Happy Healthy & at Home

A plan for the future of health and care in Bradford District and Craven

Revised and updated November 2017

Contents

1. Introduction

Our health and wellbeing is important. The things that help us stay well and support us to recover are many and varied and include our homes, jobs, and relationships, as well as our access to excellent, caring services. This plan describes how we will work together with people to build a healthy future.

Local leaders of the health service and social care services have been working together to find ways that we can change to ensure that we achieve

- Better outcomes for the people of Bradford District and Craven; more people live longer in better health, and good health is enjoyed by everyone rather than being determined by where you live
- Better services that meet the needs of people; providing access to the highest quality interventions, delivered by teams with the best expertise, at the times people want, through the routes they prefer
- Better use of the resources available to us; by reducing waste, arranging services to avoid delay and duplication, and working together to keep people well because this delivers better outcomes for people and is cost effective.

By listening to people and working together we understand where we need to change, and many improvements have already begun. We now need to engage the whole community – people, neighbourhoods, businesses and public services, in a new relationship where we all agree the role we play in building a healthy future.

This document is the next step in the development of joined up planning by the health and care system partners in Bradford District and Craven. It is owned by the Health and Wellbeing Board and delivery is led by the Integration and Change Board. This Plan complements our Joint Health and Wellbeing Strategy, and it sets out the key actions needed to achieve the three aims above. It replaces our earlier 'place based plan' that formed part of the West Yorkshire and Harrogate sustainability and transformation plan (2016), and was in turn based on our local response to the Five Year Forward View (2014).

We are refreshing our place based plan now because our Health and Wellbeing Strategy has been refreshed and we are acting together on the wider determinants of health, as well as on the health and care system itself.

This is a natural evolution of our existing plan that is informed by our greater understanding of what people want and need following the Our Say Counts engagement exercise which took place in Summer 2017 and aimed to hear the views of as many

people as possible from all communities across Bradford District and Craven. The independent local Healthwatch organisation led the conversation and produced a summary report which has influenced this plan. Chapter 3 describes what we learnt and how we are using the learning to guide us.

We are also part of the Health and Care Partnership for West Yorkshire and Harrogate, which was formerly known as the West Yorkshire and Harrogate Sustainability and Transformation Partnership. Since we first wrote our plan for health and care this regional partnership has enabled us to work with others to improve care and to access national funds. Chapter 5 includes detail of how Bradford District and Craven contributes to the Health and Care Partnership and what opportunities we see ahead through collaboration across the region. A summary of progress with the Health and Care Partnership is also available here.

It is also important to recognise that the operating context for care and health organisations has become increasingly challenging, and in line with trends seen across the country, we have increasingly struggled to meet access targets in acute care (e.g. four hour maximum wait in A&E). This reflects increased levels of demand and under supply of workforce in care homes, primary care, mental health as well as in hospitals. Our commitment to the delivery of quality care is steadfast, so this plan gives us an opportunity to reaffirm the actions we are taking as a system to meet present day demand while re-balancing investment towards longer term prevention to respond to projected rising demand and resource pressures in future.

Finally the refresh of this plan allows us to ensure that critical elements of our shared vision are brought to the fore, where they may have been implicit previously. For example;

- It emphasises the importance of community and association between people in creating health and wellbeing within neighbourhoods. This is especially important in developing a ‘community assets’ approach where populations are empowered to self-care, maintain their own and others’ wellbeing and reduce demands on traditional health and social care.
- It recognises that the health of people is mainly determined by socio-economic, environmental and genetic factors on which the NHS alone has limited impact. Our Health and Wellbeing Board includes a wider range of partners that can together influence the wider determinants of health by taking a ‘Health in All Policies’ approach.
- It describes how health and wealth are connected. In order to address health inequalities we must bring our economic and health strategies closer together.
- It recognises the importance of focusing on behaviours and culture change, as well as systems and processes of care
- Lastly it offers a chance for us to be explicit about our vision for the future of health and care, and to set out the shared values that will guide us in our transformation

1.2 Vision for the future

1.2.1 Our Vision was established in our 2016 transformation plan and remains our focus today. It is to ***create a sustainable health and care economy that supports people to be healthy, well and independent***. We have subsequently summarised this as ensuring people are ***happy, healthy and at home***

What this will mean for people is that;

- Every neighbourhood in Bradford District and Craven will be a healthy place. You will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through primary care, social care, and community organisations working together. You will have the support of peers, and you will be able to use technology to help you stay in control.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by regional centres of excellence including for cancer and stroke, and by regional specialised mental health facilities including for Secure and Children & Adolescent Mental Health service admissions.
- All of this will be planned and paid for once, with councils and the NHS working together to remove barriers and inefficiencies that are created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health and care services, and understand the increasing importance of self-care and prevention to support a sustainable future health and care system.

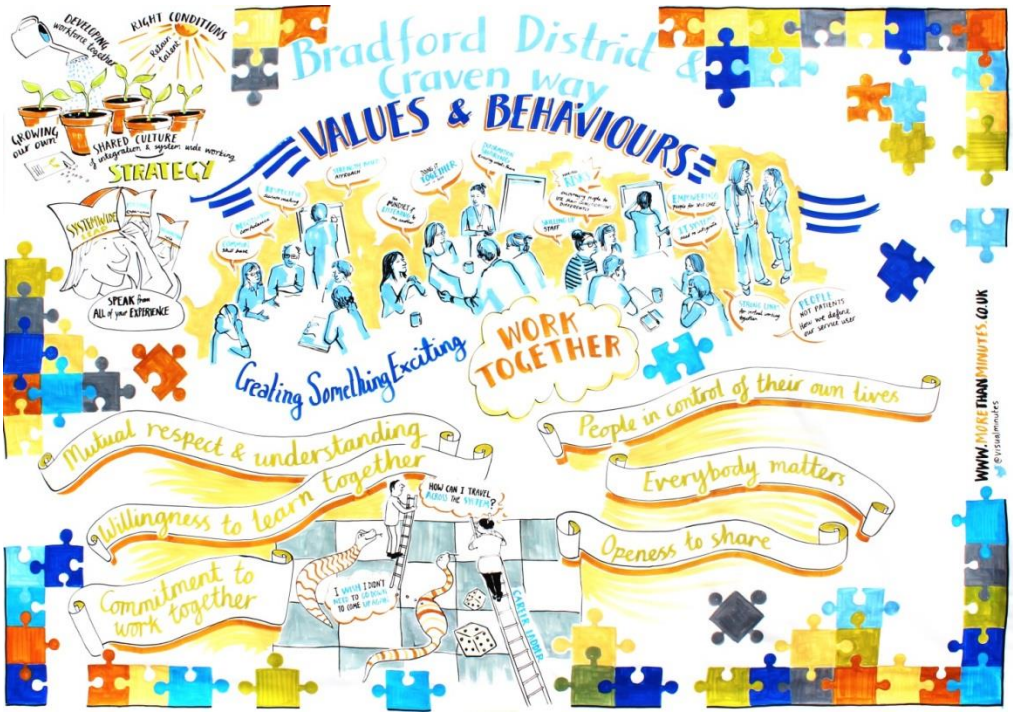
1.2.2 Our Approach to transformation is guided by a few simple principles;

- **Working with people** not doing things to them. We want a changed relationship with people, built on trust and understanding our respective strengths. They know what they need to make positive change happen in their neighbourhoods. We listen and people lead
- **Neighbourhoods and communities** are the basic building block on which our system is built. Wherever possible, services will be provided at a local neighbourhood level. Only when the safety, quality and cost-effectiveness of care are improved by providing it at a greater scale will services be delivered elsewhere. These are the founding principles for our local place-based and regional health and care partnership plans.
- **Whole systems working** is essential as we recognise the complex web of factors that interact to create health and wellbeing. We will work on the wider determinants of

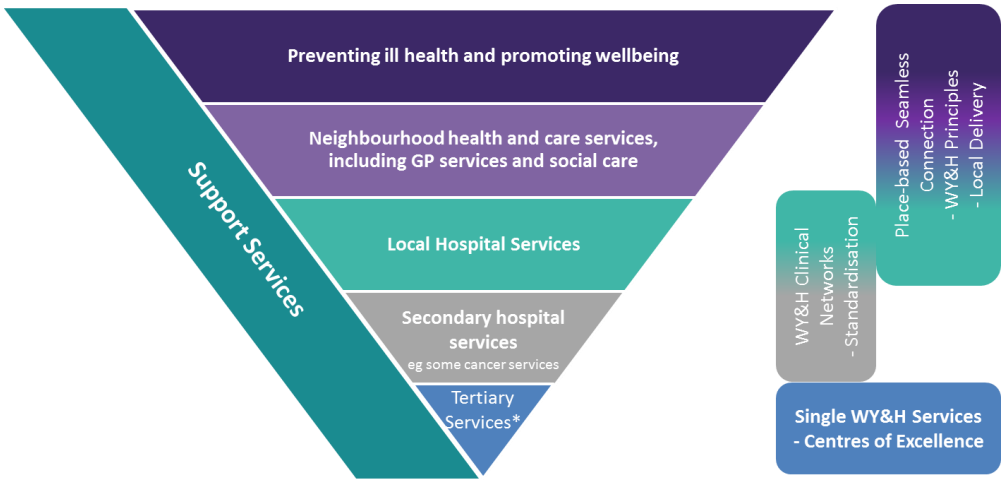
health as well as the care and health service delivery system itself. Changing social norms and maximising every opportunity in everything we do is our approach.

- **Open and honest** about difficult choices. We will have difficult choices to make to live within our financial means. It's very important that we communicate about these choices and provide clear messages that engage our populations in helping us to reduce demand, waste, inefficiencies and cost. Never before have the public been more aware of the pressures on public sector funding; this is the ideal time to begin those open, two-way conversations and co-produce system and service re-design.

1.2.3 Our Values and Behaviours describe how we will act with communities and each other.



1.2.4 Our Model of Care diagram below summarises how our neighbourhood 'place' based approach to service delivery could fit into a network of increasingly specialised services working across a wider area



* Specialised services eg heart surgery,

Neighbourhood health and care services will be tailored to meet the needs of people living in a neighbourhood of around 30-50,000 people. They will be delivered through networks like the 'primary care home' which will support extended access to GPs (at evenings and weekends).Networks will also help neighbourhood services work more seamlessly together with hospitals and social care.

Local hospital services will be planned based on the needs of Bradford District and Craven. Local hospitals will work with neighbourhood health and care services because people will often move between primary, community and hospital services. To further improve quality and the cost of care, groups of health care professionals will work together as a network of support.

Clinical Networks across West Yorkshire and Harrogate. Some hospital services need to be planned and delivered for larger areas and populations than each place, for example those that deliver some cancer care. Although operational management will remain the responsibility of each hospital, clinical networks made up of consultants, GPs and nurses etc will ensure a common approach across West Yorkshire and Harrogate by setting clear standards and procedures. In some cases, this may lead to closer working between two or more hospitals to deliver services by sharing staff, buildings, and the latest technology.

Specialised hospital services: The most complex services, such as heart surgery, will be planned, operated and managed as single services for West Yorkshire and Harrogate. Clinicians, for example specialist consultants and nurses, from different hospitals will be brought together as single team to make the most of their skills, expertise and equipment. This will improve care and support high quality research and education. In some cases this may mean reducing the number of sites delivering the more complex care, such as high risk surgery, whilst other parts, for example outpatients, diagnostics and day surgery, will remain as local as possible.

Mental Health: Some of our more specialised mental health facilities will also be provided more appropriately for larger areas and populations. This will include inpatient Child and Adolescent Mental Health Services, where collaboration has helped to secure national capital funding to develop a new 22-bedded regional unit; increasing regional capacity by 14 beds. This means that young people currently treated out of area will receive care closer to home. Similar regional collaborations will support low secure mental health services with the aim of standardising and improving care pathways and providing care as close to home as possible.

2. Where we are now

We have much to be proud of in Bradford District and Craven, and this gives us a strong base to build on. However many local people do not enjoy the long healthy lives that we believe they deserve. Our ambition is to make all our neighbourhoods healthy places where people are connected and services support them.

Successes to build upon (all need to be described in terms of what difference that makes for people)	Results we want to change
Delayed Transfers of Care performance	Rates of smoking among adults are increasing locally against a trend of fewer people smoking nationally. In Bradford 22% adults smoke, compared with 18.6% regionally. (147th out of 152 LAs) We are committed as part of the West Yorkshire and Harrogate Health and Care partnership to reduce this to 13% Cancer screening and mortality. Tobacco Control Alliance and Cancer Alliance
Bradford's Healthy Hearts programme has prevented 131 heart attacks and 74 strokes, helped over 6,000 patients to switch statins and reduce their cholesterol risk, and started 1,000 patients with irregular heartbeats on blood clotting prevention medication	In Bradford City CCG area, under 75 years coronary heart disease mortality rates are the second worst in the country (208th out of 209 CCGs), and under 75 stroke mortality rates are the fourth worst in the country (205th out of 209 CCGs).
Bradford Beating Diabetes The prevalence rate of Type 2 diabetes in England is 6.4%, here in Bradford the prevalence rate is above the national average at 8.7%. Bradford Beating Diabetes (BBD) aims to identify people who are at risk of developing Type 2 diabetes, and make sure they receive the appropriate advice, care and support to delay the onset of Type 2 diabetes. For those people who already have Type 2 diabetes BBD helps them to manage their condition and prevent serious complications. Since BBD started in 2013, more than 12,000 people in the Bradford City area who are at risk of developing diabetes have taken part in the programme.	Rates of common non-communicable diseases are much higher in Bradford than elsewhere in the country. Diabetes prevalence is the highest in the region at 8.3% of the population, giving Bradford the fifth highest rate of any English local authority; this is likely to be an underestimation of true prevalence, and hides a high level of impaired glucose tolerance
SystmOne used across primary care, acute community nursing and adult social care teams	the gap in life expectancy at birth between Bradford and England has stalled at over one and

and being implemented for mental health services by early 2018/19. BTHFT recently successfully implemented a comprehensive new electronic patient record which will imminently allow information exchange with SystmOne for primary care so we have an increasingly integrated digital care record	a half years, and may even be widening. In addition, within Bradford itself the gap in healthy life expectancy between the richest and poorest citizens is an astonishing 19.1 years for males and 22.1 years for females: one of the worst life expectancy gaps in the UK Life Expectancy 9 years less than CCG with the highest (NHS Guilford & Waverley)
Born in Bradford research base Shows that a focus on children and potential mothers would have biggest impact on outcomes.	the mortality rate from causes considered preventable has declined in both Bradford and across the UK over the past 15 years. However, the gap has remained consistent at around 50 more deaths per 100,000 persons in Bradford every year, and recently appears to be growing
Better Start Bradford is a 10 year test and learn programme, testing a range of evidence and science based interventions in the most deprived area of Bradford with a view to establishing what works in improving outcomes for children. Its on-going evaluation of both the implementation of interventions and their impact is informing change across the district.'	Obesity particularly children & Levels of physical inactivity 27% of the (council) population under 18 live in poverty
Community Connectors/ social prescribing	the housing conditions people live in that impact on health including homelessness
Elimination of adult acute mental health inpatient out of area placements supported by strong partnerships between health, social care, police and voluntary sector meaning that people are cared for closer to home.	Case mix – planned/ unplanned use of hospital resources
The Haven – supports people experiencing mental health crisis – reduces demand in other parts of the system – 80% reported that they would have attended at A&E and/ or resorted to self harm if they had not been able to receive help at the Haven	
Physical health checks in MH	Integrate Mental Health and Physical Health including national initiatives to support individuals with Long Term Conditions to manage anxiety and depression
Goldline End of Life care	

2.2 Acting on the wider determinants of health

In order to impact on the results reflected in the infographic above we know we must work as a broad partnership of communities and organisations on the underlying conditions that combine to generate these outcomes. These wider determinants include;

Economic growth that is shared equitably between people is essential. While our local growth in prosperity and productivity has increased gradually in recent years, we are significantly below national average.

Social deprivation affects health and life chances in many ways including housing, education and employment, the availability of healthy food, water and sanitation. Over

40% people in Bradford live in areas classified as being within the 20% most deprived neighbourhoods in England, and over a quarter of local children are growing up in poverty. This is increasing, and places Bradford 25th worst out of 142 local authorities for child poverty. Social disadvantage is defining their health (22% are obese at age 10/11) and their opportunities (only 48.1% of children attending Bradford schools gain 5 GCSEs Grade A*-C compared with 78.7% in England). Infant mortality is almost double the national average and levels of congenital anomalies and childhood disability are the highest in the UK.

Climate change and pollution has far-reaching implications for both physical and mental health. Bradford has experience of flooding due to extreme weather events: for example in winter 2015, when 1000 homes and businesses were flooded. In addition, although air quality in Bradford is improving, Bradford's geography, traffic and industry combine to cause high levels of air pollution in some areas. Air pollution is linked to a number of adverse health outcomes, and disproportionately affects the poorest and most vulnerable in society

3. What people say

A key part of 'where we are now' is listening to the views of people about their health and wellbeing, and the services that aim to help them. This section describes some of the big conversations that have taken place recently, what people said, and how they are influencing our work together.

Throughout July and August 2017, Healthwatch Bradford and District worked on behalf of local health and care partners to create a conversation with local people about the future of health and social care.

A number of different engagement activities took place over a six week period including an on-line survey, three public events where people took part in facilitated, deliberative discussions. In addition the Healthwatch team talked with individuals at outreach sessions in public locations e.g. transport hubs, and encouraged completion of the survey. Focus groups were also held with community groups aimed at ensuring perspectives that aren't always heard were listened to. Groups included; Carers, Older people, BME communities, Young people, and LGBT people. Healthwatch staff also visited VCS groups and held group discussion sessions.

- 112 people took part in focus group discussions
- 123 people attended our three public events
- 330 people had face-to-face conversations to complete the survey
- 355 people completed the survey online

In addition, posts on social media reached a wider audience, raising awareness of the case for change and the involvement of local people in making plans for the future of health & wellbeing – using the hashtag #oursaycounts. On Facebook, posts reached almost 40k people. On Twitter, posts had 113k impressions.

These activities covered the whole of Bradford City, Bradford Districts, and Airedale, Wharfedale and Craven CCG areas. Conversations took place in Bradford city centre, Manningham, Girlington, West Bowling, Bingley, Keighley, Steeton, Settle and Skipton.

Most people were positive about the opportunity to share their views and have their say on the future of health and care. The level of participation in this project shows that local people are willing to share ideas and take part in an honest conversation about the future of health and care.

In thinking about health and care services, people were not only thinking of their own needs but often considered wider issues and needs of the whole population.

People often raised concerns about the funding of health and care, and fears about central government approach to the NHS and local authorities. There was some cynicism about how much the local and regional system could do in the face of these challenges. To a lesser extent, there was also cynicism about the value of engagement and how we would make sure local people's views were heard.

It's important that this project is built upon, and further conversations will be needed as plans are developed. People are keen to be involved and informed.

Local people care about their local services, and want to see them protected. But if there are sound clinical reasons for delivering care in specialist centres, they can support this. People want to see that services are designed for the best outcomes and that they take into account the experience of patients, carers, or service users, so that practical issues like journey time and parking are addressed.

People talked about GP practices more often than any other aspect of health and care, particularly about access to GP appointments.

The majority of people who took part in the engagement were willing to take responsibility for their own health and wellbeing and understood their responsibilities to use services appropriately. Some people told us they needed more support to do this and clearer messages about what's available.

People came forward with lots of ideas; these were often lively, engaged discussions with people keen to help create solutions about how to make Bradford District and Craven a healthier place to be. People want to see initiatives that help people live healthier lives and therefore prevent ill health and subsequently would reduce the demands on health services. Included in these discussions was a strong theme about the need to look at individual's whole life – social, emotional, and cultural wellbeing alongside physical health.

Full details of the feedback received is available at Healthwatch A summary of the major themes of the feedback received is captured in the table below.

Protect	Reduce
Many people listed several services in their survey responses, and felt that all of health and care should be protected	People found it very challenging to think about reducing any services
Two thirds of people mentioned GP practices in their response	Many felt that by creating a focus on wellbeing or prevention, the system would reduce demand elsewhere
People wanted to protect local A&E departments and emergency care	People felt strongly that waste and duplication in health and care needs to be addressed
Mental health services were high up on people's priorities	People want consistency and to end the 'postcode lottery'
Social care support for older people and those with disabilities was also a priority for local people	Conversations highlighted changing public expectations
Many people expressed concerns about the	People worried about funding, and felt

impact of funding cuts on voluntary sector groups	privatisation was a threat People were open to changing the way they access services – e.g. using technology
Grow People wanted to see better sharing of good practice across the area, especially on access to GP practices A clear theme emerged of people wanting to see more prevention and early intervention People told us 'more is needed' when it comes to mental health Care homes and home care needs to be developed to increase capacity and improve quality People felt that more staff were needed across the system in a range of roles Technology should be used more, both for communication and in the delivery of care and treatment	**Create** People had lots of ideas and wanted to help create solutions Health and care working together - people felt integration was talked about but needs to happen in practice at every level (from sharing records to pooling budgets) Improving access and experience in GP practices was a key theme, with new approaches to technology and a wider range of roles in primary care People expressed a strong desire for local community-based services to be set up People want Bradford District & Craven to be a healthier place. They had ideas for schemes to improve mental and physical wellbeing

Throughout this report extracts from the 'Our Say Counts' engagement exercise are used to illustrate the need for change and to demonstrate the alignment between this plan and the feedback people have provided.

Engagement is a regular and integral part of how we work. In the New Year we will reconnect with people to show how we have incorporated their feedback into this plan. This will help us to check our understanding and will give people an opportunity to comment on and shape this plan.

Next Steps

- **Engagement and Communication Plan developed in January 2018 and carried out throughout 2018/19**

4. Improving Outcomes

Our Joint Health and Wellbeing Strategy 2018 – 2022 is called 'Connecting People and Place for Better Health and Wellbeing'. It sets out three key approaches that will have the biggest impact on longer term health outcomes for people in Bradford District and Craven.

- **Create a place to live that promotes health**
- **Make it easier for people to improve their health and wellbeing and prevent ill health**
- **Support people to better care for themselves and to get help earlier**

4.1 Actions

These priorities will be supported by the following actions;

A health promoting place to live
Inspire communities to build neighbourliness, reduce loneliness and isolation
Make our streets and neighbourhoods safe attractive and greener
Bring resources together to support local action
Ensure healthy living is at the core of our work to bring new businesses and better public spaces to the District
Use all our policies strategies and interventions to improve health and wellbeing
Adopt a healthy workforce approach
Encourage greener forms of private and public transport to improve air quality
Use strategies for economic growth, housing and poverty reduction to create jobs and increase affordable and energy efficient homes
Ensure more homes are accessible and easily adapted for changing needs

Promoting wellbeing, preventing ill health
Help pregnant women and their partners be well-prepared for parenthood
Make it easier for people to eat better, stop smoking and to be physically active
Enable more people to get involved in neighbourhood activities
Inspire and support more people to improve their health and wellbeing
Train health champions and staff to encourage people to change behaviour
Encourage schools to walk or run a 'daily mile'
Work with Active Bradford to make healthy lifestyles easier
Deliver the mental wellbeing strategy

Getting help earlier and self care
Support people at risk of conditions such as heart disease or diabetes to make changes to reduce their risk of deterioration
Use the early help process in children's services to support families
Support people to self care to stay well and prevent illness; including through more extensive use of technology and apps to make it easier to access advice and support
Increase the uptake of screening for common cancers
Encourage people to register with their local health services
Ensure people with mental health conditions and learning disabilities are able to access early help and self care as well as everyone else
Increase and improve home care and community based care through the Home First strategy

4.2 Outcomes

Through the delivery of these actions the Joint Health and Wellbeing Strategy will impact on outcomes for people in the following ways;

Outcome 1: Our children have the best possible start in life	
Indicators	**Measures**
• All children have opportunities to play and enjoy early learning with their peers • Children have good health and are ready to learn by the age of five • Children and young people eat healthily and are active every day • Children, young people and families have good mental wellbeing and can cope with life's ups and downs • Issues are addressed sooner and prevented from getting worse • Child health and wellbeing improves and inequalities reduce	• smoking in pregnancy • breastfeeding • infant mortality, • % of children ready to learn at age 5 • excess weight • oral health • fruit and veg intake • child mental health • child poverty and family homelessness • Gaps between District and national rates and within the District will track inequalities.

Outcome 2: People in Bradford District have good mental wellbeing	
Indicators	**Measures**
• Children and young people have emotional resilience and good mental wellbeing • People have positive relationships at home and in their schools, communities, and workplaces • People are able to cope with life's ups and downs • Fewer people are depressed or anxious • People with mental health needs have good quality of life and can access employment	• Child and adult mental health referrals and admissions. • Social isolation, quality of life for carers. • Self-reporting of long-term mental health conditions (depression, anxiety) • Access to employment • Health-related quality of life and under 75 mortality

• People with mental health needs are supported at home and in their communities as far as possible	

Outcome 3: People in all parts of the District are living well and ageing well

Indicators	Measures
• Fewer people die early from preventable illness and people live more of their lives in good health • Inequalities in life expectancy and healthy life expectancy reduce • People with long-term conditions are able to manage their conditions and stay as well as possible • People have good health and wellbeing throughout their lives • People age well - staying happy, healthy and living at home for as long as possible • People choose where they are cared for at the end of their lives and experience excellent end of life support	• Unplanned hospitalisation for chronic conditions • people with a learning disability receiving annual health check • health-related quality of life for people with long-term conditions • preventable mortality and under 75 mortality from preventable causes • Rates of smoking and harmful alcohol intake • Self-care indicators • Permanent care home admissions • delayed care transfers • National and local gaps on life/healthy life expectancy

Outcome 4: Bradford District is a healthy place to live, learn and work

Indicators	Measures
• More homes are safe and energy-efficient • People live in places where it is safe to walk and cycle • People have access to green space and children have safe places to play • Air quality improves, particularly in hotspots • The District has a healthy workforce • People are absent from work due to ill-health are supported to return to work • People with additional needs are supported to access education, training and employment	• % homes with (grade x) energy efficiency • excess winter deaths • fuel poverty • employment rates including for people with Learning disability or mental health conditions • road traffic collisions • Sickness absence and return to work • Community safety.

5. Improving quality & experience

By focusing on quality improvement we will achieve better health outcomes, reduce waste and deliver a better experience of care for people. It is also critical for attracting and retaining our skilled and caring workforce.

This section describes the work we are doing together to improve quality and the impact this will have. It also describes the ways in which we think we can organise and deliver care differently to achieve better results. We will need to engage everybody in planning changes to make sure we make the best choices for the future.

In chapter 2 above we described how we are performing in terms of achieving good outcomes for people – essentially aiming to help us live longer in good health, and for good health to be enjoyed by everyone irrespective of where they live in Bradford District and Craven.

In this section we will set out some of the key operational measures that are used to compare the quality of the health and care services we provide e.g. waiting times for treatment, and feedback from people who use services about their experiences. These operational metrics enable us and external bodies to compare how well our system is functioning compared to others. Our assessment leads us to conclude that there are some important changes we should make to improve the effectiveness of our services and the experience of using them. In many cases the things we do to improve quality will also help us to achieve better long term results for people and to use our limited resources more effectively.

5.1 Measuring quality

Each part of our health and care system uses measures of quality to understand its performance and focus its efforts. The Health and Wellbeing Board and ICB use an agreed bundle of measures taken from a number of sources in order to generate a balanced view of overall system performance. The measures in the tracker can be summarised as follows:

Since this ‘tracker’ was first developed there have been a number of new additions that will now influence the way we measure quality. These include the CCG Improvement and Assessment Framework; the Single Oversight Framework for NHS Foundation Trusts; and

a dashboard for health and care partnerships such as the West Yorkshire and Harrogate Health and Care Partnership that we are part of. Locally our Accountable Care Programme Boards have adopted a shorter suite of operational measures impacting on system performance. As a result one of our key actions for the year ahead is to review our tracker and ensure the measures remain the most pertinent for us and enable a sufficiently broad view of both social and health provision, and also focus on the wider determinants of health.

Next Steps
• **Review measures used in the tracker of system performance by April 2018**

5.2 Improving quality

Local health and care organisations are working together on many initiatives to improve the quality of services provided. A summary is provided below of the main areas of work, what they have achieved so far and what we expect each of them to contribute over the next 2-3 years.

Programme	Achievements	Impact in 2018 - 2020
Planned Care		
Urgent Care		
Women, Maternity and Children		
Mental Health	• Sustained nil out of area placements for adult acute inpatient admissions through strong partnership collaboration and provision (health, social care, VCS and police) • Alternative to inpatient admission or A&E attendance as a result of VCS initiatives like The Haven (Cellar Trust) and The Sanctuary (MIND) • Improved access to psychological therapies and Early Intervention in Psychosis services • Increased staffing levels in our Dementia Assessment Unit to ensure we can provide	• Work at West Yorkshire & Harrogate level to integrated adult acute commissioning • Provide care closer to home and develop enhanced community pathways for Children and young people – including development of CAMHS 22 bedded unit for WY&H, and development of new collaborative commissioning models • Collaborating at WY&Harrogate level to consider options to improve access to and services for BANDS and Low Secure services • Further improvements

	high quality, personalised care to people with complex needs • Partnership 'STEP' bid secured introducing health and VCS work with Job Centres to support individuals to secure employment	in access to IAPT meaning more people are treated earlier • National commitment to invest in IPS model (support to individuals accessing our Community Mental Health Teams to secure employment)
Learning Disabilities	• Hydro and rebound therapy provision re-provided from out dated and remote location to community based facilities	• Learning Disability Transformation Programme to develop community alternatives to admission to Assessment & Treatment Units

Primary Care and Community/ Out of Hospital Care	• Active signposting training for practices, and roll out of the community connectors model to help more people connect to their communities
	• More practices offering appointments at evenings and weekends
	• Support for leadership development in primary care using GP Forward View funding
		• Development of Primary Care Home Communities – more joined up support for wellness in neighbourhoods including;
		  • Additional 230 extended access appointments per week
		  • 100% coverage of direct booking into GP appointments from NHS 111
		  • 100% of practices to offer care navigation
		• Develop community beds so that people stay connected to their communities while being supported with rehabilitation and reablement.
		• Develop a community access network for people to find the right local services for them

These programmes make a significant contribution. In addition to their impact on quality they also contribute to the delivery of system-wide efficiencies. In 2017/18 these programmes have contributed to CCG QIPP savings, and in 2018/19 they are expected to deliver a further savings.

Whilst the improvements in care described above are necessary they are not sufficient to fully realise the vision we have for the health and wellbeing of Bradford District and Craven. Therefore a number of additional initiatives are underway to support the transformation required.

5.3 Provider collaboration

Across Bradford District and Craven the providers of care and health are working together to deliver more effective services for people which will lead to improved health, and to find additional ways of operating efficiently by sharing expertise and resources.

Collaboration between providers is happening in the following ways;

5.3.1 Acute hospital providers in Airedale and in Bradford are working together supported by commissioners in the 'Acute Provider Collaboration'. They have acknowledged the need to work differently in the future and are committed to developing new ways of working underpinned by collaboration.

Following joint work undertaken by clinical teams opportunities have been identified to enhance safety, quality, effectiveness and the experience for patients and staff. Work has already begun on improving the quality of care provided to Gastroenterology patients. Further improvements are being planned in Ear Nose and Throat specialisms and in Stroke care. Other clinical specialties will progress throughout 2018.

The focus of this work is not about future organisational form, it is about how to best organise clinical and support services to provide leading edge clinical practice that is both clinically and financially sustainable and best meets the needs of local people.

Within this overall framework the Acute Provider Collaboration programme will support local clinicians to consider how best to organise clinical services across the two hospitals linking up with care provided in the community.

5.3.2 General Practices are working together to improve care and create sustainable business models. They are doing this through a variety of arrangements including; federations, bigger merged partnerships and through the establishment of joint ventures owned by GP partners. These collaborations have already enabled a wider range of services to be offered in primary care e.g. access to therapists employed by several practices working together, where individual practices wouldn't have had sufficient demand. It is anticipated that general practices will work together to offer extended opening hours for patients, and to continue extending the range of expertise they can offer.

In Bradford the Bradford Care Alliance has been formed by 63 GP practices operating as Community Interest Company to improve health and wellbeing in Bradford by supporting new models of care and sustainable general practice. It is currently working on introducing GP streaming in A&E which will help more people access primary care rather than using A&E where this isn't the best choice. The Alliance is also leading the development of groups of GPs, community health and care services and their local community organisations working together to form ten neighbourhood collaborations called 'primary care homes'. The Alliance has been successful in gaining the support of the National Association of Primary Care to introduce new ways of working.

In the next year we will support the emergent primary care homes build strong relationships with local people and communities, so that a true partnership emerges which builds on the strengths and abilities of people to stay well and support each other with illnesses. This focus on wellness as well as treatment of illness is at the heart of this approach. Wherever needs arise for the redevelopment or relocation of premises we will seek opportunities to create welcoming community oriented places that join up activity and sport, access to health and care, with community action and support for community groups.

In Airedale, Wharfedale and Craven GPs are working together in several ways to find sustainable business models and to offer a wider range of services for their patients with increased access to care.

Seven practices in the Airedale and Craven localities have come together and formed a region of the national GP super-partnership, Modality Partnership. Modality Partnership are the first national super-partnership in England, led by GPs with a small centralised management team. The majority of the remaining practices predominantly in Craven and Wharfedale are also coming together under the WACA (Wharfedale and Craven Alliance) banner. The exact form of this potential super-partnership is still being worked on.

Yordales Health, the GP federation covering all bar two of the Airedale Wharfedale and Craven practices is working to establish the most appropriate way to support the resilience of general practice, and ensure that general practices are prominent in local accountable care developments. To enable this Yordales will work with practices to find the best way of ensuring their perspective is articulated clearly and coherently. It is anticipated that an agreement will be reached on how to achieve this by the end of this year.

5.3.3 Voluntary and Community Sector organisations have worked together locally for many years through the voluntary sector Assembly structure and particularly the Health and Wellbeing Forum. The members of the VCS Assembly have now established Bradford VCS Alliance Ltd. to enable even more collaborative provision. Alongside the Assembly it brings a strong unified voice for the voluntary and community sector. This will help ensure the sector is vibrant, sustainable and can play a leading role in helping people and organisations to be part of providing solutions to improve the health outcomes of our most marginalised and vulnerable communities.

In addition the local voluntary and community sector is working closely with statutory sector partners to develop practical ways in which the sustainability of the sector can be secured. This is critical as many of our policies and strategies include major roles for the VCS to help local communities to thrive. To support sustainability we will work together on building the capacity of the VCS, and developing longer term funding arrangements.

5.3.4 Provider Alliances have been developed in both the Airedale Wharfedale and Craven, and the Bradford areas. These bring together all of the providers of health and care services including those listed above along with community and mental health care providers, and social care professionals. In the future the Provider Alliances will extend invitations to local care home and home care providers and to other organisations that contribute locally (e.g. out of hours care). The Provider Alliances will offer a route through which commissioners can contract with local providers in a joined up way to deliver new models of care that focus on the outcomes and experience of care for people.

Already the Bradford Provider Alliance has worked together to develop plans for an integrated diabetes service and support outcomes framework. Once implemented this will give everyone in Bradford access to help to reduce their risk of developing type 2 diabetes, and provide support for people with diabetes to help them to confidently manage their health to reduce the risk of complications. It is anticipated that this new approach will be launched by April 2018.

The Airedale, Wharfedale and Craven Provider Alliance is working together to support the development of three communities across Airedale, Wharfedale and Craven to deliver transformed primary and community outcomes focused services and well as looking to extend the Well North/Bradford social entrepreneurial philosophies into Keighley to help transform neighbourhoods into dynamic communities where people can live, work and thrive.

Next Steps
• **Map and align localities and neighbourhoods work (primary care, VCS, social care for adults and children etc) – by March 2018**
• **Extend participation in locality based collaboration to include community pharmacies, care homes and homes care providers – by March 2018**
• **Engage Community Pharmacy West Yorkshire to develop a shared plan for the enhanced roles that pharmacies can play – by June 2018**
• **Undertake locality/ neighbourhood needs assessments to identify priorities for local action – by April 2018**
• **Join up locality based collaborations so that health, care and community participants are working together – by June 2018**
• **Develop and test new service delivery models in localities – throughout 2018/19**
• **Develop and test new ways of joining locality based service delivery with system wide governance and planning arrangements – by Sept 18**

• **Implement integrated diabetes pathway in Bradford by April 2018**
• **Extend Well Bradford initiative to Keighley, starting appreciative enquiry by April 2018**

5.4 Commissioner collaboration

NHS and Local Authority commissioners of health and care services are also collaborating in an arrangement that mirrors the alignment of the provision of care to focus on improving outcomes and using resources to join up pathways of care.

An Executive Commissioning Board has been established to align the commissioning decisions of the three local NHS CCGs and City of Bradford MBC. So far this arrangement has enabled partners to develop a successful plan for the use of the Better Care Fund and Improved Better Care Fund. This has led to fewer people having to stay in hospital after they are medically fit to leave. This is an area in which we have significantly out performed most other parts of the Country. It is better for people and helps make sure we have sufficient hospital beds available.

In the future we will extend the proportion of our health and care spend that is commissioned through this joined up planning arrangement. In the next year we will….

Next Steps
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5.5 Whole system collaboration – accountable care

All of the examples above of providers and commissioners working together contribute to the development of two accountable care partnerships for Airedale Wharfedale and Craven and for Bradford. This section describes what we mean by this, and how this will help us to deliver better outcomes, better quality and to use our limited resources as effectively as possible.

We intend to build an integrated health and care system whose purpose is to meet the ‘triple aim’

- Improved health outcomes
- Improved experience and effectiveness
- Improved use of resources

To do this we want to agree a new deal with people and communities in which we

- Invest in communities
- Rebalance relationships and share power and responsibility
- Support agency and activity in communities

- Agree together what we need to do/ do differently/ stop doing

We intend to build this future organically from the places where health is created in neighbourhoods. This sets us apart from some other approaches to accountable care which start with the creation of a framework of organisational structures and contractual arrangements. While recognising that changes to governance will be essential in due course, we believe that form should follow function, and the first job we have is to nurture behaviours of trust, innovation and collaboration.

To support these developments much is already underway;

5.5.1 Local networks of primary care have been established in both the Airedale Wharfedale and Craven (AWC), and the Bradford areas. In AWC three communities have been formed in which primary care, voluntary and community sector, community health services and social care providers are improving services. In Bradford general practices are forming ten local networks, which will shortly include a range of other partners as per AWC. These developments are learning much from their association with the National Association of Primary Care's Primary Care Home model.

5.5.2 VCS community anchor organisations There is an established and growing network of community anchor organisations across the Bradford District, including Royds Community Association, Bradford Trident , Inspired Neighbourhoods and Carlisle Business Centre, which are strongly embedded and connected in their local communities, understanding the needs and challenges of local people, including the wide range of issues that impact on health and wellbeing. Connecting community anchor organisations and emergent primary care homes is a focus for the next year

5.5.3 People Can and Asset Based Community Development People Can is a Bradford Council led campaign which actively promotes all the good things that people are already doing in their communities as well as encouraging more people to volunteer and get involved in community life. You can find out more here.

Asset Based Community Development is an approach to working with communities which starts with the assets or 'strengths' in that community and then builds the capacity of citizens to connect their skills and resources leading to citizen-led, sustainable change to improve the quality of life for everyone in that community. In Keighley a group of practitioners from a range of partner organisations including the CCG, Council, Police and voluntary and community groups have recently started meeting to support each other in implementing the ABCD approach across local neighbourhoods. They are supported by Nurture Development which is a strategic partner of the ABCD Institute, and the lead partner in Europe. It aims to support the proliferation of inclusive, bottom up, community driven change by supporting local communities and supportive civic organisations to create the conditions where any neighbourhood can identify, connect and mobilise its assets to the benefit of the whole community.

5.5.4 Airedale Care Home Vanguard is part of the national NHS England programme testing new ways of working. This particular initiative links care homes with local NHS

teams using tele-health to enhance the health and wellbeing of people living in care homes, add to the skills of care home teams and to reduce the emergency admission of care home residents into hospitals.

5.5.6 Accountable Care Programme Boards have been established for both AWC and Bradford to support and oversee the development of new ways of working. The accountable care programme boards are the groups where interaction between the component parts described above are understood and aligned, and where the balance is struck between neighbourhood level innovation and system wide governance.

Next Steps
• **Develop a clear vision and narrative on accountable care, tested with the public and agreed by partner organisations – by March 2018**
• **Agree a development plan towards accountable care which is owned by Health and Wellbeing Board and agreed by all boards of partner organisations – by June 2018**

5.6 Wider system collaboration – West Yorkshire

Most of our collaborative work is focused locally on AWC and Bradford as a largely self sufficient system. Not all needs can be met at the local level though, and there are some opportunities where it makes most sense to work with partners across a wider area e.g. for highly specialised services where resources are shared, and where great ideas can be shared between neighbouring towns and cities for everyone's benefit.

We do this through two main routes. We participate in the West Yorkshire Combined Authority and in the West Yorkshire and Harrogate Health and Care Partnership (formerly the West Yorkshire and Harrogate Sustainability and Transformation Partnership)

5.6.1 West Yorkshire and Harrogate Health and Care Partnership (HCP) is one of 44 sustainability and transformation partnerships nationally. It brings together the health and care partners across West Yorkshire and Harrogate to achieve the 'triple aim'. Our vision as a Partnership is for everyone to have the best possible outcomes for their health and wellbeing. You can read more here. Bradford District and Craven is one of six 'places' that make up the West Yorkshire and Harrogate Partnership. Work is undertaken through a mixture of local place based plans (such as this document) and West Yorkshire and Harrogate-wide programmes where it makes sense to collaborate at scale. As a place based system within the Health and Care Partnership we focus on prevention of ill health, early help and timely support, plus the creation of networks of community primary and social care provision. Working with our partners across West Yorkshire we focus on priorities including mental health, cancer and stroke.

Our commitments as a West Yorkshire and Harrogate Health and Care Partnership include;

Mental Health: Reduce by 40% the number of people experiencing a mental health crisis that attend A&E, by working with people to put in place personalised plans and by

providing alternatives such as the Haven and the First Response service which offers mental health crisis support 24 hours a day, seven days a week, to vulnerable people needing urgent crisis support. A single phone number means that people can self-refer.

Collaborating to secure national capital funding to develop a new CAMHS inpatient facility that will increase beds regionally from 8 to 22. This will allow us to provide care closer to home and by taking responsibility for commissioning budgets and care navigation that is currently managed at a Yorkshire and Humber level we hope to use resources more efficiently and use those resources to develop new community pathways.

Look to establish a single approach to commissioning adult acute inpatient beds that mean we make best use of our beds at WY&H level and mean people receive care as close to home as possible

Eliminate all out of area placements for Mental Health by 2020 through collaboration between providers and commissioners to develop new local community and inpatient services e.g. long stay rehabilitation

We are taking a zero suicide approach to prevention (with an aspiration of 10% reduction in suicides overall, and a 75% reduction in numbers in mental health settings by 2020-21)

Cancer: The Cancer Alliance of the Health and Care Partnership has successfully attracted investment of £900,000 from the national Cancer Transformation Fund and will use this support us locally to achieve better outcomes for people in Bradford at risk of/ diagnosed with lung cancer. Together we will help more people to stop smoking; raise awareness to encourage more people to seek advice for symptoms that may be linked to lung cancer; increase the number of people who are scanned and diagnosed early; and improve the speed at which people can access treatment. By taking these actions together we will save lives, improve quality of life and make best use of our resources.

Across West Yorkshire and Harrogate this will;

- Reduce adult smoking rates from 18.6% to 13%, resulting in around 125,000 fewer smokers and preventing around 11,250 admissions to hospital
- Increase 1 year cancer survival from 69.7% to 75%
- Increase the proportion of cancers diagnosed early (stages 1 and 2) from 40% to 62%, offering 3,000 extra people the chance of curative or life extending treatment.
- Improve the patient's care journey delivering a '28 day to diagnosis' standard for 95% of people investigated for cancer symptoms. This means faster diagnosis for around 5,000 people.
- Deliver estimated efficiency savings of up to £12 million over 5 years based on lower treatment costs associated with earlier stage diagnosis for many forms of cancer.

Stroke is a life changing event and is the third highest single cause of death in the UK. Evidence shows the care people receive in the first few hours can make a difference to how well they recover. We are working together to make sure everyone has access to the best treatment, and we are ensuring that all parts of the stroke pathway work together effectively for people. By doing this we will;

- Prevent more strokes; by consistently providing people with information and advice to make informed decisions about their health, and improving the detection and management of Atrial Fibrillation (erratic heartbeat) to 89%. This will save 190 strokes over 3 years.
- Reduce variation – so that no matter where people live and what time of day they are admitted to hospital, they are able to receive high quality stroke services.
- Improve use of technology - so that health care professionals can provide earlier assessment and treatment of people, and provide improved access to specialist technology, which we know can save lives.
- Stroke rehab and aftercare - improve health outcomes from prevention to specialist treatment to rehabilitation and after care.

Smoking: We want to see a reduction of 125,000 smokers. Recent figures show we have reduced this to 23,300 fewer smokers in 2015/2106. Using recent work by the Healthy London Partnerships on prevention and savings, this reduction will give £17.1m of healthcare savings over the next five years. This is good progress overall but masks differences across our area.

Alcohol: Tackling alcohol and substance abuse related harm; including those attending hospital, as well as a focus on early prevention are part of our plan. This requires a joined up approach with all partners and highlights the importance of balancing different people's circumstances and needs within budget constraints.

Diabetes: We are applying the National Diabetes Prevention Programme to reduce the numbers of people at high risk of becoming diabetic. This programme provides education on healthy eating and physical exercise programmes to support people to lose weight – a key risk factor for type 2 diabetes. Locally we have already started to implement this through the Bradford Beating Diabetes programme.

There are 226,000 people at risk of diabetes in West Yorkshire and Harrogate. Our aspiration is that 50% of these are offered diabetes prevention support, with a 50% success rate. We have secured diabetes transformation money of £2.7m to help us do this.

Developing our partnership: In the next year the West Yorkshire and Harrogate HCP will work with NHS England and central government towards being recognised as an accountable care system. This will allow greater autonomy and potentially access to some transformational funding in return for commitments to accelerate our achievement of key quality and efficiency indicators. It will be necessary to demonstrate the robustness of our partnership governance arrangements, to demonstrate a track record of improvement, and to show a clear plan for the future in order to earn this autonomy.

Next Steps
• **Continue to build our 'accountable care partnership' within the emerging West Yorkshire and Harrogate 'accountable care system'**
• **Work with the Cancer Alliance to deliver additional action to reduce lung cancer and to enhance access to treatment – starting 2018**

5.6.2 West Yorkshire Combined Authority is a grouping of local authorities, chaired by the leader of City of Bradford MDC. It enables joined up solutions to be developed for common issues. This includes ensuring that the full range of policies and interventions that local authorities make are aligned to the goal of improving health. For example policies on housing and economic growth. We will also use this route to help Health and Wellbeing Boards and Overview and Scrutiny Committees shape the development of accountable care across the region.

6. Improving use of resources

The challenges posed by limited resources and increasing demand for health and care services are significant and increasing. Increasing productivity and efficiency is necessary but not sufficient. In addition we must use resources differently to enable people to create health.

We may not be able to determine the quantum of resource available, but we can maximise our impact by deciding together how we will use our total resource.

In this section we need to cover:

- Out put of finance directors shared planning work
    - 17/18 year end forecast – and change from plan (& why changed)
    - 18/19 (and subsequent years) plan for income, expenditure and efficiencies
    - Impact of efficiencies – on people, on each organisation, and plans to mitigate impact
    - Testing feasibility of delivery with service providers and change programmes
- Principles and commitments
    - The money we have individually is viewed collectively for the people of BD&C
    - Spend to maximise outcomes
    - Prevention and early intervention
    - Focus on children – biggest impact
    - Third sector investment
    - Collective decision making (shared, aligned etc)
    - Efficient and effective support resources
    - Collaboration before competition
- Aligning commissioning – ECB development
- Aligning incentives in contracts - common outcomes

- Stabilising and securing the VCS
- Payment mechanisms and risk share

Next Steps
• **Share major change and efficiency proposals, and test impact on people and on other organisations – by December 2017**
• **Agree a system wide view of use of resources for 2018/19 – by March 2018**
• **Hard-wire partnership commitments into organisational business plans for 2018/19 – by March 2018**

7. Supporting change

Our purpose remains consistent; for people to be happy, healthy and at home. To succeed the ways in which we work with people must change significantly, and this transformation requires support and expertise.

This section describes how we will support transformation through our approach to system leadership and our expert enabling functions.

7.1 System Leadership and Development

The Health and Wellbeing Board (HWB) is the partnership forum established by statute to bring together leaders of local health and care organisations to work together to improve health and wellbeing. It owns this plan, the Health and Wellbeing Strategy, and the Joint Strategic Needs Assessment.

The Health and Social Care Overview and Scrutiny Committee (OSC) is responsible for scrutinising the Council's plans and services related to health and care. It also scrutinises local NHS policy and planning, and the impact that these have in meeting local needs and reducing health inequalities. OSC will scrutinise this plan and its delivery.

The Integration and Change Board (ICB) leads the development of this plan and its delivery through linked programmes and actions taken by partner organisations. The members of ICB are visible leaders of system change and delivery, role-modelling the values and behaviours needed to achieve our shared vision.

ICB will support and oversee the delivery of the plan by the accountable care programme boards and the enabling programmes described below. There will be a focus on

- clarifying the vision and engaging people
- creating the right conditions for change across systems, as well as within organisations
- supporting delivery through resource allocation, alignment of effort, removal of unnecessary bureaucracy, and holding to account.

In addition each partner organisation will 'hard-wire' the relevant aspects of this plan into their organisational business plans and ensure their teams are clear on the part they play in contributing to the vision.

Next Steps
• **Implement a 'System Development' (OD) plan based on principles embodied in 'Building Collaborative Places' and 'Transforming Together' – plan drafted by February 2018**
• **Clarify and align the contributions of programmes linked to ICB, ensuring delivery aligned to purpose and vision – by May 2018**
• **Align partnership resources to the achievement of this plan, and clarify 'virtual team' arrangements – by March 2018**

7.2 Enabling Programmes and Networks

To support a sustainable transformation we recognise that there are some key enabling factors that we must attend to. The ICB already has a number of enabling work streams, and this section describes what they do, and how we will support them in the future.

All of the enabling work streams draw together expertise from across our system into a virtual team. We now need to support the enablers to engage with the delivery programmes to inspire them by demonstrating the 'art of the possible', and listen and translate the operational plans of the delivery programmes into clear requirements that shape the focus of each enabler.

Our enabling programmes are;

7.2.1 Integrated Workforce Programme This enabling programme has refined its focus through repeated engagement with a wide range of stakeholders. It has four priorities:

- **Attracting and recruiting the future workforce by encouraging young people and new entrants to work in health and care. This includes** developing a health and care Industrial Centre of Excellence (ICE) for 14-16 year olds, shared apprenticeships programmes and a wide range of volunteering opportunities. An ICE provides industry led programmes for 14-16 year olds who want to learn skills, gain experience and develop a career in a particular sector. The development of a health and care ICE in the Bradford District aims to build strong and lasting partnerships between employers, schools, colleges and universities; creating career pathways that will transform the way young people think about working in health and care and developing the skills required by in the system. The ICE programmes provide a platform for apprenticeships, routes into further and higher education and professional training.
- **Developing our staff together** : . Sharing resources, and creating and delivering system wide learning and development opportunities including passports' for stat/mandatory training, joint leadership programmes and collaborative learning opportunities and system wide career pathways.

- **Improve Integration across sectors**: Developing a common set of values /behaviours for the system and applying these from recruitment through to day to day working.
- **Creating the conditions to retain staff across the system** : Engaging, listening and involving staff across the system. Promoting mental and physical health and well-being and supporting healthier lifestyles.

In addition this enabling programme influences the development of regional workforce plans through the LWAB and the West Yorkshire Health and Care Partnership workforce strategy. Key areas identified for regional collaboration include;

- Sharing the learning eg the Bradford ICE and the Leeds National Skills Academy Centre of Excellence Project
- The commissioning and provision of specialised training. Specifically, where economies of scale offer better value for money
- Supporting the development of new roles by collectively influencing the appropriate regulatory bodies

7.2.2 Digital 2020 Programme We have a wealth of digital expertise and opportunity in Bradford District and Craven. The support of the University and the Digital Health Enterprise Zone are key assets, as is the renowned development of tele-health solutions led by Airedale FT. Drawing upon this and the skills of all local health and care partners this enabling programme will focus on the following;

- A shared care record across health and care including voluntary and community sector organisations that are integral to local neighbourhood teams
- Innovations in digital service delivery. This will build upon the existing successful use of telehealth and mobile applications in our local care and health delivery.
- Solutions for smart sharing of information that puts people in control, keeps their information secure, and lets people choose what to share with each local organisation.
- Development of business intelligence and analytical capabilities that meet the needs of a joined up health and care system. This includes making sure that;
    - Every clinical/social care conversation with a person is supported by the right technology and information, for safety, effectiveness and to enhance people's experience, including initiatives to support agile working and remote access to systems
    - All neighbourhood teams have access to information that shows which people are at risk of becoming more unwell, and they are able to respond together in a timely way
    - Across the whole system we can see the impact that our health and care services have had on the health of the local population; and we can take

informed decisions about where to spend more or less in future to have the greatest impact on people's health.

In common with the other enablers the Digital 2020 programme will engage with the accountable care programme boards, their delivery programmes, and with the public to ensure that their needs are understood and form the basis of user requirements for the digital solutions that are provided. In addition the Digital 2020 group will identify areas of synergy between local partners and act on them e.g. reciprocal wi-fi, and shared infrastructure and IT services

7.2.3 Strategic Estates Programme The way we use our buildings is critical to the delivery of new ways of working, such as community teams reviewing risks together and responding in a joined up way to coordinate their visits to peoples homes. This means that one of the key priorities for this enabler work stream is to engage with the accountable care programme boards and their delivery programmes to understand the future clinical and operational models. The service strategy will drive the development of an estates strategy that supports the neighbourhood and locality hub approach.

The estates strategy will also contribute to the triple aim through the effective use of resources. We can achieve this by better utilisation of properties, more efficient operation, and more shared use of estate. In turn these measures will allow us to reduce the number of buildings we collectively use, and direct a greater proportion of our resource into people and services. The estates strategy will be developed by summer 2018.

This programme will also act opportunistically where there is potential to advance strategic aims. In the next year we will explore potential for the following:

- Keighley public service hub
- Eccleshill hub
- Girlington wellness centre

7.2.4 Self Care and Prevention Programme This programme helps ensure that we focus on what people can do, rather than what they can't. It does this by working with programmes and services to embed the principles of self care and prevention. It also directly delivers specific interventions to create more capacity for self care. The key principles are;

- Be person centred not service centred
- Increase peoples independence and maintain their dignity
- Work with people and communities, sharing responsibility for improvement
- Stop issues starting, and detect issues early to take action

Through this enabling programme we aim to ensure that

- People feel confident, resourceful and able to manage their own health and wellbeing, with support when they need and want it
- The health and care workforce has the tools, skills and attitude needed to work with people as partners in their care, taking a strength based approach
- Organisations across Bradford District and Craven support self care and prevention by prioritising it in their policies and plans

We achieve these aims through the following delivery projects:

Workforce Development: to train health and care staff to support people to self care including taking decisions about their health and care. We have already trained over 10% of the health and care workforce in ways of supporting self care and prevention. In the next year the Programme will continue to build upon this.

Community Connectors: a new social prescribing service has been launched in Bradford to deliver social, emotional and practical support to people referred through primary care. In 2017, HALE and partners have supported over 700 people to improve their wellbeing through one to one sessions using motivational interviewing techniques. We will be extending this service in 2018 and linking with the new Primary Care Home model.

Children and Young People: Working in partnership with health visitors and children's centres, we have commissioned a new education programme to empower and support parents to manage children's minor ailments. We have also developed a new resource to support frontline workers to promote self care for small children and their families. Next year we will develop a programme to deliver self care in schools.

Stakeholder and Culture: From January 2018, Engaging People will be working with people in communities to raise awareness and understand barriers to self care.

Tools and Resources: A number of tools and resources to support self care have been developed and will be promoted across the health and care partnership following consideration of stakeholder needs.

Prevention: This project focuses on integrating key and consistent messages regarding primary, secondary and tertiary prevention into existing health and care practices, and also on maximising the effectiveness and reach of commissioned prevention services such as Stop Smoking services.

7.2.5 Networks In addition to our enabler programmes a key feature of our approach is to support the development of networks across our partnership. Networks may have a more fluid membership and a non-hierarchical approach. We will foster the development of networks between people working on change, organisational development, engagement and communication. These will all be critical to success and will need to draw upon the collective expertise of the system.

Next Steps
• Facilitate engagement between enabler programmes and between enablers and delivery programmes – by January 2018 then on-going
• Agree contributions and resources with all enablers – by February '18
• Establish networks for system development, change, engagement and communications – by February 2018 then on-going

7.3 Maximising Strengths

The AWC and Bradford health and care system has many assets – some of which are unique. The strength of the local research base is one such asset. By working together we can achieve more for people and create a health and care system that systematically contributes to and applies learning from research – so we are always improving. These unique assets also form part of our narrative for policy makers and employers which helps us attract external investment.

7.3.1 Born in Bradford (BiB) is a study following the lives of children and their families who were born in the city between 2007 and 2011. Around 12,500 families and almost 30,000 citizens have chosen to take part. Detailed information has been collected about social, economic, lifestyle, and cultural factors, and about physical and mental health; biological samples such as blood are available from mothers, babies and children; and GP, hospital and local authority data have been linked, allowing researchers to measure associations between things such as health, wealth, education, lifestyle, and the environment. Since the study began researchers have identified important reasons for differences in birth size, child growth patterns, obesity and early risk factors for disease in Bradford's children. These early life differences continue into adulthood, contributing to the much higher rates of diabetes and heart disease in the city compared to the average across the rest of England.

7.3.2 Better Start Bradford (BSB) is a £49m ten year Big Lottery funded partnership programme aiming to test what works in improving outcomes for children. With a particular focus on nutrition and early social, emotional and language development, it delivers maternity and early years interventions in three Bradford wards with high levels of ethnic diversity and deprivation. It is working closely with parents, communities and local providers to ensure effective implementation and with BIB to gain insight from the world's first experimental birth cohort, and provide a centre for evaluation of cutting-edge early years interventions.

7.3.3 Active Bradford The Active Bradford Partnership has recently made a bid to Sport England to take part in an exciting multi-year initiative (2017 – 2021, £130 million shared across 12 places in England) to change the physical activity levels of children and young people aged 5-14. If successful this project aims to improve children and young peoples' physical health and mental wellbeing, individual development, quality of life and reduce health inequalities, through sport and activity. The programme also seeks to enhance social and community development and promote active citizenship. It will be co-produced

with communities, beginning with working to understand their needs, priorities, enablers, opportunities and assets; identifying and working with existing potential projects that meet the needs of the communities; and developing new innovations where there are gaps. The Active Bradford LDP includes an 'innovation hub', which will evaluate the interventions, allowing them to be modified where needed and informing commissioning decisions.

7.3.4 Well Bradford is a local programme which is part of the 'Well North' movement. It is hosted by Bradford Teaching Hospitals and supports community led action for health and wellbeing. Currently operating in Girlington, Well Bradford will expand and begin supporting community action in Holmewood and Keighley.

7.3.5 City of Research aims to help Bradford to be a city which discovers and uses research to provide the highest quality health, social and educational services and care, a place where everyone has quicker access to the latest treatments and programmes, where disease and problems are prevented as opposed to treated and where innovative ideas are turned into everyday practice. A new project called Connected Bradford is using data from 500 000 people across the city to redesign how services are delivered and improve access to them, their quality and efficiency. We want to expand on the knowledge and expertise in Born in Bradford, and are working towards a model where:

- Local citizens and organisations set the priorities for research in the city, they work together with researchers to find innovative solutions to problems, and then turn these solutions into everyday practice;
- Excellent health, social and educational practice from here and elsewhere is identified and put in place in Bradford;
- Every citizen of Bradford is invited to become involved in research;
- Every health, social, and education, organisation in Bradford is research active, evaluating their own practice services and using this evaluation to make changes;
- Findings from research are readily available for everyone to access easily;
- Research findings inform decisions about policy and how resources are used;
- Research findings are used by participants to improve their lives.

7.3.6 DHEZ the Digital Health Enterprise Zone is a £13 million public-private partnership between industry, local and national government, and academia, led by the University of Bradford and hosted at a state-of-the-art Digital Exchange.

7.3.7 Connected Bradford links routine pseudonymised data generated from primary care, secondary care, education and social care; and makes it available for research to drive innovation and improve healthcare delivery.

Next Steps
• **Develop clear narrative on local system assets and strengths and promote collectively via all communications channels**
• **Implement a collaborative approach to maximise the collective impact of all assets – including growing inward investment, and strengthening connectivity between local assets/ programmes**
• **Clarify how research, learning and innovation will improve outcomes**

8. Making a difference

This section describes how we will measure the difference our work makes for people and their health and wellbeing. It also describes how we will learn together and how we will plan for and respond to challenges along the way.

Section in development