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, 28 March 2017 at 10.00 am in Ernest Saville Room, 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 |
| Bridget Fletcher | Representative of the main NHS Provider |
| Clive Kay | Representative of the main NHS Provider |
| Nicola Lees | 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 31 January 2017 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: HOME FIRST

The Strategic Director, Health and Wellbeing will submit **Document "S"** which sets out the rationale, key aims and ambitions for the new vision (Home First) for wellbeing in the Bradford District and the new operating model for the Department of Health and Wellbeing.

The draft vision (Home First) is centred around the belief that where possible, people in the Bradford District who are in receipt of health and social care services should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities in the wider District.

The report also provides an update on the development process for the new vision and operating model and outlines key next steps for the consultation and approval of the final documents.

**Recommended-**

**(1) That the Board notes progress made towards the development of the new Home First Vision and the new operating model for the Department of Health and Wellbeing.**

**(2) That the approach set out in the vision (Home First) and the new 'To be' operating model be endorsed and that respective organisations support the implementation plans.**

(Imran Rathore – 01274 431730)

### 6. CHAIRS HIGHLIGHT REPORT: BETTER CARE FUND QUARTER 3 PERFORMANCE: UPDATES FROM BRADFORD HEALTH AND CARE INTEGRATED COMMISSIONERS GROUP AND THE INTEGRATION AND CHANGE BOARD

The Health and Wellbeing Board Chair's highlight report **(Document "T")** 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 March report covers:

- Better Care Fund - Quarter 3 Performance and update on development of the 2017-18 Better Care Fund Plan

- Business conducted at meetings of the Bradford Health and Care Integrated Commissioners Group, and the Integration and Change Board.

**Recommended-**

**(1) That the position as at the end of Quarter 3 be noted.**

**(2) That the position in relation to the Better Care Fund Planning Guidance 2017/18 and 2018/19 be noted.**

**(3) That due to the delays in publication of the Planning Guidance, that budget uplifts will be applied in line with the guidance once published with 1.8% in 2017/18 used as the indicative level of uplift, be noted.**

(Angela Hutton – 01274 437345)

## 7. A PROPOSAL FOR THE DEVELOPMENT OF A JOINT HEALTH AND WELLBEING STRATEGY FOR 2017-2022

The Strategic Director, Health and Wellbeing will submit **Document "U"** which reports that the current Joint Health and Wellbeing Strategy (JHWS) is due to expire at the end of March 2017. The report puts forward a proposal for the development of a new strategy following a Health and Wellbeing Board development session held in February 2017.

**Recommended-**

**(1) That the proposed approach to developing the Joint Health and Wellbeing Strategy as outlined in the report be agreed.**

**(2) That the Board agree that the Joint Health and Wellbeing Strategy focus on delivering the priorities for the health and wellbeing elements of the District Plan and the local Sustainability and Transformation Plan.**

(Sarah Muckle – 01274 433533)

## 8. CARDIOVASCULAR DISEASE - UPDATE

The Chief Officer of the Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups will submit **Document "V"** which provides an overview of the challenges Bradford Districts Clinical Commissioning Group faced with regards to cardiovascular disease (CVD), the actions it has taken and the outcomes seen to date.

It also describe the lessons learned and next steps in the programme and seek support from the Board to deliver its longer term aims.

**The Health and Wellbeing Board are asked to consider how the lessons learnt from the Bradford Healthy Hearts programme could be applied to the priorities of the revised Health and Wellbeing Strategy 2017-2022 (in development).**

(Kath Helliwell – 01274 237290)

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# Report of the Strategic Director, Health and Wellbeing to the meeting of Health and Wellbeing Board to be held on 28th March 2017.

**S**

**Subject: Working Better Together - A whole system approach to Health and wellbeing:**

**Home First** – a new vision for wellbeing in the Bradford District and a new operating model for the Department of Health & Wellbeing to deliver the aims set out in the new vision.

## Summary statement:

This report sets out the rationale, key aims and ambitions for the new vision (Home First) for wellbeing in Bradford and the new operating model for the department of Health and Wellbeing. The report also provides an update on the development process and outlines key next steps for the consultation and approval of the final documents.

| | |
|---|---|
| Bev Maybury<br>Strategic Director: Health and Wellbeing | Portfolio:<br>Health & Wellbeing |
| Report Contacts:<br>Imran Rathore, Transformation and Executive Support Manager<br>Phone: (01274) 431730<br>E-mail: imran.rathore@bradford.gov.uk | Overview & Scrutiny Area:<br>Health and Social Care |

## 1. SUMMARY

1.1 This report sets out the rationale, key aims and ambitions for the new vision (Home First) for wellbeing in the Bradford District and the new operating model for the Department of Health and Wellbeing.

1.2 The report also provides an update on the development process for the new vision and operating model and outlines key next steps for the consultation and approval of the final documents.

1.3 The draft vision (Home First) is centred around the belief that where possible, people in the Bradford District who are in receipt of health and social care services should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities in the wider District.

1.4 The associated draft operating model sets out the organisational policy, governance, decision making and commissioning arrangements that will support the delivery of our vision, through enabling people to have control over how they manage their Health and Social care needs with a greater focus on the use of personal and community assets and working in partnership with key partner agencies within the public, private and voluntary sector.

## 2. BACKGROUND

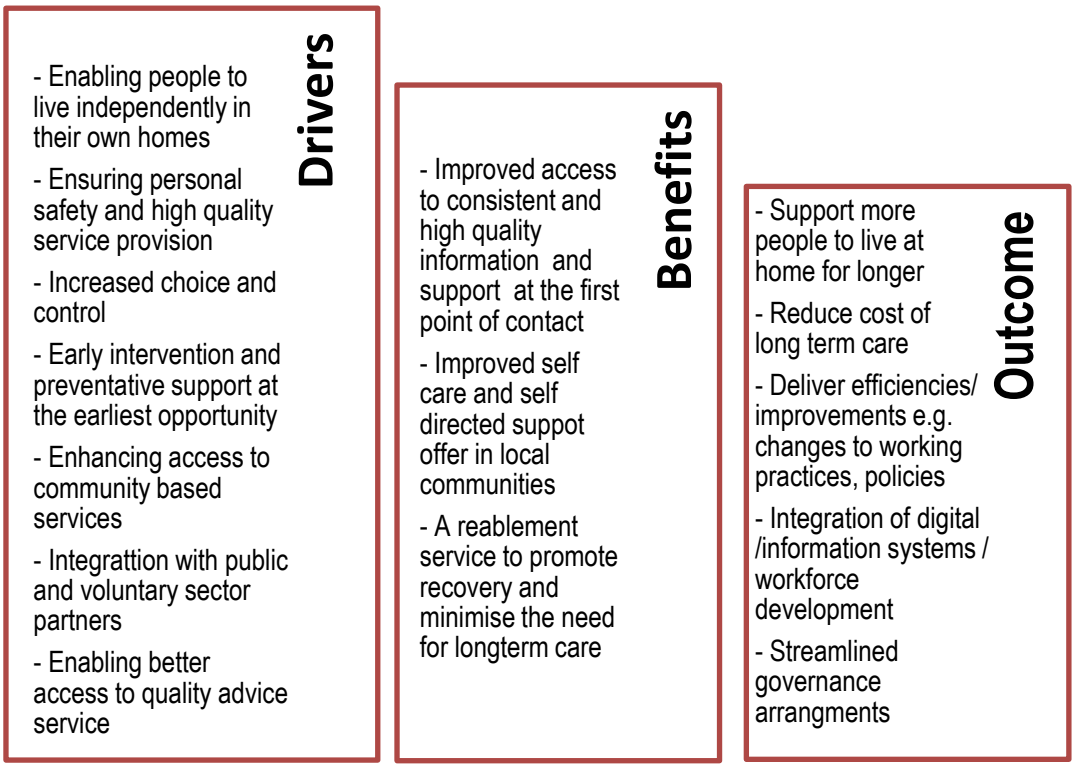
2.1 The context within which the Department of Health & Wellbeing delivers services is constantly evolving. There are significant changes in: demographics; customer needs and expectations; legislation; and financial pressures. These include:

- *The Care Act (2014) sets out a new framework of local authority duties in relation to the arrangement and funding of social care, along with a number of changes to the regulation of social care providers. The Act also demands that local authorities must promote greater integration with the NHS,*
- *The government's Spending Review and Autumn Statement (2015) sets out that every part of the country must have a plan for integrated Health and Social Care in 2017, to be implemented by 2020.*
- *The money from central government to the Council has greatly reduced and continues to do so over the life of this parliament, which is putting pressure on service delivery.*
- *The Health and Wellbeing service which is now made up of Adult and Community Services, Public Health and Environmental Health has a total proposed savings target of £20.9m in 2017/18 and £11m in 2018/19*
- *The number of people who use Adult and Social care is expected to rise from 8,500 now to 8,843 in 2 years' time, which is a 2% increase on an annual basis. We expect that the demand will continue to keep rising by 2% each year until 2030. (Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI)).*
- *ADASS annual budget survey (2016) suggests that adult social care accounts for 35% of total council spending, while the Local Government Association (LGA) analysis shows that the proportion could rise to 40% by 2020.*

2.2 The nature of the issues outlined above requires an approach that ensures sustainability of support to people, which maintains their independence, living within their own communities and improves their quality of life and general wellbeing. National best practice research also shows that a strength and community based approach can improve the quality of life for people who have health and social care needs, whilst reducing costs.

## 3. RATIONALE, PURPOSE AND APPROACH

3.1 Over the last few months, the Department of Health & Wellbeing has been reviewing how it provides support services to people in the Bradford District. One of the outcomes of this review has been the development of a new vision and operating model for Health and Wellbeing, which builds on the good work done within the department, our local experience and national good practice. The key drivers, benefits and outcomes of this work will include:




3.2 The new vision and operating model will guide and shape how we will work with our partners to deliver the high level outcomes set out in the Council's Corporate Plan 2016-20, for everyone in the district to have a long healthy and full life.

3.3 The development process for both the draft vision and operating model has included working with partner organisations in NHS, community and voluntary sector (VCS), service user groups, partnerships, networks and elected members. The draft vision and operating model incorporates feedback from these groups and are attached to this report as Appendix 1 and 2.

## 3.2 VISION – HOME FIRST

3.2.1 The issues outlined above are reflected in our aim and ambitions for the wellbeing of Bradford District, and are set out in our Home First Vision document, which is currently being developed. Our vision is centred on the belief that:

> "*where possible, people in the Bradford District who are in receipt of health and social care services should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities in the wider District".*

3.2.3 The delivery of our vision will rely heavily on a whole system approach that enables people to intervene early, and delay or prevent the need for long term care, while supporting them to maintain their independence as long as possible. As such, the vision will guide the way we work with our partners across the Health and Adult Social Care spectrum to develop, shape and commission services.

3.2.4 As a result of our approach, it is likely that, in the future there will be fewer people receiving on going, longer term social care support – however this is in the context of the drive to support people to live independently.

## 3.3 "TO BE" OPERATING MODEL

3.3.1 To support the delivery of our vision we are also reviewing our operating model to ensure that it enables us to work creatively and collaboratively with our partners within the public, private and voluntary sector.

3.3.2 The new (To Be) operating model builds on our local experience and national good practice, and is based on a vision of shared responsibility between Council (including public sector), the community and the person. It recognises that the role of the Department of Health & Wellbeing is to work collaboratively with our partners to align our resources to support people's independence and ability to be part of their communities for as long as possible.

3.3.3 By helping people to stay healthy and well, supporting them to regain their independence after illness or injury, and encouraging them to make greater use of their own and community resources, the new operating model also aims to reduce demand for public sector resourced care and support.

3.3.4 The model proposes changes to how we do things e.g. processes, team and organisational culture and working practices, for example:

- *A greater focus on resources on front line support and time limited interventions to help people get back on their feet and in their own homes.*
- *Investing in good quality information and advice which will enable people to intervene early and delay or prevent the need for long term care.*
- *Strengthening our self-care and self-directed support offer in local communities through the development of multi-agency community hubs,*
- *Delivering a workforce development programme across all agencies to ensure they are fully equipped with the right skill set to support the delivery of our shared approach.*

- *Developing an integrated strategic commissioning approach that aligns resources and supports flexible delivery solutions.*
- *Improving the use of digital information platforms to develop and deploy support services that meet the needs of people and communities.*
- *Enhancing the use of assistive technologies that enables people to maintain their independence and enhances their quality of life.*

3.3.5 Appendix 2 provides further detail on the "To Be" operating model and includes a visual description of the key components.

## 4. DEVELOPMENT, CONSULTATION AND APPROVAL

4.1 We are committed to taking an inclusive approach to the development of the new vision, operating model and associated delivery plans. The approach and principles behind the vision has been discussed with a range of stakeholder groups in draft form to help support its development and seek input on the overall approach and direction. Presentations have been given to the following groups, and feedback has been received:

- *Department of Health & Wellbeing staff roadshows – Nov to Dec 2016*
- *Strategic Disability Partnership, Older People's Partnership, Learning Disability Joint Budget Consultation Workshop – 23.01.17*
- *Health & Social Care Overview and Scrutiny Committee – 26.01.2017*
- *Bradford Talking Media User Group – Jan to Feb 2017*
- *Integrated Change Board (ICB) – 17.02.17*

4.2 Further presentations and consultations are also planned with:

- *Health & Social Care Overview and Scrutiny Committee – 2nd March 2017*
- *Health & Wellbeing Board – 28th March 2017*
- *Older People's Partnership Board - 9th March 2017*
- *Strategic Disability Partnership Board - 6th April 2017*

4.3 Feedback from these groups will be used to refine the vision, the operating model, related success measures and delivery activity. However, in general the feedback received to date has been positive and supportive of the overall approach e.g. the vision and operating model was presented to ICB who endorsed the approach set out in the documents and were keen to support the implementation plans.

4.4 The final draft of the Home First Vision and operating Model for the Department of Health & Wellbeing will be presented to the Council's Executive on 4th April 2017 for their approval.

## 5. IMPLEMENTATION TIMESCALE

5.1 Subject to Executive's approval in April we are expecting work to begin on the implementation of the Vision through the roll out of the new operating model. We envisage that it is likely to take 6 to 12 months to fully implement the core components. Appendix two includes detail of key delivery milestones.

## 6. FINANCIAL & RESOURCE APPRAISAL

6.1 Moving to a model based approach on early intervention and prevention through a greater focus on self-care, personal and community resources will play an essential role in the departments plans to reduce demand and costs. As such, the new operating model will contribute to achieving the pre-agreed savings allocated to the department by full Council for 2017/18, alongside the savings to be agreed by full Council in Feb for 2017/18 and 2018/19.

## 7. RISK MANAGEMENT AND GOVERNANCE ISSUES

7.1 The proposals are key to the Department of Health and Wellbeing in delivery of its responsibilities under the Care Act 2014 and to ensuring this is done within the allocated budget.

7.2 These proposals mitigate against potential budgetary and performance risk for the department.

7.3 Equality assessments have been carried out on the vision and operating model, and will continue to be updated to enable mitigation against any risks.

## 8. LEGAL APPRAISAL

8.1 When making decisions around service delivery, the Council must consider its specific duties under the Care Act 2014 and the Public Sector Equality Duties and consultation requirements.

## 9. OTHER IMPLICATIONS

### 9.1 EQUALITY & DIVERSITY

9.1.1 The implementation of the new vision and operating model will place the individual at the centre of services and enable wider access to services that the person can direct according to their preferences. This will promote fairness and equality by ensuring that service access requirements for people with equality protected characteristics (e.g. age, disability, ethnicity etc.) are met according to their personal choice.

9.1.2 An initial equality impact assessment has been completed for the new vision and operating model, this will be further refined and updated as we firm up the detail implementation plan and updates and as a result of feedback from the implementation process.

### 9.2 SUSTAINABILITY IMPLICATIONS

9.2.1 The long term sustainability of the Council's ability to continue to provide support to people is under considerable pressure due to the increasing demand and the reduction in funding. This issue is not isolated to Bradford and is currently being discussed nationally by the Government and other influential bodies.

### 9.3.1 GREENHOUSE GAS EMISSIONS IMPACTS

9.3.1 None

### 9.4 COMMUNITY SAFETY IMPLICATIONS

9.4.1 None.

### 9.5 HUMAN RIGHTS ACT & TRADE UNION

9.5.1 Staff have been involved in the development of both the vision and operating model from the outset of the process to help shape the approach and thinking. We will continue to involve them as we move into the implementation process. If any HR implications are identified as part of the implementation plans, then these will be managed in a formal manner in accordance to the agreed Council policy and employment legislation.

## 10. NOT FOR PUBLICATION DOCUMENTS

10.1 None.

## 11. RECOMMENDATIONS

11.1 That the Board notes progress made towards the development of the new Home First Vision and the new operating model for the Department of Health and Wellbeing.

11.2 That the approach set out in the vision (Home First) and the new 'To be' operating model be endorsed and that respective organisations support the implementation plans.

## 12. APPENDICES

**Appendix one:** Draft Home First Vision

**Appendix two:** "To be" operating model

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# Home First

## Our vision for wellbeing

January 2017

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# Foreword

## Councillor Val Slater

Deputy Leader and Health and Wellbeing Portfolio Holder

**As Deputy Leader & Health and Wellbeing Portfolio holder in Bradford Metropolitan District Council I am pleased to introduce "Home First – our vision for wellbeing" for Bradford District.**

This document sets out our vision and ambitions for wellbeing in Bradford District, which are structured around the themes of Home, Health and Happiness. I firmly believe that by focussing our activity around these key themes we will be able to improve and enhance the support and care we provide to people and to deliver the commitments we set out in the District Plan 2016 -2020

We have called the vision – "Home First" because we believe that where possible people in the Bradford District who are in receipt of Adult & Social care support should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities across the wider District.

As such, the vision will guide the way we work with our partners in the public sector (including Health), the Voluntary and the Community Sector and Private sector to deliver a range of services that will support individuals to live as independently as possible, and recognise their rights and choices about what is right for them, and to ensure they are protected when necessary.

The delivery of our vision will require a collective effort from all stakeholders in the district and therefore I look forward to working with you all to positively reshape the way we support people in the District and make this vision into reality.

**Councillor Val Slater**

## Bev Maybury

Strategic Director Health and Wellbeing

**I would like to welcome you all to 'Home First' which describes our vision for wellbeing in Bradford District. My team and I intend to use this document to share our thinking, consult and open up the discussion with people who use services, their families and carers and our wider partners about how we make the vision real. We know that there are things we can do better and I would welcome feedback on how we can work together to make positive changes.**

Through investing in good quality information and advice which enables people to intervene early and delay or prevent the need for long term care alongside investment to strengthen our self-care and self-directed support offer in localities we believe that we can better support people to feel in control and make choices about how they want their support arranged around them to meet their outcomes. Having more choice and control is empowering. We should all be equal partners in making decisions that affect us. This leads to more of us being confident and independent and achieving our aspirations for a happier, healthier and more fulfilled life. Support and care have a vital role to play in ensuring everyone can enjoy the same human rights - dignity, equality of opportunity and access. When people feel happier, in control and safe they experience improved wellbeing and health outcomes.

I hope that you find the vision document accessible, clear and interesting. Please contact 01274 435400 or tweet us at [insert] to let us know what you think.

**Bev Maybury**

# Our Department of Health and Wellbeing

**The home first vision aims to set out our ambition for health and well being in Bradford and District. We have called the vision home first because we firmly believe that people who need help from social care in Bradford would want us to do as much as we can to make sure that they are supported to stay in their own homes. Being around family, friends and in your own home is the best place to feel happy, healthy and in control of your life.**

The department's main purpose is to strengthen the connections between health and social care, with the aim to enhance the wellbeing of our residents and ensure greater independence and choice for individuals.

The department also has a leadership role in driving integration and transformation both within the Council and across the local healthcare system.

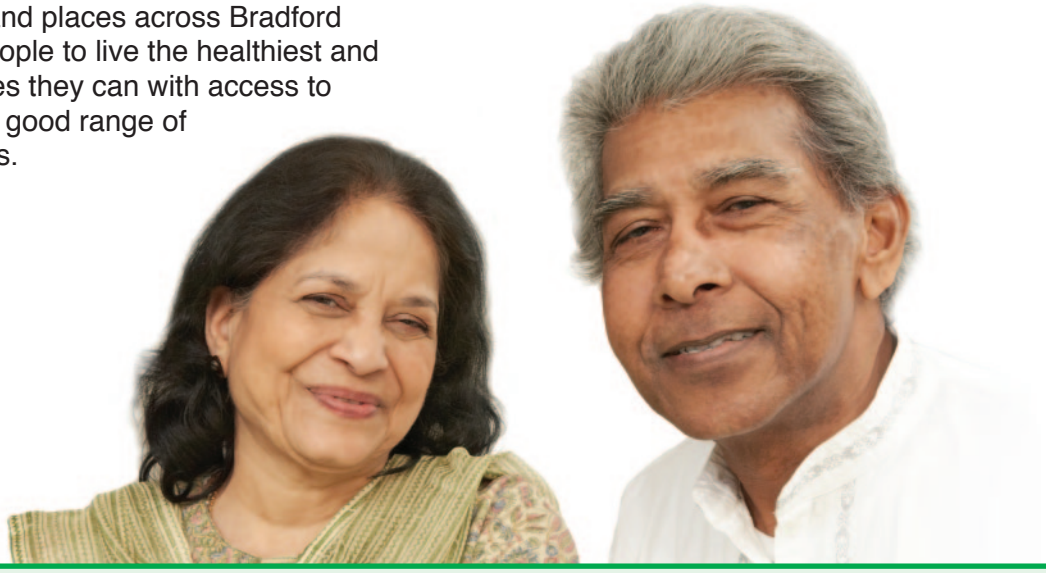
The department is made up of three service areas, which includes Public Health, Environmental Health and Adult Social Care.

- **Public Health:** The service focuses on what can make a difference to an individual's health, and then takes actions to promote healthy lifestyles, prevent disease, protect and improve general health, and improve healthcare services.
- **Environmental Health:** The service tackles and addresses many issues which are fundamental to good health and wellbeing. These include food safety, health and safety, air quality, noise and other nuisances, contaminated land, drainage and private drinking water supplies. In addition they have a key role in communicable diseases control. Outcomes are achieved through preventative work, eg with planning and other partners, inspection, advice and enforcement and in response to customer complaints.
- **Adult Social Care:** The service helps adults with eligible social care needs find care and support so they can live as independently as possible in their own homes.

# Our vision for wellbeing

**Our ambition is for Bradford to be a place where:**

- People's contribution to Bradford District is being recognised and valued.
- People are supported to live healthy, happy lives, where they are in control and able to make the best lifestyle choices for themselves and their families.
- We recognise and support the different and diverse communities that make up Bradford and District and offer support appropriately.
- Communities and places across Bradford District help people to live the healthiest and sustainable lives they can with access to clean air and a good range of housing options.
- We ensure access to information, advice and support in such a way that it enables people to help themselves.
- We empower people who choose to access support from services and empower staff involved in providing services to uphold people's rights to be in control and have their wishes, feelings and beliefs upheld.



CASE STUDY

## Betty's story

Betty has been living on her own since her husband died. Her 2 sons live close by and both pop in once a week to check that she is OK. Betty's sons have been worried about her as her home care workers have reported to them that she is losing weight. Betty had a bad infection, which made her confused and led to a bad fall during the night. The home care workers found her 6 hours later and rang for an ambulance. When she was taken to hospital they found that she had broken her hip. Betty's sons really want her to move into a care home as they were really worried about the fall but Betty really wants to go home. Through discharge to an intermediate care bed Betty's social worker has had the time and opportunity to build up a relationship with Betty and better understand Betty's strength and that she is making an informed choice to go home. The social worker arranged for a risk enablement meeting with Betty, her sons, the Occupational Therapist and other professionals to help Betty explain that she wishes to return home but needs some support around the risks. The social worker recommended that Betty has access to telecare equipment so that if she becomes confused and falls again her sons would be immediately notified and a mobile response worker would go out to help support Betty. Betty is supported by the Occupational Therapist to do a home from hospital visit. The Occupational Therapist also recommends that Betty has some equipment fitted in her bathroom. Betty's social worker arranges for a local community group worker to meet Betty from the taxi taking her home. The worker makes sure that she is settled, the heating is switched on and that she has a cup of tea. They arrange to come back each day that week and take her out every Monday and Wednesday to the local café to meet with a group of other ladies who are the same age as Betty.

CASE STUDY

## Tariq's story

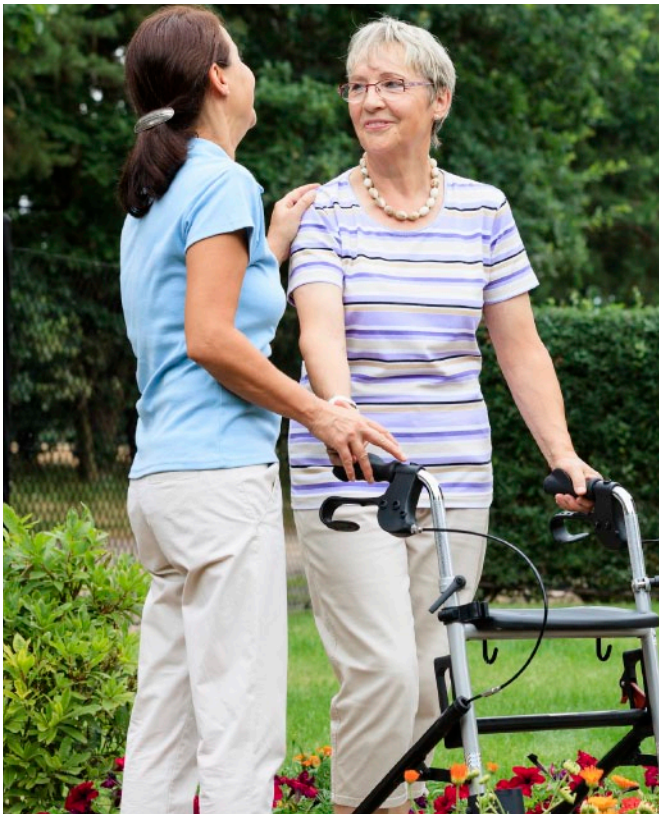
Tariq was born with a learning disability. He really likes his mum's cooking, but has over the years gained weight. The learning disability nurses have told his mum that he has diabetes. Tariq has just turned 18. He loves his mum but he wants to get out more, like other young people his age and make friends. Tariq's social worker from the Transitions Team spends time with him to find out what things are important to him in his life. The social worker finds out that Tariq likes the actors in films and TV drama. He has a top 20 of favourite actors and can tell his social worker all their best lines! Tariq's social worker makes contact with a voluntary organisation who have a regular social group which meets at a café in a local film Museum. The group have just started working with a production company that supports adults with a learning disability to produce plays and musicals. They help Tariq to learn how to become an actor and his mum is really proud to attend his first play. His mum tells you that he has started to lose weight. Tariq tells his social worker that he is planning to be a supporting actor in a television drama set in Bradford.

## Our responsibility: A General Duty of Wellbeing (Section 1 of the Care Act)

The Care Act 2014 sets out a number of new rights for adults who choose to access support from services, their carers and families the centre of adult social care and new duties for City of Bradford Metropolitan District Council. These rights are underpinned by a general duty on the Council to promote the wellbeing of all our citizens.

Wellbeing is not just the absence of disease or illness. It is a combination of physical, mental, emotional and social health factors. Wellbeing is linked to happiness and life satisfaction. In short, wellbeing could be described as how you feel about yourself and your life, being comfortable, healthy or happy.

Our approach in delivering our duty will be centred around a rational and compassionate approach.



CASE STUDY

## Healthy, Happy Lives

The transfer of public health to the Council in 2013 presented us with significant opportunities to enhance the Council's role in promoting the health, wellbeing and independence of people, and reducing avoidable differences in health in the Bradford District.

We want everyone in Bradford to have the opportunity to live as long as possible in good health. This includes creating an environment where people are supported to make healthy lifestyle choices, preventing ill health or disability, and intervening early, returning people to the lowest level of need. It also means enabling people to feel confident to make choices about their health and care, recover quickly from setbacks, and promoting independence in people and communities in Bradford District. We will do this in a number of ways.

We will move beyond targeting single health issues and lifestyle choices to an approach that is more holistic, focused instead on wellness, addressing multiple health and lifestyle issues. Focusing on what individuals can do rather that what they cannot, we will recognise and value the strengths that people have. We will look to work with people in Bradford District to develop services (often called co-production). Recognising that for significant improvements in health, and a reduction in avoidable differences in health to be made, we need to work together with partners and citizens.

Every department in the Council has a contribution to make to support people to be healthy and happy. We know that the environment in which we live, our homes, education and employment, all affect our health, wellbeing and the lifestyle choices we make. This is why we will continue to work with our colleagues across the Council to ensure that health and wellbeing is everyone's business. We will ensure that opportunities to improve the health and wellbeing of citizens are considered in everything that the Council does.

Our approach to achieving the best health outcomes for our population will be a collaborative one. We have an important role in making sure our services achieve the best possible outcomes for people in Bradford District. This includes offering opportunities to upscale prevention and supported self care. As such we will work closely with partners across Bradford District, including the NHS, to make sure that health and care services are high quality services that best meet the needs of people in Bradford District, and also provide value for money.

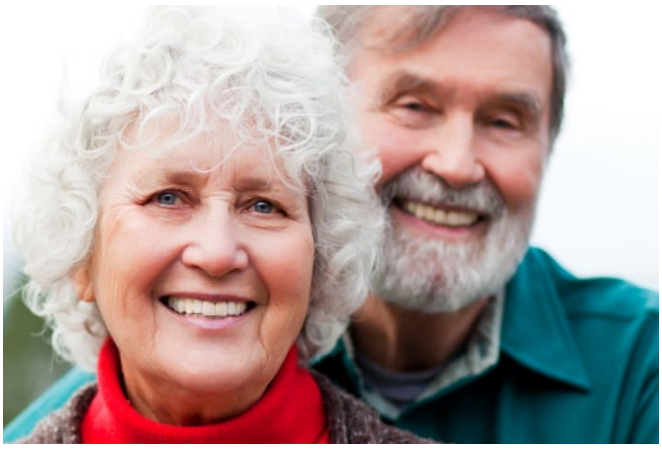
## What will Home First mean?

We will work with people who choose to access support from services, their carers and family members and our communities to develop new systems which build on their strengths. Strengths based approaches involve:

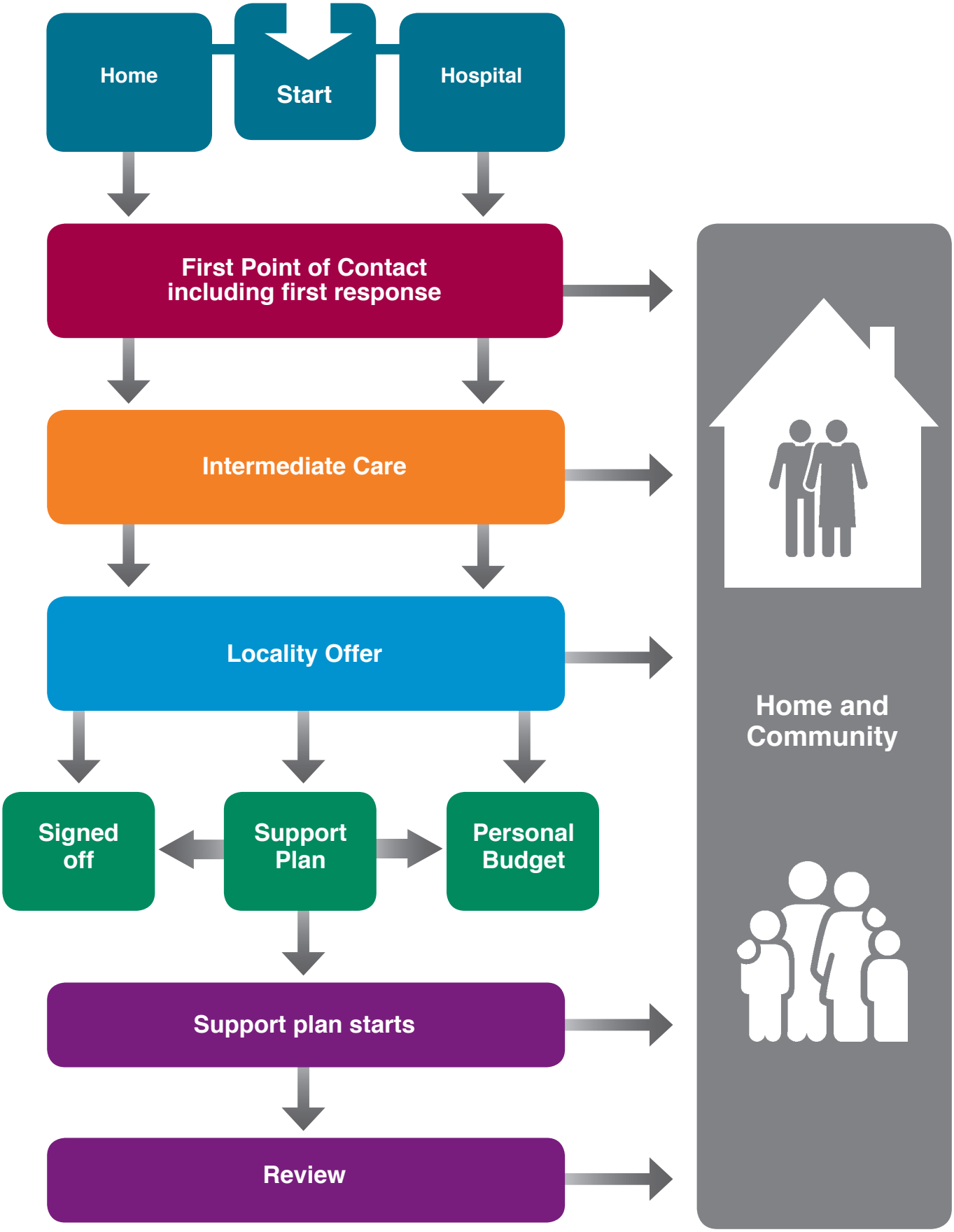
- Making information and advice easily accessible so that people can make informed decisions about their support needs
- Early intervention which builds on people's natural networks of support
- Ensuring that all practicable steps are taken to ensure the wishes, feelings and beliefs of people who have long term support needs from the services are communicated, understood and upheld.

**We will do this by:**

- Listening to people
- Improving the accessibility of our information about options
- Finding personalised solutions
- Being proactive to support for self-care which supports healthier lives
- Helping early to delay and prevent minor things developing into something major
- Strengthening and investing in our Social Workers and the culture of social work practice
- Transferring power away from traditional services to people, their families and communities
- Using technology
- Treating all people with dignity and respect
- Striving to get you home as quickly as possible – after being in hospital
- Establishing arrangements to uphold and enable people's right to take positive risks
- Ensuring that where a person is at risk of abuse that we put in place measures that ensure they remain in control
- Where a person requires the deprivation of liberty safeguards we take all practicable steps to ensure their rights are upheld.



# The Social Care customer journey



CASE STUDY

## Ian's story

Ian has lived in a care home in Wales since the age of 16. He has a physical disability and uses a wheelchair. Staff at the care home report that he has lost contact with his family in Bradford but appears bored in the home and that he is going out drinking in the town centre. They are worried that people are taking advantage of him and his money. Ian is known to enjoy buying and selling electronic goods. Ian doesn't want to speak to a social worker. He has had a yearly visit from a social worker to review his placement. He refuses to meet with the social worker when they visit. A new social worker spends time reading about Ian before making contact with him and notices that he likes electronics. The social worker asks the care home to give Ian the social media contact for the social work team. Over a period of 3 months Ian gets to know the social worker through using social media. Ian agrees that the social worker can ring him to discuss his care arrangements. The call goes well and Ian suggests that the social worker users facetime on their workphone to speak to him. He tells her that he is lonely and he misses his family. The social worker arranges for Ian to come to Bradford and spend a long weekend in a local care home with support from a Personal Assistant who supports him to visit his family and reconnect back to Bradford through visiting places he remembers from being a child. Ian decides he wants to stay in Bradford and would like to live independently using a Direct Payment to arrange support from a Personal Assistant.

# Personal Budgets

In order to deliver our approach, we will use a personal budget process which will include the following steps:

1. **Resource Allocation System (RAS)**

   An indicative personal budget is calculated to reflect the level of support required to meet the assessed need.

2. **Support Plan**

   A plan that identifies how people will spend the money allocated to them to get the life they want.

3. **Approving the Support Plan**

   The Council will have to sign off the approved support plan before the personal budget is released.

4. **Personal Budget**

   People will have four options for using their personal budget:

   a) **Direct Payment (DP) –** Money paid by the Council to an eligible person (or someone acting on their behalf) so that they may arrange their own care and support instead of receiving arranged services. Records of how the money is spent are audited regularly.

   b) **Individual Service Fund (ISF) –** Money given to a third party (fund holding provider) to hold on behalf of the person and used to pay for care and support services in line with the support plan.

   c) **Managed Care –** Services that are arranged by the Council; people who use them have less choice and control over how they are delivered.

   d) **Combination of the above**

   A DP may be used to manage some of the care and support services arranged to meet a person's needs with the rest arranged through a managed ISF arrangement.

# Summary

Our vision is centred on the belief that:

**“where possible, people in the Bradford District who are in receipt of health and social care services should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities in the wider District”.**

The implementation of our vision will rely heavily on working with our partners, as such, the vision will guide the way we work with our partners across the Health and Adult Social Care spectrum to develop, shape and commission services. We are also reviewing our operating model to ensure that it enables us to work creatively and collaboratively with our partners within the public, private and voluntary sector. The new “To Be” operating model proposes changes to how we do things e.g. processes, team and organisational culture and working practices. A copy of the operating model can be found here (attachment above).

We have taken an inclusive approach to the development of our vision, the approach and principles behind the vision has been discussed with a range of stakeholder groups in draft form to seek their input in the development process. We are committed to continue this dialogue to help shape our implementation plans and look forward to receiving you feedback via the contact details outlined in this document.

CASE STUDY

## John’s story

John celebrated his 45th birthday recently. Birthdays have always been difficult for John. It is a time when he can feel really alone. This year however things were different. John’s social worker in the Community Mental Health Trust had formed a strong relationship with him over the last 2 years and knew that he found this time of year difficult. John’s social worker arranged to meet with John in the community café at the Cellar Trust a few months earlier.

He had found out that John used to be a mechanic and he used to love working on cars. John went on the Stepping Stones course which helped him think about how to get back into work and stay well once he was in employment. He started a work placement with a local garage, working 2 days a week to begin in the week of his 45th birthday. When John’s colleagues found out about his birthday, they arranged to get him a card which they had all signed. John is starting to feel that he can remain healthy and well in work and is beginning to regain his confidence that he is not alone.

# Glossary

## The Care Act 2014:

The Care Act is a law about care and support for adults in England. It gives clear and simple rules about what care and support people should be able to get as well as what councils have to do.

**For further information on the Care Act please visit www.legislation.gov.uk/ukpga/2014/23/contents/enacted**

## Customer journey:

The experience a service user goes through at each stage from start to finish from being at home or in hospital and assessing the needs required through to the putting a plan together allowing the service user to live independently and further reviewing the support plan.

## Early Intervention:

Early intervention means taking action as soon as possible to tackle problems before they become more difficult. Its purpose is to improve the life chances of people and benefit their families and immediate communities, and at the same time reduce long term costs.

## Home First Model:

The home first vision aims to set out our ambition for health and well being in Bradford and District. We have called the vision home first because we firmly believe that people who need help from social care in Bradford would want us to do as much as we can to make sure that they are supported to stay in their own homes. Being around family, friends and in your own home is the best place to feel happy, healthy and in control of your life.

## Personalisation:

Personalisation is a way to give everyone more choice and control over the support they get. Personalisation means

- that services are tailored to the needs of every individual, rather than delivered in a one-size-fits-all fashion.
- that families get better information about care and support
- that we spend more money on keeping people well, so there is less need for care, especially residential care
- that we encourage people to stay independent.

## Individual Service Funds:

An Individual Service Fund (ISF) is a different way people can pay for the care they get at home. It means that people have choice and control over the support they need without having to take on the responsibility of managing the money.

## Better Care Fund:

The Better Care Fund (BCF) was set up by the Government to help the NHS and Local Government (health and social care) work together better.

## Accountable Care System:

This is where where groups of service providers from the public, private and voluntary sector work together to deliver support and care services. This will be more efficient, reduce costs and improve the quality of life and outcomes for patients.

## Resilient

Resilient means being able to cope when things get difficult or go wrong. We hope to be able to support people to lead happy, fulfilled lives even when they have bad experiences or poor health.

## Contacts and further information

For more information on our Home First Vision visit:
https:Homefirst.Bradford.gov.uk
Twitter:
Facebook:
Telephone: 01274 435400
Email: hwbvison@bradford.gov.uk

**Alternatively you can write to:**
Health & Wellbeing Department
5th Floor, Britannia House, Bradford, BD1 1HX

To protect the identities of service users and providers stock photographs have been used throughout this report.

The wording in this publication can be made available in other formats such as large print and Braille. Please call 01274 431989.

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# "To Be" Operating model

## Department of Health & Wellbeing

Bev Maybury

Strategic Director – Health & Wellbeing

Version 0.3 - 21st February 2017

## 1. Introduction

Our vision (Home First) for Wellbeing in Bradford is centred around the belief that where possible, people in the Bradford District who are in receipt of health and social care services should be supported to stay in their own home, so that they can continue to enjoy relationships with their family, friends and be active members of their local community while being able to participate in activities in the wider District.

To support the delivery of this vision we recognise that our policies, governance and decision making arrangements should be structured to enable us to work creatively and collaboratively with our partners within the public, private and voluntary sector.

The new "To Be" operating model has been designed to enable the department to deliver the aims and ambitions set out in our Home First Vision and is based on the principles of shared responsibility between Council (including public sector), the community and the person.

It recognises that the role of the Department of Health & Wellbeing is to work collaboratively with our partners to align our resources to support people's independence and ability to be part of their communities for as long as possible.

We believe that by helping people to stay healthy and well, supporting them to regain their independence after illness or injury, encouraging them to make greater use of their own and community resources, the new operating model will reduce demand for public sector resourced care and support.

## 2. Key components / principles

The "To Be" operating model builds on our local experience of delivering services and the good work undertaken within the department, while also incorporating national best practice. The key components of our operating model are visually described in the diagram overleaf, and are summarised below:

- A greater focus on early intervention and prevention by reshaping support to reach people earlier and being more accessible in local communities
- Strengthening our self-care and self-directed support offer in local communities through the development of multi-agency community hubs, which will enable us to better support people to feel in control and make choices about how they want their support arranged around them to meet their outcomes

- By building capacity within communities, people will be able to access support within their own communities, while also reducing isolation and loneliness.
- A greater focus of resources on front line support and time limited interventions, such as reablement services, to help people get back on their feet and in their own homes. This will also mean emphasising the importance of being highly responsive when people are in crisis and developing a plan that helps them to regain as much independence as possible
- Delivering a workforce development programme across all agencies to ensure they are fully equipped with the right skills set to support the delivery of our shared approach e.g. ensuring that our front line staff are able to identify support requirements at an early stage (e.g. safeguarding) and also help people develop and maintain skills that will maximise their independence
- Implementing an organisational change programme that is aligned to the workforce development programme and focuses on affecting culture change, enabling transformation and streamlining bureaucracy, with an emphasis on enabling a bottom up approach e.g. people centric dialogue to identify what people, their families and carers want to tell us and working with them rather than doing to them
- Making best use of digital platforms and assistive technologies to support employees to be more effective and help people to maintain their independence and enhances their quality of life
- Investing in good quality information and advice which will enable people to intervene early and delay or prevent the need for long term care. This will ensure that we have a universal approach across all our contact points that sign posts people to the right information or support service which meets their needs. For example Connect to support, website, social media and access team
- Developing an integrated strategic commissioning approach that aligns resources and supports flexible delivery solutions.

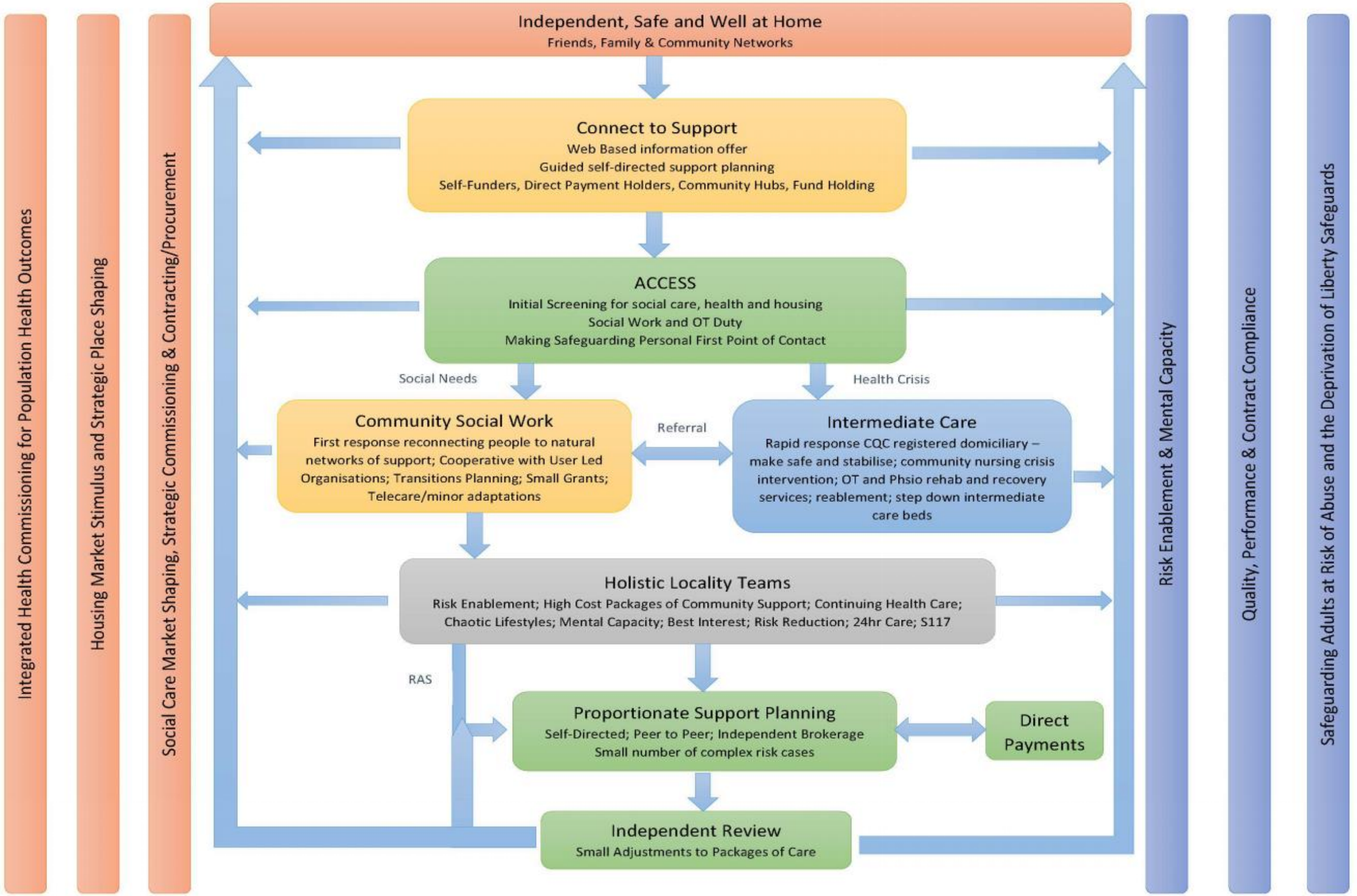
## 3. Delivery timeline

The table below provides a summary of key milestones for the implementation of the “To be” operating model:

| Activity | Description | Timescale |
|---|---|---|
| Home Vision – raising awareness | Engagement with key stakeholders (staff, people receiving support and partners) on the revised offer set out in the new vision and key | April to July 2017 |

| | | |
|---|---|---|
| | implications. | |
| Safeguarding | Make safe and stabilise - Safeguarding / Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS) | April to August 2017 |
| Information Technology and Digital Platforms | Strategic review of Information Technology (IT) Systems and Digital Transformation Capacity in partnership with IT Service | March to May 2017 |
| Personal budget | Implement Personal budget framework, which will include Direct Payments and Individual Service Funds (ISFs) | April to Sept 2017 |
| Workforce development | Roll out of work force development programme to ensure staff have the necessary skills to implement the vision | June to Dec 2017 |
| Governance arrangement | Review management and governance arrangements across the department to improve decision making, accountability, financial, risk and performance management | April to Sept 2017 |
| | Review and agree performance measures to keep track on delivery progress (building on ASCOF and Public Health | May to Sept 2017 |
| Integrated Commissioning framework | Review of strategic commissioning and procurement policies | April to Sept 2017 |
| | Establishing a joint team between the Council and CCGs | April to July 2017 |
| Locality infrastructure | Review and alignment of resources at a local level across Council departments and Partner services to enhance community resilience and capacity. E.g.<br>• establishing community hubs to coordinate local level early intervention and prevention activity,<br>• commissioning of capacity building support,<br>• alignment of ICT infrastructure to enable system connectivity | April to Dec 2017 |
| Information and advice | Review our information and advice arrangements to ensure we have a universal approach across all contact points that signs post people to the right information or support service to meet their needs – e.g. connect to support, council website, social media and front line access team) | May to Sept 2017 |

**Health and Wellbeing Department – "To Be" operating model**



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# Report of the Chair to the meeting of Bradford and Airedale Health and Wellbeing Board to be held on 28th March 2017

**T**

## Subject:

**The Health and Wellbeing Chair's highlight report summarises business conducted between Board meetings**

## Summary statement:

**Updates from Bradford Health and Care Integrated Commissioners Group and the Integration and Change Board.**
**Better Care Fund Quarter 3 performance and 2017-18 planning update.**

Councillor Susan Hinchcliffe
Chair – Bradford and Airedale Health and Wellbeing Board

Report Contact: for overall report
Angela Hutton
Health and Wellbeing Programme Manager
Phone: (01274) 437345
E-mail: angela.hutton@bradford.gov.uk

**Portfolio:**

**Health and Wellbeing**

**Overview & Scrutiny Area:**

**Health and Social Care**

## 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 issues are covered in greater by a business item on the agenda.

The March report covers:

- Better Care Fund - Quarter 3 Performance and update on development of the 2017-18 Better Care Fund Plan

- Business conducted at meetings of the Bradford Health and Care Integrated Commissioners Group, and the Integration and Change Board.

It was agreed at the January Board meeting that the next update from the Healthy Weight Board would be in July 2017.

## 2. BACKGROUND

As the Chair's report addresses multiple issues in brief, the background to each issue is included with the main report in section 3 below and the report contact for each issue is indicated here also.

## 3. OTHER CONSIDERATIONS

### 3.1 Better Care Fund

#### 3.1.1 Better Care Fund – Quarter 3 Performance

Please see the report at Appendix 1 for the performance summary.

#### 3.1.2 Better Care Fund Plan 2017-2019

The main issue for the Board to note is that delay in publication of the Planning Guidance for Better Care Fund 2017-2019 means that the planning process cannot be completed until publication of the guidance.

Draft guidance includes a set of Key Lines of Enquiry which local areas will be required to meet. The draft guidance indicates that the following aspects shall be requirements of the BCF Plan 2017/19:

- The local vision for health and social care services
- The evidence base supporting the case for change
- A coordinated and integrated plan for delivering change
- Approach towards managing risk
- Funding contribution levels including mandated elements

The following national metrics shall be included:

- non-elective admissions
- admissions to residential homes and care homes (how you intend to reduce residential admissions)
- effectiveness of reablement (how you intend to increase reablement)
- Delayed Transfers of Care - including a description of how BCF schemes will help meet the ambition set out in the local A&E improvement plan.

Appendix 1 provides a full update on progress towards development of a draft Better Care Fund Plan. The planning group aims to bring a full draft plan to the May Board meeting for approval unless there is further delay to publication of the guidance.

### 3.2 Updates from the Board sub-groups

#### 3.2.1 Bradford Health and Care Commissioners – January- March update

**Report from the Chair: Bev Maybury, Strategic Director - Health and Wellbeing, Bradford MDC**

Bradford Health and Care Commissioners (BHCC) has met three times since the last update was received by Health and Wellbeing Board members. Through BHCC, discussions have been taking place regarding our ambition to develop an approach to integrated commissioning as set out in the Sustainability and Transformation Plan (STP). An event is being held on the 31st March 2017 to take this work forward. BHCC will be replaced by updated governance arrangements as an outcome of this work. The March 2017 meeting was therefore the final meeting of BHCC as currently constituted.

In January BHCC recommended the re-commissioning of the Mental Health Wellbeing Navigation Service which is commissioned by the Local Authority and works in partnership with BDCT and a wide range of VCS and community organisations to provide services to adults with a serious and enduring mental health problem. A new service specification was signed off. Additionally, the group supported a proposal to improve the current capacity issues in the Bradford and Airedale Neurodevelopment Service.

In February BHCC received a detailed report on the actions being taken to reduce the planned overspend on the Bradford and Airedale Community Equipment Service which is a pooled budget across health and care commissioners. It has been agreed to make provision for the planned overspend in line with the Section 75 agreement and to continue with the rigour of the action plan and look at how funding is invested for 2017/18 based on the impact of the actions put in place.

BHCC is the partnership board for both the Section 75 partnership agreement between the CCG and Local Authority, and the Better Care Fund. The March BHCC meeting was primarily dedicated to the quarter 3 performance review of the BCF Q3 performance monitoring dashboard and Section 75 Quarter 3 performance monitoring dashboard (see Appendix 1). It also considered progress in quarter 3 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, it supported the development work on Bradford's potential second Social Impact Bond which is currently being led by Officers in Children's Services. The target group are parents within the Bradford District who have experienced, or at risk of having repeated children permanently removed from their care.

### 3.2.2 Integration and Change Board (ICB) January-February update

**Report from the Chair: Kersten England - Chief Executive, Bradford MDC**

The Integration and Change Board met on Friday 17th February and on 20th January 2017.

*Sustainability and Transformation Plan*

At both those meetings ICB considered and agreed the preparatory work that is underway for a workshop in early April to bring together health and care partners to consider and fully understand financial pressures in the health and care system, to enable the group to identify the risks and produce together a two year Bradford District and Craven plan to support delivery of the Sustainability and Transformation Plan. ICB has considered and supported the framework for a combined STP dashboard to report on progress to Health and Wellbeing Board and ICB; including STP programmes and enablers. It was confirmed that ICB would provide system wide assurance.

*Accountable Care*

In February ICB received updates on Accountable Care system developments from both Airedale Accountable Care Board and Bradford Accountable Care Board. It noted the change in timeline for Airedale Accountable Care with 2017/18 being the development year, and commencement in shadow form from April 2018.

At both the January and February meetings ICB explored the case for change and the new home care service model being proposed by BMDC across Bradford District. It was appraised on the detail of the operating model for Adult Social Care - Home First. Partners welcomed the alignment with other locality models of care across the health and care system.

*Deaths of people with a Learning Disability or a mental health problem*

In January a discussion took place following consideration at the Health and Wellbeing Board of the national Independent Review by Mazars of deaths of people with a Learning Disability or a mental health problem (receiving care from Southern Health). The purpose of the discussion was to provide assurance that the health, care and wellbeing system in Bradford District is providing appropriate health and care support for the local population.

The Strategic Director for Health and Wellbeing at the Council, shared local Bradford actions and it was noted that it is everyone's responsibility to ensure this work is implemented in their own organisations.

The Chief Executive of Bradford District Foundation Care Trust updated on a large piece of work being undertaken under a Northern Alliance of Mental Health and Learning Disability Trusts, led by Mazars, which will result in an agreed policy across Northern partners in the Alliance.

This work will be shared further with ICB in April 2017 to consider as a local system group which elements we will take forward together prior to this being presented back to provide system level assurance to the May meeting of Health and Wellbeing Board. Health and Wellbeing Board is asked to note the progress being made on this area of work and the timescale for reporting back.

## 4. FINANCIAL & RESOURCE APPRAISAL

See Appendix 1 for full update.

## 5. RISK MANAGEMENT AND GOVERNANCE ISSUES

See Appendix 1.

## 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 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

None

## 8. NOT FOR PUBLICATION DOCUMENTS

None.

## 9. OPTIONS

No options are provided

## 10. RECOMMENDATIONS

10.1 That the position as at the end of Quarter 3 be noted.

10.2 That the position in relation to the Better Care Fund Planning Guidance 2017/18 and 2018/19 be noted.

10.3 That due to the delays in publication of the Planning Guidance, that budget uplifts will be applied in line with the guidance once published with 1.8% in 2017/18 used as the indicative level of uplift, be noted.

## 11. APPENDICES

11.1 Report of the Strategic Director – Health and Wellbeing, Bradford MDC: Better Care Fund (BCF) 2016/17 – Quarter three progress update report

## 12. BACKGROUND DOCUMENTS

None

# Report of the Strategic Director, Health and Wellbeing to the meeting of Health and Wellbeing Board to be held on 28th March 2017.

Appendix

## Subject:

Better Care Fund (BCF) 2016/17 – quarter three progress update report

## Summary statement:

This report provides a performance update on the delivery of the Better Care Fund (BCF) as reported to the 3rd March 2017 meeting of the Bradford Health and Care Integrated Commissioners Group. It highlights areas of underperformance which require improvement activity and outlines actions which have been designed to mitigate any identified risks.

| | |
|---|---|
| Bev Maybury<br>Strategic Director: Health and Wellbeing | Portfolio:<br>Health & Wellbeing |
| Report Contacts:<br>Elaine James, Head Adult Social Care Policy and Strategy, Department of Health & Wellbeing<br>Phone: (01274) 431730<br>E-mail: elaine.james@bradford.gov.uk | Overview & Scrutiny Area:<br>Health and Social Care |

## 1. SUMMARY

1.1 This report provides a performance update on the delivery of the Better Care Fund (BCF) as reported to the 3rd March 2017 meeting of the Bradford Health and Care Integrated Commissioners Group. It highlights areas of underperformance which require improvement activity and outlines actions which have been designed to mitigate any identified risks.

## 2. BACKGROUND

2.1 The BCF was created nationally to achieve better integration of health and social care and to improve 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, resulting in an improved experience and better quality of life.

2.2 The Fund aligns resources including budgets across health and care services to improve services and reduce duplication. Locally the BCF plans support delivery of the CCG's strategic plans for 2016/17 and contributes to the Bradford District and Craven Sustainability and Transformation Plan.

2.3 The Bradford Health and Care Integrated Commissioners Executive receive regular updates on the Better Care fund, which includes a performance dashboard for the Better Care Fund and other areas covered by the 2015-16 Section 75 agreement to ensure service and financial key performance indicators are on track.

## 3. KEY ISSUES FOR CONSIDERATION

### 3.1 BCF Planning Requirements 2017/18 and 2018/19

3.1.1 As of 22nd February 2017 the BCF Planning Guidance had not been released by NHS England. Indications are that the process for submitting refreshed BCF Plans will include an Assurance Process up to April 2017 based on use the key lines of enquiry that will be used to assess the BCF narrative plans quality, however this may change due to slippage in the release date.

3.1..2 Drafts guidance includes a set of Key Lines of Enquiry which local areas will be required to meet (See Appendix C). the draft guidance indicates that the following aspects shall be requirements of the BCF Plan 2017/19:

- The local vision for health and social care services
- The evidence base supporting the case for change
- A coordinated and integrated plan for delivering change
- Approach towards managing risk
- Funding contribution levels including mandated elements

The following national metrics shall be included:

- non-elective admissions
- admissions to residential homes and care homes (how you intend to reduce residential admissions)
- effectiveness of reablement (how you intend to increase reablement)
- DTOC including a description of how BCF schemes will help meet the ambition set out in the local A&E improvement plan.

3.1.3 The indications are that the following National Conditions will remain mandatory:

1. A Better Care Fund Plan is agreed by Health & Well Being Partners which sets out a vision towards integration by 2020
2. NHS contribution to social care is maintained in line with inflation
3. Agreement to invest in NHS commissioned out-of-hospital services

3.1.4 The BCF 2017/18 and 2018/19 shall include the following elements which must be spent in keeping with their national policy intent:

- The Disabled Facilities Grant
- The Care Act 2014 Monies
- Former Carers Break Funding
- Reablement Funding (former Section 256 transfer funding)

## 3.2. Improved Better Care Fund

3.2.1 Indications are that from 2017/18, the Better Care Fund will include funding paid to Local Authorities. This funding was announced in the 2015 Spending Review as the 'improved Better Care Fund'. The funding will be paid as a direct grant under Section 31 of the Local Government Act 2003. The Policy Framework sets out that the following conditions will be applied to the grant:

- A requirement that local authorities include the funding in their contribution to the pooled Better Care Fund, unless an area has explicit Ministerial exemption from the Better Care Fund.
- A requirement that the funding is used to support adult social care

## 3.3 Pooled Budget:

3.3.1 The BCF currently operates as an aligned budget. The integrated commissioning executive is working towards establishing a pooled fund by summer 2017.

## 3.4 Performance Summary

3.4.1 Appendix 1 of this report includes a performance dashboard which summarises progress, however key issues to note are outlined below:

**a) Delayed Transfers of Care**

The DToC metric on the Bradford BCF which has been reported historically is the total number of delayed days per 100,000 population, rather than the ASCOF 2C part 1 and 2 outcomes.

Bradford are one of the best performers in the country on DToCs and in 15-16 improved further on the ASCOF 2C measure. Part 1 (NHS and Social Care) outcome at 3.38 was ranked 2nd lowest of 15 councils in Y&H and 7th lowest out of 152 councils nationally (low is good). Part 2 (Delays attributable to Social Care) at 0.19 was the best rate in the region and 4th lowest out of 152 local authorities in England. Latest data published by NHSE for Dec 2016 ranks Bradford as the best performer in the region for the number

of delayed days (Overall) and in the Top 3 Nationally (from 152 LAs). As far as delayed days attributable to Adult Social Care Bradford are ranked 4th highest performing LA (from 15 regional). Between August and December there were an increase in the number of delayed days, in line with the National trend and reflective of operational pressures during this period.

**b) Long-term support needs for people aged 65+ met by admission to residential and nursing care homes**

The impact of the BCF schemes on preventing admission to long-term care has been notable. In 2015/16 Bradford ranked 1 of 15 Local Authorities in Y&H and 35th of all 152 Councils with Social Services Responsibilities (CSSRs). 385 people aged 65+ were placed in permanent care home placements, representing a rate of 513 per 100,000 population. We have improved our reporting processes in this area and aligned to ADASS Sector Led Improvement work on data consistency, resulting in a re-submission of data to NHS Digital for both 14-15 and 15-16 ASCOF. This further strengthens our robust business intelligence which inform our joint BCF plans. Planned BCF for 2016-17 are based on whole system projections and the expected impact of all care pathway metrics including Delayed Transfers of Care, Effectiveness of re-ablement and Short Term Support to maximise independence. Information now reported from our new Integrated Digital Care Records system indicates that at the end of Quarter 3 we remain on track to meet our BCF target on this measure with a current annualised estimated out-turn of 515 (representing 392 admissions) against the BCF Target 534.

**c) Proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement / rehab services**

Performance on ASCOF 2B pt1, has deteriorated slightly year on year but at 88% Bradford remain above the 15-16 England and Regional averages which are 84%. Published 15-16 ASCOF data puts Bradford 7th out of the 15 LAs and 43/152 LAs in England. The volume of people receiving short term support to maximise independence has increased year on year and our Bradford Enablement Support Team now provide an enablement and rapid response service as part of an integrated intermediate care service at our hospitals. This ASCOF provides supporting evidence for BCF Scheme 3 Expansion of Intermediate Care Services. Data now extracted from our new Integrated Digital Care records systems indicate that at Qtr 3 we are reporting 89% and remain on track to meet the BCF Target on this outcome measure. Ongoing data quality assurance and analysis will be taking place in our preparation to completing the statutory NHS Digital SALT Data Collection where this measure is reported from.

**d) Non-Elective Admissions**

The Bradford Out of Hospital Programme continues to work towards the outcome of reducing long term admissions. In Q3, community matron and case manager services have been reconfigured to form the first stage of a Community Integrated Team (CIT) model of care which will provide intensive support to people with complex needs, who live in care homes or in their own homes.

To support the further development of CITs and other Bradford Out of Hospital projects which will reduce NEL admissions, the CCGs gave formal notice. in January 2017, to providers of critical intermediate care and community services and advised that the CCGs want to engage with current providers to consider the best model of service

delivery to address both quality improvement and value for money. From April 2018 a transformed service will be designed and commissioned. A key element of this work is to develop multi agency Community Integrated Teams across 3 geographical hubs.

**e) Diagnosis for People with Dementia**

In September 2016 the dementia diagnosis rate for CCGs in the Bradford area was 81.2% (includes Craven) and continues to significantly exceed the national standard of 66.7%. The diagnosis rate in Bradford also exceeds the national diagnosis rate of 67.5%. 4,813 people in the area have a diagnosis of dementia, of an estimated 5,925 people living with the condition.

In September 2016 the dementia diagnosis rate for CCGs in the Bradford area was 81.2% (includes Craven) and continues to significantly exceed the national standard of 66.7%. The diagnosis rate in Bradford also exceeds the national diagnosis rate of 67.5%. 4,813 people in the area have a diagnosis of dementia, of an estimated 5,925 people living with the condition.

## 4. ISSUES FOR ESCALATION

4.1 Schedule 1D of the Section 75 Agreement relate to the funding of BACES. For the financial year Schedule 1D section 7 2016/17 the CCG contribution is specified to be £1,146,700 and the Council contribution is specified to be £1,404,900. Schedule 1D section 11 specifies that any expenditure over this amount would be on a risk shared basis split 50/50.

4.2 The forecast outturn is £3,252K which would be an overspend of £700,400. In keeping with the risk share as specified in Schedule 1D Section 11 of the S75 this is a pressure of £350,200 on each of the commissioners.

4.3 The final version of the BCF Planning Template signed off by NHS England however documents that the amount identified for BACES is £1,412,000 from the CCG(s). The Council has budgeted for £1.4M plus a 50% contribution to the overspend in keeping with the risk share. The Council has forecast and committed expenditure to BACES on the assumption that a further £217,550 contribution would be made by the CCG(s) in keeping with the 50/50 risk share arrangement.

## 4. FINANCIAL & RESOURCE APPRAISAL

4.1 The Better Care Fund in 2016/17 has a mandated value of £38,090,495 of which £3,519,000 is the mandated element for the Disabled Facilities Grant and £1,356,000 is mandated for the Care Act implementation and £14,672,000 for maintaining and protecting adult social care. The final out turn position will be fully reported in the March update to the Health & Well Being Board.

4.2 The indications are that the CCG(s) should plan for an uplift of 1.8% for 2017/18 and a further 2.1% for 2018/19 for maintaining and protecting social care in keeping with the National Policy Guidance.

## 5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The Better Care Fund risk log comprises both Strategic and Operational Risks. The integrated Commissioning Executive manages Strategic Risks and the Operational Risks are managed by commissioners and programme leads. Significant risks are migrated onto the CCG's Corporate Risk Register and the Council's Corporate Risk Register as appropriate.

5.2 The BCF risk register records that all risks are currently at the level of moderate and are well managed. However, given the escalating risks associated with the DToC performance the Integrated Commissioning Executive may wish to review the current risk rating.

## 6. LEGAL APPRAISAL

6.1 A Section 75 Partnership Framework Agreement is in place between the Council and the Clinical Commissioning Group(s) is in place.

## 7. OTHER IMPLICATIONS

### 7.1 EQUALITY & DIVERSITY

7.1.1 Any service changes resulting from delivery of the plan will be subject to consideration in relation to an Equality Impact Assessment.

### 7.2.1 SUSTAINABILITY IMPLICATIONS

7.2.1 N/A

### 7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.3.1 N/A

### 7.4 COMMUNITY SAFETY IMPLICATIONS

9.4.1 N/A

### 7.5 HUMAN RIGHTS ACT & TRADE UNION

Capacity and capability to develop the plans are in line with current resource available to commissioners.

## 8. NOT FOR PUBLICATION DOCUMENTS

8.1 None.

## 9. RECOMMENDATIONS

9.1 The Health & Wellbeing Board:

a) Note the position as of the end of Quarter 3.

b) Note the position in relation to the BCF Planning Guidance 2017/18 and 2018/19.

c) Note that due to the delays in publication of the Planning Guidance, that budget uplifts will be applied in line with the guidance once published with 1.8% in 2017/18 used as the indicative level of uplift.

## 12. APPENDICES

**Appendix one:** BCF Outcomes Framework Performance

**Appendix two:** Key Lines of Enquiry for BCF Refresh

## Appendix one : BCF Outcomes Framework Performance

**Key:**

Better than England average

Worse than England average

Improved since previous reporting period

Worsened since previous reporting period

Same as previous reporting period


| | Indicator | Calderdale Value | Eng Avg | Eng Worst | England Range | Eng Best | Direction of Travel |
|---|---|---|---|---|---|---|---|
| 1 | Proportion of Social Care Clients Who Feel Safe | 73.2 | 68.9 | 55.1 | | 80.4 | |
| 2 | Social Care Related Quality of Lfe | 19.5 | 19.1 | 17.9 | | 20.7 | |
| 3 | Permanent Admissions to care homes / 100k population 65+ | 506.0 | 650.6 | 1256.2 | | 188.4 | |
| 4 | Proportion of older people still at home 91 days after discharge from reablement into hospital | 88.2 | 83.4 | 50.0 | | 100.0 | |
| 5 | Carer reported quality of life | 8.4 | 7.9 | 6.6 | | 8.9 | |
| 6 | Delayed transfers of Care / 100k | 3.2 | 10.9 | 29.4 | | 0.0 | |
| 7 | Delayed transfers of Care / 100k attributable to Social Care | 0.1 | 4.2 | 15.4 | | 0.0 | |
| 8 | Proportion Of Carers receiving Direct Payments | 81.9 | 71.3 | 0.0 | | 100.0 | |

Appendix Two – Key Lines of Enquiry for BCF Refresh

| **Planning requirement area** | **BCF Planning Requirements** ***(the confirmations for these requirements will be collected and analysed centrally)*** | **KLOEs to support assurance of the planning requirements** ***(these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)*** | **Status Check** |
|---|---|---|---|
| National condition 1: jointly agreed plan (Policy Framework) | **1. Has the area produced a plan that all parties sign up to and is agreed by the health and well being board?**<br>**2. In two tier areas, have district councils agreed to proposals to retain Disabled Facilities Grant in the BCF?** | 1. Are all partners and the HWB signed up to the plan?<br>2. Is there evidence that local providers have been involved in the plan, and that, in two-tier areas, district councils been involved in developing the elements of the plan related to housing and signed up to any plans to retain Disabled Facilities Grant within the BCF? | Plan in draft format. Planning days 27.02.17 and 31.03.17. DfG workshop planned March 2017. |
| National condition 2: Social Care Maintenance (Policy Framework) | **2. Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* for 17/18 and 18/19**<br>**1.8% for 2017/18 and a further 2.1% for 2018/19* | 3. Is there an increase in planned spend on Social Care from the BCF CCG minimum in line with inflation for 17/18 and 18/19 confirmed in the planning template?<br>4. If the planned contributions to social care spend from the BCF exceed the minimum, is there confidence in the affordability of that contribution?<br>5. Where the increase in contribution from the CCG to fund social care increases in 2017/18 to an amount greater than the expected figure for 2018/19, that the transfer to social care in 2018/19 is not lower than the transfer in 2017/18?<br>6. That in setting the contribution to social care from the CCG(s), the partners have ensured that any change does not destabilise the local health and care system as a whole; and that the contribution is to be spent on social care services that have some health benefit and support the overall aims of the plan? | Plans in place. Finance meeting scheduled 27.02.17 to consider implications and financial schedule over the lifetime of the plan including alignment with the CCG contracting and Out of Hospital Board change programme. |
| National condition 3: NHS commissioned Out of Hospital | **3. Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the** | 7. Does the area's plan demonstrate that the area has committed an amount equal to or above the minimum allocation for NHS commissioned out-of-hospital services and this is clearly set out within the summary and expenditure plan tabs of the BCF planning template? | To be tested as part of the plan refresh process. |

| Planning requirement area | BCF Planning Requirements *(the confirmations for these requirements will be collected and analysed centrally)* | KLOEs to support assurance of the planning requirements *(these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)* | Status Check |
|---|---|---|---|
| Services (Policy Framework) | **CCG minimum BCF contribution?** | 8. If an additional target has been set for Non Elective Admissions; have the partners considered whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the plan seeks to avoid?<br>9. If yes - Is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent? | |
| Local vision for health and social care | **4. A clear articulation of the local vision for integration of health and social care services, including changes to patient and service user experience and outcomes?** | 10. The narrative plan articulates the local vision for integrating health and social care services, including changes to patient and service user experience and outcomes, cross-referenced and aligned to other plans impacting on integration of health and social care such as STPs or devolution deals?<br>11. An articulation of the contribution to the commitment to fully integrate health and social care services by 2020 in line with the intent set out in the 2015 spending review?<br>12. A description of how progress will continue to be made against the former national conditions 3, 4 and 5? | Bradford District and Craven STP aligned to the West Yorkshire Plan. Further work to be undertaken to refresh the narrative plan to fully align to the scope of ambition within the STP. |
| Plan of action to contribute to delivering the vision for social and health integration | **5. Does the BCF plan provide an evidence-based plan of action that delivers against the local needs identified and the vision for integrating health and social care?** | Does the action plan make a compelling case for change, including<br>13. Quantified understanding of the current issues that the BCF plan aims to resolve through the planned schemes<br>14. Evidence based assessment of the proposed impact on the local vision for integrating health and social care services through the planned schemes and joint working arrangements | Plan refresh to commence aligned to the CCG(s) out of hospital programme board ambition. |
| Approach to programme delivery and control | **6. Is there a clear, jointly agreed approach to manage the delivery of the programme, identify learning and insight and take timely corrective and preventive action when** | 15. A description of the specifics of the overarching governance and accountability structures and management oversight in place locally to support integrated care and the delivery of the BCF plan?<br>16. Does the narrative plan have a clear approach for the management and control of the schemes including as a minimum:<br>- Benefit realisation (how will outcomes be measured and attributed?) | Additional capacity secured to support the process of reviewing and refreshing the integrated commissioning arrangements. |

| Planning requirement area | BCF Planning Requirements *(the confirmations for these requirements will be collected and analysed centrally)* | KLOEs to support assurance of the planning requirements *(these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)* | Status Check |
|---|---|---|---|
| | **needed?** | - Capturing and sharing learnings regionally and nationally<br>- An approach to identifying and addressing underperforming schemes | |
| Management of risk (financial and delivery) | **7. Is there an agreed approach to programme level risk management, financial risk management and, including where relevant, risk sharing and contingency?** | 17. Have plan delivery and financial risks, consistent with risks in partner organisations, been assessed in partnership with key stakeholders and captured in a risk log with a description on how these risks will be proportionally mitigated or managed operationally?<br>18. If risk share arrangements have been considered and included within the BCF plan, is there a confirmation that they do not put any element of the minimum contribution to social care at risk? | To be fully tested during the BCF plan refresh process.<br>Risk share arrangementsin the S75 currently restricted to BACES and do not yet capture fully wider strategic system risks. |
| Funding contributions:<br>1. Care Act,<br>2. Carers' breaks,<br>3. Reablement<br>4. DFG<br>5. iBCF | **8. Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose and this is appropriately agreed with the relevant stakeholders?** | 19. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?<br>20. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?<br>21. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?<br>22. Agreement on use of the Disabled Facilities Grant?<br>23. Local Authority Contribution matches or exceeds the allocated 'improved Better Care Fund'?<br>24. The required CCG minimum contribution and any additional CCG contributions? | To be confirmed during the plan refresh process. |
| Metrics – Non Elective Admissions | **9. Has a target been set for reducing Non Elective Admissions?** | 25. Does the narrative plan include an explanation for how this target has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?<br>26. Has a further reduction in Non Elective Admissions, additional to those in the CCG operating plan, been considered? | Input required from CCG(s) colleagues in keeping with the Operational Plan and A&E Delivery Board ambition. |
| Metrics – Non Elective Admissions | **10. If a target has been set for a further reduction in Non Elective Admissions,** | 1. Has the target taken into account performance to date and current trajectory and are schemes in place to support the target? | As above |

| Planning requirement area | BCF Planning Requirements *(the confirmations for these requirements will be collected and analysed centrally)* | KLOEs to support assurance of the planning requirements *(these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)* | Status Check |
|---|---|---|---|
| (additional | **beyond the CCG operating plan target, has a financial contingency been considered?** | 2. See also National Condition 3. | |
| Metrics Admissions to residential care homes | **11. Has a target been set to reduce permanent admissions to residential care?** | 3. Does the narrative plan include an explanation for how this target will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19? | Input required from Council BI leads to include input from the Council Performance Leads. |
| Metrics – Effectiveness of Reablement | **12. Has a target been set for increasing the number of people still at home 91 days after discharge from hospital to rehabilitation or reablement?** | 4. Does the narrative plan include an explanation for how this target will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19? | Input required from Council BI leads to include input from the Council Performance Leads. |
| Metrics Delayed Transfers of Care | **13. Has a target been set for Delayed Transfers of Care? Does this target take account of targets set at local NHS trust level as part of A&E delivery plans?** | 5. Is there evidence of a joint plan between CCGs, local authority and providers to reduce delayed transfers of care? Does the narrative set out the contribution that the BCF schemes will make to the target including an analysis of previous performance and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan?<br>6. Do the targets take account of the ambition in the A&E delivery plans? (Where geographies don't easily enable this comparison through data, assurers should take into account other qualitative factors)<br>7. Is there evidence that Clinical Commissioning Groups have put in place a Discharge to Assess model locally and have put in place, or plan to put in place, a trusted assessor model? Do these schemes align with other Local Authority led, or jointly commissioned work through BCF or cross reference other work outside the BCF? | Input required from CCG(s) colleagues in keeping with the Operational Plan and A&E Delivery Board ambition.<br><br>Is an area of escalating risk. |
| Integrity and completeness of BCF | **14. Has all the information requested in the planning template been provided** | 8. Have the Planning template and Narrative plans been locally validated for completeness and accuracy as per the planning requirements? | To be tested during the plan refresh process. |

| Planning requirement area | BCF Planning Requirements *(the confirmations for these requirements will be collected and analysed centrally)* | KLOEs to support assurance of the planning requirements *(these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)* | Status Check |
|---|---|---|---|
| planning documents | **and are all the minimum sections required in the narrative plan elaborated?** | | |

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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 28th March 2017

**U**

**Subject:** A proposal for development of a Joint Health and Wellbeing Strategy for 2017-2022

**Summary statement:** The current Joint Health and Wellbeing Strategy (JHWS) is due to expire at the end of March 2017. This briefing puts forward a proposal for the development of a new strategy.

**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 current Joint Health and Wellbeing Strategy (JHWS) is due to expire at the end of March 2017. This briefing puts forward a proposal for the development of a new strategy following a Health and Wellbeing Board development session in February this year. Health and wellbeing board members are asked to comment on the proposals in this paper and agree a way forward.

## 2. BACKGROUND

Joint Health and Wellbeing Strategies became a statutory requirement with the introduction of the Health and Social Care Act in 2012, at the same time as Health and Wellbeing Boards were being established.

The purpose of the Strategy was to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. It was intended to help determine what actions local authorities, the local NHS and other partners need to take to meet health and care needs, and to address the wider determinants that impact on health and wellbeing.

Bradford's first Joint Health and Wellbeing Strategy was written in 2012 and is due to expire in March this year. It took a life course approach and after a long consultation process identified 18 priorities and is supported by a comprehensive Health Inequalities Action Plan.

In 2014 feedback from an LGA Peer Review process highlighted some issues with the current strategy, mainly that there were too many priorities. Discussion at the Health and Wellbeing Board development session confirmed that the strategy wasn't being used and that we needed something more focused that can be used by the Health and Wellbeing Board to deliver its remit.

## 3. OTHER CONSIDERATIONS

Discussion at the development session recognised that as a partnership we have already developed plans and strategies that have gone through extensive consultation and had priorities agreed that have a focus on health and wellbeing. Board members recognised that the Joint Health and Wellbeing Strategy needs to be informed by the Joint Strategic Needs Assessment but felt that it was important to add value to and support the delivery of key partnership plans. It was agreed that key partnership plans to take into account are:

- Bradford District Plan 2016-20 – developed by the Bradford District Partnership– building on the idea of a New Deal for the District and with five priorities including Better Health, Better Lives which focuses on: preventing illness; reducing demand

for urgent and unplanned care; supporting independence; parity for mental health; self-care; child health; people being fit, active and healthy.

- Bradford District and Craven Sustainability and Transformation Plan (STP) has five major clinical or disease priorities where the District has considerable health needs and health inequalities (cardio-vascular and Type 2 diabetes, respiratory, mental health including dementia, cancer, ) and three broader themes (maternal and child health, socio-economic and environmental factors, healthy ageing). These were identified by a short review of national priorities, local priorities in existing plans and new data from the Joint Strategic Needs Assessment (JSNA). This forms one of six chapters in the West Yorkshire and Harrogate STP which is a statutory plan under NHS planning guidance for 2016-17. A Key element of the STP is to look at how we work together to close the health and wellbeing gap, i.e. reduce inequalities in health.

The Joint Health and Wellbeing Strategy should identify priorities from these key strategic plans for the Health and Wellbeing Board to focus on. Writing a new strategy offers an opportunity to review and improve the focus of the Health and Wellbeing Board and its partners. The new strategy will:

- Focus on small number of priority areas of highest impact
- Drive partnership working; health and wellbeing is everyone's business and responsibility
- Add value to current plans and strategies and becomes a guiding document for the work of the Health and Wellbeing Board and its partners

3.1 Broadly speaking the Joint Health and Wellbeing Strategy will cover the following:

**3.1.1 Introduction**
Understanding the role of the Health and Wellbeing Board, setting the context within which we are working and what a Joint Health and Wellbeing Strategy is for

**3.1.2 Understanding the health needs of the people in Bradford**
Summarising what we know about the needs of our population and key characteristics that we need to be aware of when making decisions

**3.1.3 Our approach to improving health and wellbeing**
What are our principles for where we want to focus i.e. could be focus on prevention, early intervention, returning people to lowest level of need, care closer to home, etc.; identify 6-8 key strategic priorities that the Health and Wellbeing Board can focus on

**3.1.4 A framework to inform decision-making**
To give the best chance of improving health and wellbeing and reducing inequalities it needs to be everyone's business and our ability to have a positive impact considered in all of our actions as a health and social care economy. The Strategy will provide a short toolkit to:

- Enable commissioners to understand the impact of their decisions on health and wellbeing and the opportunity to reduce health inequalities. Supporting decision-makers in health and social care to maximise the potential to improve the health of the population.
- Enable Health and Wellbeing Board members to hold people to account for improving health and wellbeing and reducing the impact of health inequalities on the population via their strategies and action plans.

See section 12 – Background documents for the recent update of our joint assessment of needs.

### 3.2 Engagement and consultation

Priorities in the District Plan and Sustainability and Transformation plan have been widely consulted on already therefore there is no need to consult on priorities if we are not identifying new ones. we will take into account messages from any relevant engagement or consultation that has taken place in the last 12-18 months (such as that for the 2016-20 District Plan) or that takes place whilst the strategy is being developed (such as that being planned for the Bradford and Craven Sustainability and Transformation Plan). The draft Strategy will be consulted on via:

- Stakeholder engagement via existing forums
- Engagement with council committees, members and partnership committees
- Public engagement planned with communications and engagement colleagues in the council and in partner organisations

## 4. FINANCIAL & RESOURCE APPRAISAL

The Directors of Finance from the Council, the Clinical Commissioning Groups and the main health providers have worked together to forecast the resources that are likely to be available to the Health and Wellbeing sector in Bradford District up to 2021 (subject to changes to national budget settlements). These have been reported through the Sustainability and Transformation Planning Process. The Board received a full finance update in September 2016 as part of this process. The priorities of the Joint Health and Wellbeing Strategy will support local decision-makers to make best use of available resources to improve health and wellbeing.

## 5. RISK MANAGEMENT AND GOVERNANCE ISSUES

The Joint Health and Wellbeing Strategy is owned by the Bradford and Airedale Health and Wellbeing Board, which in turn reports to the Bradford District Partnership. The Board also reports on progress against the Better Health, Better Lives priority of the District Plan and the process of developing the new strategy will seek consistency across the key plans and strategies in the District. Each Board member will be asked to take the final Joint

Health and Wellbeing Strategy through their organisation's governance routes for agreement

## 6. LEGAL APPRAISAL

The Joint Health and Wellbeing Strategy is a statutory requirement under the 2012 Health and Social Care Act. The commissioning plans of the local authority and local NHS organisations are required to be consistent with the priorities of the Joint Health and Wellbeing Strategy.

## 7. OTHER IMPLICATIONS

### 7.1 EQUALITY & DIVERSITY

The Joint Health and Wellbeing Strategy will seek to reduce health inequalities including as they relate to broader equalities for example, gender, ethnicity and deprivation and to protected characteristics.

### 7.2 SUSTAINABILITY IMPLICATIONS

The Strategy will deliver the Health and Wellbeing aim of the Bradford and Craven Sustainability and Transformation Plan (STP) and will contribute to the Health and Wellbeing aim of the West Yorkshire and Harrogate STP.

### 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 proposed approach to developing the Joint Health and Wellbeing Strategy as outlined in the report be agreed.

10.2 That the Board agree that the Joint Health and Wellbeing Strategy focus on delivering the priorities for the health and wellbeing elements of the District Plan and the local Sustainability and Transformation Plan.

## 11. APPENDICES

None

## 12. BACKGROUND DOCUMENTS

Joint Strategic Needs Assessment for Bradford District
https://jsna.bradford.gov.uk/JSNA.asp

City of Bradford MDC
www.bradford.gov.uk

# Report of the Chief Officer of the Bradford City, Bradford Districts and Airedale, Wharfedale Craven Clinical Commissioning Groups to the meeting of the Bradford and Airedale Health and Wellbeing Board to be held on 28th March 2017.

**V**

**Subject: Cardiovascular Disease - Update**

## Summary statement:

This report will provide an overview of the challenges Bradford Districts Clinical Commissioning Group faced with regards cardiovascular disease (CVD), the actions it has taken and the outcomes seen to date.

It will also describe the lessons learned and next steps in the programme and seek support from the Bradford and Airedale Health and Wellbeing Board to deliver its longer term aims.

Helen Hirst
Chief Officer – Bradford City, Districts and Airedale, Wharfedale and Craven CCGs
Report Contact: Kath Helliwell
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**Portfolio:**

**Health and Wellbeing**

**Overview & Scrutiny Area:**

**Health and Social Care**

## 1. SUMMARY

1.1 Cardiovascular disease (CVD)

**Today…**

- 435 people will lose their lives to CVD
- …more than 110 people will be younger than 75
- 7 million people fight their daily battles with CVD
- 515 people will go to hospital due to a heart attack
- 190 people will die from a heart attack
- 12 babies will be diagnosed with a heart defect

There are around **7 million people** living with CVD in the UK: 3.5 million men and 3.5 million women.

An ageing and growing population and improved survival rates from CVD could see these numbers rise still further.

CHD kills more than twice as many women in the UK as breast cancer.
(British Heart Foundation – CVD Statistics)

Our triple aim is to improve health and wellbeing, care and quality and achieve financial balance and efficiencies in our services. To do this we have to make large scale change, engaging with our local population to sustain this change and challenge the current outcomes to achieve success.

This paper provides the Health and Wellbeing Board with the local picture of Bradford Districts CCG, the problems we were faced with regarding our poor outcomes, and the action we took.

It will also describe the outcomes we are now seeing across Bradford Districts CCG.

## 2. BACKGROUND

2.1 Bradford's population

The resident population of NHS Bradford Districts CCG is 336,000 and 48,100 of these people are aged 65 and over. In the CCG, 39.9% of people live in the most deprived fifth of areas in England.

In 2013/14 there were 11,471 people who had been diagnosed with CVD in NHS Bradford Districts CCG. Based upon Health Survey for England results applied to this CCG, the total number of expected CHD cases is likely to be around 17,000. For the whole of "Cardiovascular Disease", there are 28,000 patients diagnosed in the CCG.

Early mortality (under 75 years) rates from CVD are significantly higher than the national

rate at 28% of all deaths under 75, despite decreasing by 28% since 2004-06. This is the 7th worst CVD death rate in the whole country.

The health of people in Bradford is generally worse than the England average. Deprivation is higher than average and about 28% (41,000) of children live in poverty. Life expectancy for both men and women is lower than the England average.

- Over 28% of all deaths are under 75 years of age
- 14.3% of people have hypertension (high blood pressure)
- Over 2,000 people have cholesterol above 4mmol/l
- Each day there are 5 non-elective admissions for CVD events
- Spend in the last year was £4.5 million just for non-elective admissions for strokes and myocardial infarction (MI)

## 3. OTHER CONSIDERATIONS

### 3.1 Living longer

Life expectancy is 9.6 years lower for men and 8.0 years lower for women in the most deprived areas of Bradford than in the least deprived areas.

The population of Bradford is ethnically diverse. The largest proportion of the district's population (63.9%) identifies themselves as White British. The district has one of the largest proportions of people of Pakistani ethnic origin (20.3%) in England.

### 3.2 Adult health

In 2012, 26.7% of adults are classified as obese. The rate of alcohol related harm hospital stays was 787, worse that the average for England. This represents 3,700 stays per year. The local rate of smoking related deaths is worse than the average for England. This represents 825 deaths per year. Estimated levels of adult smoking are worse than the England average.

…CVD still remains one of the leading causes of death, and is one of the Health and Wellbeing priorities in the Bradford and Craven Sustainability and Transformation Plan.

### 3.3 Modifiable and non-modifiable risk factors

Modifiable risk factors include: smoking, high blood pressure, diabetes, physical inactivity, being overweight and high blood cholesterol.
Many risk factors can be changed (you cannot change the risk factor, only its effect). The effect of these modifiable risk factors can be reduced if you make lifestyle changes.

Non-modifiable risk factors are: age, ethnic background and a family history of heart disease.

Smoking, obesity, alcohol and low levels of physical inactivity all contribute to increases in cardiovascular risk. Linked with our higher rates of South Asian ethnicity (another CVD

risk factor) these factors will see an increase in people with hypertension (high blood pressure), diabetes (Type 2) and high cholesterol levels.

3.4 The Programme and action taken

On 14th February 2015 Bradford Districts CCG formally launched its local programme called "Bradford's Healthy Hearts" which was developed on the back of our poor outcomes.

Over 14% of people have high blood pressure (48,000 people) with an estimated 37,000 more having undiagnosed high blood pressure.; 21,000 people were known to have cholesterol levels above 4; and each day there are 5 emergency admissions for CVD with the annual cost of these at least £4.5 million (excluding planned elective care)

Our Clinical Board supported the establishment of the programme, and all our practices remain fully engaged and committed to the programme.

Bradford's Healthy Hearts set itself a challenging ambition to reduce cardiovascular events by 10% by 2020 – a reduction which will result in 150 fewer strokes and 340 fewer heart attacks. The CCG made the commitment that "We will no longer be the seventh worst CCG in the country"

A collaborative approach was taken across the whole of the healthcare pathway involving all stakeholders and patients to design a programme that would make a change to the way we care for people in the future.

This was to be the model of how we would start to make a change to the way we care for people in the future. This way of working is now being used across other programmes.

3.5 The programme targets:

- Cholesterol management – optimisation of treatment for those with existing CVD and those at risk of developing future CVD (those with a cardiovascular risk of >10% over 10 years)

- Blood pressure:

    - Increased identification of new diagnoses of high blood pressure (the BHH programme increased this by around 2,500 patients, which is about a 5% increase of previous figures.
    - Better treatment of those already treated for high blood pressure. This includes increasing the number of patients who self-monitor their own BP and who proactively seek help based on this monitoring. After less than one year of the blood pressure program, nearly 75% of people with high blood pressure are now better treated (4,400 more people).

- Improved management of atrial fibrillation (AF) (an irregular heart rhythm that vastly increases the risk of stroke) – through blood thinning/anticoagulation.

More than 13,000 more people in the Bradford area have had their statin medication improved, and more than 1,000 people are now on vital blood thinning and stroke preventive medicine which has reduced the risk of stroke by up to 75% in these patients. In addition to these major health benefits, the CCG estimates it has made net savings of £1.2m in the first fifteen months of the programme

In the first two years of operation, Bradford's Healthy Hearts campaign has significantly improved the health of its residents, by offering nearly 21,000 health interventions to patients in the Bradford area and since the start of the campaign; there have been 211 fewer heart attacks and strokes.

Residents of Bradford Districts CCG's area are now more aware of what is needed for a healthy heart.

Whilst Bradford Districts CCG established the Bradford's Healthy Hearts Programme, Bradford City CCG was expanding their programme, Bradford Beating Diabetes (BBD). Examples of good practice and challenges have been shared from each programme between the CCGs to enable both CCGs to support delivery of the vision "Better Health for people of Bradford" and "Reducing health inequalities". These examples of best practice are thus able to be tailored to the population need of the individual CCGs.

3.6 NHS Right Care approach

NHS Right Care is all about:

*Intelligence* – using data and evidence to shine a light on unwarranted variation to support an improvement in quality
*Innovation* – working in partnership with a wide range of organisations, national programmes and patient groups to develop and test new concepts and influence policy
*Implementation and improvement* – supporting local health economies to carry out sustainable change.

The aim is to provide local health economies with:

- a high-level overarching national case for change;
- a best practice pathway for individual conditions; and
- the best practice case studies for elements of the pathway demonstrating what to change, how to change and a scale of improvement.

The NHS Right Care programme has developed a case study around our programme which can be shared and replicated across England.

NHS Scotland is piloting the BHH programme, and around 14 CCGs in England have contacted us so far to explore implementing the BHH programme. Public Health England have invited us to showcase the BHH programme at several of their CVD masterclass events nationally and are keen to continue this. We have been invited and are collaborating with the British Heart Foundation and Public Health England to develop a national cholesterol management tool which incorporates the BHH lipid work.

Our programme has received national recognition with four national awards (one of them the prestigious British Medical Journal award 2016).

We have invested in education both in our clinical teams across the CCG and also in our patients. Our GPs and practice nurses have had regular update and best practice training sessions.

Our monthly patient education sessions evaluate very positively each time. These are run on a variety of CVD related topics and provide advice and information on a range of areas from: how to reduce CVD risk, to how blood pressure medication works and how patients can take more charge of their own health.

For newly diagnosed patients with high blood pressure, a 12 month contract was successfully awarded to an external health provider, to deliver education to patients over 4 sessions aiming to improve knowledge of: the disease; how to reduce high blood pressure; how to measure and monitor their own blood pressure (patients are given their own accredited BP machine) and importantly what, if any action to take on reviewing their results.

Our Bradford's Healthy Hearts Website/page has been a huge success with a true stakeholder approach to its development. Local campaigns have brought the programme into media and helped raise awareness.

We have put a great deal of emphasis on how patients can look after their own health, and have tailored our approach by hearing from our patients on what they need in terms of advice, help and support.

3.7 Lessons Learnt

1. **Process** – provide support to practices, develop clinical searches, resources and ensure messages are evidence based. Engage stakeholders and patients from the very beginning. Incentives are not always financial, improvements and healthy competition between practices has been a driver in success. Monthly practice level reports were developed to show improvements (CCG and Practice level)

2. **Pathways** – population focus – think big. Ensure patient choice is evident throughout each step in the pathway. Think "outside the box"

Next steps

We have recently submitted a bid to the British Heart Foundation for funding to support the "Detection and Management" of individuals previously undiagnosed with hypertension. Should we be successful with this, our aim is to work collaboratively with our local stakeholders in the community.

## 4. FINANCIAL & RESOURCE APPRAISAL

The annual cost of emergency admissions for Cardiovascular disease in the Bradford Districts CCG area is at least £4.5 million (excluding planned elective care). The CCG estimates it has made net savings of £1.2m in the first fifteen months of the programme.

See also next steps above.

## 5. RISK MANAGEMENT AND GOVERNANCE ISSUES

There are regular meetings of the BHH programme board, made up of the Cardiovascular lead, Senior Responsible Officer, representative from the communications team, secondary care cardiology lead, pharmacy lead, and CCG Head of Service Improvement. This board reports to the Bradford Districts CCG clinical board.

## 6. LEGAL APPRAISAL

Not applicable

## 7. OTHER IMPLICATIONS

Not applicable

### 7.1 EQUALITY & DIVERSITY

Not applicable

### 7.2 SUSTAINABILITY IMPLICATIONS

Not applicable

### 7.3.1 GREENHOUSE GAS EMISSIONS IMPACTS

Not applicable

### 7.4 COMMUNITY SAFETY IMPLICATIONS

Not applicable

### 7.5 HUMAN RIGHTS ACT

Not applicable

### 7.6 TRADE UNION

Not applicable

## 7.7 WARD IMPLICATIONS

Not applicable

## 8. NOT FOR PUBLICATION DOCUMENTS

None submitted

## 9. OPTIONS

Not applicable

## 10. RECOMMENDATIONS

The Health and Wellbeing Board are asked to:

- Consider how the lessons learnt from the Bradford Healthy Hearts programme could be applied to the priorities of the revised Health and Wellbeing Strategy 2017-2022 (in development).

## 11. APPENDICES

None

## 12. BACKGROUND DOCUMENTS

None