Bradford District Health and Wellbeing Board

Integration and Better Care Fund

Narrative Plan for 2017-19

CONTENTS

TABLES

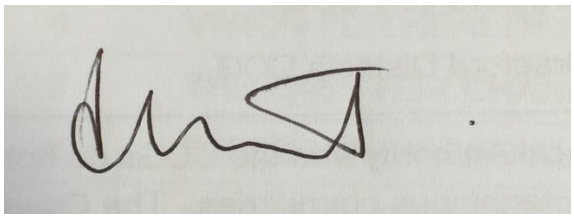
FIGURES

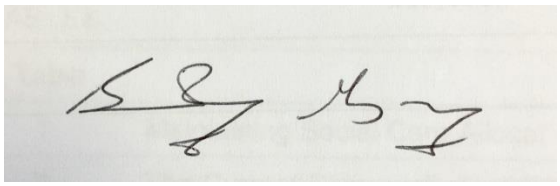
ANNEXES

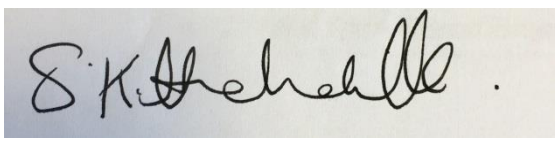
SUBMISSION SUMMARY

Local Authority	City of Bradford MDC
Clinical Commissioning Groups	NHS Airedale, Wharfedale and Craven CCG NHS Bradford City CCG NHS Bradford Districts CCG
Boundary Differences	The Local Authority and the CCGs do not have coterminous boundaries. The Craven locality is in North Yorkshire County Council.
Date agreed at Health and Wellbeing Board	Delegated authority to sign off the Bradford district BCF Plan was given to Councillor Susan Hinchcliffe 5th September 2017
Date of narrative submission:	11th September 2017
Minimum required value of pooled budget: 2016/17	£38,090,495
2017/18	£51,093,767
2018/19	£56,490,133
Total agreed value of pooled budget: 2016/17	£38,090,495
2017/18	£51,093,767
2018/19	£56,490,133
National Conditions	This plan is compliant with the following national conditions of the BCF planning framework: NC1 – A Jointly agreed plan NC 2 – NHS contribution to Social Care is maintenance in line with inflation NC 3 – Agreement to invest in NHS-Commissioned out-of-hospital services NC 4 – Implementation of the High Impact Change Model for managing Delayed Transfers of Care

AUTHORISATION AND SIGN OFF OF THE BRADFORD DISTRICT BETTER CARE FUND

Signed on behalf of the Clinical Commissioning Groups 	NHS Airedale, Wharfedale and Craven CCG NHS Bradford City CCG NHS Bradford Districts CCG
By	Helen Hirst
Position	Chief Officer
Date	06/09/2017

Signed on behalf of the Council 	City of Bradford MDC
By	Bev Maybury
Position	Strategic Director Health and Wellbeing
Date	06/09/2017

Signed on behalf of the Health and Wellbeing Board 	Bradford and District Health and Wellbeing Board
By	Councillor Susan Hinchcliffe
Position	Chair of the Health and Wellbeing Board
Date	05/09/2017

1. INTRODUCTION

1.1 The Better Care Fund brings together health and social care budgets to support more person-centred, coordinated care. The Mandate to NHS England (NHSE) requires NHSE to ring-fence funds within its overall allocation to Clinical Commissioning Groups (CCGs) to establish the Better Care Fund (BCF). The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF). The Spring Budget 2017 announced an additional £2 billion to support adult social care in England. This money is included in the iBCF grant to local authorities (LAs) and is now included in Bradford's BCF pooled funding and plans.

1.2 This Bradford Better Care Fund narrative builds on the plans previously developed for the local care economy in 2015-16 and 2016-17. In those plans we set out some core principles that describe how we intend to integrate service delivery in response to a particular set of needs for our population. Since the development of the original Better Care Fund plan our local health economy has developed and is moving towards an accountable care model of service delivery, working collaboratively with our main provider community. This plan supports the delivery of our wider objectives and strategies around health and social care as outlined in the Bradford District and Craven Health and Wellbeing Plan.

1.3 This narrative update reflects the change to the Policy Framework for the Better Care Fund to cover a two year period (2017-19) to align with NHS planning timescales. The main change from last year is the inclusion of additional local authority social care grant funding (the iBCF), which now forms part of the overall Bradford Better Care Fund.

1.4 The four National Conditions that we are required to meet through our BCF plan are:

I. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;

II. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;

III. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and

IV. All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

1.5 Bradford currently ranks 2nd of all Local Authorities (top quartile) on the new national composite metric for the Better Care Fund. As in previous years, 2015-16 and 2016-17, Bradford and District will agree and report metrics in the following areas:

- Delayed transfers of care;
- Non-elective admissions;
- Admissions to residential and care homes; and
- Effectiveness of reablement.

1.6 In addition, Bradford and District will agree and report metrics in the following new areas that contribute to the new national composite measure for the BCF:

- Emergency admissions, weekend discharges; and
- Emergency admission, length of stay.

1.7 Bradford will also monitor and report on the following iBCF indicators:

- Numbers of packages of care commissioned to facilitate hospital discharges;
- Number of hours of home care commissioned to facilitate hospital discharges;
- Number of admissions to intermediate care beds to facilitate discharge; and
- Admissions to residential and care homes to facilitate hospital discharges.

1.8 This Bradford Better Care Fund Plan for 2017-19 should be read in conjunction with the planning template that details all funding contributions, alignment, measures and metrics. This plan continues to support our Five Year Forward View and, since our last narrative plan, the Bradford District and Craven Health and Wellbeing Plan. As the first two year plan agreed between partners, the BCF programme will refresh this plan for 2018-19 as further guidance is published.

2. BACKGROUND AND CONTEXT TO THE PLAN

Our Local Story

2.1 The Bradford district Health and Wellbeing Board is the strategic partnership responsible for public health, working to create sustainable, modern, integrated services that support people to be healthy, well and independent. Our Better Care Fund brings some of our budgets together to design services that work together better, provide value for money and help us improve health and wellbeing. Bradford is a great northern city and district, with a rich history and a bright future. Bradford district has the fifth largest population for a metropolitan district in England.

2.2 Over half a million people live in the district and we have roots all over the world. We are a big economy with a skilled and enterprising workforce and a distinctive identity that reflects our young, diverse and growing population. By 2020, a further 20,000 will live in our district. A large proportion of Bradford's population is dominated by younger age groups. More than one-quarter (30.2%) of the district's population is aged less than 20 and nearly seven in ten people are aged less than 50. 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 the largest proportion of people of Pakistani ethnic origin (20.3%) in England.

2.3 Despite undoubted progress, the district faces big challenges. Due to economic technological and social challenges, and reduced public sector resource, the way key services are delivered is being transformed. New investment is balanced by our need to make cost savings and it is important that we protect those areas that are vital to health and social care. Increasing demand for services, such as health and social care, requires innovation and behaviour change across the board to ensure the sustainability of the district, our economy and our communities. Our district faces significant health inequalities. People in more deprived areas have a shorter life expectancy than those who live in less deprived areas. One of the pledges of our district plan is to achieve *Better health, better lives*[1]. Our ambition is for all of our population to be healthy, well and able to live independently for as long as possible – with the right healthcare or support for each person.

2.4 Our residential and nursing care hosts 4,292 beds, of which 37% are provided by 'hard to replace' providers. Our home care market consists of 99 providers, of which only 7 provide more than 1,000 hours a week. Our Better Care Fund plan is in place to deliver a new model of person centred care and support which ensures that the person is in control of how their support is arranged. The new iBCF investment will focus on stabilising and strengthening our home care market to better enable us to support people living at home with two or more long term conditions. Our focus is on avoiding people going to hospital and on supporting them to return home quickly and safely, avoiding a care home admission. Whilst Bradford is currently seen as an exemplar, substantial changes are needed to sustain that position and our prioritisation of this investment reflects our system-wide vision of *Happy, Healthy and at Home*.

[1] Bradford District Plan 2016-2020

3. PROGRESS SO FAR

Better Care Fund Schemes 2016/17

3.1 The detail of our Better Care Fund schemes is specified within the Section 75 Partnership Framework Agreement[2] between commissioners from the Council and the CCGs. Our 2016/17 plan[3] included:

a. Capital funding (Disabled Facilities Grants)

b. Carers break funding

c. Expansion of intermediate care services

d. Care Bill implementation

e. Protecting social care services

f. Learning disabilities and mental health

3.2 In keeping with the national conditions for the BCF, our schemes are supporting our adult social care reform and improvement programme as we fully realign our operating model to the statutory requirements of the Care Act (2014). Our schemes to date have made a step-change in the capacity and capability of community services, moving us to an accountable care system model. Progress so far can be found in the planning submission.

Better Care Fund Schemes 2017/18 and 2018/19

3.3 The table in Section 8 outlines our BCF and iBCF schemes that will be implemented during 2017/18 and 2018/19. The table captures the category of spend and funding level. During 2017/18 we are implementing a process to evaluate and measure return on investment to ensure BCF schemes are delivering scheme targets.

[2] Framework Partnership Agreement relating to Commissioning of Health and Social Care Services (Section 75)
[3] Bradford District BCF Plan 2016-17 Narrative Final

4. VISION FOR HEALTH AND CARE SERVICES INTEGRATION

Our vision for health and social care integration in Bradford and district

4.1 Our shared vision across Bradford and district is for people to be:

Happy, Healthy, at Home

4.2 The health and social care system in Bradford and district provides support and care to an estimated resident population of 534,300 people[4]. Our hospitals, GPs, health centres, community health services, community centres, voluntary organisations and social care services all play a vital role in supporting our residents. We are committed to ensuring all parts of this system are focused on reducing the significant health inequalities which our population faces.

4.3 We are proud of our approach towards improving the health of our population in Bradford District and Craven which is rooted in a deep and diverse local history and a strong sense of pride in our place. We have seen significant improvements in health, housing and social care already, including nationally recognised developments in promoting digital health care. However, we continue to face some stubborn challenges including reducing harm from preventable disease caused by tobacco, obesity, alcohol and substance abuse. Increasing numbers of people with chronic conditions are seeking support from health and social care, which can place unprecedented pressure on the system. Multi-morbidity – having two or more long term conditions – is becoming the norm for people with long term conditions. A stroke and/or a diagnosis of dementia remains a key life event which significantly increases the risk of people moving into a care home. Health inequalities remain.

4.4 Like elsewhere in the country people in Bradford are living longer, however life expectancy for men and women in Bradford is lower than the English average. In England 1 in 3 people die before the age of 75; in parts of our District it is 1 in 2. Health inequalities remain, with people living in the most deprived parts of the District experiencing poorer health and health outcomes than people living in the least deprived areas. Life expectancy is 9.3 years lower for men and 7.3 years lower for women in the most deprived areas of Bradford than in the least deprived areas.

4.5 We know that people in Bradford spend many years of their lives not in good health. For women almost 21 years on average are estimated to be spent not in good health; for men this number is just under 15. Inequalities are evident throughout the life course: 28% of children and young people live in households that are below the poverty line. Children in the poorer parts of the District have worse health and wellbeing on average: poorer dental health by age five, more likely to be overweight by age 11. Children in more deprived areas are more likely to be injured, to have long-term conditions such as asthma and to be admitted to hospital.

4.6 People's health behaviours are widely known to affect their health and risk of dying early. More disadvantaged groups are more likely to have a cluster of unhealthy

[4] https://www.bradford.gov.uk/open-data/our-datasets/population/

behaviours – smoking, drinking, poor diets, and low levels of physical activity. Whilst in Bradford overall, 1 in 5 adults smoke, in routine and manual workers this rises to 1 in 3.

4.7 Mental health issues will affect about 155,000 people in our district at some time during a person's life, with approximately 6,200 people being in need of and in contact with specialist mental health services at any given time. In Bradford, there are large numbers of people living in environments that pose a high-risk of mental illness: almost 120,000 people are thought to be income deprived, and just under 1 in 3 people were economically inactive in 2015/16. The links between physical and mental health have been recognised for many years; nearly half of people with a diagnosed mental illness have one or more long-term conditions. When people with a mental illness have long-term conditions the outcomes of healthcare can be worse, quality of life suffers and life expectancy can be lower as a result of poorly managed health.

4.8 There is more work to do to embed a *'home first'* mind-set across our system to combat frailty arising from the deconditioning impact of a stay in hospital or a care home, which further increases people's dependency on services. We know that 48% of people over the age of 85 die within a year of a hospital admission. We also know that 10 days in a hospital or care home bed causes 10 years of aging in people over the age of 80.

4.9 The key question that our Better Care Plan seeks to answer is[5]:

If you had 1,000 days left to live, how many would you choose to spend in a hospital or a care home?

4.10 Our Better Care Plan is our opportunity to set out a joint vision and a set of expectations for health and social care which will shape our commissioning intentions for the foreseeable future.

4.11 Our approach to the development of the plan was to:

- Develop a set of commissioning outcomes which enhance user experience and the quality of services received by the population of Bradford and district
- Work closely with local people, service users, and voluntary/community sector to co-produce, shape and evaluate our plans
- Ensure the Plan aligns and supports the key pledges within the NHS Constitution and the refresh of Five Year Forward View
- Build on the work of our two Accountable Care Programme Boards covering NHS Bradford City and NHS Bradford Districts CCGs and NHS Airedale, Wharfedale and Craven CCG
- Ensure connectivity with the West Yorkshire and Harrogate Sustainability & Transformation Plan

[5] http://www.last1000days.com/

- Complement the Triple Aim Methodology to address the gaps in health and wellbeing, care and quality, and finance and efficiency
- Confirm plans are evidence-based and based on population need.

4.12 Commissioners are working closely across the acute care footprint to develop innovative proposals that can tackle the growing demand for services in the District and increase the resilience by radically reshaping our models of care. The proposals seek to transform the organisation of care and the infrastructure which underpins its delivery and constitute major change under Section 244 on the NHS Act 2006. The two interlinked pieces of work are:

- Implementation of the Out of Hospital and New Models of Care programmes led by the CCGs
- Implementation of the Council's Care Act (2014) Operating Model.

4.13 These proposals are dependent on three inter-related processes which are taking place between now and 2020:

- Develop and implement an integrated commissioning architecture for health and social care
- Strengthen and change existing out of hospital services in line with the Five Year Forward View refresh
- Re-engineer the hospital changes needed to make our system safe and sustainable through acute care collaboration.

4.14 The Bradford Better Care Fund Plan is based on the Bradford Council footprint, which is coterminous with the footprint of Bradford and district CCGs. The BCF Plan provides for the architecture for development of a joint committee between the CCGs and Bradford Council to drive delivery of the Health & Wellbeing Board vision for integration at a local level.

5. THE CASE FOR CHANGE AND LOCAL PRIORITIES

Population Segmentation

5.1 Understanding the drivers of health and care activity (and therefore cost) are essential in the planning of health and care services for the population, and the development of accountable care systems. In 2014 the Public Health Team, in collaboration with the then Yorkshire and the Humber Commissioning Support Unit, used a risk stratification tool to segment the population of Bradford District and Craven, to examine trends in health and care use, and identify the main drivers of cost in the health and care system. Multi-morbidity was found to be the main driver of demand for services, rather than ageing per se. This is consistent with the published literature.

5.2 As a result of our analysis we know that:

- The majority of people registered with GPs in the District are in the very low and low risk groups, meaning that the likelihood of them being admitted to hospital in the next 12 months as an unplanned admission is low.
- Almost all children and young people (CYP) are in the very low and low risk groups, however, there is a small 'peak' in the number of CYP in the medium and high risk groups amongst the very young i.e. 0-1 year olds.
- Increasing age is associated with higher risk scores. In City and Districts 10% of 65-74 years are in the high and very high risk groups. This increases to 30% of 75-84 year olds, and 46% of persons aged 85 and above. In AWC these proportions are noticeably lower.
- In City and Districts people aged 85+ account for 21% of the 4,600 patients in the very high risk score band; in AWC it is over 30%
- The 65-74 and 75-84 age groups account for 12% and 28% of the population respectively across all three CCGs.
- In City and Districts 36% of the 4,600 people in the very high risk score band are aged 18-64 (equivalent to 1,650 patients). This figure is 25% in AWC (out of the 1,600 people in the very high risk group).
- In City and Districts 45% of the 18,300 people in the high risk group are aged 18-64 (equivalent to 8,220 patients). This figure is 30% in AWC (out of 6,300 people in the high risk group).

5.3 Multi-morbidity is defined as the presence of two or more long term conditions. Multi-morbidity is common. Around 40% of people with any long term condition experience multi-morbidity. Multi-morbidity is important for many reasons. A growing body of evidence suggests that it is multi-morbidity and not age that is the main driver of health and social care costs. Individual health care conditions can dominate healthcare delivery. The use of many services to manage individual diseases can be inefficient and frustrating for people.

5.4 In Bradford City and Districts, over 60,000 people living with two or more long term conditions are more likely to experience problems with the coordination and integration of their care, and are more likely to have unplanned admissions to hospital or avoidably move into a care home. The top 5% (very high and high risk groups) are disproportionately likely to need an avoidable hospital admission. The top 1% account for 24% of all non-elective admissions and 10% of all A&E attendances. The top 5% account for 55% of all non-elective admissions and 24% of A&E attendances. 82% of people living in care homes experience multi-morbidity. 41% experience 4 or more long term conditions. Overall 69% of care home residents are likely to be admitted to hospital for a health condition that could have been managed in the care home. Whilst over half of these are under the age of 65, prevalence increases significantly with ageing. Nearly two thirds, 63% of people aged over 65 who are living in their own home, will be admitted to hospital for a condition which could be treated at home.

5.5 We know that living in a deprived community or poor quality housing has a significant impact on the likelihood of people experiencing 2 or more long term conditions. Earlier onset of multi-morbidity is linked to deprivation. In Bradford 45.2% of people live in the 20% most deprived areas in England. This is more than double the percentage of people in England as a whole who live in the 20% most deprived areas (20.4%). Not only are people who live in the more deprived parts of the district more likely to experience multi-morbidity, but they on average develop multiple long term conditions ten years earlier than those living in the least deprived parts of the District.

5.6 Whilst this work has helped us frame our current understanding, we are mindful that analysis can only ever be a snap shot in time. Furthermore, the analysis focused on health care utilisation data and did not include demand for social care. We are also mindful that data analysis tools have significantly improved through the development of frailty indexing work led by the University of Bradford. Also we need to fully integrate analysis of the impact on long term conditions on the lives of people living in Airedale, Wharfedale and Craven into our plans; at this stage our analysis is not as robust as it is for the two Bradford CCGs. We are therefore undertaking a refresh of this analysis during 2017/18 with input from the New Economics Foundation to ensure that our Out of Hospital plans are fully aligned with the ambitions of the Five Year Forward View.

6. INTEGRATION AND ALIGNMENT OF PLANS

Emerging plans and transformation programmes

6.1 Our BCF plan aligns to the West Yorkshire Sustainable Transformation Plan in planning for social care sustainability and enhanced personalised support pathways. This includes housing options and underpins the development of local pathways home for people who are within regional, specialist and tertiary services.

6.2 In addition to the minimum mandated budget alignment, Bradford and district has also aligned several significant budgets where there are opportunities offered through integrated commissioning and service delivery that will give our population better outcomes overall. As these are new additions to our Better Care planning they are outlined below.

6.3 One of the great challenges we have committed to as a system is to design and implement two new ***accountable care systems*** in the Bradford district, which recognise that person and community-based approaches can increase people's self-efficacy and confidence to manage their own health and care, improve health outcomes and experience and build community capacity and resilience, among other outcomes.

6.4 Our design principles are to:

- Develop a model of care and support that is effectively; person-centred, personalised, integrated, empowering. It will be co-produced in partnership with carers, citizens and communities and supported by mobilisation of front line staff, volunteers and a commitment to community engagement
- Transform the way our system currently operates so there is a greater focus on the prevention of ill health, and upholding of rights, mental capacity and risk as a positive force resulting in reductions in premature death and dependency, and improvement in health, health inequalities and wellbeing
- Shift the balance from avoidable hospital admissions to personalised health, housing and social care models which are led and managed by the person as an expert of their own experience and delivered out of hospital
- Ensure that there is a high degree of replicability in our work, which provides a benefit much wider than the district and enables us to critically reflect, learn and further develop our understanding of the issues.

Accountable Care System – Airedale

6.5 The aim of Accountable Care Airedale[6] programme is to re-design the way we deliver and receive care, ensuring that our local population receive exceptional care now and into the future. At the heart of the ACA desired future state is a strong primary and community-based out of hospital model of care that cares for the majority of the health and wellbeing needs of the local population. The model works alongside individuals,

[6] Improving the health and wellbeing of the Airedale, Wharfedale and Craven Population (2017)

carers, families and the wider community to provide a range of person-centred and community-centred care approaches to support health and wellbeing. The model is a coalition of primary, community, mental health, social care, voluntary and urgent care services.

6.6 Our accountable care model complements the Better Care Fund plans. With less of a focus on single episodes of care and more on the overall impact of work on sustained wellbeing for people, there is a strong message of prevention, care navigation and non-medical support in recognition of the value and effectiveness of navigation support through health and care services.

6.7 The focus of the iBCF investment on technology supports our care model to harness digital technology to revolutionise the care delivery process both for staff and for the people who receive care and support.

6.8 The model is a coalition of primary, community, mental health, social care, VCS and urgent care services. By working in collaboration the model will seek to increase the breadth and depth of services available in the community including services that have been traditionally delivered in hospital or outpatient services.

6.9 A multi-disciplinary care service for people living with complex care in now in the 3rd year of development and our Enhanced Primary Care offer delivers proactive and preventative approaches to health and care delivered by GP practices

6.10 A range of services and initiatives centred on care homes, including telemedicine in care homes, advanced care in care homes vanguard and training and support for care home staff. Our intermediate Care Hub will provide a single point of entry into intermediate and rehabilitation care services across Airedale, Wharfedale and Craven that enables professionals to arrange the right care for urgent and non-urgent referrals, helping to prevent avoidable hospital admissions and effectively manage long-term conditions in the right place at the right time.

Accountable Care System – Bradford

6.11 The Bradford Accountable Care Programme continues to work towards implementing a transformed service by April 2021 with step changes from this year. Integration models are being tested through testing new models of care for diabetes during 2017/18. Providers and commissioners in Bradford City and Districts are using a 'structured collaboration' approach to transform existing service into a more people-centred, integrated model of community health and care services. Our intention is to move from focusing on (and paying for) activity, towards a focus in outcomes. A number of projects within the accountable care programme for Bradford are aligned to the intentions and aspirations of the Better Care Plan. Some of the schemes are outlined below.

6.12 The mobilisation process for the new medicines management service has been successfully implemented and the new service went live on 1st April 2017. This service will be delivered to people with complex needs in their own homes, contributing to a reduction in non-elective admissions and demand for GP appointments.

6.13 Collaborative work has taken place amongst providers to develop and agree a shared, single operating procedure for the initial phase of Multi-Agency Integrated Discharge Team (MAIDT). This new team integrates social work, acute and community nursing to improve discharge processes by creating a seamless pathway between community, intermediate and acute care settings. Community nursing staff have started working in the team.

6.14 The Home from Hospital (HFH) service has been expanded to support discharge from the acute setting, in addition to the intermediate care support they provide in community settings.

6.15 A new Local Improvement Scheme 'Proactive Care for People with Complex Needs'[7] has been developed for implementation in General Practice from the 1st April 2017. This will help in defining the cohort of people with complex needs for the Out of Hospital Programme and will result in GP practices providing an enhanced level of support to people who are housebound or residing in Care Homes. The information gathered will be used to inform the development of a future enhanced model of service delivery. This scheme aims to support people to remain in their preferred place of residence for as long as possible.

6.16 A review of telemedicine was carried out in Q4 to determine the effectiveness of the service and to inform commissioning intentions for 2017/18. An algorithm was developed to align resources with complex needs and, following the end of the Airedale and Partners EHCH Vanguard, telemedicine will be retained in 48 care homes in Bradford.

6.17 Commissioners and providers have been working together to develop a shared strategy for the provision of all community beds across Bradford. A set of principles have been agreed and the strategy will be implemented as part of the structured collaboration process for transforming out of hospital services. This strategy will introduce a single bed base, with a single point of access based on shared assessments from a multi-agency, integrated team.

6.18 Work to develop the new models of care for out of hospital services has continued in Q4, and draft proposals for new models of care have been shared with stakeholders. Further detail on some of these schemes is presented under National Condition 3 in chapter 7.

[7] Proactive care for people with complex needs. GP Local Improvement Scheme 2017

Primary Care Commissioning Strategy

6.19 The primary medical care commissioning strategy for Bradford[8] sets out the commissioning aspirations for the next 5 years. The three CCGs in Bradford and district hold delegated responsibility to commission primary medical services on behalf of NHS England. It is a key enabler in developing seamless integrated out of hospital services around the diverse needs of our populations.

6.20 To support the delivery of emerging accountable care systems, primary medical care must move to operate at scale with sufficient infrastructure. Our risk stratification and predictive modelling tools will allow targeted interventions. This work will also help to identify protected groups that may not access healthcare. Our strategy has six priority themes. Priority 5: collaborative working describes our plans for collaboration across practices and with partners. This includes working together, sharing specific functions and reducing silo working. This priority underpins the plans to work in localities of 50,000 patients. Services such as extended access and GPs with special interest training will be commissioned at greater scale.

People First – Digital First

6.21 Our BCF Plan aligns with our ***Local Digital Roadmap*** and our vision for digitally enabled integrated strategic commissioning by 2020. In relation to one of the BCF National Conditions, the NHS Number will be used as a consistent identifier within Health and (Adult) Social Care services from Autumn 2017. Informatics Teams across the district are working together to realise this ambition and define how this can be extended to encompass Children. Our Local Digital Roadmap set out a Vision for Digital Health and Care in 2020, under the banner of 'People First - Digital First'.

6.22 By 2020, Bradford, Airedale and Wharfedale district shall be a place where:

- Health and care is digitally facilitated to enable individuals to take control of the health and well-being of themselves and of others, fundamentally changing the relationship between citizens and their relevant health and care professionals through access to knowledge
- Big problems and issues in the health and care system are addressed through technology and data
- Health and care information is collected once and used many times
- Citizens have confidence in the security of their health and care data security and application in benefitting the health and wellbeing of the population
- The health and care workforce are skilled and confident users of technology and data, and use these skills to deliver care more efficiently and effectively
- Rapid and accelerated adoption of proven technology and data innovation takes place to improve the health and well-being of citizens

[8] Primary Medical Commissioning Strategy 2016-2021

- The evaluation of the impact and benefits of utilising technology and data to improve health and care outcomes provides evidence for digital health adoption for other parts of the country (and beyond)
- Others from around the country come to learn how health and care organisations, local government, the business sector and academia have overcome organisational boundaries to work effectively in partnership for their local communities
- New digital health and care businesses are formed and existing businesses are attracted to the area to develop their digital health and care products and services.

Transforming Care in Learning Disabilities, Autism and ADHD

6.23 Our Transforming Care Partnership Plan is for all people with Learning Disabilities, Autism or ADHD and is framed around ***Building the Right Support*** and the national service model. Through our Transforming Care Partnership we are investing £40.5M a year in supporting an estimated learning disability community of 8,700. Across all 3 CCG's for 2016/17, there are a total of 3,775 people with LD on the GP registers (from age of 13 onwards) and a total number of adults (18+) of 3,063 and 1,500 of those adults receive a service from the Local Authority.

6.24 Our priorities are to:

- Reshape current provision of services to reduce dependency on in-patient provision
- Develop and enhancing the range of community options available to support all people with a Learning Disability including those with complex needs, Autism or both, to live in the community and near their families if they choose. Improve the preventative support provided by general practice and primary care for all people with learning disabilities including people with complex needs, autism or both.

6.25 We are also finalising our strategies for **autism and ADHD** and **dementia** which provides us with an opportunity to tackle areas of service improvement that need further development.

Our Mental Wellbeing

6.26 Through our ***Mental Wellbeing Strategy*** we are developing a response to the parity of esteem agenda which recognises the equal value of mental and physical health. Our ambitious all-age strategy for mental wellbeing in Bradford and district has three strategic priorities for the next 5 years:

- Our wellbeing: building resilience, promoting mental wellbeing and delivering early intervention
- Our mental and physical health: developing and delivering care through the integration of mental and physical health and care
- Care when we need it: ensuring that when people experience mental ill health they can access high quality, evidence-based care

6.27 Our plans to deliver our mental wellbeing strategy include a commitment to protect the current level of investment in mental health services, recognising the importance of effective mental health and wellbeing interventions in reducing the overall health and care system wide costs. Our strategic commitments and action plan are monitored by the Mental Health Partnership Board which report to the Health and Wellbeing Board. It includes a clear focus on promoting mental wellbeing and tackling social and environmental factors to prevent mental ill health occurring or worsening. The strategy acknowledges that physical health conditions can affect mental wellbeing and that people with mental health care needs also require care for their physical health. We will commission high-quality, evidence based services to meet their needs.

Improving People's Experience of Integrated Care

6.28 Examples of how local people have been involved with the key areas of the plan are:

Mental wellbeing strategy: The development of the strategy was informed by engagement and co-production with a wide range of stakeholders including service users, children and young people and their families, commissioners and providers and voluntary and community sector organisations. We reviewed what local people had already told us, engaged via face to face interviews, with local organisations including those working with seldom heard groups and through community held events and ran a communications campaign to support this engagement work.

The People's Board: The People's Board is a group of members of the public who represent different communities and experiences across the Bradford CCGs. We have worked in partnership with them to gain feedback and insight in three key areas of self-care and prevention (social prescribing; self-care hubs; and digital self-care) as well as out of hospital care. The feedback and ideas will be fed into our overall programmes of work.

Grass Roots: We continuously gather patient experience information from a wide range of sources in order to understand the themes and the trends across the services that the CCGs commission. These are presented as part of our embedded reporting mechanisms across the organisation and new pieces of work routinely scope what local people have been saying in a particular area.

- We have well established – and varied – mechanisms of engaging with local people and working together to co-produce our plans in addition to the above. These include:
- We are launching a programme of engagement around our local health and care plans to understand further what matters to local people and to foster greater understanding through open and honest dialogue.
- Through our Engaging People approach, we work in partnership with the VCS and Healthwatch to ensure reach into our diverse local communities and that people have the opportunity to influence and work with us in developing plans and priorities.

- We also work with specialist partnerships, communities and networks including the maternity partnership, the Airedale, Wharfedale and Craven health and wellbeing hub and our patient participation groups and their networks.
- Patient feedback is actively and routinely sought out and used through for example, social media, our website feedback mechanisms, complaints, comments and concerns, specific engagement activities and consultations.
- This section also needs input from the local authority to capture the work they have done around, eg Cost of Care, Home First etc.

6.29 Taken together, the multitude of plans that are now in the implementation phase provide resilience to the local framework for sustainability and transformation in Bradford and district.

7. NATIONAL CONDITIONS

7.1 The following section provides a brief description of how the plan meets each of the national conditions for the BCF 2017-19.

National Condition 1 – Plans to be jointly agreed

7.2 The BCF Plan has been signed off by the three Clinical Commissioning Groups, City of Bradford Metropolitan District Council and by the Bradford Health and Wellbeing Board. Details of the plan have been discussed with the main health and social care providers in terms of the impact and alignment with local plans. The Housing Authority is represented on the Health and Wellbeing Board. Arrangements for management of the Disabled Facilities Grant are being reviewed in partnership with the leads for occupational therapy and accessible homes.

National Condition 2 - Social Care Services maintenance

7.3 Sections 2 and 4 of the Planning Return Template set out the sums made available in 2017/18 and 2018/19 for maintaining Social Care which incorporates the implementation of the Care Act, reablement and funding of dedicated carer specific support. The total amount allocated for all of these from the mandated BCF minimum allocation in 2017/18 is £18,795,524 and £19,152,640 in 2018/19, and has been maintained in real terms compared to 2016/17. Also, Disabled Facilities Grant funding of £3,857,621 (2017/18) and £4,195,774 (2018/19) is included in the Better Care Fund spending plan, representing much more than a real terms increase compared to 2016/17.

7.4 In addition, in 2017/18 the BCF includes the improved Better Care Fund (iBCF) which will be paid as a direct grant to the Council under Section 31 of the Local Government Act 2003 and has a total value of £12,045,821 (2017/18) and £16,435,418 (2018/19). The funding for maintaining Social Care is summarised in Table 1 below.

Table 1: Maintaining Social Care Allocations 2017/18 and 2018/19

£	Maintaining Social Care	Carers Specific Support	Care Act	Reablement	Disabled Facilities Grant	iBCF
2016/17	14,672,000	925,000	1,366,000	1,502,000	3,519,468	0
2017/18	14,934,629	941,558	1,390,451	1,528,886	3,857,621	12,045,821
2018/19	15,218,387	959,448	1,416,870	1,557,935	4,195,774	16,435,418

7.5 Maintaining social care services in the District means ensuring that those in need within our local communities continue to receive the support they require in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility criteria is one aspect of this, our primary focus is on developing new forms of person centred, coordinated support. This approach helps to ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole.

7.6 By proactively intervening to support people at the earliest opportunity and ensuring that they are resilient, resourceful, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

7.7 City of Bradford MDC has maintained and enhanced investment to meet Prevention and Wellbeing duties in keeping with Section 1 and Section 2 of the Care Act (2014). Our local Plan underpins a strategic shift of resources towards delivering care closer to home and significantly reducing the numbers of people who are avoidably admitted to hospital, placed into residential care settings and dying prematurely. Income optimisation support for self-funders has been enhanced during 2016/17. This will be further strengthened during 2017/18 through further investment in our primary prevention approach including:

- Realising the potential of being part of the ADASS regional works including the Digital Prevention and Connect to Support Programme Board (Bradford is leading on an LGA Bid to pilot virtual technologies to enhance our self-care navigation offer)
- Enhancing Access as our first point of contact to social care streamlining pathways to ensure a timely a proportionate response to people who are seeking support.
- Investing in our social work demand management approach across our localities, promoting and sustaining independence through reconnecting people back to natural networks of support.

Financial Stability and QIPP

7.8 The CCGs 2-Year Financial Plan sets a strong financial position within which the creation of the BCF can take place. Through its prudent approach to financial planning and its strong contractual approach with its main acute providers, the CCG remains confident in its ability to maintain the fund without financially destabilising the acute trusts. Our QIPP transformational plans were developed and aligned to delivery of our system and organisational priorities - this is consistent with our financial submission.

National Condition 3 – NHS Commissioned Out of Hospital Services

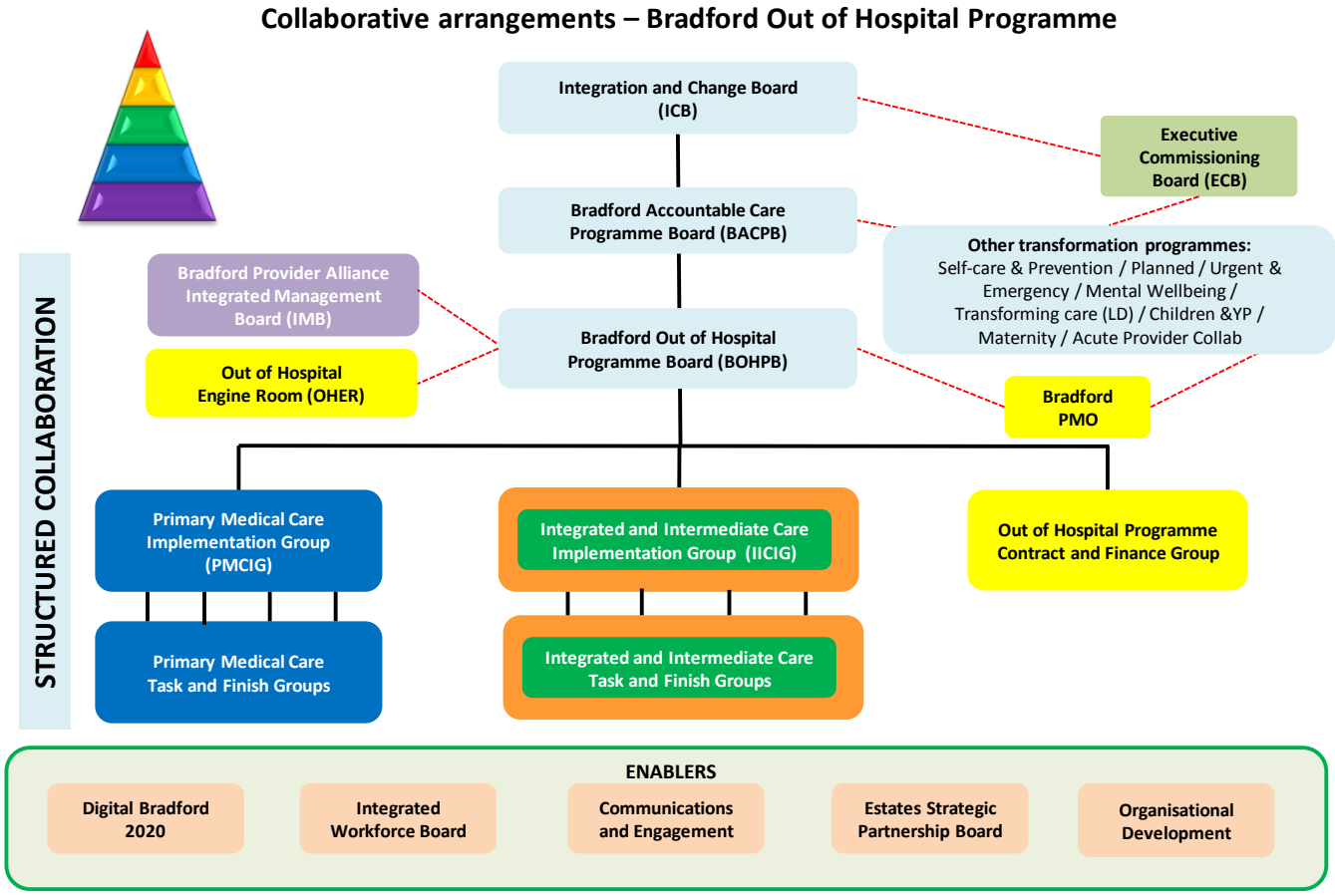
7.9 The BCF plan confirms the following ringfenced funding for NHS-commissioned out-of-hospital spend.

Table 2: Ringfenced NHS-commissioned out-of-hospital spend 2017/18 and 2018/19

£	NHS-commissioned out-of-hospital spend
2017/18	16,394,801
2018/19	16,706,302

7.10 The Bradford Out of Hospital Programme continues to work towards the outcome of reducing long term admissions. During 2016/17, community matron and case manager services were 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.

Figure 1: Out of Hospital Programme Collaborative



7.11 The first phase of the out of hospital programme is schedule to be operational by the end of September 2017. Community Integrated Teams are aligned with practices giving care to communities of 50-60,000 people. Alongside this, community complex care teams (CCCT) have been established staffed by community matrons and case managers with the aim of providing an equitable reactive and proactive service for people with complex escalating needs. Together, these services offer a needs-led service for adults with complex health, care and support requirements, delivering joined up care and support to achieve admission avoidance where appropriate.

7.12 The Bed Bureau was developed in conjunction with the Intermediate Care Hub, and became operational in 2015. The intention was to create a single access point for all community beds, so that people who needed a bed could be referred to the most appropriate one for their needs. However, there are some occasions when the Bed Bureau is not used when people are discharged from hospital into a community bed.

7.13 In October 2016, the Bradford CCGs undertook a review of intermediate care beds which set out the current position of both health and social care beds and the range of interventions provided within these services. Following this review, a system wide strategy has been developed by the Bradford CCGs, acute hospital trusts and CBMDC. This strategy was signed off by all organisations in May 2017.

7.14 The aim of the strategy is for community beds to be a realistic alternative to hospital admission. This will be achieved by development of new pathways which are leaner than current models, provide better value for money and provide a more joined up service for people and achieve better outcomes. Care planning is based on the principle of 'home first'.

Table 3: The Current Community Bed Base

Bradford Teaching Hospitals Foundation Trust (BTHFT) 72 beds across four sites	
BD8 8RA Westbourne Green	BD6 3NL Westwood Park
BD5 0NA St Luke's Hospital	BD10 0JE Eccleshill Community Hospital

City of Bradford Metropolitan District Council (CBMDC) 38 intermediate care beds and 83 short terms care beds (121 in total) across six sites	
BD6 1EX Norman Lodge	BD22 6AB Beckfield
BD4 9BT Holmeview	BD22 6AB Holmewood
BD16 2EP Thompson Court	BD15 7YT Woodward Court

National Condition 4 – Managing Transfers of Care

IBCF – Home First in Bradford

7.15 The Care Act 2014 places new duties on City of Bradford MDC to promote the efficient and effective operation of the Market Shaping and Commissioning Guidance in order to facilitate a diverse and sustainable market of high quality support for the benefit of their whole local population, regardless of how the services are funded. This can be considered a duty to facilitate the market, in the sense of using a wide range of approaches to encourage and shape it, so that the local care and support market in Bradford and Districts meets the needs of all people in our area who need care and support, whether arranged or funded by the Council, by the individual themselves, or in other ways.

7.16 Local Authority adult social care commissioners have undertaken a baseline analysis of current financial spend, activity and outcomes from the current home care market to support the initial stages of developing an operating model for out of hospital services which support people to be happy, healthy, and will bring care closer to people in their own home. Key areas of opportunity are:

a. To rapidly expand and enable self-care and self-directed support options, including optimising the Connect to Support e-gateway to the social care provider market place. Enabling people to self-navigate the system and make decisions earlier in their journey about options which may delay or prevent their need for more complex care and support. The Council is leading on behalf of ADASS Yorkshire Humber work to develop Connect to Support, including piloting of virtual assistant new technologies.

b. To establish and stabilise the current baseline position for the CQC registered domiciliary care market of 99 contracted providers in the District. 93% of the market is small, providing less than 1,000 hours a week of contracted care for the Council. 40% of providers are assessed by commissioners as being amber/red rated for risk of immediate market failure. The Council has taken action to increase the level of fees paid by commissioners using the social care precept from April 2017. The Council has reached agreement with the Bradford Care Association to work towards a fair cost of care by undertaking a joint modelling exercise during 2017/18 using the CIPFA/ADASS Guidance – *Working with Care Providers to understand costs.*

c. To invest 50% of the Improved Better Care Fund against new models of CQC registered domiciliary care closer to home, diversifying the offer to local people and the income streams which sustain the local market. This includes:

- Developing a new approach towards supporting people with dementia and their carers during the later stages of the disease progression;
- Developing a model of home care in hospital whereby the care and support follows the person and enables timey and effective early discharge;
- expanding out of hours home care to enable people with complex support needs to remain at home; and
- expanding the capacity of rapid response services to enable people to be cared and supported at home during times of crisis so that the situation can be stabilised and made safe without the need for a care home or hospital admission.

d. Investing for a sustainable workforce and to ensure that the sector remains competitive. The baseline has established that the local supermarket workforce are offered between £7 and £10 per hour with additional incentives including a single work location, staff discounts and structured career pathways. The model the Council is discussing with the sector includes:

- Working with providers to develop a local understanding of the living wage with an aim of working towards a level of equalisation with health care level 2 and 3 workers.
- Developing structured career pathways in partnership with Bradford College and the University of Bradford including progression of healthcare workers to Nursing Associates.

7.17 If this approach is to be effective, there is a challenge for system leaders to support a change of culture by promoting a mind-set shift from a dependency model (deficit based, fixing people) to one that promotes independence and resilience (strength based model, focus on what people can do and positive risk taking so people can live their lives to the full).

8. PLAN: SCHEMES AND SPENDING

Schemes and Expenditure

8.1 The BCF and iBCF schemes and expenditure plans have been approved by the Health and Wellbeing Board for 2017/18. During this year we are reviewing the impact of schemes and return on investment for commissioners. Our review is aligned to commissioning intentions identified through our Out of Hospital Programme Board.

8.2 The summary of schemes is shown below.

Table 4: Summary of Schemes and Expenditure

Scheme	Scheme Type	Lead	2017/18 £	2017/18 £
Primary Prevention				
Local Schemes	Primary prevention Early Intervention	CCG	2,164,770	2,308,276
Intermediate and Integrated Care and Support				
Reablement	Intermediate care services Rehabilitation services Reablement	CCG	1,354,000	1,383,952
Reablement	Intermediate care services Rehabilitation services Reablement	LA	1,511,730	1,557,935
Virtual Ward	Intermediate care services Step down	CCG	3,710,000	3,792,069
ACCT	Intermediate care services Step down	CCG	969,000	990,435
Intermediate Care Beds	Intermediate care services Step down	CCG	6,104,495	6,166,247
Early Supported Discharge	Integrated care planning Integrated care packages	CCG	592,000	605,096
High Impact Changes				
iBCF - BACES - Home First Strategy	High Impact Change Home First / Discharge to Assess	LA	500,000	500,000
iBCF - Winter pressure beds	High Impact Change Home First / Discharge to Assess	LA	1,000,000	1,000,000
iBCF - Intermediate Care Reviewing team	High Impact Change Home First / Discharge to Assess	LA	500,000	500,000

New Technologies and Digital Integration				
iBCF - Transformation and Assistive Technology	Assistive Technologies Digital participation services	LA	1,000,000	0
Domiciliary Care				
iBCF - Increased Home care Capacity	Domiciliary care at home Dom Care Packages	LA	4,979,821	4,545,472
Carers Services				
Carers Support	Carers services Carer advice and support	LA	955,291	959,448

8.3 Consultation on the iBCF additional monies has taken place since its inception. A&E Delivery Board, Accountable Care Bradford and providers were consulted throughout the planning process, in order to discuss allocation of the iBCF and ensure shared agreement between commissioners and providers

Scheme	Scheme Type	Lead	2017/18 £	2017/18 £
Equipment / Adaptation				
SeEIP02 Disabled Facilities Grant	DFG - Adaptations	LA	3,857,621	4,195,774
S1PS02 Community Equipment	Provision of Community Equipment	Joint	1,412,000	1,102,500
Care Act Duties and Maintaining Social Care				
S4CA01 Maintaining Social Care Services	Care Act Duties	LA	14,954,203	15,218,387
S4CA02 Care Act New Duties	Care Act Duties	LA	1,374,300	1,416,870
iBCF - Protecting Social Care	Care Act Duties	LA	4,066,000	9,889,946

9. OVERVIEW OF FUNDING CONTRIBUTIONS

Minimum Funding Contributions

9.1 The planning return confirms that the local area has met its minimum contributions for the following spend areas:

Table 5: Minimum Funding Contributions

Spend area	Minimum funding 2017/18 £	Minimum funding 2018/19 £	Main use for minimum funding contributions
CCG Contributions **NHS Airedale, Wharfedale and Craven** **NHS Bradford City** **NHS Bradford Districts**	 7,048,000 6,257,000 21,886,000	 7,182,000 6,376,000 22,302,000	Consistent with national requirement
Out of Hospital Services	16,394,801	16,706,302	Consistent with National requirement
Disabled Facilities Grant	3,857,621	4,195,774	Consistent with National requirement
Care Act 2014 Monies	1,390,451	1,416,870	Consistent with national requirement
Former Carers' Break Funding	£941,558	959,448	Carers offer in line with Care Act duties
Reablement Funding	1,528,886	1,557,935	Consistent with national requirement
iBCF	12,045,821	16,435,418	Consistent with national requirement

9.2 Funding contributions for the BCF have been agreed and confirmed. This includes agreement on funding for Care Act duties, reablement and carers breaks from the CCG minimum contribution. Further detail is included in the Planning Template.

Table 1 (as page 28): Maintaining Social Care Allocations 2017/18 and 2018/19

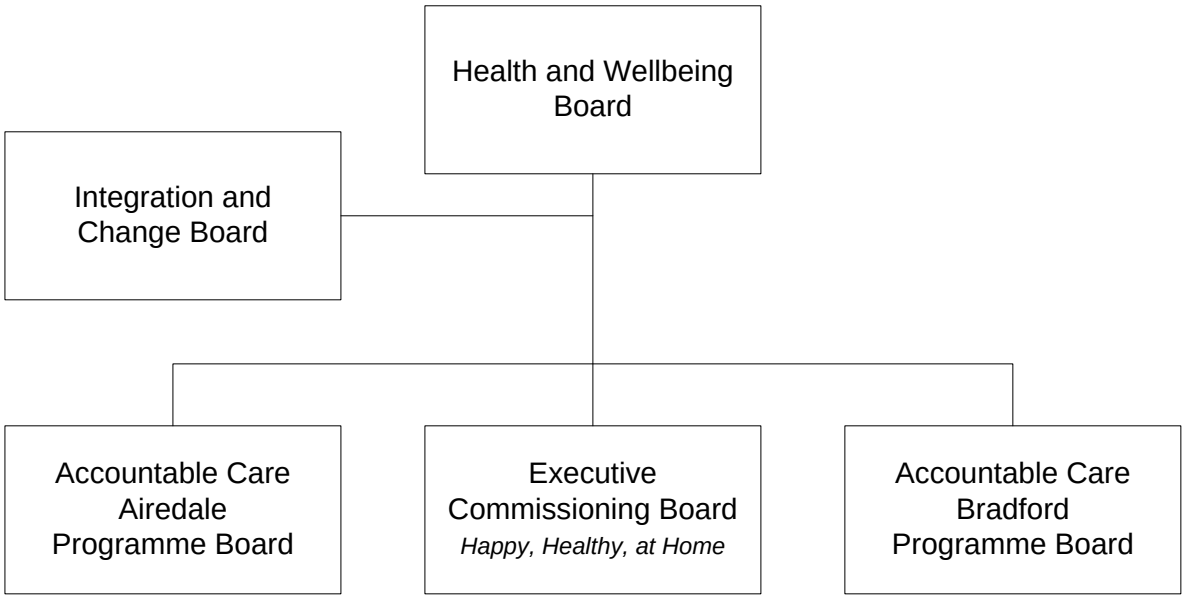
£	Maintaining Social Care	Carers Specific Support	Care Act	Reablement	Disabled Facilities Grant	iBCF
2016/17	14,672,000	925,000	1,366,000	1,502,000	3,519,468	0
2017/18	14,934,629	941,558	1,390,451	1,528,886	3,857,621	12,045,821
2018/19	15,218,387	959,448	1,416,870	1,557,935	4,195,774	16,435,418

10. PROGRAMME GOVERNANCE

Governance and Accountability Structures

10.1 Governance of the Better Care Programme is through the Bradford Health and Wellbeing Board which, since April 2013, has functioned as a statutory committee of Bradford Council. The Board operates with major contributions by the Local Authority and the CCGs. Following the Bradford Council LGA Peer Review there is a need to streamline the governance structure supporting integrated commissioning.

Figure 2: BCF Plan Governance



Management and Oversight of Delivery of the Better Care Fund

10.2 During 2017/18, work shall be progressed to build the framework within which our integrated commissioning approach will operate and will be embodied in a revised section 75 agreement.

Scheme Management

10.3 In terms of performance managing Better Care Fund Schemes and escalating significant issues to the Executive Commissioning Board, the Health and Wellbeing Board and into both organisations Governance Committees, the following process applies. If a BCF scheme is starting to go off track the expectation would be that the Pooled Fund Manager would flag this both to their own organisation's managing committee and to the Integrated Finance and Performance Group. Any issues for escalation to the Executive Commissioning Board would be confirmed at that point together with feedback to each organisation.

10.4 The benefits realisation and outcomes of schemes will be closely monitored by integrated finance and performance subgroup. Where schemes are felt to be under-performing or not having the required impact on the wider BCF outcomes, Pooled Fund Managers will be supported to review their schemes in line with the BCF methodology following the principles of establishing impact of schemes through a logic modelling process. Following this process schemes may be revised or refreshed in order to ensure impact.

Legal Framework

10.5 The Better Care Fund in Bradford is managed through a Section 75 Framework Partnership Agreement between the Council and the CCGs. The Framework approach was agreed to best reflect where the Council and the CCG are in terms of developing an integrated commissioning approach in that it provides for a dedicated lead commissioner for each scheme. In the event of under spends achieved through prudent fund management, these will be managed in line with the Section 75 agreement.

Assurance Framework

10.6 A high level Assurance Framework has been developed and is supported by a Dashboard to monitor trajectories for key Better Care Metrics and implications for risk sharing. The Assurance Framework is monitored through the Executive Commissioning Board which holds responsibility for managing remedial actions should plans go off track. Updates are provided to the Health & Well Being Board on a quarterly basis. A comprehensive Better Care Fund Risk Register shall be put into place during 2017/18. This shall include risks and mitigation in the following five areas; Finance, Operational, Quality, Governance and IT/IG. Updates on risk and mitigating actions shall feed into each organisation's own risk registers and performance management processes.

Culture and Systems Leadership

10.7 The Health and Wellbeing Board have mandated our system leaders to integrate the strategic commissioning of health and social care by 2021. This formal mandate will provide a backbone for the BCF Plan and ensure that we collaborate as a joined up system to work seamlessly together to deliver better quality care. We are committed to transforming our systems and modernising health and social care in our area so that our local communities can enjoy the right quality of service and support at the right place at the right time, provided by the right person(s). Our success in doing so will be determined by local people and depend on our ability to positively fuse and maximise the potential of the different organisational cultures across health and social care. Our approach requires determined and purposeful leadership that recognises and steps up to the challenge of a creating and actualising a new ambition.

11. ASSESSMENT OF RISK AND RISK MANAGEMENT

Risk Log

11.1 Each party to the Better Care Fund pooled budget carries any significant risks in their own risk registers as well as in the joint BCF risk register. This ensures that everyone is fully aware of the risks and the impact on their own organisation. In assessing the likely impact of financial risks, we have predominantly assessed the impact of the cost of additional activity. For operational and quality risks, we have taken into consideration the cost of returning to acceptable levels of quality or service. In translating the BCF risks into each party's risk registers we are building on the risk sharing arrangements set out in the Section 75 Agreement. In addition, risk sharing and indemnities are set out in CCG and Council contracts with providers.

11.2 Every scheme has a Pooled Fund Manager. The role of Pooled Fund Managers in flagging potential risks and ensuring they are mitigated and managed is covered in the Section 75 Agreement. The BCF risk register is proactively monitored by the BCF Operational Commissioning Group with escalation to the Executive Commissioning Board as appropriate, including mitigating actions. Risk management includes managing the immediate impact of the risks occurring and planning to resolve the root cause of the problem. The BCF risk register is attached in the annexe.

Contingency Plan and Risk Sharing

11.3 The Health and Wellbeing Board has received quarterly update briefings on the BCF as a standing item during 2016/17.

11.4 Strategic risks have been monitored during 2016/17 through the Bradford Health & Care Commissioners which is becoming the Executive Commissioning Board in 2017/18, including financial and non-financial risks. The five key commissioning risk areas which shall be reported to the Executive Commissioning Board relate to:

1. Finance
2. Operational
3. Quality
4. Governance
5. Information Technology and Information Governance

12. NATIONAL CONDITIONS - DToC

Managing Transfers of Care and the High Impact Change Model

12.1 The context for the development of this plan is that delayed transfer of care is a significant issue both locally and nationally. The impact of a person being in a hospital bed longer than is necessary has a negative impact on patient outcomes, patient experience and the ability of the system to match capacity with demand. The NHS England Mandate for 2017-18 sets a target for reducing Delayed Transfers of Care (DToC) nationally to 3.5% of occupied bed days by September 2017. Bradford has achieved this standard and our focus is to make that standard sustainable.

12.2 Bradford commissioners have worked collaboratively with local providers, including those from the voluntary sector, to develop a multi-agency, integrated approach to planning hospital discharge for people with complex needs, leading to the formation of a multi-agency integrated discharge team (MAIDT) and an expansion in the range and capacity of support available to people on immediately leaving hospital. As a system, we are considering through our Accountable Care Programme Boards the actions that are required so that we can fully adopt the High Impact Change Model for managing transfers of care to underpin our service improvement approach to reducing delays and improving people's experiences. This model is endorsed at a national level by NHSE, ADASS, LGA, NHS Improvement and the Department of Health. The model recognises that there is no simple solution to creating an effective local system of health and social care, but that where health and wellbeing partners are committed to working together to identify what can be done to improve outcomes for people, high impact changes can be made.

12.3 A workshop took place to undertake a self-assessment against the high impact change model with partners from across the health and social care system in Bradford and Districts in June 2017. Membership included the 3 CCGs, the Local Authority, Bradford Care Trust, Bradford Teaching Hospitals Trust and Airedale Hospital Trust. The outcome was agreement across the partnership that Bradford, Airedale, Wharfedale and Craven systems have made progress in implementing the High Impact Changes. In the main, these areas have been progressed through existing service improvement work and reprioritisation across collaborative systems across the health and social care economies.

12.4 There are different stages of development in the Bradford and Airedale localities that each have their own local governance arrangements for out of hospital care. However, there are clear opportunities for both adopting and spreading good practice and joint initiatives and plans. There is the potential to accelerate progress through sharing emerging good practice across the two planning footprints of Bradford and Airedale. The CCGs are working to agree DToC improvement trajectories based on the current level being sustained with the acute Trusts. Commissioners are working towards further integration of commissioning datasets and optimising the potential from using the NHS number as a single unique identifier to further enable transparency of how people experience the health and social care system and granularity of detail in relation to cost and outcomes from commissioning across the system as a whole.

13. IMPROVED BETTER CARE FUND NATIONAL REQUIREMENTS

Homecare Capacity

13.1 As of March 2017, 24,000 hours per week of home care was being provided to 2,302 people as part of their planned support arrangements. Of this, 15% was provided by the Bradford Enablement Support Team (BEST) service. Of the remainder, 75% was called off from the Council's Framework Agreement for home care services and 25% was arranged through self-directed support including use of Direct Payments. Our BCF funded BEST service provides support to people who need reablement and support to optimise their rehabilitation and recovery before they are assessed for long term home care.

Residential and Nursing Home Capacity

13.2 There are over 4,200 older people in care homes in Bradford. Bradford benchmarks as having high numbers of people over the age of 65 living in care homes. The rate of new admissions led to 441 new placements for people over the age of 65 during 2016/17. The 2016/17 outturn position was 2056 people over the age of 65 in care homes per 100,000 population, which was above national and regional averages (Bradford was ranked 10 of 15 in Yorkshire Humber). The rate of admission for younger people is high and increasing. There are very high numbers of people whose annual cost of care is high (range £35 – 175K). In keeping with the Health and Wellbeing Board's strategic intent to promote a Home First mind set, commissioners are working with the sector to mitigate known risks associated with changes to the size of the care home sector. There remains room for further improvement in reducing placements to meet CIPFA and national top quartile performance, particularly as the strategic shift towards extra care is realised with new developments coming on stream in the next two to three years in keeping with the Council's ambition for Home First in Bradford and Districts. There is a need for careful market oversight of the impact on the sector and system as a whole as these changes are implemented.

13.2.1 Care Home Improvement Programme

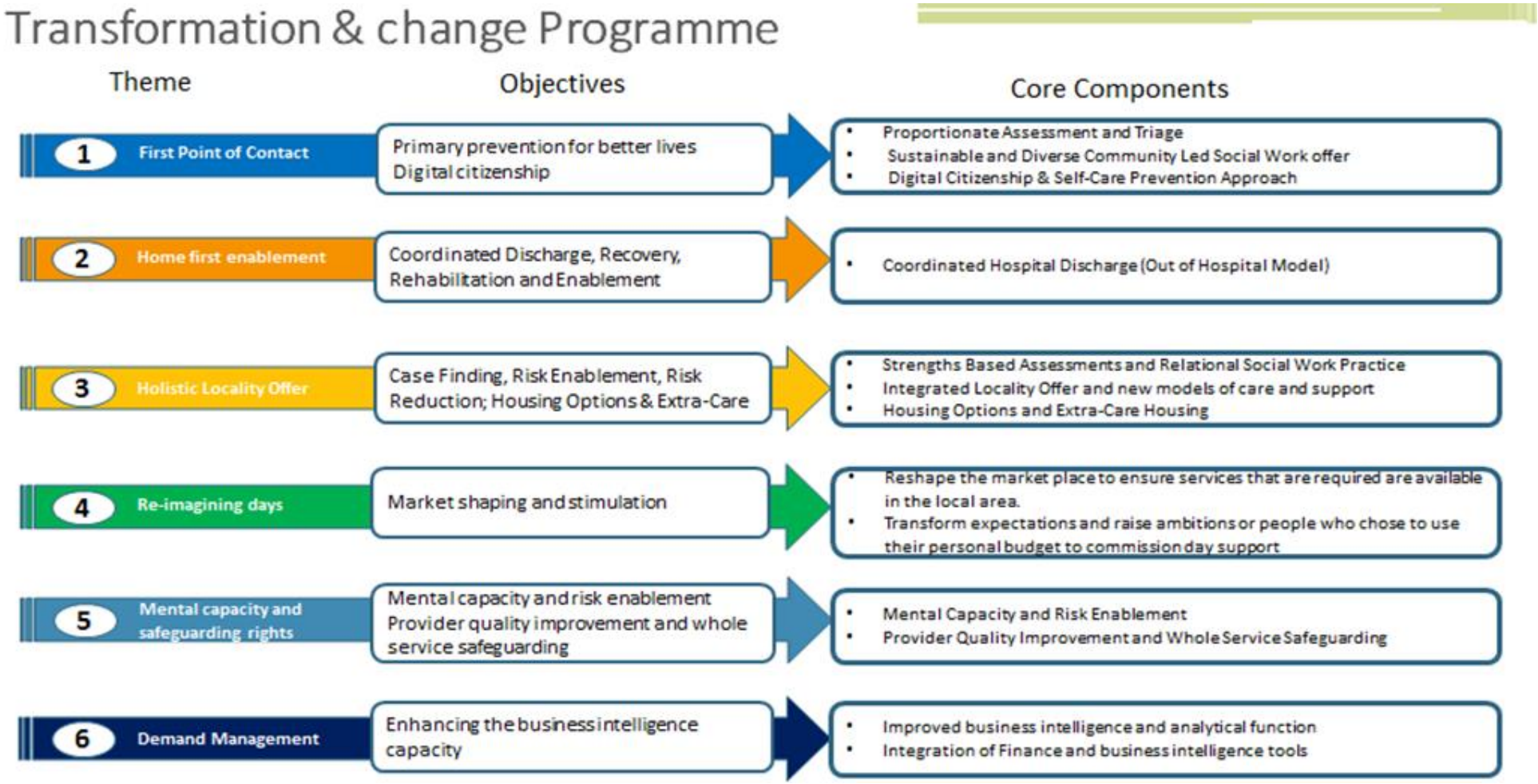
In order to stabilise and improve the quality of care in the care homes sector, targeted support has been offered by the system. This has included training, support with CQC inspection processes, specialist equipment provision and use of technology. This has enabled improvements in setting with fewer homes being rated as inadequate and more homes being rated as good or outstanding.

Intermediate Care Capacity

13.3 Intermediate care services across the District are provided by a range of providers to people in their own home and also in bed based settings in local authority and community hospital beds. The National Audit for Intermediate Care (NAIC) is conducted annually; results have consistently shown that there is insufficient intermediate care nationally to meet population need. Modelling based on the NAIC

and local data also suggests that more people could benefit from intermediate care in the District than are currently doing so. Models estimate that more than 14,000 people aged 65+ could benefit from intermediate care each year in Bradford and Districts. Furthermore, consistent with the national picture, local intermediate care services predominantly support people to leave hospital; opportunities for preventing admissions to acute beds through the provision of step up intermediate care remain.

Figure 3: Adult Social Care Transformation and Change Programme



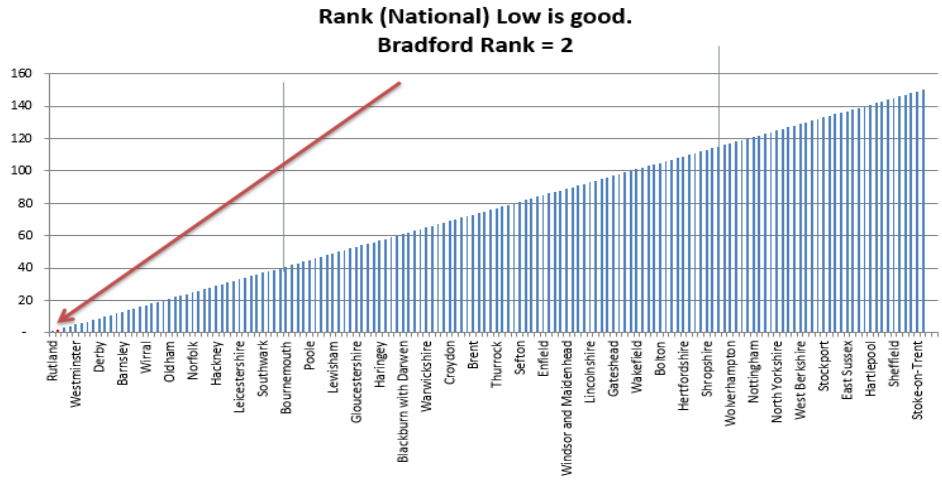
ANNEXES

ANNEX 1 BCF NATIONAL METRICS

1. Composite Metric

Bradford is ranked 2 for the new composite measure nationally.

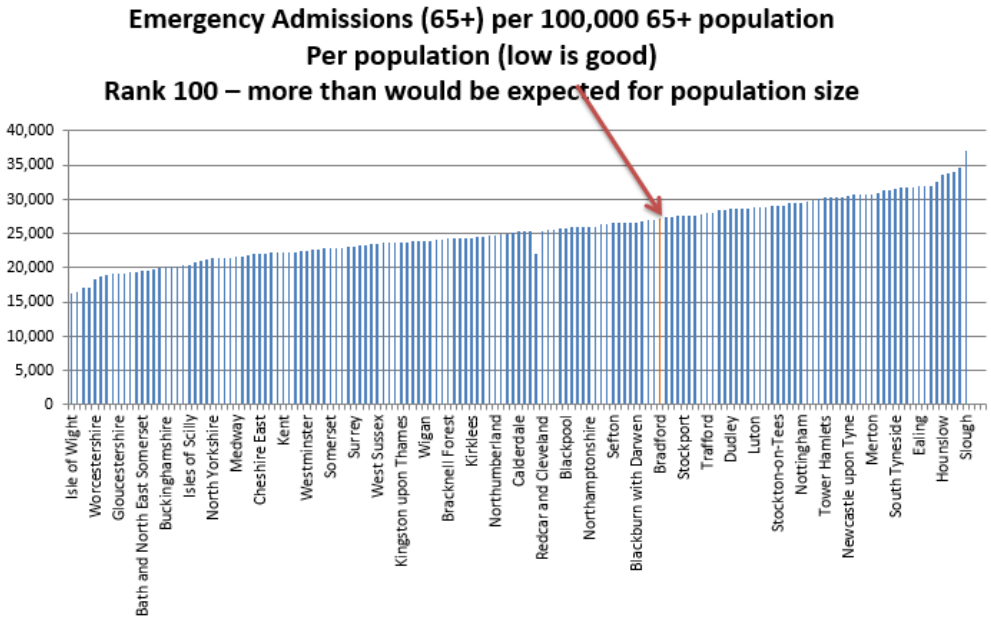
Figure 1: National Ranking for new BCF Composite Metric



2. Non-elective admissions

There were 27,223 non-elective admissions Mar 2016 - Feb 2017. Bradford is ranked 100 of all Health and Well Being Board areas with higher than would be expected for the size of population levels of emergency admissions.

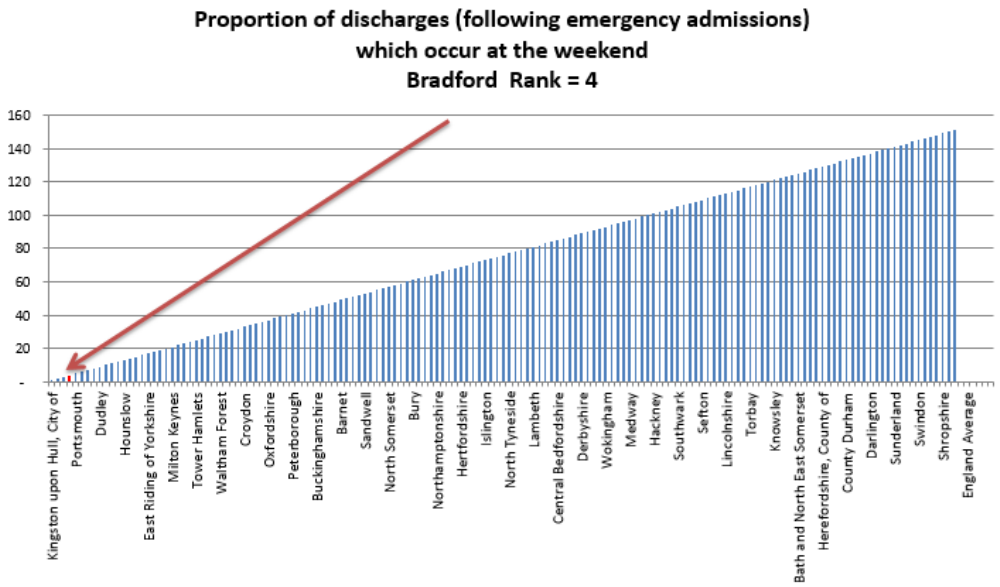
Figure 2: Emergency Admissions (65+) per 100,000 65+ population



2a. Non-Elective Admissions – Weekend Discharges

This is a new metric which contributes to the BCF composite metric score. Bradford is ranked 4 nationally and ranked 1 of 16 compared with statistical neighbours.

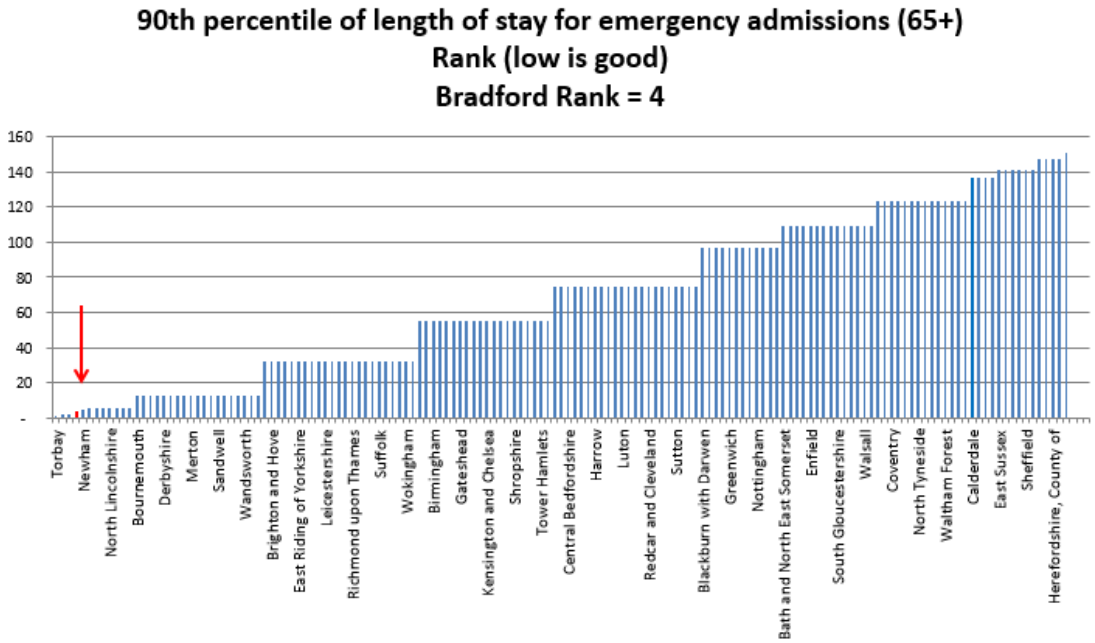
Figure 3: Proportion of discharges (following emergency admissions) which occur at the weekend



2b. Non-Elective Admission – Length of Stay

This is a new metric which contributes to the BCF composite metric score. Bradford is ranked 4 nationally and ranked 1 compared with statistical neighbours.

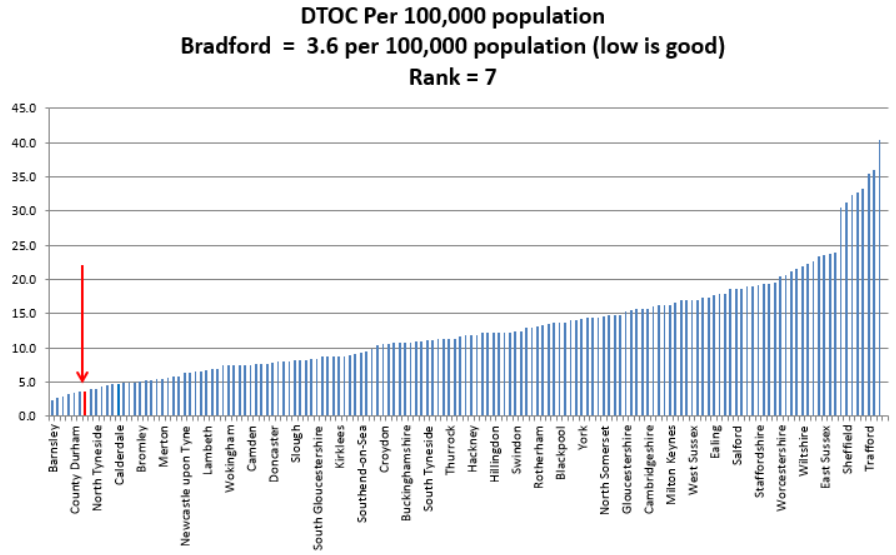
Figure 4: Proportion of discharges (following emergency admissions)which occur at the weekend



3. Delayed Transfers of Care

Bradford is ranked 7 nationally and ranked 3 compared with statistical neighbours with current performance at 3.6 per 100,000 population. NHS England have set a target for Bradford to perform better than 3.8 per 100,000 population for all delays: of which 2.8 per 100,000 are attributable to the NHS and 1 per 100,000 is attributable to social care.

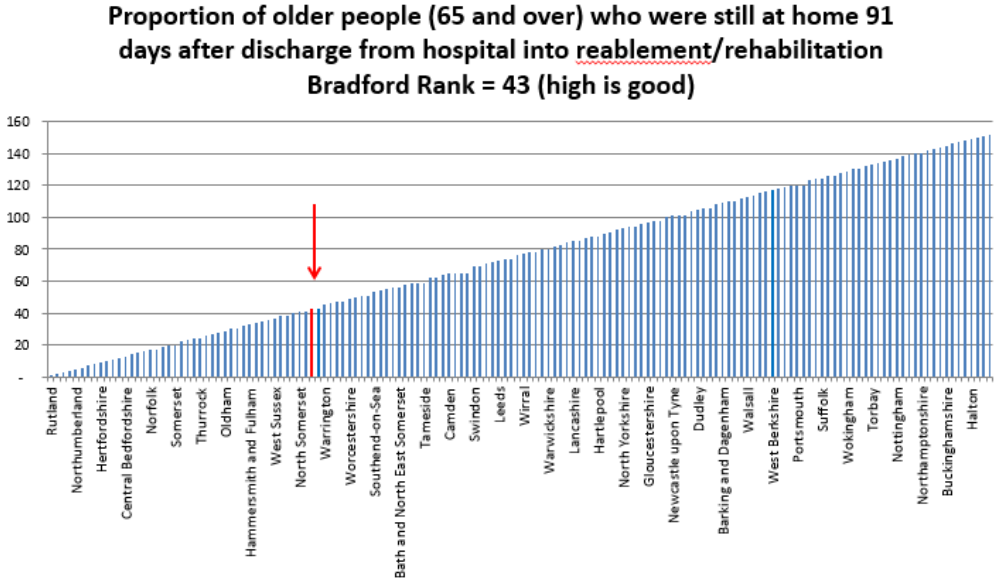
Figure 5: Total Delayed Days per 100,000 18+ population



4. Reablement

Bradford is ranked 43 nationally and ranked 6 compared with statistical neighbours.

Figure 6: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services



ANNEX 2 BCF SPENDING PLAN

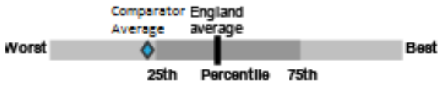
Scheme Name	2017/18 Expenditure (£)	2018/19 Expenditure (£)
Local Schemes	£2,164,770	£2,308,276
Virtual Ward	£3,750,810	£3,792,069
Early Supported Discharge	£598,512	£605,096
Re-ablement Services	£1,368,894	£1,383,952
Re-ablement Services	£1,528,886	£1,557,935
ACCT	£979,659	£990,435
Intermediate Care Beds	£6,099,156	£6,166,247
Community Equipment	£1,433,000	£1,460,227
Disabled Facilities Grant	£3,857,621	£4,195,774
Carers Support	£941,558	£959,448
Maintaining Social Services	£14,934,629	£15,218,386
Care Act New Duties	£1,390,451	£1,416,870
BACES - Home First	£500,000	£500,000
Winter Pressure Beds	£1,000,000	£1,000,000
Intermed. Care Reviewing Team	£500,000	£500,000
Transformation and Assistive Technologies	£1,000,000	
Increased Home Care Capacity	£4,979,821	£4,545,472
Protecting Social Care	£4,066,000	£9,889,946
	£51,093,767	**£56,490,133**

ANNEX 3 ADULT SOCIAL CARE OUTCOMES FRAMEWORK

Key:

Better than England average

Worse than England average



Indicator	Bradford Value	Eng Avg	England Range	Direction of Travel	Overall Rating
1A-Social Care Quality Of Life	19.4	19.1		↓	
1B-Control Over Daily Life	75.1	76.6		↓	
1C(1a)-Self Directed Support (Cared For)	82.0	86.9		↓	
1C(1b)-Self Directed Support (Carers)	100.0	77.7		↑	
1C(2a)-Direct Payments (Cared For)	16.7	28.1		↓	
1C(2b)-Direct Payments (Carers)	82.6	67.4		↑	
1D-Carers QOL	8.2	7.9		↓	
1E-LD Employment	3.3	5.8		↓	
1F-MH Employment	8.0	6.7		↑	
1G-LD Independence	88.9	75.4		↑	
1H-MH Independence	73.0	58.6		↑	
1I(1)-Social Contact	50.3	45.4		↓	
1I(2)-Social Contact Carers	41.6	38.5		↓	
2A(i)-Perm Admissions To Care 18-64	17.1	13.3		↓	
2A(ii)-Perm Admissions To Care 65+	580.0	628.2		↓	
2B(i)-Re-ablement (effectiveness)	87.8	82.7		↓	
2B(ii)-Re-ablement (offered)	2.6	2.9		↓	
2C(i)-Delayed Transfers of Care (ALL)	3.0	12.1		↑	
2C(ii)-Delayed Transfers of Care (social care)	0.6	4.7		↓	
2D-Outcomes from Short Term Support	57.5	75.8		↓	
3A-Satisfaction	64.5	64.4		↑	
3B-Carers Satisfaction	37.4	41.2		↓	
3C-Carers Discussion/Consultation	74.9	72.3		↓	
3D(1)-Information and Advice	69.9	73.5		↓	
3D(2)-Carers Info & Advice	72.4	65.5		↑	
4A-Feeling Safe	73.1	69.2		↓	
4B-Feeling Safe As A Result of Services	86.0	85.4		↑	

ANNEX 4 RELATED DOCUMENTATION

Document or information title	Synopsis and links
Bradford & Airedale Joint Strategic Needs Assessment	Assessment by the Health & Wellbeing Board of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities in Bradford District and Craven https://jsna.bradford.gov.uk/JSNA.asp
Bradford Joint Health & Well Being Strategy 2013 – 2017	The Wellbeing Strategy sets out the priorities and actions to tackle systemic health inequalities in Bradford and Districts http://Bradfordforward.org.uk/Bradford-wellbeing-strategy/
West Yorkshire & Harrogate Sustainability & Transformation Plan	Sets out the approach towards meeting national challenges for health services across West Yorkshire and the priorities for the 'Healthy Futures' Programme. http://southwestyorkshire.nhs.uk/wp-content/uploads/2016/10/Final-draft-submission-plan.pdf
Bradford District & Craven Sustainability & Transformation Plan	Sets out the approach towards meeting challenges for health services across Bradford District and Craven and the priorities for developing an accountable care system which transforms primary care and enhances the out of hospital services model. http://bradfordcityccg.nhs.uk/be-informed/our-publications/sustainability-and-transformation-plan/
Clinical Commissioning Groups Operational Plans	A public facing document which places the patient at the centre of the care and describes the case for change consistent with the 5YFV. It sets out the ambition of each CCG to co-create solutions with local people and transform the way services are delivered. http://www.bdct.nhs.uk/wp-content/uploads/2017/04/BDCFT-2017-19-Plan-ex-FINAL.pdf

Document or information title	Synopsis and links
City of Bradford MDC Home First: Vision for Well Being in Bradford & District	Sets out the strategy for meeting population wide wellbeing outcomes and the Council's general duty of wellbeing towards individuals with social care needs and their carers (S1 Care Act 2014). https://www.bradford.gov.uk/adult-social-care/policies-and-reports/home-first-vision/
City of Bradford MDC Adult Social Care Market Position Statement	Market facing document(s) which describes the current state of the market and the offer of support the Council is making to providers to encourage them to develop their business models within the District. https://bradford.gov.uk/business/commissioning-adult-health-and-social-care-services/commissioning-adult-health-and-social-care-services/
City of Bradford MDC Adult Social Care Local Account	A public facing document which describes the performance of adult social care and the extent to which social care maximises people's independence and upholds people's rights. https://bradford.gov.uk/adult-social-care/policies-and-reports/adult-and-community-services-local-accounts/
Bradford District and Craven Transforming Learning Disabilities Plan	A public facing document which describes our programme to improve community infrastructures and reshape services for people with a learning disability and autism. The plan is framed around Building the Right Support and the National Service Model. https://bradford.gov.uk/media/3306/bradford-learning-disabilities-transformation-plan.pdf
Great Places to Grow Old: Bradford District's Housing Strategy for the Over 50s 2011 - 2021	Describes how many and what type of homes will be needed in Bradford and Districts to meet demand for housing for the over 50. Also describes the strategy for affordable warmth and tackling fuel poverty. https://bradford.gov.uk/media/1858/greatplacestogrowold.pdf

Document or information title	Synopsis and links
Individual CCG QIPP Plans and Local Authority Budget Savings Programme Plans	Detailed plans by Bradford & Districts CCG and the Council for the funding and delivery of services and associated efficiency targets. http://www.bradforddistrictsccg.nhs.uk/about-us/what-we-do/qipp-programme/
BCF Risk Register	A commissioning document capturing key strategic and operational risks associated with the implementation of the BCF Programme and cross referenced to the Clinical Commissioning Group(s) Assurance Frameworks and City of Bradford MDC scrutiny functions.
NHS Five Year Forward View (5YFV)	Sets out NHS England's strategy vision for the next five years and espouses a number of new care models including multispecialty community providers, primary and acute care systems, and urgent and emergency care networks. https://www.england.nhs.uk/five-year-forward-view/