose and book for patients to select.
BCA	Bradford Care Alliance	A Community Interest Company (CIC) established in June 2016. Represents the provider voice of the vast majority of member practices across Bradford.
BBB	Bradford Breathing Better	A CCG programme to raise awareness about respiratory issues such as asthma, COPD etc.
BDCfT	Bradford District Care Foundation Trust	Provider of mental health, learning disabilities and community health services across Bradford, Airedale and Craven.
BHWB	Bradford Health and Wellbeing Board	The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. As a result, patients and the public should experience more joined-up services from the NHS and local councils.
BMDC	Bradford Metropolitan District Council	Provider of social care, reablement and rehabilitation services, public health services across Bradford and Airedale.

BPA	Bradford Provider Alliance (working title)	Formal group of providers who are working together under the BPA title. Group includes BTHFT, BDCFT, BCA, BMDC and VCS organisations.
BPMCA	Bradford Primary Medical Care Academy	BPMCA or something similar to be developed to help workforce roles that are not currently in place via local and national initiatives, including physician associates and medical assistant roles.
BSL	British Sign Language	BSL is a visual means of communicating using gestures, facial expression, and body language. Sign Language is used mainly by people who are Deaf or have hearing impairments.
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust	Hospital trust made up of Bradford Royal Infirmary (BRI) and St Luke's Hospital. Key provider of hospital services locally.
CAB	Citizens Advice Bureau	Provider of free independent advice and advocacy services.
CB	Clinical Board	Responsible for leading and setting the vision and strategy, developing commissioning plans and overseeing the commissioning process across the CCG.
CCF	Clinical Commissioning Forums	GPs and Practice Managers attend these meetings and get involved in the work of the CCG.
CCG	Clinical Commissioning Group	Established in 2013 with Clinicians at the heart of decision making. CCGs responsible for commissioning health services: - Bradford City CCG made up of 27 member practices and 124,000 registered patients - Bradford Districts CCG made up of 40 member practices and 339,000 registered patients
CIC	Community Interest Company	A CIC is a type of company introduced in 2005 under the Companies Act 2004 and is designed for social enterprises that want to use their profits and assets for the public good.
CoM	Council of Members (Bradford City CCG)	Main GP forum within the CCG and is responsible for agreeing the vision, values and overall strategy of Bradford City CCG.
CoR	Council of Representatives (Bradford Districts CCG)	Main GP forum within the CCG and is responsible for agreeing the vision, values and overall strategy of Bradford Districts CCG.
CQC	Care Quality Commission	Independent regulator of health and adult social care in England. The CQC makes sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve
DES	Directed Enhanced Service	Directed Enhanced Services (ES) require an enhanced level of provision above what is required under core GMS

		contracts. Commissioners taking part in the ES ensure they have read and understood the requirements in the Directions and NHS England service specifications, as well as the guidance provided.
EFR	Equitable Funding Review	In January 2014, NHSE agreed that the current funding arrangements for General Medical Services (GMS) and Personal Medical Services (PMS) practices would be reviewed with a view to addressing the wide variation in core funding per patient and to ensure that funding.
GB	Governing Body	Responsible for ensuring that the Clinical Commissioning Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically.
GMC	General Medical Council	Regulator of the medical profession. Its purpose is to protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of medicine.
GMS	General Medical Services	The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. NHS Employers leads negotiations with the General Practitioners Committee (GPC), which is part of the British Medical Association (BMA) on changes to the GMS contract.
GP	General Practitioners	A Doctor who works from a local surgery or Health Centre. Most are independent contractors providing services to patients through a contract with the NHS.
GPFV	General Practice Forward View	NHS England document which 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.
GPPQIG	General Practice Performance and Quality Improvement Group (Districts)	The GPPQIG is a sub-committee of the Primary Care Commissioning Committee and contributes to ensuring the achievement of the CCG strategy and fulfilling the duty of the CCG in relation to the quality of primary medical services. (Also see Primary Care Commissioning Committees - City and Districts)
GPwSI	GP with Special Interest	A GPwSI supplements their role as a GP by providing an additional service while still working in the community as a GP.
HCA	Health Care Assistants	HCAs are a vital part of any practice, hospital or care setting nursing team.
HEE	Health Education England	HEE was established to support the delivery of healthcare and health improvement to the patients and public of England by ensuring that the workforce has the right numbers, skills, values and behaviours, at the right time

		and in the right place.
HF	Healthy Futures	The CCGs of West Yorkshire and Harrogate and Rural District have agreed to work collaboratively under the Healthy Futures banner. Initially work is focussed on cancer, urgent and emergency care and mental health.
ICB	Integration and Change Board	Partnership between health, social care and the VCS to promote integration. The ICB oversees a portfolio of programmes.
JCB	Joint Clinical Board	Combination of the Clinical Boards for Bradford City & Bradford Districts CCGS.
LCD	Local Care Direct	A community owned healthcare provider delivering a wide range of NHS services 24 hours a day, 365 days a year. Current provider of out-of-hours services across West Yorkshire.
LES	Local Enhanced Service	Schemes agreed by CCGs in response to local needs and priorities, sometimes adopting national service specifications.
LMC	Local Medical Committee (also see YORLMC)	A LMC is a statutory body in the UK. LMCs are recognised by successive NHS Acts as the professional organisation representing individual GPs and GP practices. The NHS Act 1999 extended the LMC role to include representation of all GPs whatever their contractual status.
LTC	Long Term Condition	Long Term Condition is defined as a condition that cannot, at present be cured but can be controlled by medication and other therapies. Examples of Long Term Conditions are diabetes, heart disease and chronic obstructive pulmonary disease. There are 15.4 million people living with a long-term condition in England.
NHSE	NHS England	NHSE leads the National Health Service (NHS) in England and sets the priorities and direction of the NHS. It also encourages and informs the national debate to improve health and care.
NPSA	National Patient Safety Agency	The NPSA leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector. It is an Arm's Length Body of the Department of Health and through its divisions covers the UK health service.
OHP	Out of Hospital Programme	New programme that has embarked on a structured collaborative approach for services outside of hospital (community services). It's vision is "*I can plan my care with people who work together to understand me and my carer, allow me control, and bring together services to achieve the outcomes that are important to me'*
PCCC	Primary Care Commissioning Committees (City and Districts)	On 1 April 2015, the CCGs accepted full delegated responsibility from NHS England to commission GP primary care services. The PCCC make decisions on the

		review, planning and procurement of primary care services.
PG	Protected Groups	Nine groups covered by the Equality Act 2010 - Age - Disability - gender reassignment - marriage and civil partnership - pregnancy and maternity - race - religion or belief - sex - sexual orientation
PMS	Personal Medical Services	Locally agreed alternative to General Medical Services (GMS) for providers of general practice, which offers greater flexibility for the GP. PMS agreements aim to improve access to and the quality of services within primary care, recruit and retain GPs in areas of greatest need, develop new ways of delivering services, and help integrate services.
PQIP	Practice Quality Improvement Group (City)	PQIG was established in September 2013. The role of this group is to support our member practices in improving the quality of primary medical services that they deliver through leadership and skills development. (Also see Primary Care Commissioning Committees - City and Districts)
PSED	Public Sector Equality Duty (Equality Act 2010)	The Public Sector Equality Duty requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.
QOF	Quality and Outcomes Framework	The QOF is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care.
RCGP	Royal College of General Practitioners	The RCGP is the professional membership body for GPs in the UK and overseas. The RCGP is committed to improving patient care, clinical standards and GP training.
StC	Structured Collaboration	Commissioners, providers, patients, service users, carers and the public working in partnership to define outcomes and agree the scope prior to awarding and mobilising services.
SCP	Self-care and Prevention	Self-care is a way for people to look after themselves (with support as required) in a healthy way.
STP	Sustainability and Transformation Plan	Introduced in December 2015 as part of the NHS Shared Planning Guidance 2016/17 – 2020/21. Every health and care system in England will produce a multi-year

		Sustainability and Transformation Plan (STP) showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.
U&EC	Urgent and Emergency Care	Urgent & Emergency Care services provide life-saving care so patients get safe and effective care whenever they need it.
VCS	Voluntary and Community Sector	Not for profit organisations
YAS	Yorkshire Ambulance Service	Provider of Ambulance services across Yorkshire
YORLMC	YOR Local Medical Committee (also see Local Medical Committee)	Local Medical Committee for Bradford GPs.

Appendix 2 – Measures that matter

Metric	Impact
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	Maintenance or reduction in number of patients admitted
Patient experience of primary care - GP services	Increase in number of patients reporting 'good' or 'very good' Experience of making an appointment
Patient safety incidents reported	Increase in number of patient safety incidents reported (short term) Longer term reduction as learning is embedded
Primary medical care: Management of LTCs	People with a LTC who feel supported to manage their condition Reduced / no increase in admissions to hospital for people with a LTC Reduced / no increase in admissions to hospital for conditions which should not require a hospital admission
Primary medical care: Primary care workforce	Increased number of professionals working within primary care
Cancer screening coverage	Increase in percentage of patients screened Early diagnosis One year survival rates
Population vaccination coverage	Increase in percentage of patients vaccinated
Health-related quality of life for people with a long term mental health condition	Increase in quality of life reported
Anti-microbial resistance: Appropriate prescribing of antibiotics in primary care	Reduction in number of antibiotics prescribed

Appendix 3 – Alignment with STP and GPFV

Key areas outlined in Primary Medical Care Commissioning Strategy	General Practice Forward View					Sustainability & Transformation Plan Gaps		
	Investment	Workforce	Workload	Practice Infrastructure	Care Redesign	Health & Wellbeing	Care & Quality	Finance & Efficiency
Core access	√	√	√	√	√	√	√	√
Out of hours access	√	√	√		√	√	√	√
Digital access	√	√	√	√	√	√	√	√
Extended hours access	√	√	√	√	√	√	√	√
Use of technology	√	√	√	√	√	√	√	√
Long term conditions	√	√	√		√	√	√	√
High quality care		√		√	√	√	√	√
Continuity of care		√			√	√	√	√
Parity of esteem	√	√	√	√	√	√	√	√
Consistent and safe care		√	√		√	√	√	√
Sustainable workforce	√	√	√			√	√	√
Integrated workforce	√	√	√		√	√	√	√
Evolving workforce	√	√	√		√	√	√	√
Skilled workforce	√	√	√	√		√	√	√
Motivated workforce		√	√			√	√	√
Prevention		√	√		√	√	√	√
Self-care skill development	√	√				√	√	√
People power	√		√	√	√	√	√	√
New models of self-care	√	√	√	√	√	√	√	√
Primary medical care at scale	√	√	√	√	√	√	√	√
Using our assets		√	√		√	√	√	√
Co-production		√	√		√	√	√	√
New models of primary medical care	√	√	√	√	√	√	√	√
Estates	√			√	√		√	√
Outcome based and integrated contracting		√	√		√		√	√
Fair contracting	√	√					√	√
New ways of contracting	√	√	√		√	√	√	√

Appendix 4: Policy Documents and References

1. NHSE Five Year Forward View - https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
2. 5 Year Forward View (2014-19) Bradford District and Craven Health and Care Economy http://www.bradforddistrictsccg.nhs.uk/wp-content/uploads/2014/08/Bradford-and-Craven-five-year-forward-view.pdf
3. General Practice Forward View April 2016 https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
4. GP Contract documentation https://www.england.nhs.uk/commissioning/gp-contract/
5. The RCGP (2013) – the 2022 GP – A vision for GP in the future NHS http://www.rcgp.org.uk/~/media/Files/Policy/A-Z-policy/The-2022-GP-A-Vision-for-General-Practice-in-the-Future-NHS.ashx
6. NHS Alliance – Think big act now http://www.nhsalliance.org/wp-content/uploads/2014/10/THINK-BIGACT-NOW-FINAL-1.pdf
7. The BMA discussion paper on General Practice and Integrationhttp://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-current-issues/general-practice-and-integration
8. Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/contents
9. The Brown Principles http://www.moray.gov.uk/downloads/file89347.pdf
10. Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
11. NHS England Call to Action https://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/
12. Accountable Care Organisations explained www.khn.org
13. The Keogh Urgent and Emergency Care Review http://www.nhs.uk/NHSEngland/keogh-review/Pages/urgent-and-emergency-care-review.aspx
14. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes NICE guideline https://www.nice.org.uk/guidance/ng5/resources/medicines-optimisation-the-safe-and-effective-use-of-medicines-to-enable-the-best-possible-outcomes-51041805253
15. NHS Outcomes Framework https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/
16. Kings fund – workforce planning in the NHS http://www.kingsfund.org.uk/publications/workforce-planning-nhs
17. Centre for Workforce Intelligence file:///Z:/Documents/Downloads/CfWI%20GP%20in-depth%20review%20summary_July%202014.pdf
18. A Very General Practice Report https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVeryGeneralPractice_May2015.pdf
19. Invisible at the desk http://www.healthwatchbradford.co.uk/news/invisible-desk-healthwatch-publishes-report-gp-services-0

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Report of the Strategic Director - Health and Wellbeing to the meeting of the Bradford and Airedale Health and Wellbeing Board to be held on 31st January 2017

Q

Subject: The 2017-19 budget proposals of City of Bradford Metropolitan District Council

Summary statement: The Board is invited to consider the Council's 2017-19 budget proposals.

Bev Maybury –Strategic Director-Health and Wellbeing, CBMDC

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Portfolio:

Health and Wellbeing

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

The Board is invited to consider the Council's 2017-19 budget proposals.

2. BACKGROUND

At the September 2016 Health and Wellbeing Board meeting, members received a presentation from the Directors of Finance Group (Finance Directors from the Clinical Commissioning Groups, the main health providers and the Local Authority) that outlined a four year financial forecast for the Health and Wellbeing sector and place the forecast in the context of high and growing demand for services as a result of demographic changes, for example an ageing population.

On the 6th December Council budget proposals for 2017-19 were approved for public consultation.

3. OTHER CONSIDERATIONS

Each of the Delivery Partnerships for the District Plan outcomes is asked to consider the budget proposals, and to provide feedback on areas of potential impact and options for mitigating risk across the health and wellbeing sector.

Board members are invited to review the proposals in the summary paper attached as Appendix 1 and to follow the link to the full papers in section 12 below.

4. FINANCIAL & RESOURCE APPRAISAL

The presentation at the Board meeting will cover the financial and resource appraisal for the health and social care sector.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Council Executive is responsible for governance and risk management in respect of Council budget proposals. The proposals have also been considered at senior management levels within the Council.

6. LEGAL APPRAISAL

Legal appraisal has been undertaken in relation to the budget processes of the Council and partner organisations for 2017-19 onwards.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

Council budget proposals are accompanied by Equality Impact Assessments.

7.2 SUSTAINABILITY IMPLICATIONS

None

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None

7.4 COMMUNITY SAFETY IMPLICATIONS

None

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

None

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

None provided

10. RECOMMENDATIONS

10.1 That the Board provides feedback on the 2017-19 Council Budget proposals.

11. APPENDICES

11.1 A balanced four-year budget: Bradford Council Executive's Budget and Council Tax Proposals for 2017/18–2020/21

12. BACKGROUND DOCUMENTS

12.1 Link to Council Budget Consultation pages:
https://www.bradford.gov.uk/your-council/have-your-say-on-2017-18-and-2018-19-budget-

and-council-tax-proposals/have-your-say-on-2017-18-and-2018-19-budget-and-council-tax-proposals/

A balanced four-year budget: Bradford Council Executive's Budget and Council Tax Proposals for 2017/18–2020/21

For consideration at the meeting of the Executive on 6 December 2016

1 Introduction: financial context

1.1 Bradford Council has had to find more than £250m in savings and increased income over the past six years due to imposed funding cuts from central government, rising demand for services and increasing costs.

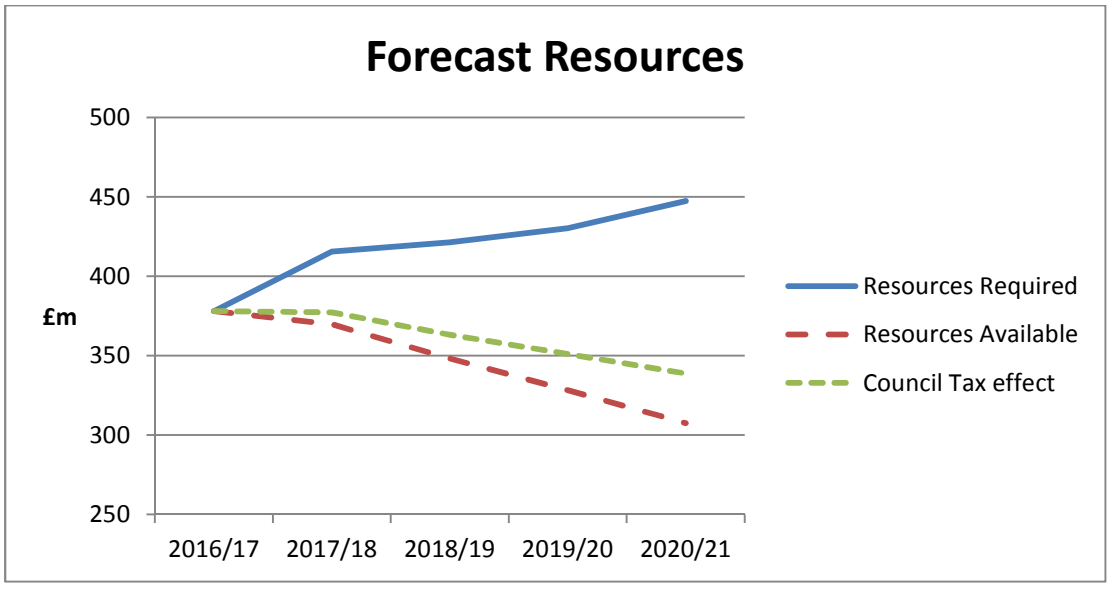
1.2 Between now and 2020 we are forced to find another £82m of savings and extra income to balance the books; this is on top of pre-agreed savings of £24m and further increases in Council Tax. This is against the backdrop of the cuts already implemented since the government began its austerity policy in 2010.

1.3 Bradford Council's net budget in 2020 will be around half what it was in 2010 in real terms, accounting for inflation and the growing demand for services.

1.4 Having already managed £250m in savings and additional income since 2010, we have faced extremely difficult decisions in our challenge to close Bradford's £82m funding gap over the next four years. Any organisation no matter how efficient or innovative would face a major challenge in managing a 50% cut to its spending power. Local residents, staff and partner organisations will inevitably feel the impact as the government's policy to cut local authority funding significantly reduces services.

1.5 We must not let the cuts dim our ambitions for the Bradford District. In the proposals we have set out our detailed choices for the next two years and our broader plan for the subsequent period to 2020 to close the significant funding gap while achieving the best possible outcomes.

1.6 The graph below illustrates the gap we are faced with if we fail to act:



2 The impact of the austerity policy on Bradford District

2.1 Bradford has shouldered a disproportionate share of the Government's austerity policy. Funding decisions which favour less deprived areas are resulting in a postcode lottery around the country. In last year's budget proposals we cited the government's own figures which showed Bradford's spending power had reduced by twice the national average, while Wokingham, the country's least deprived authority, had actually seen an increase.

2.2 Recent research published by the IFS on 28 November 2016 also suggests there have been very different levels of cuts in different part of the country between 2009/10 and 2016/17. According

to the IFS, Bradford Council has had to cut its spending on services by 33%, whereas Surrey and Hampshire, for example, have each made cuts of just 1%. The IFS figures have been adjusted to remove spending in new areas or changing responsibilities and as a result exclude cuts to funding streams such as Public Health grant, which masks the full picture.

2.3 As government policy places an increasing emphasis on council tax and business rates income for funding local services, there is a risk that areas like Bradford with fewer high-value properties and relatively lower business rates face an ever growing challenge to close the gap with wealthier areas.

2.4 In his autumn statement on 23 November 2016, the Chancellor confirmed the government has withdrawn its pledge to achieve a surplus in the economy by 2020. He also said that new investment, not just cuts, is necessary to unlock economic growth. We welcome the new approach to invest in infrastructure. This Executive will continue to push for a fair allocation for the Bradford District of infrastructure investments and we are willing to work constructively with the government and neighbouring authorities to achieve it.

2.5 Bradford is not unique in facing spending cuts. Statistics suggest that since 2010 the UK's local government workforce has been cut by around 25%. The central government workforce has increased by almost 4% in the same period (ONS June 2016). Many parts of the country have lost libraries, theatres, museums, leisure centres, children's centres and community centres; and seen reductions in many other services. In Bradford District we have successfully maintained important services and worked hard to minimise the impact on residents, visitors and partner organisations. But the decisions are increasingly difficult.

3 We are focused on outcomes

3.1 We must maintain a pinpoint focus on our priorities while our funding reductions continue. From the outset in this budgeting process, we have refused to simply sit back and preside over departmental and service reductions. Instead, we have worked with officers to identify the district's absolute priorities and the activities which have the greatest impact for local people. Instead of simply reducing existing services, officers have been tasked with looking afresh at our activities right across the board and ensuring every penny spent has the greatest possible effect on the key priorities we have outlined in our Council Plan:

- Better skills, more good jobs and a growing economy
- Decent homes that people can afford to live in
- A great start and good schools for all our children
- Better health, better lives
- Safe, clean and active communities
- A well-run council.

3.2 The reality of the budgeting process means that, as with previous years, we have had to take decisions we would not otherwise wish to take; we have been faced time and again with competing choices each with a compelling cause.

3.3 However, we want to assure local people that we will continue to fight for a fairer deal for this district and not simply accept ongoing cuts. We are making every effort to ensure our voice is heard nationally and we will continue to make rigorous representations for the proper investment our district needs to help unlock its huge potential and ensure local people get a fair share of any future national economic growth.

4 Inclusive growth

4.1 The current government has, encouragingly, spoken about inclusive growth. We remain hopeful that the government's policies will match the rhetoric and that they will work constructively with us to ensure people in Bradford District don't miss out on future opportunities. We will continue to make the case for major infrastructure investments in our district.

4.2 We are committed to helping ensure that individual rights are protected and respected regardless of age, disability, sex, gender, race, religion or sexual orientation. That commitment underpins everything we do and in putting forward each of the proposals we have considered the potential impact on all protected characteristics. The equality impact assessments are included in the published budget documents.

4.3 As well as our commitment to safeguarding individual rights, we are also calling on local people, partner organisations, community groups and businesses to take on greater responsibilities and work with us in achieving our mutual goals for the district.

4.4 We will work with staff and trade unions as we rise to the challenges. We value our staff and wholeheartedly believe that their skills and work ethic must be a fundamental part of the solution as we move forward and evolve into a smaller but still hugely influential organisation in the future. We are grateful to our employees – 80% of whom are residents in the district – for their impressive work amid the challenging circumstances of austerity and we will continue to do everything we can to mitigate the inevitable impact.

5 Our proposals

5.1 We are determined to focus on what our district can achieve. In spite of the severity of the government cuts, we are making a commitment for the next two years to:

- Protect the youth service – we are the youngest city in the country
- Keep all four of our museums open
- Keep all seven of our children's centre clusters open
- Ensure continuing libraries provision

5.2 However we will not be able to retain all of the above services in their current form all the way to 2020 given the gap arising from more government cuts and rising demand and costs. We will have no option but to look at how these services and others outside our statutory role can be remodelled in order to ensure continuing provision for local people.

5.3 This means that beyond the detailed proposals we have set out for the next two years, nothing can be taken for granted. There is the very real risk that services will have to cease if we are unable to find new ways of retaining them at a reduced cost, such as through alternative models of delivery or greater community or volunteer involvement.

5.4 Our proposed savings for the next two years include:

- Taking £8m a year out of Adult social care as part of a transformation of the service
- Closing all public toilets except the facilities next to the mirror pool at City Park for children's changing
- Transferring all 7 community halls via asset transfer to communities, failing that they will close
- Withdrawing funding for Jamie's Ministry of Food

- Withdrawing from the direct management and maintenance of sports pitches and bowling greens
- Reducing clean teams and mechanical sweepers
- Deleting the post of Deputy Lord Mayor
- Cutting 20% of the events and festivals budget
- Introducing limited street lighting hours for non principal roads
- Further reducing the libraries budget with increasing reliance on volunteers
- Cutting 416 jobs on top of more than 2,000 jobs we've had to cut over the last five years
- Reduce economic development funding, but target it for greatest impact

6 Council tax

6.1 We feel we have little choice but to raise council tax by 1.99% and implement the social care levy by the government's stated maximum of 2% for each of the next two years. In 2017/18 this 3.99% increase amounts to an additional cost of £2.66 a month for a Band A council tax payer and £7.97 a month for a Band H payer. In 2018/19, it amounts to an additional monthly increase of £2.76 in Band A and £8.28 in Band H.

6.2 If we did not raise council tax in this way, even more services would be lost as we would be forced to find another estimated £27 million over four years.

6.3 Our council tax is currently the lowest in West Yorkshire. Nevertheless we don't take the decision lightly and we recognise the additional burden on local people at a time of economic hardship.

6.4 The government's policy for addressing the funding gap in local services is for people to pay more council tax with an expectation that councils will implement the social care precept. The effect of the government's approach is that nationally people are paying more council tax while seeing local services continue to reduce, especially in less wealthy areas with fewer high value properties, as the council tax income falls well short of filling the shortfall.

7 Social care

7.1 There is a national funding crisis around adult social care. Local authorities from across the political spectrum, health professionals, charities and many others raised concerns when the chancellor did not mention social care in his autumn statement. We have argued that having a proper plan for social care will improve people's lives and ease pressures on the NHS.

7.2 There is a growing national consensus that the social care precept falls considerably short of solving the social care funding crisis as demand rises with a growing elderly population. In the next two years, the social care precept will bring in an additional £6.6m, which is unlikely to meet the increased cost of the national living wage.

7.3 Nevertheless we are committed to rising to the challenge in spite of our shrinking resources. We are committed to ensuring that the most vulnerable people in our society get the best possible care. We are committed to ensuring that the local authority does not simply become a sub-division of the NHS. We must continue to ensure people get the universal services they rightly expect. We are proposing a radical adult services transformation plan which we accept is a major challenge and aims to save £8m every year to 2020.

7.4 The £8m annual saving is in addition to the pre-agreed 2017/18 savings of £10.2m in adult services which will also have to be delivered.

7.5 We will focus our investment on frontline social work. We will increase the level of preventative support for people, with a focus on supporting them in what they can do rather than what they can't do. Earlier and better interventions help people to stay independent and in their own homes for longer and reduce the need for more intensive and costly interventions.

7.6 We want people to be empowered to live fulfilled and independent lives for as long as possible. Supporting people to stay independent also costs the state less money and saves valuable resources for our NHS partners.

7.7 We will offer people more choice and control in their own lives so they have a greater say in the support they receive. We will work closer than ever with health partners with the aim of integrating systems and sharing resources more effectively.

8 The impact on low income groups

8.1 We understand that increases in council tax and charges are an additional burden on local people, in particular those with the lowest incomes. We do not take these decisions lightly and we have considered this impact in making the proposals.

8.2 The best way of supporting people out of poverty is through employment and we recognise that the cuts may impact on our efforts to achieve this. However in mitigation we are continuing to invest in skills programmes aimed towards hard to reach groups which, although a non-statutory service, have a strong track record of helping people into work. We are also committed to working with schools, the voluntary sector, communities and businesses so we have a shared commitment to helping people on the education and employment ladder.

8.3 Depending on their circumstances people on low incomes will continue to have access to various services aimed at easing the burden. These include passport to leisure, housing benefit, discretionary housing payments, council tax reductions and our equity home loans scheme. The Council also continues to support the Bradford District Credit Union.

8.4 We will continue to look at all options for mitigating the impact of austerity cuts on our lowest earning residents.

9 The impact on the voluntary sector

9.1 We work in partnership with the voluntary and community sector (VCS) and we value that partnership which benefits local people. We want to continue working closely with the VCS in future as together we evolve to meet the restrictions of our funding. We want to work with the sector to support its transformation so that its value can be sustained.

9.2 Given our close links and many shared goals, the cut in funding from central government will inevitably also be felt by the VCS. We have considered this impact in making these proposals and we are committed to doing all we can to mitigate it. With shrinking resources and as part of our budgeting process which is focused on outcomes, we have had to review all the activities we fund to date and assess the scale of their impact and value for money.

9.3 We are committed to hearing the views of the VCS on these proposals during the consultation process, including in dedicated events, and we will continue to work closely with the VCS to achieve the best outcomes for the district.

10 Looking to the future: the cuts must not dim our ambitions for the Bradford District

10.1 We want to be honest about the challenges the district faces but we don't want people to be overwhelmed. We want to work with government, with the NHS, with the voluntary sector, businesses and residents to make sure we build a better Bradford District together.

10.2 The government has said it wants to be inclusive. We wanted the autumn statement to give a strong indication that it was going to match those words with action. We still have hope that the government's commitment to fund infrastructure will come to pass. Our district, with 530,000 people, needs to be off the branch line and on the Northern Powerhouse Rail line. Bradford must not be left behind.

10.3 On education the government is cutting the £7m Education Services Grant and increasingly resources are going direct to academies and free schools. However education remains our top priority. We have 102,000 children in school. Wherever our children are being educated, whether it be in a maintained school, academy or free school, we want to make sure they get the best education. We want to work with government to get the best for our young people. For the North to see an increase in productivity, the children of Bradford District need to be successful; they are the workforce of the future.

10.4 Bradford is a big, powerful city. We are bigger than Liverpool, Newcastle and Bristol. We have the youngest population in the UK. Nearly 25% of our population are under the age of 16. We have strong global links with 85% of our businesses trading internationally. That puts us in a strong position for a post Brexit world and we must capitalise on that strength.

10.5 To reach our potential the council cannot achieve this alone. The government cuts are drastically reducing the size of local government. So we are calling on our communities, public sector partners, businesses, the voluntary sector, faith groups, schools and residents to join with us in creating a better Bradford District. We will not let our challenges dim our ambitions. Such great ambitions can only be realised by us all working together.

11 Have your say: we will listen to your views

11.1 We want local people and organisations to have their say on these proposals. We are committed to considering all feedback we receive throughout the consultation period. We welcome all views on the proposals and the equality impacts. We have a track record of listening.

11.2 The consultation period started when the proposals were published last week and it will run until 12 February 2017.

11.3 Where possible people are encouraged to submit their views via the online questionnaire on the dedicated budget consultation pages on our website where the proposals are outlined in full. Click on the banner on the homepage or go to www.bradford.gov.uk/budget

11.4 Alternatively people are welcome to submit their views to the freepost address: Freepost RTLC-KEGA-JGRX, Bradford Council, Budget Consultation, Britannia House, Hall Ings, Bradford, BD1 1HX.

11.5 We will also be publicising the consultation on our social media and digital channels.

11.6 We will be holding a series of meetings with Communities of Interest to discuss the proposals and allow for feedback and ensure the voices of specific groups are heard.

APPENDIX C - DETAILED BUDGET CHANGES PROPOSED FOR 2017/18 - 2018/19 & SUBJECT TO CONSULTATION

Better Health, Better Lives

Total Savings Proposed - £22.1m	**2017-18**	**2018-19**
	£11.0m	**£11.1m**

Health and Wellbeing - Public Health

Ref - 4PH2 Public Health - Substance Misuse

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £10.9m

2017-18	**2018-19**	**Total**	**% of current base**
£1,169,000	**£1,634,000**	**£2,803,000**	**26%**

The Substance Misuse service provides a number of recovery-focussed services in the prevention, reduction and treatment of drug and alcohol misuse and its associated harms for individuals, families and communities. The service is currently provided for 4500 individuals in various locations across the district.

The budget for substance misuse services will be reduced through a combination of redesign and re-commissioning of services and services ceasing.

- The Substance Misuse Recovery Service is the new integrated drug and alcohol service currently out to tender, through which individuals receive a continuum of preventive measures, treatment interventions and recovery options. The review of the service will achieve savings in 2017-18 of £1.088m and £1.076m in 2018-19.

- The Substance Misuse Dual Diagnosis Service provides a specialist Dual Diagnosis from premises in both Bradford and Keighley, delivered by a team of specialist health care professionals. Over 4 years, patients will be gradually transferred to, and managed by, mainstream NHS Mental Health services and/or substance misuse services. This service will reduce in 2018-19 resulting in a saving of £487,000.

- The Supervised Medication Programme is delivered by 130 pharmacies across the district. The programme ensures that individuals in drug treatment are supervised in consumption of substitution medication within pharmacies and a reduction in demand for this service will lead to an annual saving of £56,000 in 2017-18 and £6,000 in 2018-19.

- Inpatient Detoxification services are provided by a number of contracted organisations on an approved provider basis outside of the district and provide detoxification in a residential setting. There is little evidence of continued abstinence following discharge, and detoxification can be delivered within the community under the new recovery service and therefore by 2018-19 this service will reduce resulting in an annual saving of £35,000.

- The Needle Exchange programme offers an open-access service to any drug injector because every person engaged in this activity is at risk of contracting a life-

threatening blood-borne virus, particularly HIV, Hepatitis B and Hepatitis C. The service is being reviewed to identify cost effectiveness and ensure geographical coverage of service. It is anticipated that a new delivery model and this redesign will lead to an annual saving of £25,000 in 2017-18 and £30,000 in 2018-19.

Equality impact on the Equality Duty protected characteristics & low income groups

Impact assessments have identified that this range of proposals could have impacts on a wide range of service users across the range of protected characteristics.

Mitigation

Any new contracts will continue to have the same equality requirements of the Provider under the Equality Act 2010 as the current tender. The new service specification being commissioned requires that the service is provided through various types of provision and that the service is integrated throughout providing continuity for service users. Services will be more community based with access points in multiple sites in non-substance misuse specific services making it easier for all sections of society to access them.

See EIA 4PH2

Ref - 4PH3 Public Health - Sexual Health

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £4.7m

2017-18	2018-19	Total	% of current base
£70,500	£25,000	£95,500	2%

The Sexual Health service provides open access to Bradford residents to all forms of Contraception, Sexually Transmitted Infection testing and treatment, information and support, allowing easy access to services by giving them the choice of either an appointment or access to drop-in clinics across the district.

The budget for the service will be reduced through a combination of redesign and review of services, and other services ceasing.

'Prism' is a service in which a Health Development Worker works with young people, delivering information, advice, support and referral (where appropriate) through 1-1, 'Drop In' and Group Interventions. The proposal is that this service will cease from 31 March 2017 resulting in an annual budget reduction of £55,500.

Step2 is a service which supports the delivery of a Sex and Relationship Education (SRE) programme in schools. The SRE programme is delivered in 9 upper schools within the district and is co delivered by a teacher, Step2 or School Nurse in the class room and discusses sexual exploitation, sexuality, and abusive relationships, as well as a range of other topics giving young people information around local services and where they can access support. The proposal is that this service will cease from 31 March 2017 resulting in an annual budget reduction of £15,000.

Emergency Hormonal Contraception (EHC) is made available in Pharmacies, free-of-charge,

to those aged 25 and under. Pharmacists also provide condoms and chlamydia screening giving advice on contraception and sexual health and signposting to Sexual and Reproductive Health Service (SRHS) for further support. The proposal is that this service will cease from 31 March 2018 resulting in an annual budget reduction of £25,000.

Equality impact on the Equality Duty protected characteristics & low income groups

Some of the services are designed specifically for parts of the population who share a protected characteristic. Therefore services are provided disproportionately to those parts of the population and the impact will reflect this.

The financial implications of this reduction in budget will be applied across the whole of the contract and therefore will impact upon all potential users of the services.

Mitigation

The SRHS that is commissioned is part of a wider Sexual Health economy with GPs providing oral contraception and STI testing which is commissioned by NHSE from GP practices as part of their core service offer.

Bradford residents would still be able to access SHRS (oral contraceptives and STI screening) within their community through their GP practice and Long Acting Reversible Contraceptives (coils and implants) and STI testing and treatment, through the SHRS that would stay situated centrally within the city centre making it accessible to all.

See EIA 4PH3

Ref - 4PH4 Public Health - Tobacco

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.8m

2017-18	2018-19	Total	% of current base
£2,000	£59,200	£61,200	8%

The tobacco service provides and commissions services to reduce smoking prevalence across the district and prevent the uptake of smoking by young people. The budget for the service will be reduced through a combination of the redesign and review of services which will see some currently commissioned services ceasing and a reduction in the number of people accessing services.

Dental Practices across Bradford District are currently commissioned to provide a practice-based stop smoking service. As part of the redesign of stop smoking services, dental practices will not continue to be commissioned to provide this service and therefore will cease in April 2017 resulting in an annual budget reduction of £2,000.

Stop smoking medication is available on prescription to smokers, through the Bradford district stop smoking service. This will be limited to geographical areas identified as having higher smoking prevalence and priority groups e.g. pregnant smokers, patients with a long term condition etc. This redesign will lead to an annual saving of £44,000.

The Midwifery-based stop smoking service provides a specialist stop smoking midwife to provide and coordinate training, implement and monitor interventions to reduce smoking and promote smoke free homes throughout pregnancy. This service will cease in January 2019 resulting in a budget reduction in 2018/19 of £15,200.

Equality impact on the Equality Duty protected characteristics & low income groups

Equality assessment carried out indicated that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share protected characteristics

Mitigation

N/A

See EIA 4PH4

Ref - 4PH5 Public Health - Homestart, Worksafe and Injury Minimisation Programme

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.2m

2017-18	2018-19	Total	% of current base
£190,000	£55,000	£245,000	100%

The services commissioned are for children, young people and their families with a focus on accident prevention, and support for vulnerable parents and children age 0-5 years. The proposal is to phase out the services detailed below over two years, with a view to some activities being mainstreamed into the wider transformation plan for children and young people and families in the District.

- Homestart

Homestart is a national charity with independent schemes in local communities which recruit and train volunteers to help families with young children by visiting them in their homes. The proposed plan is to end the current grant agreement with Homestart in 2016/17. The service would therefore cease resulting in an annual saving of £155,000.

- Injury Minimisation Programme (IMPs)

The Programme is aimed at all year 6 children in all Primary schools and aims to reduce injuries and empower young people to take personal responsibility for managing their own risk. It is proposed that the service will cease in 2016-17, giving the required 6 months notice from April 2017 (therefore terminating at the end of September 2017), resulting in an annual saving of £70,000, (£35,000 in each of the two years).

- Worksafe

This Voluntary and Community Sector (VCS) service provides training, advice and information about a range of safety issues to selected primary schools and to children with special needs. It is proposed that this continues for one year and stops in year 2018/19. This service will cease resulting in an annual saving of £20,000.

Equality impact on the Equality Duty protected characteristics & low income groups

Impact assessments have identified that this range of proposals could have impacts on a wide range of service users across the range of protected characteristics particularly age, disability, race and low income families. There will be impact on key public health outcomes which are likely to widen inequalities in some of our vulnerable groups as these services are delivered across the areas that have already been identified as a strategic priority within the District's Health Inequalities Action Plan.

Mitigation

Some activities may be mainstreamed into the wider transformation plan for children and young people and families in the District going forward but there will be some that will not be mitigated against.

In order to manage any negative affects we will use a phased approach so that we can identify any potential risks in the first year.

Some risk may be mitigated with funding from other areas within the District through Better Start and Big lottery in Keighley so the negative consequences are not as high as would be expected if the service was completely decommissioned.

See EIA 4PH5

Ref - 4PH6 Public Health - Physical Activity, Food and Nutrition

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £2.0m

2017-18	2018-19	Total	% of current base
£1,000,000	£0	£1,000,000	51%

The Health Improvement Team currently provides grants to 24 VCS organisations which deliver a range of interventions including activities such as 'cook & eat' programmes, physical activity sessions for inactive adults and children, food growing activities and breastfeeding support.

These grant agreements come to an end on 31 March 2017 and it is proposed that they will not be extended which will result in an annual saving of £1m.

Equality impact on the Equality Duty protected characteristics & low income groups

Services are currently commissioned from a variety of BME organisations and groups based in low income areas to ensure positive outcomes for all parts of the community. The race equality impact is judged to be high, because of the high BME take up of VCS services.

Mitigation
The Health Improvement Team will support providers/organisations and service users proactively with advice and sign-posting as opportunities are identified.

See EIA 4PH6

Ref - 4PH7 Public Health - Small Grants (Wider Determinants)

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.1m

2017-18	2018-19	Total	% of current base
£101,000	£0	£101,000	100%

The Public Health Department funds VCS organisations through the small grants scheme to deliver a range of interventions addressing broader public health outcomes including sexual health, smoking cessation, cancer awareness, teenage pregnancy and healthy lifestyles interventions.

These grant agreements come to an end on 31 March 2017 and it is proposed that they will not be extended which will result in an annual saving of £101,000.

Equality impact on the Equality Duty protected characteristics & low income groups

Equality assessment carried out indicated that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share protected characteristics

Mitigation

N/A

See EIA 4PH7

Ref - 4PH8 Public Health - Warm Homes Healthy People Programme

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.08m

2017-18	2018-19	Total	% of current base
£25,000	£40,000	£65,000	76%

The Warm Homes Healthy People (WHHP) is a short-term, winter activity based programme which supports those most in need of Winter Warmth services in Bradford and Airedale area.

Services offered include food parcels and hampers; cook and eat sessions; big lunches; provision of practical needs such as coats; hats; duvets and emergency heating appliances; small fuel poverty remedies (radiator foils, draft excluders etc), energy efficiency assessments; fuel debt relief; top-ups for prepaid fuel meters and community activity such as snow clearance, befriending schemes etc.

The proposal is to reduce this service, resulting in an annual saving of £65,000.

(Note: This proposal is 'exclusive' of £30,000 currently received from City and District Clinical Commissioning Groups (CCG's) via the local resilience fund).

Equality impact on the Equality Duty protected characteristics & low income groups

Currently the proposal offers support to a range of vulnerable householders, many of whom share particular protected characteristics. Removing the programme's main funding reduces the breadth of service offered and may disadvantage some people.

Mitigation

The current budget includes £30,000 received from City and District's CCG's Resilience fund. This may continue to be available beyond the time when funding via Health and Well-being ends. Should the CCG contribution continue it would not be able to support a WHHP programme the size it is now; tighter more specific client targeting would be required.

In 2016/17 support to develop a new approach to funding was granted to the partners, this has allowed the creation of a crowd funding website which plans to raise £25k this year. It is planned to build on this in 2017/18 with the hope that core services such as fuel poverty and food poverty work streams can be maintained.

Additionally there are existing partners such as Ground Works/ Family Action and others who fund raise for services independently and join in the programme each winter. It is hoped this can be continued.

See EIA 4PH8

Ref - 4PH9 Public Health - Back office CCG funding transfer

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.5m

2017-18	2018-19	Total	% of current base
£0	£499,000	£499,000	100%

The funding is a budget adjustment, transferring funding to Bradford Clinical Commissiong Group's (CCG's); the funding is then paid to provider Bradford District Care Foundation Trust (BDCFT) as part of existing contracts held between CCGs and BDCFT. The funding was, prior to 2016-17, part of a contract between Public Health and BDCFT. Specific services are not described as part of this funding agreement and known only to CCGs. It is proposed that services are redesigned as part of an accountable care system/organisation development involving health, social care and other providers, resulting in an annual budget reduction of £499,000.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4PH10 Public Health - Staffing and operational cost reductions

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £3.4m

2017-18	2018-19	Total	% of current base
£300,000	£350,000	£650,000	19%

The Public Health staff team comprises of the Public Health management team, analysts and commissioning/business unit staff who are responsible for supporting and directing strategic needs assessment for the district and commissioning services directly to meet identified need in responsible areas. In addition, the department employs operational staff to deliver some public health services, specifically sexual health, stop smoking and health improvement (physical activity, anti-obesity).

It is proposed that the Public Health staff team is reduced in line with Public Health redirecting its investment profile towards reducing demand and maintaining health and well-being.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4PH11 Public Health - Environmental Health Restructure

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £1.0m

2017-18	2018-19	Total	% of current base
£35,000	£40,000	£75,000	8%

It is proposed to undertake a management restructure within the Environmental Health Service as part of wider changes in the Department of Health and Wellbeing.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Environment and Sport

Ref - 4E11 Environment and Sport - Sport and Physical Activity Service

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £2.3m

2017-18	2018-19	Total	% of current base
£0	£150,000	£150,000	6%

Swimming pools, sports centres, swimming development, sports development and outdoor adventure activities form the basis of this service. A number of changes are proposed. In the first instance the service will investigate through an options appraisal all methods of future operational service delivery and this will include the potential for a 'not for profit' trust model to be established as part of the potential savings required in 2018-19.

Equality impact on the Equality Duty protected characteristics & low income groups

Equality assessment carried out indicated that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share protected characteristics

Mitigation

N/A

See EIA 4E11

Health and Wellbeing – Adult and Community Services

Ref - 4A1 Adult and Community Services - Overall Demand Management Strategy

Total 2016-17 Budget for Service Area £108.4m

2017-18	2018-19	Total	% of current base
£8,000,000	£8,000,000	£16,000,000	15%

The latest statistics from Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) projects a 2% yearly increase in the number of service users up to 2030.

The challenge is to change the culture in Adult Social Care and with the NHS to move from a dependency model to one that promotes independence and resilience (a strength based model, with a focus on what people can do, and positive risk-management so people can live their lives to the full).

The Sustainability and Transformation Plan includes development of an Accountable Care System. The aim of this will be to use our investment to improve the health and wellbeing of people in the Bradford District. We will do this by targeting our collective resources to maximise independence and resilience, regardless of age, disability or condition and protecting and safeguarding the most vulnerable in our communities.

The challenge in Adult Social Care is to deliver services to growing numbers of bother young and older people, whilst at the same time discharging our statutory duties.

We will where possible support people to be safe and independent at home and so reduce the need for some people to go into residential/nursing Care. We will do this by working with our NHS and community and voluntary services partners to promote independence through strength based assessments, a greater focus on prevention/early intervention and using enabling technologies. This approach will be underpinned by an integrated workforce development plan which will focus on the Home First Model:

1. Reducing the number of people coming into care through an enhanced preventative focused (early intervention) approach, which will aim to minimise the need for long term support by addressing underlying needs at the earliest stage possible, and reduce the need for some people to go into hospital or a care facility.

2. Changing the culture across the care system: moving to a strength (asset) based model that will require an open dialogue with the people, their families and carers to draw on these resources to maximise independence; and ensuring that people get the right level and type of support i.e. not too little and not too much.

3. Speeding up integration with Health to ensure we can establish a whole systems approach across the Health and Social Care sector and secure efficiencies and economies e.g. Integration of complex care teams with partners within NHS and Voluntary and Community sector, so that service users receive the right care at the time in the right place, and so that support from Health and Social Care is seamless. Ensure all service users are reviewed on a regular basis in line with the guidance set out in the Care Act, so that the appropriate package of care is delivered subject to the individual's needs.

4. Moving away from expensive traditional forms of support through targeted care and enhanced reviews of care needs. This could include options such as extra care or improved home care services and only using residential or nursing care when people really need it.

5. Redesigning our approach to enablement to reduce costs and maintain independence of people e.g. more investment in home care. We will do our utmost to support people to regain skills and confidence to stay independent including use of technology.

6. Reviewing the financial needs of people to ensure that they are provided with the appropriate level of funding to meet their care need. When we assess people we will ensure that they get the right support from either health or social care funders.

7. Continuing the implementation of personalisation including the use of ISF's (Individual Servicer Fund). ISFs are a third party agreement that will ensure that people can have choice and control without the worries of looking after the money.

Our approach builds on our local experience and research undertaken by national bodies which has demonstrated that significant amounts can be saved through effective demand management across the support system. The key underlying principle will be to ensure we deliver services in the short term, while using this time to develop the provider market to take on service delivery in the medium and long term.

These proposals are designed to enable the costs of the services to be contained within the

proposed available resources, despite the predicted rise in demand of approximately 2% annually, and inflationary increases in costs affecting Adult Services. This proposal reflects our conclusion that we need to make changes to the way we deliver services in order to avoid annually £8m of costs that would otherwise be incurred. This level of saving is required even after the use of additional income from the Better Care Fund, and from the Social Care precept equivalent to 2% of Council Tax. This is a challenging, yet achievable goal.

Equality impact on the Equality Duty protected characteristics & low income groups

Older people and people with Mental Health & Learning Disabilities will predominantly be affected by this proposal but the focus will be on personalised services for people so the impact on protected characteristics will be mitigated at individual level.

As part of the Strategy to reduce residential and nursing places it is intended that more extra care schemes are developed, which will help to improve people's lives and reduce expenditure across all groups.

As the proposal is developed, the detail of impacts will be further assessed to ensure any potential implications on protected characteristics are minimised.

Mitigation

Our approach will seek to focus on people's strengths and enabling people to manage properly understood, proportionate and positive risks in living their lives.

We will undertake individual assessments and carry out extensive engagement with service users, carers and advocates to ensure seamless transitions for any service users affected. This will enable us to meet our duty under the Care Act 2014 and mitigate against any disproportionate negative impact on any person with a protective characteristic.

By offering other options for people in terms of housing and care support, people will have the opportunity to access appropriate services that meet their assessed needs and be in a position to maintain their independence and to continue to have a positive contribution and be inclusive in their local community. This will ensure where possible people with particular characteristics are not disproportionately affected. We will further review the potential impact on protected characteristics as part of the development of the delivery programme.

See EIA 4A1

Children's Services - Children's Social Care

Ref - 4C4 Child Protection management restructure

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £7.0m

2017-18	2018-19	Total	% of current base
£240,000	£240,000	£480,000	7%

This activity area includes the work of the fourteen teams who work in front line Child Protection in the District, the specialist services management team, and the interpreting budget for children in the care system. The proposal is to undertake a review in year 1 to

align the Child Protection teams with a revised approach to delivering early help to children and families that includes a range of services to be delivered at a locality level. Currently there are fourteen team leaders in the child protection teams. The proposal is that the number of teams is reduced by four to ten, potentially resulting in a reduction in the number of team managers. This process will be started in year 1 but full savings will not be realised until year 2 due to the requirements for review and consultation.

In addition the proposal is to review the overall staffing & non staffing budgets and identify further saving in years 1 and 2 of 2% in each year.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4C5 Service Wide - Further management savings

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £57m

2017-18	2018-19	Total	% of current base
£85,000	£85,000	£170,000	0.3%

Across Children's Social Care, the role of team managers is to oversee cases and support social workers to put in place good plans for children. They are responsible for an outcome area within specialist services.

This proposal is that a review is undertaken of the management structure within children's social care, reducing it by two service manager posts and one team manager in addition to team manager reductions identified in other service areas.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation
N/A

Ref - 4C6 Early Help - Review management structure and commissioned services

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £4.7m

2017-18	2018-19	Total	% of current base
£80,000	£120,000	£200,000	4%

Within the scope of this activity is early help for children and families commissioned from the VCS, Youth Offending Team, crime prevention and the family centres, families first and other early help services offered through children's centres, and for disabled children and young people

The targeted early help portfolio includes a range of statutory, early intervention and prevention services. These seek to help vulnerable families to help themselves, become more resilient and take action early in the life of a problem for children of all ages. Funding comes from a number of sources including the council, Youth Justice Board and Troubled Families Programme.

This proposal is to undertake a review of the management structure resulting in the reduction of 1 Team Manager, and a review of the external commissioning budget to achieve a reduction of 15% in year 2. In addition there will an overall review of the service to achieve a 1% budget reduction.

Equality impact on the Equality Duty protected characteristics & low income groups

This service works with a higher percentage of children and families from disadvantaged households and any reduction in service may result in a disproportionate affect on low income groups needing this support.

Mitigation

The review will ensure that resource is most effectively targeted at areas of need, with careful mapping of service needs and outcomes. This process will be done alongside the VCS to ensure that impact is mitigated where possible. Where possible, resources will be reduced in back office and management functions.

See EIA 4C6

Ref - 4C7 Looked After Team

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £1.9m

2017-18	2018-19	Total	% of current base
£19,000	£19,000	£38,000	2%

Within the scope of this activity is the Looked After Children's team, young peoples advocacy and the Children in Care Council

This proposal is to undertake a review of overall staffing & non staffing budget and save 1% each year from within the service.

Equality impact on the Equality Duty protected characteristics & low income groups
N/A

Mitigation
N/A

Ref - 4C8 Fostering and Adoption management restructure

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £17.9m

2017-18	2018-19	Total	% of current base
£0	£50,000	£50,000	0%

Within the scope of this activity is the staffing of fostering service; buildings; marketing; fostering fees; foster care assessments and panels; family and friends carer assessments and allowances; fostering fees and allowances; crisis and carer support costs.

The change proposed is to review the team manager structure of the service to remove one post in year 2 making a saving of £50,000. This will be achieved through a review of workload and rationalising the current four teams into three.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4C9 Disabled Children Team

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £5.2m

2017-18	2018-19	Total	% of current base
£250,000	£34,000	£284,000	5%

Within the scope of this activity is the Children's Complex Health and Disabilities team staffing, placement support, inclusion intensive support, Children and Adolescent Mental Health Service (CAMHS), under 18 drugs and alcohol, short breaks, family intervention, trusted adult, shared care and contract carers.

The Children with Disabilities Service is made up of two elements.

- 3 Residential Units; Clockhouse, Wedgewood and Valley View
- 3 Statutory Social Work Teams.

This proposal is to build on the review already underway with CAMHS to ensure a service that meets the needs of children moving forward and is delivered within a reduced budget saving £250,000. In addition the proposal is to review the overall staffing & non staffing budget and save £34,000 in Year 2.

Equality impact on the Equality Duty protected characteristics & low income groups

This service works with disabled children who have are a group with a protected characteristic. Reduction in this service impacts on this specific group of young people.

Mitigation

A review of the CAMHS service with a financial appraisal will ensure that through achieving better value for money, direct service reductions are minimised. The review will ensure that resource is most effectively targeted at areas of need, with careful mapping of service needs and outcomes. Where possible resources will be reduced in back office and management functions. This change impacts on disabled children, but reductions are in place across the full service and have not targeted this group disproportionally.

See EIA 4C9

Ref - 4C10 Child Protection Review Team

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £1.2m

2017-18	2018-19	Total	% of current base
£0	£24,000	£24,000	2%

The services in scope are the Independent Reviewing Officer and Child Protection Chairs, and the LADO (Local Authority Statutory Officer). These services are all statutory.

This proposal is to undertake a review of all staffing & non staffing budgets and achieve a saving of 2% of budget in Year 2. Areas that will be looked at include vacancy management and use of software to reduce administrative requirements.

The review will prioritise non staff spending for reduction but there may be a requirement for staff reductions.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4C11 Leaving Care

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £3.5m

2017-18	2018-19	Total	% of current base
£68,000	£34,000	£102,000	3%

Within the scope of this activity is the staffing of the service, university support, Southwark judgement costs, semi independent placements and stepping stone support.

This proposal is to review overall staffing & non staffing budgets to achieve a saving of 2% in Year 1 & a further 1% in Year 2. Areas that will be looked at include vacancy management, improved procurement arrangements on items bought for young people, a review of agreements with providers of purchased services and closer monitoring of grants paid to young people to ensure that this is in line with the agreed policy.

The review will prioritise non staff spending for reduction but there may be a requirement for staff reductions.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4C13 Drugs and Alcohol Team

Note - This relates to funding linked to a Public Health Inter Departmental Agreement and should be seen as a loss of funding to the Service

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.3m

2017-18	2018-19	Total	% of current base
£50,000	£50,000	£100,000	29%

The Alcohol and Drugs Team is a specialist service tasked to address substance misuse as it affects children, young people and young adults who are parents.

This proposal includes a review of the work of the team and all of the other services that support young people with alcohol and drug issues to achieve a saving of £50,000 in year 1 and a further £50,000 in year 2.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

NB - Public Health England announced further cuts in Public Health grant of £1.085m in 2017/18 and a further £1.116m in 2018/19, total reduction over the two years of £2.201m. These reductions in grant will be met by some of the reductions in Public Health services shown above.

The total for Better Health, Better Lives savings proposals are reduced by this figure

Great Start, Good Schools

Total Savings Proposed - £1.1m	**2017-18**	**2018-19**
	£0.5m	**£0.6m**

Children's Services

Ref - 4C1 Children's Services - Education Services

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £3.8m

2017-18	**2018-19**	**Total**	**% of current base**
£0	**£0**	**£0**	**0%**

NB - the proposal below relates to reductions in grant funding and not Council Base Budgets.

The services within scope of this budget relate to services in Education, Employment and Skills including school improvement, Behaviour Support, Diversity and Cohesion, Educational Psychologists, School Governance, SEN core services for statutory duties and Trade Union Facility time.

Funding is provided through Dedicated Schools Grant (DSG), Education Support Grant (ESG) and High Needs Funding.

A significant proportion of the funding for these services is provided through the Dedicated School Grant (DSG) including high proportions of funding for the School Improvement team (including Governors and the data team) £1.3m, Behaviour and Attendance £426,400, Fischer Family Trust school licenses £33,500, Trade Union Facility time £415,800, EEMA £94,000.

From 2017 part of the DSG element will be removed from the Council and passed directly to schools with what remains to be removed in March 2018.

The total amount of DSG funding used to pay for the current services is £2.4m. This is therefore the sum which is at risk for the current services provided. Future decisions by the Bradford Schools Forum, as well as the Government's prescriptions about how funding can and will be used, will affect the scale of this risk.

While the resources will stay in the wider education system – and therefore be available to support the Council's wider ambitions for children - the shift from Council to schools will impact on the services the Council provides and the staff who provide them. High Needs Funding may be affected by proposed changes to the National Funding Formula for schools.

Plans are being formulated whereby a more targeted service will be provided for areas such as school improvement. However the majority of available funding will be utilised to tackle the education safeguarding agenda.

Equality impact on the Equality Duty protected characteristics & low income groups

The equality assessment carried out indicates that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share

protected characteristics.

Essential statutory services will be maintained by the LA. Part of the proposal is the recognition of the significant expertise that exists in schools. This expertise will increasingly be available to those schools through school-to-school support. In many cases the available capacity, expertise and level of resource available in schools can lead to heightened services for pupils and training for staff.

Mitigation

Resources will transfer into the schools system and the Council will work together with school leaders to ensure that schools are able to access the support that they need to drive improvement.

See EIA 4C1 & 4C2

Ref - 4C2 Children's Services - Early Years

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £9.4m

2017-18	2018-19	Total	% of current base
£0	£0	£0	0%

NB - the proposal below relates to reductions in grant funding and not Council Base Budgets.

The services within scope of this budget reduction relate to early years services in Education, Employment and Skills. Outcomes for children have been improving for early years in recent years with the highest results so far being achieved in 2016.
Funding is provided through Dedicated Schools Grant (DSG), Education Support Grant (ESG) and High Needs Funding.

A significant proportion of the funding for these services is provided through the DSG including a large proportion of funding for the Play Team (£220,000), Family Information Service (£234,000), Pre School Language Development (£44,600), Early Years team (£155,400).

The DSG element of early years is removed from the Council in part in March 2017 and the remaining in March 2018.This without any other funding cuts amounts to a budget decrease of £654,000 by March 2018.

The Council will have to work with others to review all its early years' provision. Plans are being formulated to develop a coherent and targeted suite of early years' services including early help, family centres and early years' services including Children's Centres.

Equality impact on the Equality Duty protected characteristics & low income groups

The equality assessment carried out indicates that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share protected characteristics. However, as the plans are being formulated to develop a coherent

and targeted suite of early years and early help services, the equality impacts will be reviewed and the impact assessment updated.

Mitigation

The Council will work together with other public sector leaders to ensure that the District retains a wide ranging early years offer, with the Council's own resources primarily targeted at those in greatest need.

See EIA 4C1 & 4C2

Ref - 4C12 Children's Services - Early Years School Readiness

Note - This relates to funding linked to a Public Health Inter Departmental Agreement and should be seen as a loss of funding to the Service

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.4m

2017-18	2018-19	Total	% of current base
£60,000	£0	£60,000	15%

This project funds a range of small VCS providers to undertake community based activity to help prepare children for school.

The budget proposal is to review this funding opportunity from 2017-18 and to make a reduction in the grants offered, ensuring that projects funded in the future meet the criteria of ensuring school readiness in line with the Council priority.

Equality impact on the Equality Duty protected characteristics & low income groups

Equality assessment carried out indicates that this proposal is unlikely to have any detrimental impact and so there is no disproportionate impact on any group that shared protected characteristics.

Mitigation

N/A

Health and Wellbeing - Public Health

Ref - 4PH1 Public Health - Services for Children 0-19

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £14.4m

2017-18	2018-19	Total	% of current base
£827,000	£1,390,000	£2,217,000	15.4%

NB - This proposal is split between the outcomes for Better Health, Better Lives and Great Start, Good Schools for accounting purposes but merged to describe the proposal

The services within the Scope of this Budget Reduction proposal relate to Public Health Services commissioned for children aged 0-19 and their families, and cover:

- **Health Visiting** (HV): a universal service for all children age 0-5 years, including the targeted Family Nurse Partnership (FNP) service for young mothers (under 20 years of age) in more deprived areas;
- **School Nursing** (SN): a universal service for 5-19 year olds;
- **Oral Health** (OH): a programme to improve children's oral health across the district;

The proposal is to reduce the overall Public Health budget for 0-19 years from £14.4m to £12.2m by 2018-19. The reduction will be phased over two years and identified through service based efficiency savings.

Health Visiting and School Nursing Services:
The service will be subject to 5% savings during 2017-18 and 10% during 2018-19 which will be realised by a review of current service delivery and staffing structures, primarily identifying savings through management and back office savings, and vacancy control.

Oral Health:
The Programme will be subject to a £50,000 (7%) reduction in 2017-18 and £100,000 (17%) in 2018-19 which the provider will be required to find through management and back office savings, stopping all training (including midwifery) and campaigns, and the Healthy Teeth Award and Health Promotion Practice Award.

Equality impact on the Equality Duty protected characteristics & low income groups

Any reduction in Public Health investment carries with it a risk that the children and young people will experience deterioration in health and wellbeing within the district.

The reduction in service will impact on quality and access as all training and resources will be withdrawn and providers will not access up to date training which could impact on partnership working both externally and internally, which in return will result in lack of awareness amongst their clients groups which are mainly the protected groups such as mothers/parents, babies and early year's children services.

Mitigation

Using a phased approach will help to plan and prepare any risks which can then be managed through the transformation process for a more integrated model for children and young people and the service will continue to provide statutory services.

See EIA 4PH1

Better Skills, More Good Jobs and a Growing Economy

Total Savings Proposed - £4.2m	**2017-18**	**2018-19**
	£1.8m	**£2.4m**

Environment and Sport

Ref - 4E7 Environment and Sport - Remodel of Visitor Information & frontline service

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.3m

2017-18	**2018-19**	**Total**	**% of current base**
£0	**£50,000**	**£50,000**	**16%**

A review of tourism and visitor economy services is currently taking place and will reduce the number and/or size of Visitor Information Centres across the district. The service will move to a more digital basis promoting the district to target audiences, with the potential for VIC information points as a co-located provision in buildings which are available and financially sustainable.

Equality impact on the Equality Duty protected characteristics & low income groups

The potential closure of VICs could have a disproportionate impact on older customers unable to access information electronically.

Mitigation

Alternative options are being explored including seasonal visitor information centres in destinations such as Saltaire, Haworth and Ilkley with support from local groups.

See EIA 4E7

Ref - 4E8 Environment and Sport - Events and Festivals

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.8m

2017-18	**2018-19**	**Total**	**% of current base**
£0	**£150,000**	**£150,000**	**18%**

There will be a review of the programme and an investment approach in future years in order to develop a more sustainable and balanced events programme between community, regional and national events, increased income streams and greater emphasis on partnership events across the key providers in the City, benefiting the wider economy that supports the event and visitor economy.

This budget also supports grants to voluntary arts and culture bodies and the City of Film work. Direct funding to this initiative will be removed through a more commercial approach to the work and there will be a review of the funding to external arts and cultural organisations. We will seek to ensure that we minimise the impact of the District's ability to leverage external arts and culture funding.

Equality impact on the Equality Duty protected characteristics & low income groups

Equality assessment carried out indicated that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share protected characteristics

Mitigation

N/A

See EIA 4E8

Ref - 4E9 Environment and Sport - Libraries

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £3.0m

2017-18	2018-19	Total	% of current base
£0	£100,000	£100,000	3%

There are currently 30 libraries and in the future there will be a reduction in the number of libraries directly provided. The service will investigate the potential for the libraries to be included in an alternative delivery model which could include a 'not for profit' trust model.

Equality impact on the Equality Duty protected characteristics & low income groups

Equality assessment carried out indicated that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share protected characteristics

Mitigation

N/A

See EIA 4E9

Ref - 4E10 Environment and Sport - Theatres and Community Halls

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.4m

2017-18	2018-19	Total	% of current base
£0	£130,000	£130,000	32%

Currently there is a feasibility study looking at the potential for a trust type model to be adopted in the Theatre and Halls Service. No decision has yet been made pending the outcome of this study.

In regard to community centres/halls it is proposed that they will be transferred as part of a community asset transfer. If this is not successful, they will then be reviewed and may form part of future proposals.

Equality impact on the Equality Duty protected characteristics & low income groups

Equality assessment carried out indicated that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share protected characteristics

Mitigation

N/A

See EIA 4E10

Ref - 4E12 Environment and Sport - Ministry of Food

Note - This relates to funding linked to a Public Health Inter Departmental Agreement and should be seen as a loss of funding to the Service

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.1m

2017-18	2018-19	Total	% of current base
£0	£96,000	£96,000	100%

The Ministry of Food (MOF) teaches people how to cook and eat and to improve their long-term health and wellbeing and is a practical hands-on community based cooking programme that teaches people of all ages how to cook from scratch.

The service will no longer be able to offer cookery groups for parents with children, students and young adults, young families, disabled people, VCS organisations, community groups, and the general public. In addition, the service will no longer be able to offer an outreach service across the district which includes cookery demonstrations, presentations and general information around health and well-being by teaching cooking skills.

Equality impact on the Equality Duty protected characteristics & low income groups

Whilst the Ministry of Food is a discretionary service provided by the Council, its closure will by definition have a disproportionate effect upon those people who share a protected characteristic. Those attracted to the services provided by the Ministry of Food tend to be those from disadvantaged communities where behaviour change is required to reduce obesity through education and teaching cooking skills.

Mitigation

The Health Improvement Team will support providers/organisations proactively with advice and sign-posting as opportunities are identified.
See EIA 4E12

Children's Services

Ref - 4C3 Children's Services - A prepared and Skilled Workforce

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £2.0m

2017-18	2018-19	Total	% of current base
£150,000	£150,000	£300,000	15%

The proposed savings will be made by reducing the Connexions Contract by £150,000 per annum in 2017-18 and 2018-19.

This and other savings proposals set out below will see an overall reduction of £2.3 million on 2016-17 budget (including reserve funding) in Education Employment and Skills. Furthermore, there will be a £1.2million reduction in projected income for Skills for Work during the period by 2018 as the Work and Work Choice Programme ends from April 2017 that will have to be factored into the savings required.

Key elements of the proposals are:

- To restructure Skills for Work and reduce staff in line with a reduction in income with the finishing of the government's Work and Work Choice programmes from April 2017.
- To reduce the Connexions Contract by £150,000 per annum in 2017-18 and 2018-19.
- At the end of the current Connexion Contract in August 2019 re-design the activity and bring the service in-house at a reduced cost.
- Explore the feasibility of establishing a regional young person tracking data centre with other West Yorkshire local authorities to make savings.
- To make Skills House funded from base budget from April 2020
- Cease funding the Employment Opportunity Fund (EOF) from April 2017.

Equality impact on the Equality Duty protected characteristics & low income groups

This proposal in regard to the Connexions Service contract will have a negative impact on people who share a protected characteristic. This service directly supports young people who are NEET, the cohort being comprised of young people with complex and multiple needs related to the protected characteristics and long-term low-income unemployed adults.

Mitigation

To mitigate the potential disproportionate impact of the Connexions Service propsal, there will be a re-design of the Connexions type activity to provide a minimum statutory service with a greater reliance on the Bradford Pathways approach that will be underpinned with more effective information, advice and guidance framework. Greater linkages and working with other front line staff working with young people will also be explored. It is not feasible to fully mitigate the impact of the proposals given proposed funding levels.

See EIA 4C3

Regeneration Services

Ref - 4R1 Regeneration Services - Industrial Services Group Operational Savings

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.04m

2017-18	2018-19	Total	% of current base
£0	£43,300	£43,300	100%

Industrial Services Group (ISG) is a trading service currently running at a cost to the Council. The proposal is to reduce the staffing structure to suit the present workloads starting with bringing the service back into line with the base budget. Further changes and reductions will be made to bring the service back to a nil operating budget.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4R2 Regeneration Services - West Yorkshire Combined Authority (WYCA) Transport Levy

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £24.0m

2017-18	2018-19	Total	% of current base
£750,000	£750,000	£1,500,000	6%

This proposals relates to the £24m contribution from Bradford paid to West Yorkshire Metro for transport operations. The contribution is raised as a levy, based on population size, across all 5 West Yorkshire Councils. Bradford's contribution includes a £1.4m Transport Fund for investment in transport infrastructure projects.

West Yorkshire Local Authority colleagues have requested that the WYCA consider a minimum 3% reduction (£750,000 for Bradford) in the 2016/17 levy and then a further percentage reduction per year to achieve a £750,000 saving each year.

Equality impact on the Equality Duty protected characteristics & low income groups

This proposal could have an adversely disproportionate impact on both the young (under 18's) and elderly sectors of the community as the funding which is being reduced is specifically used to fund schemes/programmes which are delivered for these groups.

Mitigation

The negative impacts would need to be considered within the wider West Yorkshire context

in consultation with WYCA with whom the ultimate decisions on which aspects of their budgets to reduce would rest.

Some aspects of expenditure of the Transport Levy are protected by national regulation and hence are likely to remain largely unaffected by any reductions as a consequence of this proposal. It is therefore anticipated that those elements of expenditure which are discretionary are likely to bear the majority of any agreed levy reduction.

See EIA 4R2

Ref - 4R3 Regeneration Services - Commercialise Highway Delivery Unit function

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £2.4m

2017-18	2018-19	Total	% of current base
£223,000	£223,000	£446,000	18%

This proposal is to increase the range of services provided by the Council's Highway Delivery Unit through increasing involvement in existing capital works programmes (other than highway maintenance) and delivery of services which are externally funded (e.g. installation of residential dropped crossings or services under the New Roads and Street Works Act).

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4R4 Regeneration Services - Centralisation of Urban Traffic Control including reduced maintenance of street lighting asset

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.5m

2017-18	2018-19	Total	% of current base
£119,000	£246,000	£365,000	77%

This proposal is based around the current West Yorkshire Combined Authority programme to establish a West Yorkshire UTMC (Urban Traffic Management & Control) service combining all traffic signal staff from all West Yorkshire districts with a presence from bus operators, emergency services & WYCA in a central location.

It should be noted that as this project is not within the direct control of the Council. Delays in implementation may adversely impact the delivery of savings within the proposed timeframe.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4R5 Regeneration Services - Increase charges within Planning, Transportation and Highways Services

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.6m

2017-18	2018-19	Total	% of current base
£30,000	£30,000	£60,000	11%

The scope of this proposal is to increase discretionary charges within the Planning, Transportation & Highways Services together with introducing new charges for aspects of the services functions which bring it in line with neighbouring authorities. Specific proposals within Transportation & Highways include:

- Increasing charges associated with Section 38 and Section 278 Agreements including raising the minimum amount of charge payable including to £2,000 per agreement with a standard charge of 9% of the bond amount for technical inspection and validation.
- Introducing a new annual charge for café licence applications, inspections and approvals of £500 per permit.
- Introducing a minimum charge for events on the highway to cover staff costs associated with their planning and co-ordination except where such events are street parties.
- Introducing a charge to permit the temporary installation of developer signs on street lighting columns inclusive of their manufacture and removal at the end of a prescribed period.

Proposals within Planning include:

- Increasing pre-application advice service charges above the standard rate of inflation.
- Introducing a charge for dealing with high hedge complaints.
- Introduction of a charge for the street naming and numbering services with appropriate exception for street names associated with injured/killed military service personnel.

Equality impact on the Equality Duty protected characteristics & low income groups

The introduction of fees and charges in relation to dealing with high hedge complaints may lead to disproportionate impacts on the low paid sectors of the community and senior citizens. Currently, receipt and investigation of complaints in relation to high hedges are processed by the Council on a free of charge basis.

Introduction of a minimum charge for co-ordination and marshalling of events on the highway could adversely affect those community interest groups/areas of protected characteristics who wish to arrange an event on the highway. The impact of this proposal may lead to a number of events no longer taking place along traditional routes given the costs associated with the administration and approval of traffic management.

Mitigation

Discounts for various types of organisations in relation to charges for events on the highway could be introduced to help minimise the impact of this aspect of the proposal. It should be noted that this proposal will not affect the holding of a street party which will remain free of charge as per national guidance.

The mechanism for charging for dealing with high hedge complaints may similarly introduce a discount for members of the community over a certain age making a complaint.

See EIA 4R5

Ref - 4R6 Regeneration Services - Options related to discretionary budgets for highway maintenance works including minor drainage improvements, pavement repairs and footpath and snicket maintenance.

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.7m

2017-18	2018-19	Total	% of current base
£128,000	(£6,400)	£121,600	18%

The above savings profile assumes adoption of the level of service defined below whereby a direct budget reduction of £128,000 would be implemented in the 2017-18 financial year.

The Council currently allocates an annual budget of £50,000 per parliamentary constituency to allow minor scale maintenance works such as drainage repairs and improvements, pavement and pedestrian area maintenance, footpath maintenance and urban snicket maintenance.

The proposal would see a reduction of the current service level provision meaning each parliamentary constituency would receive circa £25,000 for minor maintenance repairs. Under this proposal works would continue to be prioritised on drainage maintenance, unclassified road maintenance, issues with a “life and death” consequence with very minimal levels of funding for footpath work per constituency and no funding to undertake snicket maintenance.

Equality impact on the Equality Duty protected characteristics & low income groups

Whilst the cost of the works delivered through the local area maintenance budgets may be relatively small, the impact of non-action could have a disproportionate impact on the lives of the districts citizens. Some footpaths and snickets are currently impassable due to lack of maintenance which is a consequence of the current reduced budget allocation.

Mitigation

As the scope of the impact arising from this proposal could be wide ranging and dependent upon the nature of any specific maintenance requirements, it is not possible to propose measures to fully mitigate or eliminate the disproportionate impacts.

However, the nature of the prioritisation framework (which is still to be developed), which would be used to assess the priority for action of any requests, could incorporate appropriate consideration of the characteristic of the person needing action (e.g. include age and/or disability criteria).

See EIA 4R6

Ref - 4R7 Regeneration Services - Reduction in Highways Services operational budgets associated with operational accommodation, transport gateway and subway maintenance.

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.2m

2017-18	2018-19	Total	% of current base
£64,000	£31,600	£95,600	43%

Transport Gateway and Subway Maintenance

This proposal would reduce maintenance activities on gateway corridors to Bradford city centre together with maintenance of current subways and underpasses in the city centre. The Council currently allocates an annual budget of £127,000 to fund minor scale maintenance works.

HDU Depot Reduction

This proposal is to reduce the operational bases used by both the Highways Delivery Unit (DLO), Traffic & Road Safety (North) and Highway Maintenance (North) teams through relocation of existing staff, plant and materials from Stockbridge depot to other operational bases to realise budget savings equivalent to the annual maintenance and running costs of the Stockbridge facility charged to the service.

Equality impact on the Equality Duty protected characteristics & low income groups

Failure to undertake any maintenance of gateways and subways will very rapidly lead to these assets deteriorating and potentially becoming impassable.

Winter maintenance operations would be significantly impacted by the reduction in DLO operational bases meaning longer times being necessary to grit the routes in the district, potentially meaning that areas in the north of the district may be untreated in periods of inclement weather.

This could therefore impact on some of the protected characteristics.

Mitigation

Any loss of a subway/underpass facility could be offset through the introduction of a

crossing. Research has shown that these types of crossing are more attractive to pedestrian users than subways as they are generally perceived as reducing the fear of attack/crime for pedestrian users. However, such facilities on major corridors are problematic as they need to cross six lanes of traffic and therefore their design can lead to increased delays for general traffic and increased frustration for drivers.

The impact of the closure of the depot at Stocksbridge and the consequent impact on winter maintenance operations will need to be carefully considered within the context of winter gritting routes and treatment programmes. Consideration of more pro-active treatment regimes for areas in the north of the district will need to be developed in order to ensure that problems associated with reactive maintenance are mitigated.

See EIA 4R7

Ref - 4R8 Regeneration Services - Increase fine income by increasing enforcement of contraventions by statutory undertakers of the Yorkshire Common Permit Scheme (YCPS) on highways.

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £n/a

2017-18	2018-19	Total	% of current base
£30,000	£70,000	£100,000	n/a

The Council has a statutory duty under the Traffic Management Act 2004 to coordinate road works to ensure traffic moves efficiently around its network. In recognition of this duty the Council sought powers from the Secretary of State to introduce a Permit Scheme on key transport corridors in the District. This scheme provides income both from the applications for permits to carry out works on the highway and from the statutory powers to fine utility companies that breach the scheme.

The income from permit applications is used to cover the staff costs of operating the scheme. The Council must review its fee income every year to ensure that surpluses are not accruing and similarly that costs are not exceeding income. Where either of these conditions occur it must adjust its fee charges every third year to reflect operational realities (either increasing or decreasing charges accordingly).

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4R9 Regeneration Services - Reduce Area Committee support by Highways and stop processing/charge for all requests for service delivery for non-casualty led projects.

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.3m

2017-18	2018-19	Total	% of current base
£0	£124,000	£124,000	40%

Introduce an alternative Governance structure for consideration of all highway related matters rather than the current Area Committee structure thereby reducing the officer numbers required to effectively service five committees. In addition, this proposal recommends that elements of non-casualty led works and requests for service delivery are either stopped or charged for at cost rates.

Equality impact on the Equality Duty protected characteristics & low income groups

Any replacement decision making body would need to appropriately consider the views and opinions of the protected characteristics and demonstrate appropriate consideration/due regard to the Equality Act duties. The exact form of this decision making body is yet to be determined and hence the impact of this proposal cannot fully be explored at this time.

The introduction of an administrative charge to cover the additional processing necessary for checking the validity of a disabled persons parking permit (DPPP) would produce a disproportionate negative impact on this protected characteristic.

Provision of some of the other proposed highway services (e.g. vehicular dropped crossings and keep clear markings) may similarly have a disproportionate impact on those sectors of the community where the ability to pay for services will be an issue (e.g. elderly residents or those residents on low income).

Mitigation

Decisions taken through the new body would need to ensure that appropriate consideration is given to the Equalities Act on all matters progressed. Therefore any decision recording process must ensure that an appropriate record of the regard given to Equalities matters on the decision matter is retained.

See EIA 4R9

Ref - 4R10 Regeneration Services - Payment Reductions - Capital Team

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £1.8m

2017-18	2018-19	Total	% of current base
£50,000	£50,000	£100,000	5%

£50,000 will be taken from the budget in 2017-18 to reduce it to £1.8m by a combination of

savings due to salary savings and a reduction in facilities management and other charges.

In 2018-19 the final payment of £50,000 will have been made by the Council for the temporary classrooms at Ryecroft Primary School and this money can be released as a saving.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4R11 Regeneration Services - Introduction of limited lighting hours / switch off of street lighting on non-principal road network

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £1.4m

2017-18	2018-19	Total	% of current base
£50,000	£60,000	£110,000	8%

This proposal is to arrange for the introduction of limited lighting hours or switch off of street lighting on non-principal road network to save energy costs. Typical non-lit hours could be from 12am-5am (or longer on lesser populated/used areas of the non-principal network). Proposals for groups of streets to be included in any switch off zone would need to be developed in accordance with appropriate standards including assessment of road traffic collision data, criminal activity and infrastructure condition/type etc.

A small capital investment in appropriate lighting management equipment/software would initially be required for any sections of non-principal network selected for limited lighting hours but this initial cost would be rapidly recovered as energy costs are fully saved during non-lit hours.

Equality impact on the Equality Duty protected characteristics & low income groups

Introduction of this proposal in additional areas of the district will have a disproportionately negative impact on some protected characteristics.

Fear of crime amongst the elderly will increase where back streets and residential roads are unlit during the early hours of the morning and it is from this characteristic group that the greatest impact is anticipated.

Similarly fear of crime on unlit streets could adversely impact the protected characteristic groups of disability, race, religion/belief and sex who may all experience increased levels of concern about the proposal.

Mitigation

The Council has developed a set of criteria which are used to select streets where limited

lighting hours are introduced. These criteria assess road safety statistics, criminal activity records, infrastructure condition and involve consultation with the local community on any proposals being prepared.

Any streets which are considered appropriate to be included in the programme of limited lighting operation will be fully appraised using this model before a decision is taken on whether or not to implement the limited lighting hours infrastructure is taken. Those streets with high criminal activity and/or poor road safety records will not be included in the project beyond their initial assessment.

To avoid any undue distress to local residents only those streets which "pass" the desktop assessment will be consulted upon with the local community.

See EIA 4R11

Ref - 4R12 Regeneration Services - Increasing the profitability of the FM service for schools

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding (£0.7m)

2017-18	2018-19	Total	% of current base
£30,000	£35,000	£65,000	(9%)

This proposal is to increase the trading surplus of School Catering & Cleaning by up to 10% through increased sales and price reviews while being mindful of the need to maintain value for money and retain the existing client base. Additionally, work is on-going to assess the option of these services being provided via various alternative delivery models.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4R13 Regeneration Services - Businesses starting-up, growing and investing - Economic Development Service

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £2.2m

2017-18	2018-19	Total	% of current base
£150,500	£0	£150,500	7%

Proposal is as below;

- £70,000 to be removed from the £320,000 City Park Sinking Fund, further reducing the maintenance fund for major works to £250,000.

- Reduce match funding of £72,500 for European Strategic Investment Fund programmes and projects.

- Remove support for the Bfunded community funding information website saving £8,000. Financial and officer support will cease in 2018 and a transfer to Third Sector partners is under negotiation.

Remaining work areas will be refocused to meet new priorities around Inclusive Growth and increasing our business rates income.

Equality impact on the Equality Duty protected characteristics & low income groups

Equality assessment carried out indicated that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share protected characteristics

Mitigation

N/A

See EIA 4R13

Ref - 4R20 Regeneration - Sustrans promotes young people travelling to school actively and/or sustainably

Note - This relates to funding linked to a Public Health Inter Departmental Agreement and should be seen as a loss of funding to the Service

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.056m

2017-18	2018-19	Total	% of current base
£0	£28,000	£28,000	50%

This budget saving proposal is phased over two financial years commencing in 2018-19 to allow for discussions with schools involved in supporting the programme. The first change in 2017-18 would be to no longer accept new schools onto the programme with existing schools provision being phased out over the following years of this budget proposal.

Equality impact on the Equality Duty protected characteristics & low income groups

The nature of the Active School Travel programme is such that its cessation would effectively adversely affect the young children and adolescents which the programme targets through removal of the opportunities afforded under the programme to embed health lifestyle choices.

Similarly, as children with a sedentary lifestyle are predominantly found in areas of deprivation and low incomes, the cessation of this programme would likewise have an

impact on this protected characteristic.

Mitigation

Working with schools it may be possible to introduce aspects of the programme into the school curriculum, however given the demands on pupil contact time created by the national curriculum this may not be a significant mitigation proposition.

See EIA 4R20

Ref - 4R21 Regeneration - Road Safety Training programme in Schools

Note - This relates to funding linked to a Public Health Inter Departmental Agreement and should be seen as a loss of funding to the Service

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.3m

2017-18	2018-19	Total	% of current base
£0	£62,500	£62,500	24%

The Road Safety Team operates on a district-wide basis. Staff and financial resources are allocated to education, training and publicity programmes based on priorities identified for greatest impact on casualty reduction. This reduction would result in a net reduction of staff resources available for this type of work.

This proposal would reduce the funding for the team, effectively reducing the exposure of road safety training and support to local children of both pre- and school age.

Equality impact on the Equality Duty protected characteristics & low income groups

This proposal will adversely affect the younger sections of society, or those from wards with a particular road safety problem (which tend to be predominantly low income inner city wards) who will not be able to access the same level of training and awareness activities as are currently provided by the Road Safety Team.

Mitigation

Nominal charges for provision of training programmes could be introduced, however these have historically been seen as barriers to ensuring take up of the training provided and therefore may have a counter effect to that anticipated.

Programmes of training interventions may need to be targeted to Key Wards in each year due to reduced resources. This would ensure that those wards with an identified road safety issue receive some training but may mean that some areas of the district similarly are not offered any training in future.

Alternative funding sources for the provision of this service could be explored within West Yorkshire to offset the reduction in funding.

See EIA 4R21

Decent homes that people can afford to live in

Total Savings Proposed - £0.076m	**2017-18**	**2018-19**
	£0.03m	**£0.04m**

Regeneration Services

Ref - 4R18 Regeneration - Housing - Homelessness Private Rented Housing Development Officer

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £1.9m

2017-18	**2018-19**	**Total**	**% of current base**
£32,000	**£0**	**£32,000**	**2%**

Delete the vacant post of private rented housing development officer.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4R19 Regeneration - Housing - Increase income generation from agency fees

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £1.0m

2017-18	**2018-19**	**Total**	**% of current base**
£0	**£44,000**	**£44,000**	**4%**

To increase fee income for the Housing Operations service from agency fees by £44,000

The increase in fee income is achievable due to the current levels of demand and delivery of Disabled Facilities Grants (DFGs). The Housing service which administers DFG's offers an agency service to procure and manage works on the clients' behalf. In 2015-16 87% of clients chose to use the agency service and the number of referrals for DFG continues to increase year on year. In 2015-16 Housing received 603 new referrals for DFG compared to 357 in 2013-14 and 489 in 2014-15.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Safe, Clean and Active Communities

Total Savings Proposed - £1.5m	**2017-18**	**2018-19**
	£0.1m	**£1.4m**

Environment and Sport

Ref - 4E1 Environment and Sport - Parks and Bereavement

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £2.35m

2017-18	**2018-19**	**Total**	**% of current base**
£0	**£160,000**	**£160,000**	**7%**

Parks, Recreation Grounds and Woodlands are to be offered as community asset transfer initiatives.

Tree work & Wood Management services will rationalise the management structure & reduce work to trees & woodlands.

In relation to sports pitches & bowling greens the Council will withdraw from the direct management and maintenance of sports pitches and bowling greens and explore the potential of increasing charges.

The Council will use the consultation period to discuss with the groups affected, the options available.

Bereavement Service - Raise prices 3% above inflation in financial year 2018-19.

Equality impact on the Equality Duty protected characteristics & low income groups

With regard to bereavement service proposals, any increase in charges, particularly at a rate above inflation, will by definition have a disproportionate effect upon those on low incomes for a service that cannot be viewed as discretionary.

Given that cremation charges are currently lower than burial charges, particularly should a new grave be required, any percentage price rise will generate a higher cash increase in the cost of burials than that of cremations. This could represent a disproportionate effect for those religious and faith communities that favour burial.

The implementation of a flat rate cash increase to both cremations and burials would however have increased the cremation charge to a level disproportionate to that of the burial charge in terms of comparator values of neighbouring Councils.

Mitigation

The most deprived/low income communities receive support for the cost of funerals from the Council through Adult Services.

The proposed above inflation increase in charges for funerals will result in local service users continuing to pay less than the average within West Yorkshire for all services.

It is intended to introduce a reduced rate for the walling of graves to coffin height which will mitigate the effect of the increases for those faith groups that adopt such a requirement.

See EIA 4E1

Ref - 4E2 Environment and Sport - Waste Collection and Disposal Services

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £21.6m

2017-18	2018-19	Total	% of current base
£50,000	£807,000	£857,000	4%

Budget proposals have already been approved for the introduction of Alternate Weekly Collection (AWC) of residual waste, which will also see the introduction of fully co-mingled recycling via a Mechanical Recycling Facility which has been installed at Bowling Back Lane Household Waste and Recycling Centre. This will enable residents to re-cycle all types of plastics and therefore further reduce waste into the residual bin which will support residents with this change to AWC and encourage greater recycling. The year 2 savings (2018-19) will include the remaining full year effect of the year 1 planned reduction in rounds and a further reduction of 3 rounds with associated restructuring of Waste Services.

The Council is currently part way through a procurement process to award a contract for the disposal of its residual waste following the approval of the "Municipal Waste Minimisation & Management Strategy" by Executive in January 2015. The procurement of new waste treatment arrangements are due to be finalised by October 2017.

Equality impact on the Equality Duty protected characteristics & low income groups

The proposal is likely to have no or a low impact on everyone so it is considered that there is no disproportionate impact on any group who share protected characteristics. It is however recognised that a move to alternate weekly collection could result in the residual waste bin being heavier to move around.

Mitigation

It is recognised that the elderly and disabled could be impacted upon by a heavier bin where there are mobility or accessibility issues. The Council already provides assisted bin lifts for residents in such circumstances. If this service is required, residents can call the Council Contact Centre and a home visit will be arranged to see how the Council can help.

See EIA 4E2

Ref - 4E3 Environment and Sport - Trade Waste

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding (£0.5m)

2017-18	2018-19	Total	% of current base
£50,000	£0	£50,000	(9%)

The Council operates a Trade Waste Collection Service to local businesses. It currently has approximately 3000 customers collecting 19,500 tonnes of residual waste and 800 tonnes of recycling. Process improvements have been identified which will release cashable savings from a revision of the existing charging policy and a move to cashless payment systems. In addition the service actively seeks out new business to generate additional revenue. Our customers are predominantly small to medium size businesses which in the future could be supported by the domestic waste collection service. This would then reduce trade waste service costs and make the service more competitive.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4E4 Environment and Sport - Customer Services

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £3.1m

2017-18	2018-19	Total	% of current base
£0	£50,000	£50,000	2%

A continuation of the Customer Services Strategy seeking to redirect face to face contact towards self service and telephone services will see a continuing decline in contact resulting in staffing efficiencies.

Automated services will increase with fewer options for people to speak to a customer services advisor. More people will be expected to 'self serve' using on line services. Automation will be used to take requests for services where appropriate.

Equality impact on the Equality Duty protected characteristics & low income groups

The Council recognises that any move toward increasing dependency on digital/online access to Services or information may potentially have a detrimental impact on residents who do not have English as a first language or who don't/can't access IT. Making services available electronically could impact on those unable to access due to ability or lack of available technology. Those with a preference or requirement to deal with a person may feel anxious and vulnerable.

The majority of current face-to-face customer service and an increasing proportion of telephony work is with low wage/low income groups, including people with disabilities, and older people although there has been a significant increase in enquiries from customers from Eastern Europe who have language barriers.

Customer service teams carry out some home visits to customers who are unable to access Council services in other ways.

However, in the context of the number of enquiries handled by the Council each year, the relative numbers of people adversely impacted by the proposed change is small.

Mitigation

To mitigate the potentially disproportionate impact the Council remains committed to the Five Principles of Producing Better Information for Disabled People, and will also continue to make sure the Council website is accessible.

Greater self service access will provide the majority of citizens with a more efficient service; thereby freeing up the limited resources to focus on those who need the additional support. By minimising avoidable face-to-face and telephone contact with the council, officer time can be better directed to those customers who require it.

See EIA 4E4

Ref - 4E5 Environment and Sport - Street Cleansing and Public Conveniences

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £4.5m

2017-18	2018-19	Total	% of current base
£0	£336,300	£336,300	7%

There are currently 25 Ward based clean teams and 17 mechanical sweepers. This proposal would see a reduction in the number of ward based clean teams and mechanical sweepers (precise number to be determined during consultation period) and the removal of funding for all public toilets (except City Park).

The service would continue to employ any new starters working to a standard 30 hour working week, mitigating the impact through increased use of technology.

Potential income from a City and Town Centre environmental enforcement contract may generate Fixed Penalty Notice income to offset the loss of the one street cleansing team.

Equality impact on the Equality Duty protected characteristics & low income groups

The proposal has the potential to have a low impact on predominantly inner city highly densely populated areas. The people who live in these areas are in the main white people on low incomes and communities from BME backgrounds.

In terms of closure of the toilets there is likely to be a disproportionate impact on older people, pregnant women, parents requiring access to baby changing facilities, young

children, transgender community, disabled people, particularly those with complex needs, and people who, because of their physical condition, may need to visit the toilet more regularly.

Mitigation

Increased waste awareness and anti litter/education campaigns in affected areas and the new robust enforcement model for targeting those people that drop litter, will mitigate the impact the street cleansing proposals.

In the case of public toilets work will take place to ascertain whether Parish/Town Councils, community or other voluntary groups could take over the running of those blocks proposed for closure. Consideration will also be given to whether local businesses, cafes, restaurants etc. would allow people to use their facilities.

See EIA 4E5

Ref - 4E6 Environment and Sport - Cessation of the Pest Control Service

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.036m

2017-18	2018-19	Total	% of current base
£0	£36,200	£36,200	100%

The Council will stop providing a Pest Control Service. The provision of a pest control treatment service is not a statutory service and it is currently running at a loss. Due to the availability within the private sector for a similar product at a similar cost it is proposed to stop delivery of this service.

The Council's prices for pest control treatments are similar to the private sector. Therefore the financial impact on residents would be minimal.

Equality impact on the Equality Duty protected characteristics & low income groups

This proposal could have an adverse impact on people on low incomes as it removes the facility to pay for treatments in instalments although the equality assessment carried out indicated that this proposal is likely to have no or a low impact on everyone, and so there is no disproportionate impact on any group who share protected characteristics

Mitigation

The most common request for treatment is to deal with rats and mice and there is at least one company in Bradford which is able to provide the service cheaper than the Council.

See EIA 4E6

A Well-Run Council

Total Savings Proposed - £3.3m	**2017-18**	**2018-19**
	£0.6m	**£2.7m**

Financial Services

Ref - 4F1 Financial Services - Restructure

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £2.8m

2017-18	**2018-19**	**Total**	**% of current base**
£32,000	**£130,000**	**£162,000**	**6%**

The size of the Financial Services function will continue to gradually reduce, reflecting reduced emphasis on retrospective reporting, more self-service by budget managers, and targeting staffing resources at highest risk, most complex issues. We will also consider if transactional functions across the Department will be more efficient and sustainable if we bring them together. This will be achieved through further restructuring.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4F2 Financial Services - Manage insurance risks and claims

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £6.0m

2017-18	**2018-19**	**Total**	**% of current base**
£200,000	**£300,000**	**£500,000**	**8%**

The proposal aims to reduce the total cost of insurance, including premiums paid to the Council's insurer, the cost of maintaining an internal insurance fund for self-insured risks and the cost of meeting claims.

The scope will include:

- Reassessing the level of self-insurance
- Exploring with the Council's insurers the options for reducing premiums
- Working with Departments to take action to reduce claimable risks
- Maximising the benefit of the impact of Ministry of Justice reforms of the legal costs allowable in claims
- Selling on insurance cover to schools to generate marginal income

Equality impact on the Equality Duty protected characteristics & low income groups
N/A

Mitigation
N/A

Ref - 4F3 Revenues and Benefits - Rationalisation of the cash management function

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £0.3m

2017-18	2018-19	Total	% of current base
£0	£160,000	£160,000	49%

Reduce significantly the amount of cash used by and within the organisation and reduce the cost of cash management functions through the increased digitalisation of customer payment options.

We will also consider if transactional functions across the Department of Finance will be more efficient and sustainable by bringing them together.

Equality impact on the Equality Duty protected characteristics & low income groups
N/A

Mitigation
N/A

Ref - 4F4 Financial Services - Contribution to West Yorkshire Joint Committees

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £1.2m

2017-18	2018-19	Total	% of current base
£75,000	£35,000	£110,000	9%

West Yorkshire Joint Services is a shared services organisation led by a Joint Committee from the five District Councils. It carries out specialist collective functions. The proposal is to cap Bradford's contribution to joint committees at £1.1m, which will require concerted action with other Councils.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation
N/A

Ref - 4S1 Information Technology Services

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £12.5m

2017-18	2018-19	Total	% of current base
£0	£500,000	£500,000	4%

The proposal is comprised of two main components:

- Re-sizing of IT Services to reflect the broader organisational changes affecting the Council. The assumption is that there will be a significant reduction in the number of Council supported desktop/laptop devices over time. This will enable IT Services to reduce costs associated with device support, licenses and infrastructure.

- Fit for purpose IT application architecture - This component will involve switching technology solutions where better value can be achieved and rationalising the number of existing IT applications to simplify the technology in use.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Human Resources

Ref - 4H1 Human Resources - Restructure

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £4.6m

2017-18	2018-19	Total	% of current base
£0	£204,000	£204,000	4%

The proposal is to reduce transactional HR support, to reduce volume of service specific training, to return 'non HR' activities such as Coroners office, Finance and Mail Distribution and Archive to more appropriate Corporate Service functions.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4H2 Human Resources - Terms & Conditions

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £1.65m

2017-18	2018-19	Total	% of current base
£0	£400,000	£400,000	24%

Removal of non contractual overtime payments and removal of essential car allowance lump sum payments.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Legal and Democratic Services

Ref - 4L1 Legal and Democratic Services

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £5.7m

2017-18	2018-19	Total	% of current base
£20,000	£55,000	£75,000	1%

To reflect the reduced size and scope of the Council, reductions to Civic, Legal and Committee Services, including Overview and Scrutiny, are proposed. It is not possible to describe the precise changes until the Council decides what it requires from these services in the future.

The Civic profile of the Council is proposed to diminish, including no longer having a Deputy Lord Mayor. As the Council reduces in size and scope there will be an impact on the number and frequency of Committee meetings, including Overview and Scrutiny. As reductions are agreed some reductions in staffing will need to be considered.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Office of the Chief Executive

Ref - 4X1 Office of the Chief Executive - Restructure

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £3.6m

2017-18	2018-19	Total	% of current base
£0	£479,000	£479,000	13%

In February 2016 Council agreed a saving of £541,000 in 2017-18 from a "review and restructure of Chief Executive's Office, Public Affairs and Communications (PAC) and Policy Programmes and Change (PPC)." Further cuts of £479,000 are proposed for 2018-19.

This proposal suggests a radical restructure of the Office of Chief Executive to improve the coherence and integration of core corporate functions, so they can support and improve the Council's leadership of the District. The authority will need to continue to change in order to have the agility, skills and capacity to influence, negotiate, communicate and collaborate with communities and partners to deliver the district's priorities.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Regeneration Services

Ref - 4R14 Regeneration - Asset Management - Manage the Operational and Investment Estate

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £n/a

2017-18	2018-19	Total	% of current base
£270,000	£240,000	£510,000	n/a

The proposal foresees changes in the management of:

- the Council's operational and investment estate;
- Delivery of the capital receipts programme
- Community Asset Transfers and Assets of Community Value
- One Public Estate Programme

This aims to make the best use of the Council's and public sector partners' estate working with the Voluntary and Community Sector.

We will also seek investment in non-operational property to generate surplus income. The proposal targets £260,000 gross cost reductions and £250,000 additional surplus income.

Overall it is proposed to increase surplus income to £1million p.a. by 2020.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4R15 Regeneration - Facilities Management Operational cost reductions

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £4.5m

2017-18	2018-19	Total	% of current base
£0	£100,000	£100,000	2%

Allowing for the planned release of Future House and Jacobs Well and further estate rationalisation reflecting the continued contraction of the organisation. Operational estate costs including cleaning, will fall.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

Ref - 4R16 Regeneration - Facilities Management - Operational Savings

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £3.2m

2017-18	2018-19	Total	% of current base
£0	£100,000	£100,000	3%

Planned reductions in Facilities Management will take the current net budget down from £3.9m to £3.8m. A further reduction in future years is likely but would be dependent on the Council's estate shrinking further.

Equality impact on the Equality Duty protected characteristics & low income groups
N/A

Mitigation
N/A

Ref - 4R17 Regeneration – Facilities Management - Manage New Energy Projects & Corporate Utility consumption

Total 2016-17 Net Budget for Service Area after pre-agreed savings & removal of transitional funding £4.6m

2017-18	2018-19	Total	% of current base
£0	£50,000	£50,000	1%

Sharper procurement and control of utilities to all Council buildings, managing carbon taxes and statutory annual carbon emissions reporting, and the current energy efficiency capital programme will all deliver savings.

The energy industry is forecasting 35% energy price inflation by 2020, due to increased non-commodity price increases, grid/network costs etc. It is anticipated that there will be a commensurate reduction in the size of the estate during this period, allowing offsetting savings.

Equality impact on the Equality Duty protected characteristics & low income groups

N/A

Mitigation

N/A

APPENDIX E- SCHEDULE OF AMENDMENTS TO PREVIOUS BUDGET DECISIONS & SUBJECT TO CONSULTATION

Children's Services

Ref - 3C8 Reducing cost of high cost placements & reducing numbers of Looked After Children £1,630,000 in 2017-18

Alternative compensatory proposals

Ref - 4C14 Reducing Agency Spending in Children's Social Care Services

2017-18	2018-19	Total
£1,025,000	£36,000	£1,061,000

This replacement proposal is to reduce spending on agency social workers and agency staff in Residential Homes. There will always be instances where staff turnover and unplanned change means that to be safe, the Service will need to employ agency staff at short notice. This project will deliver an overall reduction in the spending on agency staff of £1million. This will be achieved through a number of strands which will start with a review of caseload numbers in social work, which is already underway.

Ref - 4C15 Front Door Customer Contact to Children's Social Care Services

2017-18	2018-19	Total
£0	£46,000	£46,000

This project will achieve savings at the first point of contact for social care through a review of the current arrangements. A review will identify clearer pathways from the first contact through to assessment and staffing efficiencies will be achieved following this.

The project will review all access points to Children's Services and look to integrate them into one single point of contact.

Ref - 4C16 Administrative Support restructure

2017-18	2018-19	Total
£100,000	£0	£100,000

The proposal is to review the administrative structure within Children's Specialist Services to identify potential for some rationalisation of the supervision and management structure.

NB - The pre-agreed savings for Children's services that are no longer achievable are not fully matched by compensatory savings. As a result additional funding has been included in the proposed future base budget.

Environment & Sport

Ref - 3E25 Parking Services Income Generation £319,000 in 2017-18

Alternative compensatory proposal

Ref - 4E13 Parking Services Income Generation

2017-18	2018-19	Total
£222,000	£108,000	£330,000

This proposal sets out the adjustments to this year's budget decision in respect of income generation from amendments to on- and off-street parking orders, taking into account schemes which have not been implemented or where income estimates will not be achieved due to changes in shopping habits in the city centre since the introduction of The Broadway.

This replacement proposal is to;

- Remove Christmas parking concessions from next year

- Little Germany
- amend the tariffs in the Little Germany area of the city centre in line with charges in the rest of the city centre. Remove the half hour charge and increase to 70p per hour in accordance with the rest of the city centre.
- Extend the charging hours to bring them in line with the opening hours of The Broadway. Extend charging hours until 8pm during the week

- Introduce charging hours on Saturdays between 8:00 - 20.00 and Sundays 11:00 - 17:00 with a rate of £1 for a maximum of a 4 hour stay**.**

- Other Car Parks
- introduce an evening charge at South Hawksworth Car Park in line with car parks in Bradford City Centre. Valid Monday to Sunday 18:00 - Midnight. £1 flat rate charge
- Remove staff parking at Shipley and Bingley pools in line with staff parking schemes at the Council - staff could purchase contracts through salary sacrifice
- Introduce evening and Sunday charges at main car parks in Bingley
- Increase charges for waiver permits from £5 to £10 (or £15 if purchased on the day)

Adult & Community Services

Ref - 3A5 Staffing efficiencies £2,000,000 in 2017-18

Alternative compensatory proposal

Ref - 4A2 Adult Services Demand Management

2017-18	**2018-19**	**Total**
£2,000,000	**£0**	**£2,000,000**

The Department has reviewed its plan to reduce its front line staffing spend by £2m in 2017-18, and this replacement proposal is to address the required saving through the following approach as part of its delivery of the overall demand management strategy:

- Further reduction in high cost packages
- Further reduction in Supported Living contracts/ packages
- Various reductions in travel and fees

A combination of the above savings will achieve a net budget reduction of £2m during 2017-18 and will promote positive risk taking, enablement and independence and will maximise the use of assistive technology which reduces the number of care hours required to support individuals.

See also proposal 4A1 in Appendix C for more detail on the proposed actions in 2017-18.

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Report of the Chair to the meeting of Bradford and Airedale Health and Wellbeing Board to be held on 31st January 2017

R

Subject:

The Health and Wellbeing Chair's highlight report summarises business conducted between Board meetings

Summary statement:

Better Care Fund Quarter 2 performance; updates from Bradford Health and Care Commissioners and the Integration and Change Board including revised Terms of Reference; Healthy Weight Deliver Board update.

Councillor Susan Hinchcliffe
Chair – Bradford and Airedale Health and Wellbeing Board

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Portfolio:

Health and Wellbeing

Overview & Scrutiny Area:

Health and Social Care

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1. SUMMARY

The Health and Wellbeing Board Chair's highlight report summarises business conducted between meetings: where for example reporting or bid deadlines fall between Board meetings or business conducted at any meetings not held in public where these are necessary to consider material that is not yet in the public domain.

Reporting through a highlight report means that any such business is discussed and formally minuted in a public Board meeting.

The report also brings updates from the Health and Wellbeing Board sub groups – the Bradford Health and Care Commissioners meeting and the Integration and Change Board unless the issues are covered by a standing business item under the approach to 'Working Better Together – A Whole System for Health and Wellbeing'. Increasingly the business of both sub-groups will focus on work under the Sustainability and Transformation Plan (STP) for Bradford and Craven, and the broader West Yorkshire and Harrogate STP.

The January 2017 report covers:

- Better Care Fund - Quarter 2 Performance
- Business conducted at the November and December meetings of the Bradford Health and Care Commissioners Group and the Integration and Change Board.
- A further update on establishing a whole system approach to Healthy Weight from the Healthy Weight Delivery Board.

2. BACKGROUND

As this report addresses multiple issues in brief, the background to each issue is included with the main report in section 3 below.

3. OTHER CONSIDERATIONS

3.1 Better Care Fund – 2016-17 Quarter 2 performance

The Better Care Fund (BCF) - a partnership between health and care partners and the Local Authority was created nationally with the aim of achieving better integration of health and social care and improving the lives of some of the most vulnerable people in our society - placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care, to provide an improved experience of care when it is needed and better quality of life. Locally, the Fund aligns resources, including budgets, across health and care services to improve services and reduce duplication. Bradford Health and Care Commissioners (BHCC) have overseen the development of the Bradford District and Craven Better Care Fund (BCF) for 2016/17.

3.1.1 Quarter 2 Performance

The 2016/17 Better Care Fund (BCF) quarter two report was submitted to NHS England on the 25th November. Due to the submission date being out of sync with Health and Wellbeing Board dates the report was presented to the chair of the Health and Wellbeing Board for approval ahead of submission and a forecast dashboard was shared with the Health and Wellbeing Board at its 29th November Board meeting.

Summary:
The report demonstrates that progress is continuing against the implementation plan. To support this, BCF metrics and performance indicators demonstrate consistency with the plan.

Performance for our local metric (increase the diagnosis rate for people with dementia) has continued to be strong and consistently above the target throughout Q1 and Q2 with September data showing 81.2% against a target of 71%. Comparing the first 6 months of the BCF in 2016/17 to the same period in 2015/16 we have seen a year on year increase in the diagnosis rate for people with dementia. N.B. this metric is based on the footprint of the three CCGs – we are currently unable to split out Craven GP practices population.

Whilst Delayed Transfers of Care (DTOC) figures fell slightly short of our target in both Q1 and Q2 performance remains strong compared to others in the region and nationally. Both acute providers have reported continued concerns about pressures on bed capacity and A&E performance as a result of delays in discharging people to community based care. As such BCF partners have agreed to a full independent review of our processes regarding DTOC and people who are medically fit for discharge. An independent resource is being sought to undertake the review. The A&E delivery board will oversee development and delivery of a DTOC action plan and is due to receive an update at the December meeting.

Throughout 15/16 BCF partners reported an ongoing risk regarding Non Elective activity (NEL). Our BCF schemes aim to respond to this risk with reductions in such admissions via schemes such as the expanded virtual ward (Bradford) and complex and enhanced care (AWC). A reduction in NEL is anticipated throughout 16/17 as a result of these schemes. When comparing the first 6 months of the BCF for 2016/17 against 2015/16 Non Elective Activity has increased by 2664 and 2257 for Q1 and Q2 respectively. It should be noted however that during this time period national data sources have changed which could impact numbers marginally. The BCF team remain sighted on this metric.

At the meeting of Bradford Health and Care Commissioners in November it was

agreed to build on the work to date in developing the BCF dashboard as a means to monitor and measure the performance of each BCF scheme. Throughout Q3 Public Health partners will work with the BCF team to consider additional methods of evaluating and monitoring the schemes. Copies of the BCF dashboard will be provided at the meeting.

Better Care Fund Plan 2017-18

Development of the 2017-18 Better Care Fund Plan is in progress and will initially be considered at the Board's development session in February.

3.2 Updates from the Board sub-groups

3.2.1 Bradford Health and Care Commissioners (BHCC) December update

BHCC in December agreed to support a piece of partnership based work with Bradford Teaching Hospitals Foundation Trust (BTHFT), the Clinical Commissioning Groups (CCGs) and Public Health to develop a new service and approach to supporting vulnerable women during pregnancy.

Operating as the partnership board for both the Section 75 partnership agreement between the CCG and Local Authority, and the Better Care Fund (BCF) the December BHCC meeting was primarily dedicated to the quarter 2 performance review of the BCF Q2 performance monitoring dashboard and Section 75 Quarter 2 performance monitoring dashboard.

As part of the Section 75 review BHCC received a report from the Bradford and Airedale Community Equipment Service which included an update on actions to mitigate the increase in spend during the period 1st April – 31st October 2016 and the forecast year-end overspend. A detailed programme of work has been developed and will report back to BHCC in February 2017. Linked to discussions regarding the Section 75, BHCC requested that work is undertaken to look at the risks and opportunities in moving towards pooling budgets for Mental Health and Learning Disability Services within the 2017/18 Section 75. It also considered progress regarding integrated personalised commissioning for people with mental ill health, learning disabilities, older people and people with disabilities in line with the Care Act and NHS integrated personalised commissioning plans.

Finally, the group recommended the recommissioning of the Mental Health Wellbeing Navigation Service which is commissioned by the Local Authority and works in partnership with Bradford District Care Foundation Trust (BDCFT) and a wide range of VCS and community organisations to provide services to adults with a serious and enduring mental health problem, with a new service specification under development.

3.2.2 Integration and Change Board (ICB) December update

The November 18th ICB meeting was held in conjunction with the Children's Commissioner's Takeover Challenge which puts children and young people in decision-making positions and encourages organisations and businesses to hear their views. Vinay Verma, a student was taking over from Kersten England, Chair of ICB and found the meeting interesting and appreciated the challenges health and care system leaders are dealing with as they plan for the future together.

As part of the discussion on aligning strategic and operational planning it was agreed to make a case for our local STP footprint accessing our fair share of transformation funds linked to inequalities and for providers to submit a joined up response regarding planned changes to provider financial control totals.

The annual review of ICB terms of reference took place, along with a discussion on governance arrangements to support system sustainability and transformation and an agreement to progress recruitment for a Programme Director level to support the scale of transformational change. See Appendix 1.

Bev Maybury, Strategic Director, Health and Wellbeing, BMDC shared a presentation on adult social care and thinking about the future model of care. Discussions will continue with partners in the system and Bev will be bringing a case for change to the January 2017 ICB.

The self-care and prevention programme updated ICB with a revisit of the strategic overview of self-care to re-energise and embed the programme across care processes led by key partners. The work will focus on 3 priority areas; including people and communities - providing tools and resources and support to empower people to self-care, workforce - with self-care skills development programme for staff in health, social care and wider partners, and system change - with behavioural and culture change in programmes and organisations.

December ICB agreed to recruit a Programme Director to support delivery of Sustainability and Transformation across the health and care economy and welcomed Christina Walters into this role on an interim basis to support ICB partners. Following the review of ICB terms of reference in November they are presented to HWB for approval – attached at Appendix 1. A significant proportion of the meeting focused on the Council's budget proposals and the system impact and consideration of the work to mitigate the impact, which will include an event planned for March 2017 to consider health and care budgets, operational plans and mitigating the risks at system level.

An update was received on the integrated workforce programme including the Bradford District and Craven workforce strategy, and progress across the 4 priority areas including; growing our own, developing our workforce together, creating the conditions to retain talent within the system and developing a shared culture of integration and system wide working and details were shared regarding pursuing an Industrial Centre of Excellence (ICE) for health and care with an ambition to have something in place by September 2017.

Finally, an update was provided on Well Bradford which is a public health initiative with funding from Well North. Bradford is one of 11 sites chosen to be part of this initiative. It was acknowledged that local ownership and engagement in Girlington is growing and an action plan has been developed which once approved by Well North will unlock resources to do the work: 6 areas will be focused on which have been identified by the local community. The test bed will be Girlington and this will then potentially be expanded to Keighley and Holmewood.

3.3 Healthy Weight Programme

At the time of writing the Healthy Weight Delivery Board is about to meet for the second time to consider relevant strategies and high-level action plans that are currently in place or in development and to receive a presentation from Public Health on how behaviour change approaches can help people to take steps to improve their health and can provide a coherent framework for the work of staff, volunteers and peers as they seek to support people to improve their health.

A full update on the proposed development of a District wide approach to healthy weight as part of wider focus on health and wellbeing will be brought to the March Board as part of the Cardio-Vascular- Healthy Heart theme planned for that Board meeting.

4. FINANCIAL & RESOURCE APPRAISAL

Resource levels for the Better Care Fund in 2017-18 are not yet agreed and are subject to ongoing Council Budget processes. The resources committed to the Programme will be described in detail for the Board as the Better Care Fund framework for 2017-18 is developed.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

In relation to the Bradford District Care Fund, risk is managed by Bradford Health and Care Commissioners with the Health and Wellbeing Board having overall governance responsibility. Risk issues are reported alongside quarterly performance reporting.

In relation to the Bradford and District STP, risk is managed through a risk register by the partnership-based Integration and Change Board.

Governance and risk management of the West Yorkshire Sustainability and Transformation Plan is still being established, with input from local Clinical Commissioning Groups, Council Leaders and Chairs of the West Yorkshire Health and Wellbeing Boards.

6. LEGAL APPRAISAL

The legal status of the Better Care Fund has been established through a Section 75 agreement between the Council and the Clinical Commissioning Groups.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

None

7.2 SUSTAINABILITY IMPLICATIONS

The Sustainability and Transformation Plans (STP) for Bradford District and Craven and for West Yorkshire plus Harrogate have been developed to date in accordance with 2016-17 NHS Planning Guidance with the aim of bringing local health economies onto a sustainable footing by 2020-21. Operational plans are in development as directed by 2017-19 NHS Planning Guidance.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None

7.4 COMMUNITY SAFETY IMPLICATIONS

None

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

At this stage it is not possible to anticipate what, if any impact on Trade Union issues the development of transformation programmes under the West Yorkshire Sustainability and Transformation Plan.

8. NOT FOR PUBLICATION DOCUMENTS

None.

9. OPTIONS

No options are provided

10. RECOMMENDATIONS

10.1 The Board approves the Terms of Reference for the Integration and Change Board.

10.2 The Board notes the 2016-17 Quarter 2 Performance of the Better Care Fund

and the preparation of the Better Care Fund Plan 2017-18.

11. APPENDICES

11.1 Integration and Change Board - Terms of Reference November 2016.

12. BACKGROUND DOCUMENTS

12.1 Better Care Fund Quarter 2 performance dashboard. Copies will be available at the Board meeting.

Appendix 1
TERMS OF REFERENCE

Integration and Change Board

Chair	Chief Executive, CBMDC
Vice Chair	Chief Executive, NHS AFT
Management Lead	Director of Collaboration, NHS B&A CCGs, CBMDC
Frequency	Monthly
Accountable to	**Bradford and Airedale Health and Wellbeing Board**
Reporting to this group ***(Governance structure attached)***	1. Healthy Futures Programme 2. AWC Accountable Care Board 3. Bradford Accountable Care Board 4. Local A&E Delivery Board (Systems Resilience Group) 5. Transformation Programme Enablers 6. Well Bradford 7. Acute Collaborative Programme
Key Purpose	• Setting the strategic direction for Bradford Health and Care Economy* within the context of the partnership organisations and wider change initiatives. * *This includes Bradford Metropolitan District Council & Craven*
Scope	• Interface between partner organisations across the Bradford Health and Care Economy • Strategic issues and initiatives impacting or have the potential to impact on the Bradford District and Craven Health and Care Economy Sustainability and Transformation Plan (STP)
Key Responsibilities	• Provide system leadership (operating within the principles of ICB#) • Operate as the local Sustainability and Transformation Board - provide strategic direction for Transformational and Sustainable Change • Continue to develop effective partnership between the partnership organisations • Define STP benefits • Advise and resolve strategic issues within the STP • Horizon scanning of other strategic change initiatives

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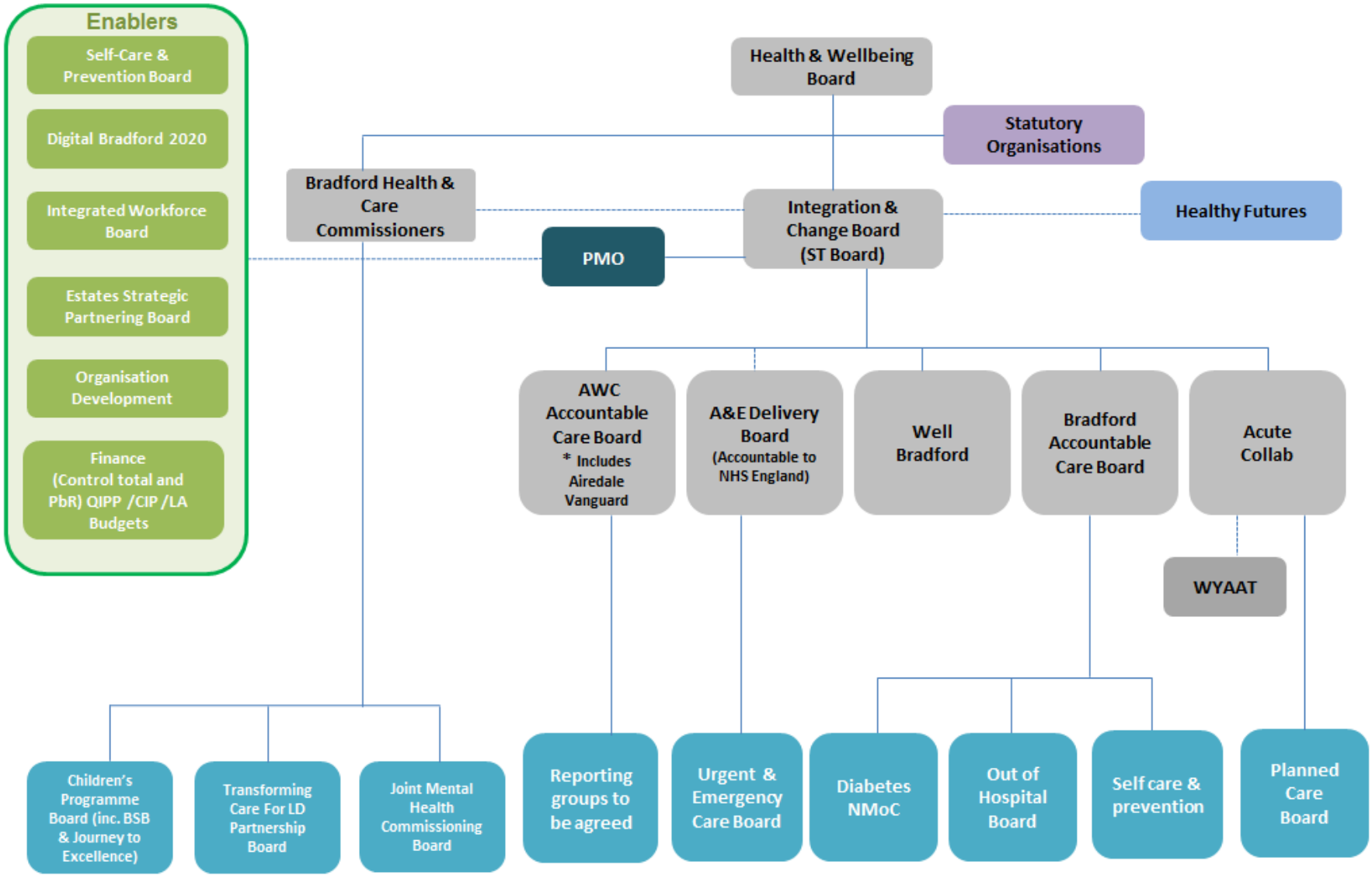
	• Define risk appetite, including oversight of the strategic risk register • Develop and implement a mechanism for a system wide (health) control total • Development, engagement and communication of the Transformation Vision • Review and shape communication framework and key messages • Unblocking issues that can't be resolved elsewhere # *Previously agreed September 2013*
Membership	• Chief Executive, Bradford Teaching Hospitals NHS Foundation trust • Chief Executive, Bradford District Care Foundation Trust • Chief Executive, Airedale NHS Foundation Trust • Chair, GP Federation – Bradford • Chair, GP Federation - YORDALES • Chief Executive, CBMDC • Strategic Director of Health and Wellbeing, CBMDC • Strategic Director of Children Services, CNMDC • Director of Collaboration, NHS B&A CCGs, CBMDC • Chief Officer, NHS AWC, BC and BD CCGs • Clinical Chair, AWC CCG • Clinical Chair, BC CCG • Clinical Chair, BD CCG • Invitation to NYCC, as required
Support	• CCG Collaboration Senior Lead – NHS B&A CCGs • PMO(In line with specification)
Administrative Support	Christie Bridge, PA, NHS AWC, BC and NHS BD CCGs
Quorum	One member from each Partner Organisation.
Review period	To be reviewed at least annually (September 2017)

Bradford District & Craven – Sustainability & Transformation Governance



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