

**Board of Directors:** 12.07.2018  
**Agenda Item:** Bo.7.18.6

**Report from the Chief Executive**  
**July 2018**

<b>Presented by:</b>	Professor Clive Kay, Chief Executive	<b>Author:</b>	Helen Haslam, Executive Officer to Chief Executive Officer
<b>Previously considered by:</b>	Not applicable		

<b>Key points</b>	<b>Purpose:</b>
<b>1. Visits and External Communications</b> <ul style="list-style-type: none"> <li>a. Care Quality Commission (CQC) Report into Bradford Teaching Hospitals NHS Foundation Trust.</li> <li>b. King's Fund Visit to West Yorkshire and Harrogate (WY&amp;H) Health and Care Partnership – Focus Session with WY&amp;H Cancer Alliance Leadership Team and System Leadership Executive Group – 27th June 2018.</li> <li>c. Communication from the Home Office - update on Citizens' rights and EU Settlement Scheme.</li> <li>d. NHS Improvement (NHSI) communication – reducing long stays in hospital to reduce patient harm and bed occupancy.</li> <li>e. NHS Providers 'On the Day briefing' <i>Health and Social Care Select Committee report Integrated care: organisations, partnerships and systems</i>.</li> <li>f. NHS Providers 'On the Day Briefing' 2017/18 Quarter 4 Finances and Performance.</li> <li>g. Lord Carter's Review into unwarranted variations in mental health and community health services.</li> <li>h. Care Quality Commission (CQC) Local Service Review Final Report.</li> <li>i. West Yorkshire and Harrogate (WY&amp;H) Cancer Alliance Board communication – Place-based Representation.</li> <li>j. Five-year funding settlement for the NHS.</li> <li>k. Local Health and Care Record Exemplar (LHCRE).</li> <li>l. Breast Screening National Screening Programme Incident Update.</li> <li>m. The Report of the Gosport Panel.</li> </ul>	To discuss and note
<b>2. Quality, Investment and Development</b> <ul style="list-style-type: none"> <li>a. Installation of New Computer Tomography (CT) Scanner.</li> </ul>	To discuss and note
<b>3. Workforce</b> <ul style="list-style-type: none"> <li>a. New consultants in post.</li> </ul>	To discuss and note
<b>4. Celebrating Success</b> <ul style="list-style-type: none"> <li>a. National Award for <i>Project Search</i>.</li> </ul>	To discuss and note

<b>Executive Summary:</b>
This paper outlines the key developments and occurrences from May and June 2018 that the Chief Executive wishes to discuss with the Board of Directors.

Board of Directors: 12.07.2018

Agenda Item: Bo.7.18.6

<b>Financial implications:</b>
No

<b>Regulatory relevance:</b>
------------------------------

<b>Monitor:</b>	Risk Assessment Framework
	Quality Governance Framework

<b>Equality Impact / Implications:</b>	<p><b>Is there likely to be any impact on any of the protected characteristics?</b> (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights)</p> <p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, what is the mitigation against this?</p>
--	---

<b>Other:</b>	
<b>Strategic Objective:</b>	To provide outstanding care for patients
<i>Reference to Strategic Objective(s) this paper relates to</i>	To deliver our financial plan and key performance targets
	To be in the top 20% of NHS employers
	To be a continually learning organisation
	To collaborate effectively with local and regional partners

## Report from the Chief Executive – July 2018

### 1. Visits and External Communications

#### a) **Care Quality Commission (CQC) Report into Bradford Teaching Hospitals NHS Foundation Trust.**

As the Board is aware, the 'next' phase of CQC regulation began in 2017 after a period of consultation, which resulted in a new operating model and the CQC inspection regime changed to a more frequent and targeted approach. Inspections are now targeted on a risk-based approach, and formally initiated with the issue of the Provider Information Request. However, the CQC can inspect a trust at any time in the year if they believe it to be necessary.

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

---

Bradford Teaching Hospitals NHS Foundation Trust's CQC report was published on the 15<sup>th</sup> June 2018, following an unannounced inspection in January 2018 and a 'Well-Led' inspection in February 2018. The CQC commented, *"Overall we found that care was patient centred and compassionate and we received positive feedback from the patients and relatives we spoke with. This demonstrates positive improvement since the last inspection....."*

The CQC inspection process and report has helpfully articulated and confirmed for us much of what we already knew about our services, and the quality of care we provide. However, as two of the services not inspected on this visit had elements of requires improvement, this has not allowed the hospital to raise its rating overall, and the trust remains rated as 'requires improvement'.

It is pleasing that the trust has achieved an overall rating in the 'Well-Led' domain as 'good'. This rating reflects an assessment of the leadership and governance at trust board, and executive team-level, the overall organisational vision and strategy, the organisation-wide governance, management, improvement, and organisational culture and levels of engagement.

It is clear, however, that we still have work to do across a number of our services. Maternity and medical services were both rated as requires improvement.

In summary, the trust was issued with 8 compliance actions and 41 recommendations. In addition, 22 optimising actions have been identified through the analysis of the report in detail. There is a separate paper to the Board of Directors describing the response to the compliance actions and recommendations.

**b) King's Fund Visit to West Yorkshire and Harrogate (WY&H) Health and Care Partnership – Focus Session with WY&H Cancer Alliance Leadership Team and System Leadership Executive Group – 27<sup>th</sup> June 2018.**

On 27th June 2018, Professor Sir Chris Ham, Chief Executive of the King's Fund and Professor Don Berwick, International Visiting Fellow at the Fund, attended focus sessions with the teams of West Yorkshire and Harrogate (WY&H) Health and Care Partnership's Cancer Alliance Leadership team and members of the System Leadership Executive Group (SLEG). I participated in both sessions, as Chair of the WY&H Cancer Alliance Board, and as a member of the SLEG.

The focus session was an opportunity for Chris and Don to converse with the system, and further understand the complex West Yorkshire and Harrogate Sustainability and Transformation Partnership (STP) in the NHS. The discussions centred around how a mutually accountable system might work using cancer as an example, and how to overcome barriers.

The session consisted of an overview of where the partnership was currently at, and the aspirations around mutual accountability.

**c) Communication from the Home Office - update on Citizens' rights and EU Settlement Scheme.**

On 21<sup>st</sup> June 2018, I received a letter on behalf of the Home Office from the Home Secretary Rt Hon Sajid Javid MP.

The letter provides details of the new scheme for EU citizens and their families, to allow them to continue living and working here after the UK leaves the EU.

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

---

A simple and straightforward scheme will be phased in later this year, and will gradually open more widely until its full launch by the end of March 2019, to enable EU citizens arriving before the end of 2020 to apply for their status. The publication includes the draft rules for the scheme, as well as confirming that:

- Applications will be via a short online process.
- Most EU citizens will only need to prove their identity and demonstrate their residence in the UK. They will be required to declare whether they have any criminal convictions and the Home Office will check that they are not a serious or persistent criminal.
- Applications will cost £65 and £32.50 for children under 16.
- Applications will be free for those with valid documented permanent residence or valid indefinite leave to remain or enter.

A range of user-friendly guidance and support, including a customer contact centre, will be in place when the scheme launches to help citizens through the process, and the Home Office is taking particular care that adequate support is in place for more vulnerable citizens.

The Immigration Rules for the scheme will be formally laid before Parliament later this summer, meanwhile, engagement will continue with stakeholders, including employers, local authority representatives and community groups, about the detailed design of the scheme.

EU citizens and their family members are not required to do anything now. There will be no change to their current rights until the end of the implementation period on 31 December 2020, and the deadline for applications to the scheme for those resident here by the end of 2020, will be 30 June 2021.

The trust has cascaded the information to staff, for their attention.

A copy of the letter is attached for your information at **Appendix 1**.

**d) NHS Improvement (NHSI) communication – reducing long stays in hospital to reduce patient harm and bed occupancy.**

On the 13<sup>th</sup> June 2018, I received a letter from Pauline Philip, National Director of Urgent and Emergency Care for NHSI with regards to reducing long stays in hospital to reduce patient harm and bed occupancy.

The letter thanked colleagues for their continued work ensuring sufficient capacity to deliver elective and emergency care performance and prepare for winter, and to announce a new national ambition to lower bed occupancy by reducing the number of long stay patients (and long stay beds) in acute hospitals by 25%, and asked acute trusts to work with system partners to deliver this ambition.

Tackling long stays in hospital will reduce the risk of patient harm, unwarranted cost, and improve our ability to deliver high quality services. This is why NHSI believe that the ambition to significantly reduce the number of long-stay patients in acute hospitals should be a top priority.

NHSI's ambition is to reduce the number of beds occupied by long stay patients by 25%, freeing up at least 4,000 beds compared to 2017/18. This capacity is required by December 2018.

In support of this ambition, NHSI are:

- sharing a summary of actions to be taken to deliver the ambition (Appendix 2, annex 2)
- publishing an improvement guide to support delivery

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

---

- shortly publishing the evidence base that shows A&E performance is significantly impacted by bed occupancy and the number of long stay patients in hospital
- inviting local system leadership teams to participate in a two-day change leaders programme focussed on how they can design and deliver the programme of interventions to deliver this ambition
- expanding and re-focussing the ECIST programme team to work in regions supporting you in delivering this ambition
- finalising technical guidance on the measurement of the ambition and dashboards to enable progress to be monitored
- following up with a further letter in a few weeks about other actions that should be taken to improve delivery for this winter

A copy of the letter, including annex 2, is attached for your information at **Appendix 2**.

**e) NHS Providers 'On the Day Briefing' *Health and Social Care Select Committee report Integrated care: organisations, partnerships and systems.***

On 11th June 2018, I received the NHS Providers 'On the Day Briefing' with regards to the *Health and Social Care Select Committee Report Integrated Care: organisations, partnerships and systems*.

The briefing informed that the Health and Social Care Select Committee (the Committee) had published the report of its inquiry into 'the development of new integrated ways of planning and delivering local health and care services'. This timely inquiry focussed on the development of Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs) and Accountable Care Organisations (ACOs). The briefing also provided an overview of the Committee's key findings and recommendations.

Unusually, in addition to providing oral evidence to the inquiry, NHS England (NHSE) and NHS Improvement (NHSI) published a written submission to the Committee, which effectively summarised the shift in national policy focus from competition to collaboration.

Summary of key recommendations

- The Government and the NHS must improve how they communicate NHS reforms to the public, making the case for change in the health service, clearly and persuasively.
- The Department of Health and Social Care (DHSC) and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The law would need to change to enable the structural integration of health and care.
- The national bodies should clearly define the outcomes they are seeking to achieve for patients by promoting more integrated care, and the criteria they will use to measure this.
- DHSC, NHS England (NHSE), NHS Improvement (NHSI), Health Education England (HEE), Public Health England (PHE) and Care Quality Commission (CQC), should develop a joint national transformation strategy setting out how they will support STPs and ICSs.
- STPs should be encouraged to adopt the principle of subsidiarity so that decisions are made at the most appropriate local level
- ACOs should be introduced in primary legislation as NHS bodies, if a decision is taken, following a careful evaluation of pilots, to extend their use. The national bodies must take proactive steps to dispel misleading assertions about the privatisation and Americanisation of the NHS including the publication of an annual assessment of private sector involvement in NHS care.
- The greatest risks to accelerating progress are the lack of funding and workforce capacity to design and implement change. The Government must recognise the importance of adequate transformation

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

and capital funding in enabling service change. The long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention.

A copy of the briefing is attached for your information at **Appendix 3**, and the report can be accessed via the web link at <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/65002.htm>

#### **f) NHS Providers 'On the Day Briefing' 2017/18 Quarter 4 Finances and Performance**

On the 31<sup>st</sup> May 2018, NHS Improvement (NHSI) released the quarter four (Q4) finance and operational performance figures for the provider sector. These figures cover the period 1<sup>st</sup> April 2017 to 31<sup>st</sup> March 2018. This briefing summarised the key headlines for those figures:

#### **Key headlines**

- The Q4 net deficit for the sector is £960m, compared to the £791m deficit reported at year end in 2016/17. At the beginning of the year the sector had planned for a £496m deficit.
- The year-end position represents an improvement on the £1.28bn actual deficit recorded at Q3, but a slight deterioration (£29m) on the £931m year-end forecast that quarter.
- The year-end outturn was £464m worse than the £496m planned deficit, set by NHS Improvement at the start of the financial year. Clinical Commissioning Groups (CCGs) finished the year £251m overspent, but the commissioning sector overall underspent by £955m due to NHS England central underspends.
- 102 (44%) of 234 trusts have ended the year in deficit, down from 139 at Q3; these were largely in the acute sector. Just under two thirds (89) of acute trusts finished the year in deficit, compared to only 13 ambulance, community, mental health and specialist providers. Results at Q4 last year showed a similar pattern. The deficit continued to be heavily concentrated in the acute sector, and is in part due to the unprecedented winter pressures faced by emergency departments. Winter demand also appeared to have impacted ambulance trust finances. Overspend in the CCG sector risks undermining necessary investment in community and mental health services.

#### **Key performance and workforce information at Q4**

- Around 5.34 million patients attended A&E departments during Q4, an increase of 3.4% (like for like) on the same period last year. Across the twelve months of the year, 21.88 million people attended A&E. NHS England data shows 84.97% of A&E patients were treated, admitted or discharged within four hours, although NHS Improvement's data shows trust performance at 83.53%. However, trusts treated more people within four hours this year compared to last. It is clear that there was a fundamental mismatch between demand and capacity over 2017/18.
- There were 6.26 million non-elective admissions across the year, which is 2.2% above plan and 3.5% more than the same period in 2016/ 17.
- The elective waiting list now stands at 3.84 million, a 2.9% increase compared to a year ago. However when taking into account non-reporting trusts, the total waiting list is likely to stand at around 4.1 million. Referral-to-treatment (RTT) performance was 87.2%, down from 88.2% at Q3, and 90% for Q4 2016/17. The number of patients waiting longer than 52 weeks has also increased, up by 75% compared to the same period last year. The continued slippage of performance against waiting time targets is a symptom of the capacity constraints across the system.
- Only one of the six new ambulance performance targets were met. This was for Category 1 calls, 90<sup>th</sup> percentile under 15 minutes.

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

---

- In terms of capacity, there were fewer general and acute beds at Q4 this year compared to the same period last year. In 2017/ 18 the sector ended the year with 101,326 beds, whilst in 2016/17 the number was 101,827. The £337m winter funding was welcome, but NHS Improvement acknowledges "static bed supply, and the marked increase in postponed elective activity suggests this extra funding would have had a greater impact if it were received earlier in the year".
- There are around 92,694 vacancies within NHS trusts, which is about 8% of the total 1.1 m whole time equivalent workforce. Vacancies across the sector are driving spend on temporary staff. In terms of nursing vacancies, around 65% of posts are being filled with bank staff, with a further 35% filled with agency staff. The rates are highest in London (14.1%) and the South (10.9%). For medical vacancies, posts are being filled by a mix of bank (45%), and agency or locum staff (55%), with the midlands and east experiencing the highest vacancy rates (10.1 %).

A copy of the briefing is attached for your information at **Appendix 4**.

**g) Lord Carter's Review into unwarranted variations in mental health and community health services.**

On the 24<sup>th</sup> May 2018, Lord Carter's review into unwarranted variations in mental health and community health services was published.

Lord Carter's review identified unwarranted variation in the delivery of mental health and community health services, as well as the potential savings of nearly £1 billion that could be made in efficiencies by 2020/21.

Following Lord Carter's 2016 review into the operational productivity of acute non-specialists trusts, the mental health and community sectors requested a similar review into its services to help them understand that which good looks like.

The findings tell us that over the past 18 months, NHSI have worked closely with a cohort of mental health and community providers, to understand the services they deliver to patients, and the large areas of spend across both sectors.

Each provider demonstrated some areas where they are performing well, however, across mental health and community sectors there was still unwarranted variation which, if eliminated, could save the NHS nearly £1 billion in efficiencies by 2020/21.

A copy of the report is attached for your information at **Appendix 5**

**h) Care Quality Commission (CQC) Local Service Review Final Report.**

The Secretaries of State for Health and Social Care, and for Housing, Communities and Local Government requested that the CQC undertook a programme of targeted reviews of local authority areas. The purpose of the reviews was to understand how people (those over the age of 65) move through the health and social care system with a focus on the interfaces between services. The reviews are being carried out under Section 48 of the Health and Social Care Act 2008. This Act gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin their regular inspection activity. By exploring local area commissioning arrangements and how organisations work together to develop person-centred, coordinated care for people who use services, their families and carers, they are able to understand people's experience of care across the local area, and how improvements can be made.

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

---

The CQC Local System Review in Bradford was carried out from the 12<sup>th</sup> to 16<sup>th</sup> February 2018, and the CQC published the report on the 25th May 2018. The report is one of 20 local area reports produced as part of the local system reviews programme, and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review report describes what is working well in Bradford and identifies where there are opportunities for improving how the system works for patients using services.

Key findings included:

- There was a clear shared and agreed purpose, vision and strategy described in the Happy, Healthy at Home plan, which had been developed by the system.
- System leaders across health and social care were compassionate and caring. They were clear that the needs of the person sat at the heart of their strategy and vision.
- There was a defined system-wide governance arrangement that pulled the system together and a clear architecture for development and roll out of the transformation of services in line with the plan.
- There were good joined up interagency processes.
- Despite pressures on the workforce owing to difficulties around recruitment across health and social care, the workforce managed the flow through the system well and referrals, assessments and delivery of services were timely.
- People who lived in Bradford were supported to live in their own homes and their communities for as long as possible. They received holistic assessments of their care that took into account all of their social and health needs based around their strengths. Where possible, the provision of virtual wards meant that people could receive consultant-led medical care at home rather than in hospital.
- People did not have to stay in hospital longer than they needed to. There was good support to enable them to return home safely.

There were also some key areas of focus for the trust identified during the review, including the support for patients to administer their own medication whilst being cared for on a ward, the movement of patients between wards, especially during the night and optimisation of medicines management through the discharge process. All these areas are subject to internal review and actions required to address them are being identified.

A copy of the CQC Local System Review is attached for your information at **Appendix 6.**

**i) West Yorkshire and Harrogate (WY&H) Cancer Alliance Board communication – Place-based Representation.**

On 15<sup>th</sup> May 2018, the WY&H Cancer Alliance Board wrote to the relevant stake-holders explaining the agreement to restructure and strengthen the Cancer Alliance Board to enable it to set the strategic direction for cancer on behalf of the WY&H Health and Care Partnership. This direction includes taking responsibility for delivery of the WY&H Cancer Delivery Plan. The letter asks for a representative from the trust to be nominated as a member of the WY&H Alliance Board.

The reshaped Alliance Board will be responsible for:

- Recommending the overall objectives of the Alliance to the WY&H System Leadership Executive Group.

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

---

- Providing a mechanism for joint action and joint decision-making for those cancer-related issues that are best tackled at scale.
- Overseeing prioritisation, deployment and assurance of resources specifically allocated to the Alliance (core team allocation and cancer specific transformation funds).
- Supporting the development of robust local partnership arrangements in each place to deliver person centred, integrated care to people affected by cancer.
- Developing and implementing a mutual accountability framework for cancer which provides a single, consistent approach for assurance and accountability between alliance partners.
- Adopting an approach to making collective decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours for the Partnership, keeping improved patient outcomes and experience at the heart of decision-making.

Bradford Teaching Hospitals NHS Foundation trust have nominated Sandra Shannon, Chief Operating Officer/Deputy CEO to represent the trust on this Board, and Sandra will be attending future meetings to ensure that the trust has full involvement with the strategic direction of the Board.

A copy of the letter is attached for your information at **Appendix 7**.

**j) Five-year funding settlement for the NHS.**

On the 18<sup>th</sup> June 2018, the government announced a new five-year funding settlement for the NHS, giving the service real-terms growth of more than 3% for the next five years. In a major speech to outline the settlement (appendix 8), the Prime Minister also tasked the NHS with producing a 10-year plan to improve performance, specifically on cancer and mental health care, and unpick barriers to progress.

The key announcements are as follows:

- The government has announced a major new package of funding for the NHS covering the five financial years from 2019-20.
- The average annual uplift is 3.4 per cent per year above inflation – based on Office for Budget Responsibility projections.
- The funding is frontloaded, meaning the annual rates of growth are: 3.6%; 3.6%; 3.1%; 3.1%; 3.4%.
- This will equate to £20.5bn more revenue in real terms compared with 2018-19.
- A further £1.25bn has been found to deal with an increase in pensions costs associated with the new Agenda for Change pay deal.
- The funding is for the NHS England commissioning budget only. This means it does not include capital funding, public health, health education, or social care.
- In an appearance in front of the Public Accounts Committee, Simon Stevens, Chief Executive of NHS England (NHSE), said there was an explicit commitment from the government that the adult social care budget would be set to not put further pressure on the NHS.

**A 10 year plan**

- In return for the increase in funding, the NHS has been tasked to develop a 10-year plan, via an “assembly” convened by national leaders. The prime minister has emphasised that this should have strong clinical input.

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

---

The 10-year plan, which will likely be delivered by the autumn budget, should set out how the service intends to deliver major improvements in mental health and cancer care.

- Ministers may be considering legislative reform: the prime minister described the number of contracts held between NHS organisations as a “problem”, and said she wanted the service to suggest ways of breaking down any barriers that might hold up progress, including in the regulatory framework.
- The prime minister set out five priorities for the NHS: Putting the patient at the heart of how care is organised; a workforce empowered to deliver the NHS of the future; harnessing the power of innovation; a focus on prevention; and “true parity of care” between mental and physical health.
- The prime minister said she would like to see the 10-year plan set out ambitious “clinically defined access standards” for mental health.
- And, she said clinicians should confirm the NHS is focused on the right performance targets for both physical and mental health – indicating that ministers may be willing to reconsider key performance standards.

**k) Local Health and Care Record Exemplar (LHCRE).**

On Wednesday 27<sup>th</sup> June 2018, NHS England announced that Yorkshire and Humber had been successful in its bid to become a Local Health and Care Record Exemplar (LHCRE). This means our region will receive up to £7.5 million over two years, to put in place an electronic shared local health and care record that makes the relevant information about people instantly available to everyone involved in their care and support. After this initial phase, the shared care record’s aim is to support population health management. There were five regions selected across the country that will then be expected to both extend and connect together.

Work to deliver the programme will be led by the Yorkshire and Humber Digital Care Board that will be chaired by one of the STP/ICS leads and will include the other STP/ICS leads, and CEO representatives from the local government, NHS Trusts and CCG sectors.

The Yorkshire and Humber Care Record will be complemented by the work the trust is leading on to create shared diagnostic imaging via the Yorkshire Imaging Collaborative, and builds off the shared record already in place with Calderdale & Huddersfield Foundation Trust, and the multi-year work progressing the shared care record in Bradford, Airedale, Wharfedale and Craven.

**l) Breast Screening National Screening Programme Incident Update.**

In May 2018, the trust was notified that there had been an issue with the NHS Breast Screening Programme, which identified that some women had not been invited for their final screen between their 68th and 71st birthday. Bradford Teaching Hospitals NHS Foundation Trust was initially informed that the number of women affected by the incident within the trust’s Pennine Breast Screening (PBS) service totalled 4,652.

We were advised that all women aged 70-71 were to be appointed, and women aged 72-79 would have the option to self-refer for screening via the national helpline. There is the expectation that all women will be screened before 31<sup>st</sup> October 2018.

NHS England send bi-weekly updated guidance. PBS escalates any concerns and questions via the Public Health England (PHE) commissioning board.

**m) The Report of the Gosport Panel.**

The Report of the Gosport Panel, which undertook a review of the circumstances around the deaths of patients being cared for at the Gosport War Memorial Hospital between 1988 and 2000, was published on the 20<sup>th</sup> June 2018.

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

---

The trust is currently reviewing the implications of the report, however, has taken some immediate steps to ensure and assure that urgent queries from regulators and commissioners were addressed. To that end a survey was completed (as required by NHS Improvement), which demonstrated that the Graseby syringe drivers referenced in the report are not in use in this trust, and have not been since 2011.

A similar return was made to the Clinical Commissioning Group. The Quality Committee will receive a detailed review of the Report and a summary of any implications for the Trust.

## **2. Quality, Investment and Development**

### **a) Installation of New Computer Tomography (CT) Scanner.**

I am pleased to report our new CT scanner has been installed and is up and running in the CT scanning suite.

The £700,000 machine was installed and customised for the precise needs of the trust, and 12 of the trust's Radiology staff have been trained on the machine to ensure it is utilised to its maximum potential.

The scanner strengthens the scanning capabilities, as it produces a better quality image than previous models, and therefore is able to perform more complex scans, and also delivers lower radiation doses.

The machine can scan 320 slices at a time, producing extremely detailed images that provide a diagnosis to help guide a patient's care and treatment.

This is a great investment for the trust, to enable us to provide better patient care.

## **3. Workforce**

### **a) New consultants in post**

**Dr Simon Carr** joined the Trust on 6<sup>th</sup> June 2018 as a Consultant in Paediatric Otolaryngology, working two Programmed Activities (PAs). Dr Carr was previously a registrar at Doncaster Royal Infirmary in 2015, and later became a Locum Consultant here at Bradford Teaching Hospitals NHS Foundation Trust in 2016. He then left to obtain a fellowship in Toronto, Canada for 15 months. His fellowship involved Neurology and skull base surgery, and he also gained experience in complex paediatric cochlear implantation and management of paediatric airway.

**Dr Ahsan Syed** joined the Trust on 11<sup>th</sup> June 2018 as a Consultant in Acute and Renal Medicine.

Previously a Consultant at Hull and East Yorkshire Hospitals NHS Trust, Dr Syed has previously worked at Bradford Teaching Hospitals NHS Foundation Trust as a Consultant in acute medicine from 2014 to 2015. Dr Syed has also sat as Chair on a Task and Finish group for haemodialysis fistula care.

## **4. Celebrating Success**

### **a) National Award for *Project Search*.**

I am delighted to report that our *Project Search* team have deservedly received a top accolade in the Healthcare People Management Association (HPMA) Awards 2018.

**Board of Directors: 12.07.2018**

**Agenda Item: Bo.7.18.6**

---

*Project Search* here at the Trust helps to equip young people with learning difficulties with new skills, and aims to secure these individual's jobs and improved confidence. This is carried out through nine month in-house training and work experience, alongside systematic instruction and mentoring. Since the programme started in 2013, the Trust has supported 36 interns through the programme to graduation, and 26 of these have gained employment, with a success rate of over 70%, compared to the national employment rate of around 6% for people with learning difficulties.

The HPMA awards recognise and reward outstanding work in healthcare human resources management, and were presented at a ceremony in London. The judging panel were full of praise for the team, commenting that this trail-blazing project showed clear benefits over time and strong communications. The judges felt the team were very passionate about the individual stories of the young people they have helped.

I wish to congratulate the *Project Search* team on behalf of the Board for their success, and thank them for all their hard work.

The Board of Directors is asked to receive and note this report.

21 June 2018

Dear Chief Executive

### **Citizens' rights and EU Settlement Scheme – update**

Today the UK Government has published more details about the new scheme for EU citizens and their families, to allow them to continue living and working here as now after the UK leaves the EU. This is an important step in delivering the reciprocal agreement with the EU, which also guarantees the rights of UK nationals living in the EU. The agreement recognises the valuable contribution that EU citizens make to the UK, and that UK nationals make to the EU. We want EU citizens and their families who have made the UK their home to stay, and the process we are setting up will mean they can do so quickly and easily.

A simple and straightforward scheme will be phased in later this year, and will gradually open more widely until its full launch by the end of March 2019, to enable EU citizens arriving before the end of 2020 to apply for their status. Today's publication includes the draft Rules for the scheme, as well as confirming that:

- Applications will be via a short online process.
- Most EU citizens will only need to prove their identity and demonstrate their residence in the UK. They will be required to declare whether they have any criminal convictions and we will check that they are not a serious or persistent criminal.
- It will cost £65 and £32.50 for children under 16.
- It will be free for those with valid documented permanent residence or valid indefinite leave to remain or enter.

A range of user-friendly guidance and support, including a customer contact centre, will be in place when the scheme launches to help citizens through the process, and we are taking particular care that adequate support is in place for more vulnerable citizens.

The Immigration Rules for the scheme will be formally laid before Parliament later this summer and we will, meanwhile, continue to engage with stakeholders, including employers, local authority representatives and community groups, about the detailed design of the scheme.

You can read more about the scheme at [GOV.UK](https://www.gov.uk). Also, look out for communications tools which employers, service providers and networks can use to help keep EU citizens informed. We will be in touch with further information about this soon.

**EU citizens and their family members do not need to do anything now.** There will be no change to their current rights until the end of the implementation period on 31 December 2020, and the deadline for applications to the scheme for those resident here by the end of 2020 will be 30 June 2021.

We greatly appreciate your continued support in communicating about the scheme and providing reassurance to EU citizens. Please encourage EU citizens in your organisation and networks to visit [GOV.UK](https://www.gov.uk) and [sign up](#) to the UK Government email list to receive regular updates.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'S. Javid', with a small comma at the end.

**Rt Hon Sajid Javid MP**



To Chief executives acute trusts  
CCG Accountable officers  
STP leads

Copy Health and wellbeing board chairs  
Directors of adult social services  
Regional directors NHSE & NHSI  
Chief executives mental health and community trusts  
Members of the National Emergency Pressures Panel

13<sup>th</sup> June 2018

Dear colleague

### **Reducing long stays in hospital - to reduce patient harm and bed occupancy**

Thank you for your continued work to ensure that you have sufficient capacity to deliver elective and emergency care performance and prepare for winter. I am writing to announce a new national ambition to lower bed occupancy by reducing the number of long stay patients (and long stay bed days) in acute hospitals by 25% and to ask you to work with your system partners to deliver on this ambition. This needs to be delivered whilst holding and/or reducing the length of stay for all other patients, and reducing bed occupancy to manageable levels.

### **The opportunity to reduce the number of long-stay patients in hospital**

Nearly 350,000 patients spend more than three weeks in an acute hospital each year. Long stay patients account for 8% of admissions requiring an overnight stay and have an average length of stay of 40 days. Around one-fifth of beds are occupied by patients who have already been in hospital for more than three weeks.

Many of these patients are older people with reduced functional ability (frailty) and/or cognitive impairment (delirium or dementia), who deteriorate because they are in hospital. This is due to unnecessary waiting, sleep deprivation, increased risk of falls, increased likelihood of catching healthcare-associated infections and avoidable loss of muscle strength, leading to greater physical dependency (sometimes described as deconditioning). Hospital-related functional decline in older patients and the subsequent harm have poor consequences for many patients. A stay in hospital over 10 days leads to 10 years' muscle ageing for people most at risk. Repeat audits show that up to 50% of patients in hospital do not need to be in an acute bed and many could have avoided hospital admission altogether. Many of these are the people whose stay becomes longer, due to deconditioning and additional hospital acquired illness, infection and falls.

Congested hospitals struggle to deliver best care. By reducing the number of long stay patients in hospital we will collectively reduce bed occupancy to increase safe flow through the system, greatly improving the working and care environment, reducing A&E crowding and enabling patients to be treated consistently in the right bed by clinical teams with the right skills.

Tackling long stays in hospital will reduce risk of patient harm, unwarranted cost, and improve our ability to deliver high quality services. This is why we believe that the ambition to significantly reduce the number of long-stay patients in acute hospitals should be a top priority.

Our ambition is to reduce the number of beds occupied by long stay patients by 25%, freeing up at least 4,000 beds compared to 2017/18. This capacity is required by December 2018.

This initiative is important as providers and commissioners recently submitted plans for 2018/19 showing the NHS is expecting to increase activity and improve performance up to and during winter. These plans lack sufficient improvements in capacity, productivity or length of stay to give us confidence that they will be achieved. We recognise that most hospitals do not have the physical space or access to the nurse staffing to grow their bed base while maintaining a safe and productive care environment, so the NHS must have an unrelenting approach to reducing length of stay. Ian Dalton has recently written to acute trust chairs regarding the plans.

In supporting local systems to work together to deliver the ambition I enclose baselines for each acute trust, CCG and local authority on the number of beds occupied by long stay patients in 2017/18 and the corresponding ambitions to deliver a 25% reduction nationally (annex 1). The level of improvement expected from each system is based on the proportion of beds occupied by long stay patients, with the most challenged systems expected to make the greatest levels of improvement.

Achieving this will require concerted effort across the whole health and care leadership system: at least half the opportunity rests within the direct control of hospitals, and the remainder in joint working with GPs, local authorities, community health and social care providers and others.

We have not identified the specific local share of the contribution to come from acute, community and local authority sectors, this needs to be agreed locally. It is however imperative that all stakeholder recognise the need to reduce occupancy levels within acute trusts. Regions and STPs will play a critical role in supporting and monitoring delivery, and for local authorities that will be with the regional local government representatives.

The focus on reducing long stays in hospital will also need to be supported by a continued focus on reducing delayed transfers of care (DTOC). While progress was made in 2017/18 in reducing delays there is still further work to do to achieve the national ambition of no more than 4000 daily DTOC delays.

In support of this ambition we are:

- sharing a summary of actions to be taken to deliver the ambition (annex 2)
- publishing an improvement guide to support delivery
- shortly publishing the evidence base that shows A&E performance is significantly impacted by bed occupancy and the number of long stay patients in hospital
- inviting local system leadership teams to participate in a two-day change leaders programme focussed on how they can design and deliver the programme of interventions to deliver this ambition
- expanding and refocussing the ECIST programme team to work in regions supporting you in delivering this ambition
- finalising technical guidance on the measurement of the ambition and dashboards to enable progress to be monitored
- following up with a further letter in a few weeks about other actions that should be taken to improve delivery for this winter

You will remember the work generated last year by our difficulty in establishing how many beds were open and occupied. In too many hospitals bed managers are not using technology to manage beds and rely instead on telephone calls or walking around wards to find empty beds, meaning that patients wait for extended periods in emergency departments. In order to reduce the burden of reporting and, more importantly to support good bed management, we need every hospital to keep their PAS up to date in real time – admissions, discharges and internal patient transfers. This will enable the PAS or a connected system to provide a 'live' bed status.

In developing this length of stay ambition, we have modelled our approach on the successful work to significantly reduce healthcare-associated infections in the 2000s. It is strongly supported by the National Emergency Pressures Panel and is being co-developed with social care partners so that we ensure a timely return to the patient's own home for the vast majority of people.

Yours

A handwritten signature in dark ink, appearing to read 'Pauline Philip', with a stylized, cursive script.

**Pauline Philip**  
**National director of urgent and emergency care**

## **Annex 2 – actions to be taken to deliver the ambition**

### **How do you expect systems to deliver this?**

1. Delivering this ambition will require the same level of focus, grip and leadership as when the significant reductions in healthcare acquired infections were delivered a decade ago.
2. What will work in each local system will differ based on local circumstances but the key activities which are required to deliver this improvement will include;
  - whole system leadership and partnership working with a shared aim grounded in patient safety and avoiding harm;
  - long-stay patient reviews and multi agency discharge events to ensure whole system partnership working in delivering the overall ambition;
  - putting in place executive lead escalation arrangements working with senior leadership across health and social care systems to tackle blockages that can't be addressed locally or internally;
  - delivering the existing delayed transfer of care reduction ambitions;
  - 7 day working to reduce the variation between weekday and weekend non-elective discharge volumes from acute hospitals.
3. For acute trusts a focus on:
  - treating lengths of stay above best practice guidelines as a safety issue which need urgently addressing ;
  - getting and using accurate daily information on all long stay patients in hospital, supported by real time use of Patient Administration Systems used for bed management and to give automatic capacity and occupancy information;
  - work at the front door (and ideally before it), including ambulatory emergency care, therapy services and appropriate care pathways to avoid admissions for patients who do not require acute care in hospital and are at risk of deconditioning if they do. This will reduce the number of complex discharges;
  - routinely screening within 2 hours of presentation all older people (aged 75 and over) for their prior degree of frailty using a validated tool, their prior level of functional need and their present cognitive status. This data and clinical judgment should be used to identify within 72 hours of admission and pro-actively plan for discharge home of:

- those patients who are most vulnerable to hospital-associated de-conditioning and who are judged fit enough to be provided rehabilitation and recovery care in a community setting
  - those patients who require end of life care and for whom this can be provided in a community setting
  - trusts implementing processes so that patients who require admission for more than 72 hours are not moved from their admitting ward until discharge from hospital except where this is deemed necessary on clinical grounds by a senior clinician (equivalent ST3 level doctor or above);
  - ensuring that simple and timely discharges are optimised, including through criteria led discharge ;
  - work in the hospital to address bottlenecks and expedite discharges, including by implementing Red2Green and SAFER patient flow bundle systematically across ALL wards;
  - supporting hospital therapy, medical and nursing teams to identify and address inappropriate risk adversity which may be delaying assessment for , or leading to the requesting of excessive packages of community care;
  - work closely, supportively and continuously with community health and social care partners to expedite discharges from acute and community beds in order to ensure whole system flow;
  - ensuring effective Board accountability, including publishing monthly board reports on number of stranded (7 days or more) and long stay (21 days or more) patients delayed in hospital and the coded reasons for these delays.
4. For system partners in community and local government a focus on:
- delivering 100% access to extended GP services;
  - preventing unnecessary hospital admissions - the default should be that all care home residents with 'urgent' and 'less urgent' needs at risk of admission to hospital, first have a clinical assessment, through a GP, paramedic or other health professional based 'Hear & Treat'/'See & Treat' model;
  - ensuring that home and bed based intermediate care, crisis response and reablement should be available in all areas for step up care as an alternative to hospital admission as well as on discharge. These should be available to self funders as well as people needing council or NHS funded support;

- ensuring staff in hospitals have timely access to social care assessment staff and social care practitioners seven days a week, and that multi-disciplinary teams work together to make referrals and support discharge seven days a week;
- ensuring that all inpatients and their relatives, and in particular those who arrange and fund their own support, have access to information and advice in hospitals so that they can begin to make plans for discharge as soon as possible;
- offering a co-designed and mutually supported (by care providers) trusted assessment service for care homes, so that care home managers do not have to come into hospitals themselves and can rely on a trusted assessment in order to decide about potential admissions;
- home and bed based intermediate care, crisis response and reablement (for step up and step down care) should commence within 2 days of receiving the appropriate referrals. [NICE guidance (NG74) for bed based services extended to home based services to avoid a perverse incentive to refer patients to bed based services];
- care homes accept admissions (discharges from hospital) 7 days a week; for new residents until 5pm and returning residents up until 8pm;
- ensuring discharge to assess services are available in all areas, so that there is default expectation of home first, with increasing proportion of patients supported to return to their own home rather than going into long term care.
- An improvement guide on reducing long stays in hospital will be available at <https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays>

### **How will progress be measured?**

5. Technical guidance will be published in due course.
6. The ambition will be for each local system to deliver. Every acute trust will be required to report progress through their Board papers. A proposed dashboard for operational use and for Board reporting is being developed.
7. We encourage trusts to collect data frequently and regularly on their current inpatients, including their current length of stay, expected date of discharge, the number of patients 'who no longer require hospital care and are well enough for cared in a [named] community setting' and the reasons for patients still being in hospital. There are a number of tools and approaches to support this including use of Red2Green and number of stranded patients at 7, 14 and 21 days. Where trusts have significant performance challenges or are off track with their agreed improvement trajectory we may require additional reporting.

## Health and Social Care Select Committee report Integrated care: organisations, partnerships and systems

The Health and Social Care Select Committee (the Committee) has published the **report** of its inquiry into 'the development of new integrated ways of planning and delivering local health and care services'<sup>1</sup>. This timely inquiry focusses on the development of Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs) and Accountable Care Organisations (ACOs). This briefing provides an overview of the Committee's key findings and recommendations.

Unusually, in addition to providing oral evidence to the inquiry, NHS England (NHSE) and NHS Improvement (NHSI) published a **written submission** to the Committee, which effectively summarises the shift in national policy focus from competition to collaboration.

### Summary of key recommendations

- The Government and the NHS must improve how they communicate NHS reforms to the public, making the case for change in the health service, clearly and persuasively.
- The Department of Health and Social Care (DHSC) and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The law would need to change to enable the structural integration of health and care.
- The national bodies should clearly define the outcomes they are seeking to achieve for patients by promoting more integrated care, and the criteria they will use to measure this.
- DHSC, NHS England (NHSE), NHS Improvement (NHSI), Health Education England (HEE), Public Health England (PHE) and Care Quality Commission (CQC), should develop a joint national transformation strategy setting out how they will support STPs and ICSs.
- STPs should be encouraged to adopt the principle of subsidiarity so that decisions are made at the most appropriate local level
- ACOs should be introduced in primary legislation as NHS bodies, if a decision is taken, following a careful evaluation of pilots, to extend their use. The national bodies must take proactive steps to dispel misleading assertions about the privatisation and Americanisation of the NHS including the publication of an annual assessment of private sector involvement in NHS care.

---

<sup>1</sup> P.4 of the Committee's report

- The greatest risks to accelerating progress are the lack of funding and workforce capacity to design and implement change. The Government must recognise the importance of adequate transformation and capital funding in enabling service change. The long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention.

## Integrated care

The Committee found that more integrated care will improve patient experience, particularly for those with long-term conditions. However while it may reduce demand on hospital services, the Committee concluded there is a lack of evidence that integration, at least in the short term, saves money.

The Committee recommends that:

- DHSC, NHSE and NHSI clearly define what outcomes should be delivered from integrating care, from the patient's perspective, and the criteria they will use to measure this.
- Government should confirm whether it will meet its target to achieve integrated health and care across the country by 2020, as well as plans for 50% of the country to be covered by new care models.

## STPs and ICSs

### Sustainability and transformation partnerships

The Committee highlights the challenges which local bodies have faced in coming together through STPs to make very difficult decisions about changes to local health and care services within a very tight timeline. These challenges have been exacerbated in those areas without a history of collaborative working. In many STPs, proposals were not supported by robust evidence of population need or workforce plans.

The national bodies' initial mismanagement of the process, including misguided instructions not to share plans, made it very difficult for local areas to explain the case for change. Poor consultation, communication and financial constraints have fuelled concerns that STPs were secret plans and a vehicle for cuts.

The practical issues arising from STP boundaries have significantly affected progress so far. STP footprints with a smaller population, a smaller number of partners, boundaries that align with patient flows between services and coterminous organisational boundaries between partners tend to be further ahead.

STPs have become the vehicle for delivering national priorities and targets, improving financial management across the system and managing demands, particularly on acute care, despite the governance and infrastructure being fragile and in development. However the STP dashboard has no indicators to measure integration or the progress local areas have made in transforming care, such as progress made against their STP plans.

The Committee recommends that:

- STPs, particularly those with more complex geographical boundaries, should be supported to allow local areas to identify, define and develop meaningful boundaries within their patch in which local services can work together around the needs of the population.
- STPs should be encouraged to adopt the principle of subsidiarity in which decisions are made at the most appropriate local level. NHSE and NHSI should set out in their planning guidance for 2019/20 advice and support to achieve these recommendations.
- Although STPs provide a useful forum through which local bodies can come together in difficult circumstances to manage finite resources, they are not, the sole solution to the funding and workforce pressures on the system. The national bodies must not overburden STPs by increasingly making them the default footprint for the delivery of national policies.

## Integrated Care Systems

The Committee explored the achievements of the ICSs, and the challenges still facing them. The Committee recommends that:

- The national bodies, including the DHSC, NHSE, NHSI, HEE, PHE and CQC, develop a joint national transformation strategy setting out how national bodies will support STPs, at different stages of development, to progress to achieve integrated care system status. This strategy should:
  - set out how national bodies plan to support local areas to cultivate strong relationships;
  - strengthen the programme infrastructure of STPs;
  - consider whether, and how, support, resources and flexibilities currently available to ICSs could be rolled out to other help other areas;
  - develop a more sophisticated approach to assessing the performance of STPs and their readiness to progress to integrated care status. This should include an assessment of local community engagement, the strength of local relationships and the progress towards preventative and integrated care. An assessment of prevention should encompass a broader definition than preventing demands on hospitals and integration should focus on how to improve patients' experience and outcomes;
  - how they will judge whether an area is ready to be an ICS;
  - how they will support STP areas to become ICSs;
  - what they will do in areas that fail to meet the criteria or which will never meet the criteria;
  - how they will monitor the performance of existing ICS areas and provide support including the necessary funding to ensure they continue to make progress; and
  - how they will address serious performance problems in ICS areas.

## Accountable Care Organisations (ACOs)

The Committee reviewed the arguments for and against ACOs. It concludes that, rather than leading to increasing privatisation and charges for healthcare, the consequence of the introduction of ACOs is more likely be less competition and a diminution of the internal market and private sector involvement.

Given the controversy surrounding their introduction in the NHS, the Committee recommends that:

- ACO models should be piloted before being rolled-out. There should be an incremental approach to the introduction of ACOs, with areas choosing to go down this route carefully evaluated.
- If a decision is made to introduce ACOs more widely, they should be established in primary legislation as NHS bodies. This will require a fundamental revisiting of the Health and Social Care Act 2012 and other legislation. These organisations should have the freedom to involve, and contract with, non-statutory bodies where that is in the best interests of patients.
- The national bodies take proactive steps to dispel misleading assertions about the privatisation and Americanisation of NHS. The DHSC should publish an annual assessment of the extent of private sector in the NHS, including the value, number and percentage of contracts awarded to NHS, private providers, charities, social enterprises and community interest companies.

## The case for change

The Committee concludes that there has not been a sufficiently clear and compelling explanation of the direction of travel and the benefits of integration to patients and the public. It recommends that:

- The case for change must be made in a way that is meaningful to patients and local communities. The DHSC and national bodies should develop a narrative in collaboration with representatives of communities, NHS bodies, local government, national charities and patient groups and should explain how they plan to support efforts to engage and communicate with the public.
- NHSE and NHSI should make clear that they actively support local areas in communicating and co-designing service changes with local communities and elected representatives.

## Funding and workforce pressures

The Committee believes that funding and workforce pressures on NHS, social care and public health services present significant risks to the ability of the NHS to maintain standards of care, let alone to transform. The NHS and local government have not been given adequate investment, support and time to embark on the scale of transformation envisaged.

The Committee recommends that:

- Government's long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention.
- National and local bodies should develop an estimate of the transformation funding they require by looking at the experience of new care models and Greater Manchester. This should include an estimate of funding required in each area to provide staff with the capacity to engage in transformation, develop new skills and facilitate the double running of services.

## Oversight and regulation

The Committee reports there is a widespread perception of competing priorities between the key national bodies, particularly the DHSC, NHE, NHSI and the CQC and concludes that incoherence in the approach of national bodies is a key factor holding back progress. The Committee therefore welcomes the recent

announcement from NHSE and NHSI on how they will work more collaboratively and align priorities and processes. The Committee did not hear clear evidence about how the arms-length bodies, particularly NHSE and NHSI, are seeking to accelerate the scale-up and spread of transformative changes to the delivery of care, such as the new models of care.

The Committee recommends that:

- CQC and NHSI conduct a joint survey in one years' time to assess whether these commitments have made a tangible difference to those on the frontline.
- NHSE and NHSI undertake a review of the first cohort of ICSs in April 2019, including the level of financial support underpinning transformation, and make the key findings available to all STP areas.

The Committee requests:

- A joint response from the DHSC, NHSE, NHSI, HEE and CQC setting out how their roles, responsibilities, functions and policies support the factors that are critical to transformation and integrated care including skills and capacity of frontline staff; NHS leadership; financial incentives; infrastructure; and coherent oversight and regulation.

## Governance and legislation

The Committee has set out the main problems and challenges posed by the current legislation and views on legislative reform. It highlights that legal decision-making powers rest with the organisations involved rather than the STPs or ICSs. These constituent NHS and local government bodies have different legal duties and powers. For example, local councils are democratic institutions in their own right, and are unable to run a deficit, unlike NHS bodies.

The Committee is concerned that providers and commissioners are operating with significant risks to their governance and decision-making, as these arrangements increase the distance of decision-makers from the decisions they are taking. This approach is also time-consuming. The most limiting aspect of the existing framework are requirements covering CCGs' procurement of NHS services. There are also immediate legal obstacles that the Government and national bodies should seek to address to enable local areas to progress before primary legislation can be introduced, for example, differences in VAT exemptions covering NHS and local government.

- The Committee believes the law will need to change to enable greater collaboration and integration. The Department and NHSE should establish an advisory group, or groups, comprised of local leaders from across the country, including areas that are more advanced and those further behind, and representatives from the health and care community, to lead on and formulate legislative proposals to remove barriers to integrated care.
- Until legislation is introduced, national bodies should support local areas to develop transparent and effective governance arrangements that allow them to make progress within the current framework. National bodies should also provide greater clarity over what is permissible within current procurement law and develop support for local areas in working through these issues.

## NHS Providers' view

The Committee's report offers a valuable insight into the challenges, opportunities and complexities, facing providers and their partners as they seek to integrate health and care services. This is all the more pertinent as the NHS approaches its 70<sup>th</sup> birthday with the promise of a new funding settlement and a ten year plan for delivery.

We were pleased to engage with the Committee as it shaped its inquiry (including suggesting a number of trusts and local areas they chose to visit) and we are pleased that the committee has reflected many of the concerns we raised both in our [written submission](#) and during the oral evidence session.

We need a clearer strategy to support the move to integrated care. But as the Committee highlights, there is a growing tendency to pin performance and financial obligations on STPs, even though they lack the mandate, the means and the legal authority to deliver them. We are concerned that providers are operating with significant risks to their governance and decision-making and are pleased that the Committee has recommended that the national bodies provide more support for local areas on governance frameworks that allow them to make progress within the current legislation.

Our recent regulation survey demonstrated that NHS trusts do not feel the current direction of travel is clear and that considerable duplication and fragmentation persists among the national bodies. We believe that the Committee's recommendation for the national bodies to develop a joint national transformation strategy could play an important part in giving providers and their local partners a clearer, enabling framework within which to lead transformation programmes locally.

## Press statement

Saffron Cordery, Director of Policy and Strategy and Deputy Chief Executive said:

*"This is a valuable and timely report which reflects many of the concerns we raised with the committee.*

*"It highlights the growing tendency to pin performance and financial obligations on STPs, even though they lack the mandate, the means and the legal authority to deliver them.*

*"The report also helpfully identifies the conditions and characteristics required for closer integration, while recognising that some areas have been able to move ahead much more quickly than others.*

*"We agree with the committee that much of the debate around accountable care organisations (ACOs) has been confused and misleading.*

*"We need a clearer strategy to support the move to integrated care.*

*"The forthcoming long term funding settlement presents a good opportunity to invest in transforming the NHS, adapting it to meet the changing needs of local communities."*

## 2017/18 Quarter 4 finances and performance

NHS Improvement (NHSI) has released the **quarter four (Q4) finance and operational performance figures** for the provider sector. These figures cover the period 1 April 2017 to 31 March 2018. This briefing summarises the key headlines for those figures as well as our view on what they mean.

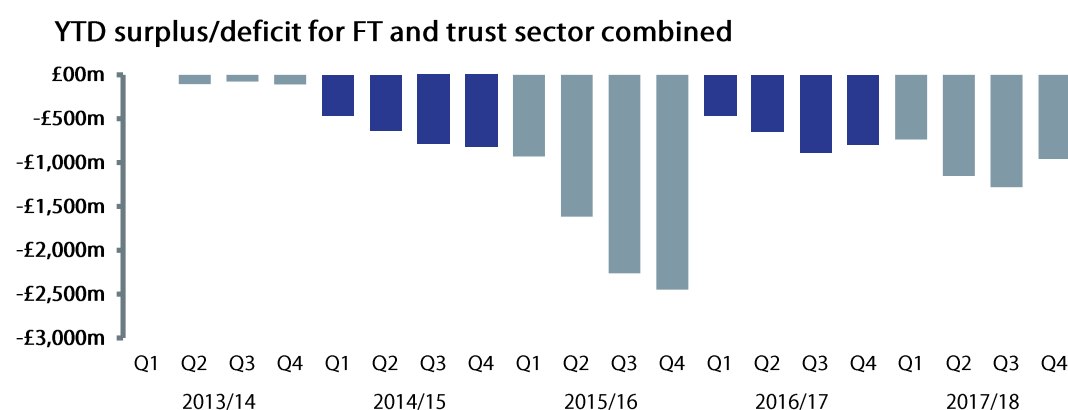
If you have any feedback or questions regarding any of the content in this briefing please contact: [David.Williams@NHSProviders.org](mailto:David.Williams@NHSProviders.org) or [Adam.Wright@NHSProviders.org](mailto:Adam.Wright@NHSProviders.org)

### Key headlines

- The Q4 net deficit for the sector is £960m, compared to the £791m deficit reported at year end in 2016/17 (figure 1). At the beginning of the year the sector had planned for a £496m deficit.
- The year end position represents an improvement on the £1.28bn actual deficit recorded at Q3, but a slight deterioration (£29m) on the £931m year end forecast that quarter.

FIGURE 1

Year to date surplus/deficit for NHS provider sector (£m)

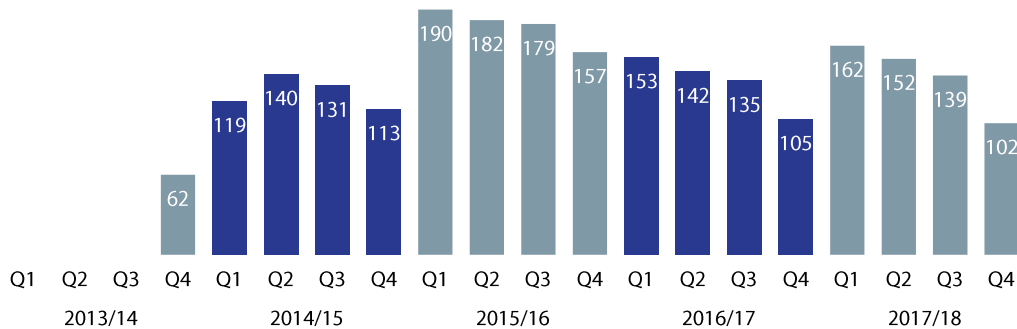


- The year end outturn was £464m worse than the £496m planned deficit, set by NHS Improvement at the start of the financial year. CCGs finished the year £251m overspent, but the commissioning sector overall underspent by £955m due to NHS England central underspends.
- 102 (44%) of 234 trusts have ended the year in deficit, down from 139 at Q3; these were largely in the acute sector. Just under two thirds (89) of acute trusts finished the year in deficit, compared to only 13 ambulance, community, mental health and specialist providers. Results at Q4 last year showed a similar pattern. The deficit continues to be heavily concentrated in the acute sector is in part due to the unprecedented winter pressures faced by emergency departments. Winter demand also appears to

have impacted ambulance trust finances. The overspend in the CCG sector risks undermining necessary investment in community and mental health services.

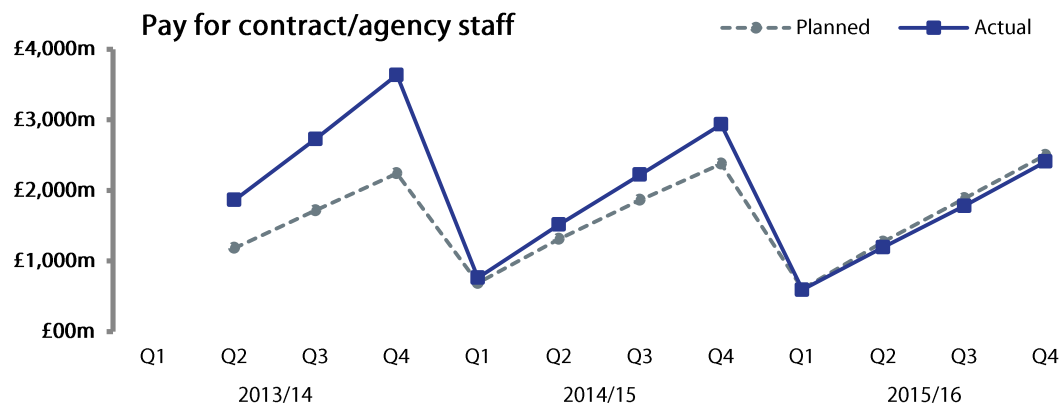
FIGURE 2

### Number of providers in deficit



- The larger than planned deficit was mainly driven by:
  - **Under delivery of planned efficiency savings.** Trusts delivered Cost Improvement Plans (CIPs) worth £3.2bn in total, but this was £477m under plan. The largest under-delivery was in savings related to pay, with a £521m shortfall.
  - **Unprecedented winter pressures.** A&E attendances increased by 3.4% compared with Q4 last year. Elective income across the trust sector was £358m under plan at year end, with less lucrative non elective activity up by 3.8%. A contributing factor was the National Emergency Pressures Panel's recommendation to postpone planned operations, which is estimated to have reduced elective activity by around 22,800 admissions over the course of winter.
  - **Overspend on pay costs.** At year end trusts overspent on employee costs by £1.49bn, and overall spend increased by 1.2% in real terms on 2016/17 levels. The sector overspent on bank staff by £976m. However thanks to the continued success in reducing spend on agency workers (down 18% on last year), the overall spend on temporary staff decreased by £67m, or 1.2%. Given the widespread workforce shortages across all sectors, this demonstrates the hard work trusts have made this year in continuing to reduce their temporary staffing costs.
  - **Overspend on non-pay costs.** Spend on non-pay items significantly increased during the last quarter, with trusts ending the year £681m overspent. The main causes were overspends in clinical and general supplies and services (£203m), purchase of healthcare from other providers (£278m, of which £173m was spent with non-NHS bodies), and spend on premises (£105m). Following the publication of the community and mental health operational productivity review earlier this month, NHS Improvement will be asking all trusts to tackle non-pay costs.

FIGURE 3



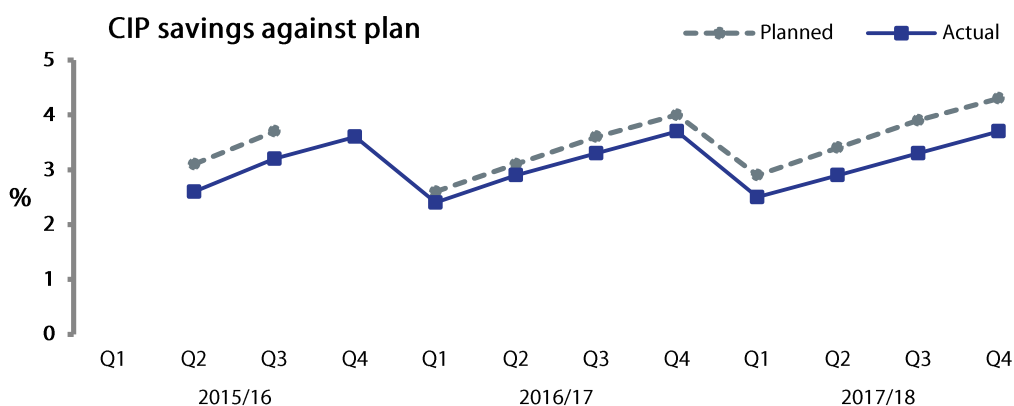
## Other key finance data at Q4

- Trusts received £1.78bn in STF payments throughout the year. NHS Improvement distributed £824m through the core element, £350m through the pound for pound incentive scheme, £199m through the bonus scheme and for the first time £410m was allocated via the general distribution. Around £17m of the original STF envelope has been withheld from trusts. Of this, £10m will eventually be distributed to providers between draft and final accounts, while £7.3m has been diverted to the Getting It Right First Time (GIRFT) programme. It is not clear exactly how this funding for the GIRFT programme has been used to support the sector.
- 22 trusts did not sign up to control totals in 2017/18 and subsequently did not receive any STF funding throughout the year.
- Ambulance, community and mental health trusts received £72m more in STF compared to last year. Acute trusts received around £355m of STF in the year-end general distribution, which represents 27% of the total STF funds distributed to the sector. While we welcomed the fact that this funding was distributed across the sector, we were concerned at how late the additional funds were communicated to the sector.
- Of the £337m winter funding announced by the chancellor at the last Autumn Budget, around £50m has been held back by NHS England. The Q4 report states that £25m of that has been included in NHS England's accounts, but the same sum has also been reflected in the revised position for the provider sector. It is not clear how this £25m has been used, given it appears to have been included in both NHS England finances and provider income.
- Capital expenditure was £3bn, which represents an underspend against plan of £1.3bn. The underspend grew by £256m in the final quarter. The report notes there is no mechanism for the return of this funding in 2018/19. We know there are ongoing concerns about the way in which the capital regime currently works for the sector, and are engaging in the Department's capital review.
- Total CIP delivery was £3.2bn (figure 4), £110m more than what was delivered in 2016/17. Trusts are increasingly relying on non recurrent savings (which now account for 26% of the total delivered), and under delivered on planned recurrent savings by £1bn. Recurrent savings represented 2.73% of total spend, down 2.75% on last year.

- The implied productivity for the year was 1.2%, which is significantly better than the wider UK economy. However NHS Improvement makes clear this level of productivity is unsustainable in the long run given the increasing reliance on non recurrent savings.
- Financial penalties imposed on trusts by commissioners continue to fall, and now stand at around £40m nationally. However impact of the marginal rate emergency tariff continues to have an impact on acute trusts, with £338m being withheld (up £70m on 2016/17) with only £15m reinvested in demand management schemes.

FIGURE 4

### Forecast CIP savings against plan



### Key performance and workforce information at Q4

- Around 5.34 million patients attended A&E departments during Q4, an increase of 3.4% (like for like) on the same period last year. Across the twelve months of the year, 21.88 million people attended A&E. NHS England data shows 84.97% of A&E patients were treated, admitted or discharged within four hours, although NHS Improvement's data shows trust performance at 83.53%. However trusts treated more people within four hours this year compared to last. It is clear that there was a fundamental mismatch between demand and capacity over 2017/18.
- There were 6.26 million non elective admissions across the year, which is 2.2% above plan and 3.5% more than the same period in 2016/17.
- The elective waiting list now stands at 3.84 million, a 2.9% increase compared to a year ago. However when taking into account non reporting trusts, the total waiting list is likely to stand at around 4.1 million. Referral-to-treatment (RTT) performance was 87.2%, down from 88.2% at Q3, and 90% for Q4 2016/17. The number of patients waiting longer than 52 weeks has also increased, up by 75% compared to the same period last year. The continue slippage of performance against waiting time targets is a symptom of the capacity constraints across the system.
- Only one of the six new ambulance performance targets were met. This was for Category 1 calls, 90<sup>th</sup> percentile under 15 minutes.
- In terms of capacity, there were fewer general and acute beds at Q4 this year compared to the same period last year. In 2017/18 the sector ended the year with 101,326 beds, while in 2016/17 the number was 101,827. The £337m winter funding was welcome, but NHS Improvement acknowledges "static

bed supply and the marked increase in postponed elective activity suggests this extra funding would have had a greater impact if it were received earlier in the year”.

- There are around 92,694 vacancies within NHS trusts, which is about 8% of the total 1.1m whole time equivalent workforce. Vacancies across the sector are driving spend on temporary staff. In terms of nursing vacancies, around 65% of posts are being filled with bank staff, with a further 35% filled with agency staff. The rates are highest in London (14.1%) and the South (10.9%). For medical vacancies, posts are being filled by a mix of bank (45%) and agency or locum staff (55%), with the midlands and east experiencing the highest vacancy rates (10.1%).

## Next steps

The Q4 figures reflect the considerable effort undertaken by NHS trusts and their staff. The provider sector continues to outperform the rest of the UK economy in terms of productivity, and trusts should be commended for the level of savings they have delivered this year and continued progress towards reducing agency spend. But it is clear the situation is unsustainable, trusts are increasingly reliant on non-recurrent measures and the financial regime is not effective for the vast majority of the sector.

- The current financial framework, including control totals and sustainability funding, needs to be revisited. We are starting to work with NHS Improvement to help shape their planning framework for 2019/20 and beyond.
- Trusts must be able to access capital funding to address their growing backlog maintenance and transformational requirements. The Department of Health and Social Care is undertaking a review of the current capital regime but this needs to be done in partnership with NHS trusts and NHS central bodies.
- The upcoming health and care workforce strategy is welcome, and it must address with urgency given the immediate workforce challenges faced by trusts.
- We are continuing to engage with the Department of Health and Social Care and Treasury on proposals for a long term financial settlement. As the government continues these discussions, we need to be realistic about how much funding might be required to close the current financial, workforce and operational gaps.

## Press release

Commenting on the year-end financial and performance figures for the NHS provider sector, the chief executive of NHS Providers, Chris Hopson, said:

“NHS trusts and frontline staff are working harder than ever in the face of a relentless rise in demand for care, severe workforce pressures and a continued funding squeeze.

“The figures we see today reflect the worrying gap between what the NHS is being asked to deliver and the resources available following almost a decade of austerity. And we must remember that today’s figure

masks the full underlying deficit which is much higher, and how reliant the NHS continues to be on one-off savings.

“These pressures are being felt by patients and staff right across health and social care. There are not enough staff, ambulances, community and mental health capacity or hospital beds to cope.

“This has become a year-round challenge, but the problems were compounded by severe winter conditions, with the result that too often, standards of care fell short of what trusts want to provide, and what the public has a right to expect.

“These pressures have had a substantial impact on trust finances. There was also a significant financial impact. The additional A&E activity and the sharp rise in emergency admissions meant there was less income than expected from planned procedures such as knee and hip replacements. There were also extra staffing costs to cover increased vacancies, sickness and staff turnover.

“In those circumstances, the overall deficit of £960m was a creditable performance. Once again, the NHS has also outperformed the wider economy on productivity. Spending on agency staff fell by more than £500m compared with the previous year, and trusts delivered cost improvements equivalent to £3.2bn ([3.7]% of trust turnover) – £110m more than 2016/17.

“However, looking ahead to 2018/19, financial and workforce pressures continue to increase. For the longer term, we welcome the prime minister’s recent commitment to increase long term funding for health and care and look forward to the new comprehensive health and care workforce strategy.

“But today’s figures show a substantial part of any additional spending on the NHS in the future, will be spent on fixing the shortfalls that have built up in recent years.”

# NHS operational productivity: unwarranted variations

## Mental health services and community health services

### *Summary document*

#### Foreword by Lord Carter of Coles

Like all parts of the NHS, mental health and community services face a number of challenges that can be partly addressed through operational and structural improvements. NHS mental health and community health services account for about £17 billion of NHS expenditure in England, complementing the £52 billion spent on acute services, and providing critical support for over 2 million patients every day.

The role and importance of mental health services are clear, but that of community health services, with a wide range of local specifications and provisions, is not. If the aspirations expressed in the Five Year Forward View are to be met, we will need to shorten the average length of stay in English acute hospitals from its current 7 days to something approaching Denmark at 5.5 days or the United States at 6.1 days<sup>1</sup>, although some estimates put these even lower. To achieve this, the provision and efficiency of community health services will have to be significantly strengthened. The key challenge for mental health services, by contrast, is in meeting the significant levels of unmet demand. Even taking into account the significant expansion in children's mental health services, workforce constraints mean that by 2020/21 we only plan on meeting the needs of a third of children with diagnosable mental health conditions. Improving the productivity of services is an important part of the answer to how we go further in both sectors.

#### *Operational improvement – £1 billion savings opportunity to support patients*

Since January 2017 we have engaged with many mental health trusts and providers of community services, and talked to the healthcare teams and patients who use their services. As a result of that engagement, this review has identified critical and unwarranted variations in all key resource areas. It is clear from the performance of some providers that parts of the sectors know what to do well – the challenge we face is how we raise the average standard of performance closer to the level of the best. Our work has identified four important areas where operational improvement must be made.

1. **Staff:** we spend £10.4 billion per year on staff; giving detailed attention to how they use their time, particularly at this moment of critical labour shortages in all grades, is of the utmost importance. Effective rostering, job planning, managing sickness absence, maximising the clinical time of community staff, appropriate skills mixing, and effective training all lend themselves to detailed management attention. This is, however,

---

<sup>1</sup> OECD, 'Health at a Glance 2017'; [https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017\\_health\\_glance-2017-en](https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en)

something that we have found to be missing in too many providers. Culturally, the high levels of bullying and harassment staff report is inconsistent with the continued mantra that our staff are our most valuable asset.

2. **Contract specification:** the approach to contract specification and management is inconsistent and overly bureaucratic. Clinical commissioning groups commission core services against hugely detailed and often very different specifications. These variations are often unwarranted and the approach has resulted in the imposition of too many reporting requirements – in one case 6,000 in a single trust. This creates confusion and unacceptable frictional cost.
3. **Technology:** the use of technology is not optimal and lags behind even other public sector services, let alone the best in class. Over a quarter of trusts still operate paper-based systems for community nursing services and, where they do exist, many of the case management systems in community and mental health services are cumbersome and time-consuming for staff to use. The inability to provide a single view of the patient across organisations to date is lamentable. This lack of investment in adequate systems is indefensible in 2018, and means valuable staff time is wasted and patients do not receive the best care. While many trusts have, or are implementing mobile working, e-rostering systems and dynamic scheduling, much more needs to be done to ensure these are being used effectively and driving the productivity and efficiency gains that are possible. There must also be questions about electronic procurement, stock management and the use of electronic prescriptions which are not at a sufficiently advanced stage.
4. **Delivery:** ensuring that these issues are dealt with is the responsibility of NHS Improvement in the case of operational matters, and NHS England in the case of commissioning. NHS Improvement needs to have a clear idea of ‘what good looks like’ in these areas by broadening the focus of the clinically led Getting It Right First Time (GIRFT) programme and providing effective benchmarking information to providers through an adapted Model Hospital. The proposed new regional structure across both organisations will need to be implemented at pace to help providers up their game.

In summary, we could find no reason why the system should not move more quickly to adopt best practice, save for the constraints of capability and capacity.

### ***Structural issues – supporting the Five Year Forward View***

There are a number of structural issues in the provision of services delivered in the community that are well recognised but have not been adequately dealt with and which community health services could play a more significant role in resolving.

1. **Delayed transfers of care:** these remain one of the biggest problems in the NHS. They account for about 5,000 beds at any one time. The main NHS reason given for these delays is the number of patients ‘awaiting further non-acute NHS care’. We saw examples where effective use of community health services and social care has reduced average length of stay in acute beds by four days.

2. **Wound care:** research has shown that the NHS spends about £5 billion a year managing wounds, undertaking over 40 million patient visits. But most trusts do not capture clinical information or operate within nationally defined pathways. The GIRFT programme must extend its approach to community health services to support more efficient pathways in the community.
3. **Community hospitals:** in many areas it is unclear how community health services should be provided to best support patients: some areas have inpatient community hospitals while others have none. We were unable to find any evidence that the often expensive provision of inpatient community hospitals improved outcomes. Patients need to access appropriate local services and there is scope for a wide range of community services to be located in 'hubs'. In doing so we need to achieve a reasonable balance of size and accessibility if such hubs are to secure the confidence of their local communities and funders. A much clearer idea of 'what good looks like' is needed but one thing is certain – an isolated 10-bedded inpatient facility is unlikely to be clinically or financially secure. Effective national leadership working with local sustainability and transformation partnerships (STPs) across community health, mental health, primary care, general practice and social care services needs to take this forward.
4. **Lifetime healthcare costs:** at current funding levels the lifetime healthcare costs of an individual in England are approximately £185,000, and if social care costs are added this could rise to over £220,000<sup>2</sup>. As Lord Darzi's recent review of health and care<sup>3</sup> draws out, nearly half of this expenditure occurs after the age of 65. The average length of stay for non-elective patients, for example, is 13 days for those aged over 85. It is critical that the management of these groups of patients is undertaken on a much more focused basis to ensure that acute care interventions are minimised and a much more effective system of dealing with the co-morbidities of old age is found.
5. **Integrated care:** The expansion of the role of the Secretary of State for Health and Social Care to include responsibility for social care should make the dream of integrated care more realistic. The dilemma of social care being means-tested and acute care being free at the point of delivery causes inevitable tensions. There must be some way of incentivising acute hospitals to discharge medically fit patients to step-down and intermediate care facilities, for if nothing else it will enable these hospitals to undertake their economically rewarding elective care work and reduce waiting lists for patients. Other healthcare economies have regarded post-acute care, for a limited period, as an essential part of the acute hospital financing package, aiming as they must to keep the optimal flow of patients through the highest risk and most expensive part of the healthcare continuum. Resolving these issues, as part of the move to place the funding of the NHS on a long-term sustainable basis is critical.

I am grateful for the opportunity to extend my work and undertake this review and I would like to thank the cohort of 23 trusts that has dedicated considerable personal time and effort to

---

<sup>2</sup> NHS Improvement analysis

<sup>3</sup> The Lord Darzi Review of Health and Care: Interim report: <https://www.ippr.org/publications/darzi-review-interim-report>

supporting the work. This review is as much theirs as mine. I would also like to thank my team and all those who advised and supported me over the last 18 months.

I am confident that if the recommendations in this report are implemented, up to £1 billion of efficiency and productivity savings per year can be achieved by 2021. The structural issues will be more difficult to resolve in the short term, and we have not at this stage quantified the benefits although I believe them to be significant. At the simplest level this will mean paying much closer attention to how the wider system supports reductions in avoidable admissions and limits the average length of stay, particularly for older patients. If we are to be successful in delivering the Five Year Forward View, these simple tests must be met.

A handwritten signature in black ink, reading 'Carter of Coles' in a cursive script.

**Lord Carter of Coles**

May 2018

## Executive Summary

This review has looked at the productivity and efficiency of mental health and community health services. It has done so in the context of the Five Year Forward View and its delivery plan which are clear that these services provide critical support to patients in the most appropriate setting, and assist the better management of mental and physical health conditions.

The review makes 16 recommendations across eight chapters. They are designed to improve productivity and enable the benefits to be reinvested in improving quality and access to care. We developed them by working closely with trusts delivering these services across England, in particular a cohort of 23 trusts. In doing so we identified many examples of 'what good looks like' in all aspects of service delivery and patient care, and significant good practice. We also found a significant amount of unwarranted variation. The findings are summarised below:

- There is significant good practice but there needs to be stronger mechanisms for sharing this between trusts.
- Workforce productivity is mixed, particularly in services delivered in the community, and NHS Improvement must step up its support for trusts to drive improvements in the engagement, retention and wellbeing of their staff.
- The Getting It Right First Time (GIRFT) programme should extend its approach to community health and mental health services, and specify more efficient and high quality pathways of care for patients.
- The use of mobile working and technology to drive efficiency and productivity is inconsistent and poor in many areas.
- There is scope for trusts to take action across all areas of spend including corporate services, procurement and estates.

### Chapter 1: Mental health and community health services

The NHS in England spends about £17 billion providing community and mental health services. There are currently 53 specialist providers of mental health services and 18 community trusts, but many more trusts deliver some services in these areas. We have found significant diversity in what trusts provide. The Five Year Forward View for Mental Health described a number of challenges facing mental health services, with the critical areas of concern being historical underfunding of mental health services, the extent of unmet need in mental healthcare, which is higher than other sectors, and the lack of parity of esteem with physical health. NHS England is making good progress in tackling these through investment and reform under clear national leadership and with support from partners across the system. Community health services provide an equally important role in supporting patients and the wider health system. This has been described in national strategies including the Five Year Forward View. However, there is a disparity in the extent of clear national leadership between mental health and community health services. We

recommend that NHS Improvement and NHS England do more to recognise the role of community health services in a way that builds on the new models of care.

## **Chapter 2: Quality and efficiency across the pathway**

Examining the whole patient pathway is a crucial means of understanding where productivity and efficiency improvements can be made. This includes where patients could be better cared for in terms of quality of care, patient experience, efficiency and value for money. Analysis of an individual's lifetime care costs shows how spend is skewed towards acute hospital care, when in fact providing care to patients in their homes or the community can be better in terms of quality and efficiency. The Getting It Right First Time (GIRFT) programme is well established in 35 clinical work streams, and is supporting improvements in quality and efficiency across these. It must now extend its approach to mental health and community health services. For mental health inpatient services, this approach will support national efforts to reduce the estimated £500 million spent each year on inappropriate out of area placements. Alongside this, there is scope to strengthen and simplify existing commissioning and contract arrangements to drive standardisation in the community health services 'offer'. Trusts currently have to work with a number of commissioners delivering the same service against often different specifications, and the approach to contract management can create an unnecessary administrative burden for trusts. There are also specific areas of care provision that warrant a closer focus and support, specifically healthcare for veterans and restricted patients.

## **Chapter 3: Engaging the workforce**

We recognise that staff are our biggest asset but more can be done to support them in delivering effective and efficient care to patients. All staff in mental health and community health services are committed to delivering high quality services to patients, but we were told that they are coming under increasing strain. Staff engagement, sickness absence, bullying and harassment and retention levels are concerning and show significant variation between different organisations. Effective action must be taken to support trusts in addressing these issues. This includes an emphasis on leadership at all levels in the organisation and the importance of the role of trust boards in driving this. NHS Improvement must work with all trusts to help improve the engagement, retention and wellbeing of their staff.

## **Chapter 4: Optimising clinical resources in the community**

Services delivered in the community account for about 70% of mental health and community trusts' clinical work. To better understand the productivity and efficiency challenges and solutions in these services, the review team collected data from cohort trusts and worked closely with them to analyse this. This showed that there is a large amount of unwarranted variation in metrics such as direct care time per clinical day, and the number and duration of contacts. Similar variation was observed in other services delivered in the community. The review also saw large differences in how services are managed between trusts including the way referrals are managed, approaches to case management and the effective use of administrative resources. We found that a key enabler for improving workforce productivity in these services was the use and uptake of digital technology and mobile working. Often this was inconsistent and poor, with estimates

showing that a quarter of community nursing services are still paper-based, and many clinical record systems in mental health trusts being time-consuming and difficult for staff to use. NHS Improvement needs to support trusts to change this by developing guidance on good operating practices for services delivered in the community, and providing benchmarking metrics for mental health and community health service lines on the Model Hospital by April 2019.

## **Chapter 5: Optimising inpatient services and other clinical resources**

Unwarranted variation was also seen for other clinical services. We examined the inpatient workforce, medical staff, and medicines and pharmacy. For inpatient services, the nursing cost per bed varies significantly between trusts, and for smaller-sized units can be over £100,000 for an occupied bed per year in both mental health and community health wards. The review collected data for care hours per patient day (CHPPD) and reviewed rostering practices. In many cases there was scope for significant improvements to better manage unused hours, approve rosters at least six weeks in advance, and reduce spend on bank and agency staff. NHS Improvement will refine the CHPPD collection methodology, including developing tools to show levels of acuity and dependency, and will develop good practice guidance for all trusts around inpatient workforce deployment and e-rostering. Medical staff job planning is mixed, and early data collected suggests that this is an area that requires further examination. The review also focused on medicines and pharmacy optimisation. This was recognised as a critical clinical service that had a profound impact on costs and care quality across the patient pathway. There were specific challenges facing trusts around the infrastructure that ensures the supply of medicines and how pharmacists were deployed across services delivered in the community and inpatient services. Trusts should assess where they can make changes to allow pharmacists and other pharmacy staff to spend more time on patient-facing medicines optimisation, especially in community settings.

## **Chapter 6: Optimising non-clinical resources**

Non-clinical resources account for about 30% of mental health and community trust spend, and are a critical enabler of frontline patient care. Expenditure on corporate services tends to be higher on average for mental health and community trusts compared to other provider organisations, owing to their smaller scale. There was also variation in the costs of core corporate services functions, such as the cost per payslip and human resources cost per employee. There are opportunities for trusts in the sectors to collaborate and share their corporate services provision across neighbouring organisations, including sustainability and transformation partnerships (STPs). For estates and facilities management, in the £1.3 billion spend per year by mental health and community trusts there was significant variation in the running costs per square metre, from about £30 to over £230, and in the use of space. There is scope for trusts to rationalise their estate, building on good practice demonstrated by a number of trusts across the sectors, and in line with ongoing work in STPs. One trust found it could dispose of 14% of its properties. NHS Improvement will provide a more comprehensive set of benchmarks for the sectors, and trusts should review their estate to identify opportunities for consolidation and rationalisation. To support this, NHS Improvement will also review the current arrangements for estates leased from property companies. The review also examined trusts' procurement practices and

functions. This found significant unwarranted variation in prices paid for the same product, including one type of dressing where the price paid varied from £1.62 to £20.29 per unit. Our engagement showed that trusts are not leveraging their buying power or collaborating at scale to secure the best price. Trusts should use the Purchase Price Index and Benchmarking tool to evaluate prices paid for products, and NHS Improvement's National Procurement Programme will focus on a set of common goods used by trusts in the sectors to support better cross-sector buying power.

## **Chapter 7: Expanding the Model Hospital**

A key recommendation from the acute hospital sector operational productivity review was the establishment of the Model Hospital to provide benchmarking data to trusts to identify efficiency and productivity opportunities. Expanding and extending benchmarking data on the Model Hospital to include mental health and community health services will be a central element of implementing the recommendations in this review, in particular to show the metrics for services delivered in the community as set out in chapter 4. This will take time to develop fully but rapid progress must be made. As part of this, NHS Improvement will review the branding of the Model Hospital as it expands to incorporate different types of providers.

## **Chapter 8: Securing effective implementation**

The implementation of the recommendations in this report will be supported by a team in NHS Improvement's Operational Productivity Directorate that will engage with trusts across community health and mental health services. However, it will need leadership and action far beyond that from a range of partners and stakeholders, and the challenge to NHS Improvement, NHS England and individual trusts from this review is how to lead, operationalise and sustain significant action against the review's recommendations. Although some trusts have already started to tackle some of the issues hindering their productivity, achieving long-term efficiencies and improvements to quality will also require targeted support from national bodies working more closely together.

The findings in this report are underpinned by our identification of significant unwarranted variation across clinical and non-clinical resources. We consider that removing this unwarranted variation would result in an efficiency opportunity worth up to £1 billion a year by 2020/21 from a more productive and efficient use of existing resources. Removing this variation will support providers in delivering their required annual efficiencies and existing cost improvement plans. In some cases, delivering the identified efficiencies may require investment in infrastructure to release longer-term benefits for the NHS, patients and the taxpayer. It is critical that all savings identified in this report are reinvested alongside new investment to ensure that more people are able to gain timely access to evidence-based mental health and community health services. The Five Year Forward View for Mental Health is clear that mental health services have been underfunded for decades and our recommendations will help ensure that the investment made to move towards parity of esteem both maximises the support to patients and delivers value for money.

## Summary of Recommendations

1. **Learning from new models of care:** NHS England should codify and share the learnings from new models of care and the successful 'Vanguards' to support community health services to play their full role in supporting the wider system.
2. **Quality of care and Getting It Right First Time (GIRFT):** The GIRFT programme should ensure that the role of community health services is considered in all relevant clinical specialities and make rapid progress in undertaking work in mental health. For mental health, this should include supporting the elimination of inappropriate out of area placements for adult mental healthcare by 2021.
3. **Driving standardisation in the community health services 'offer':** NHS England should help strengthen commissioning and contracting mechanisms for mental health and community health services. This should include supporting providers and commissioners to work together within sustainability and transformation partnerships to develop model frameworks for specifications of services.
4. **Restricted patients:** The Department of Health and Social Care, Ministry of Justice and their arm's length bodies should work more closely to improve the administrative management of restricted patients.
5. **Optimising workforce well-being and engagement:** Improving cultures are critical to better staff engagement, driving positive change across organisations and improving both productivity and care quality. NHS Improvement should work with all mental health and community trust boards to help improve the engagement, retention and wellbeing of their staff.
6. **Strengthening the oversight of workforce productivity for services delivered in the community:** With support from NHS Improvement and NHS Digital, and using the Model Hospital as a national benchmarking dashboard, providers should improve their understanding and management of productivity at organisational, service and individual level.
7. **Improving the productivity of the clinical workforce for services delivered in the community:** Providers of services delivered in the community should increase the productivity of their clinical workforce by improving and modernising their delivery models, in particular through better use of digital solutions and mobile working.

- 8. Cost of inpatient care and care hours per patient day:** NHS Improvement should develop and implement measures for analysing workforce deployment, and trusts should use these to report on the cost and efficiency of their inpatient services to their boards during 2018/19.
- 9. Inpatient rostering and e-rostering:** All community and mental health trusts should use an effective e-rostering system and set up formal processes to tackle areas of rostering practice that require improvement. NHS Improvement should undertake a review of the rostering good practice guidance to ensure it is inclusive of all sectors.
- 10. Medical job planning:** NHS Improvement should work with trusts to ensure that the right doctor is available for patients at all times using effective and comprehensive job planning and rostering, and identify improvements in clinical efficiency and productivity.
- 11. Medicines and pharmacy optimisation:** Trusts should develop plans to ensure their pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation.
- 12. Corporate services:** Trusts should reduce the variation in the cost of their corporate service functions. As part of this, they should examine the opportunities to collaborate and share corporate service functions.
- 13. Estates and facilities management:** NHS Improvement should develop a comprehensive and tailored set of benchmarks for the sector by 2019/20, and all mental health and community trusts should review their existing estates and facilities and provide a report to their boards by April 2019.
- 14. Procurement:** Trusts should reduce unwarranted price variation in the procurement of goods and services by improving procurement practices, local and national collaboration and price benchmarking.
- 15. Model Hospital:** NHS Improvement should develop the current Model Hospital and the underlying metrics to ensure there is one repository of data, benchmarks and good practice so all trusts can identify what good looks like for services they deliver.
- 16. Implementation:** Trusts, NHS Improvement, NHS England and other national bodies must take the action required to implement these recommendations. NHS Improvement must ensure that the best practice observed throughout this review is shared, key benchmarks are specified, and more intensive support is provided.

# Bradford

## Local system review report Health and Wellbeing Board

Date of review:  
12 – 16 February 2018

### Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Social Care and for Housing, Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

### The review team

Our review team was led by:  
Senior Responsible Officer: Alison Holbourn, CQC  
Lead reviewer: Deanna Westwood, CQC

The team included:

- Two CQC chief inspectors
- One reviewer
- Three inspectors

- Two CQC Experts by Experience; and
- Three specialist advisors (a LGA representative, a Director of Adult Social Services and a Consultant Physician)

## How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from Bradford City Council (the local authority); NHS Airedale, Wharfedale and Craven Clinical Commissioning Group, Bradford District Clinical Commissioning Group, and Bradford City Clinical Commissioning Group (referred to collectively as the CCGs); Bradford Teaching Hospitals NHS Foundation Trust (BTHFT); Airedale NHS Foundation Trust (ANHSFT); Bradford District Care NHS Foundation Trust (BDCFT); and the Health and Wellbeing Board.
- Health and social care professionals including hospital staff, commissioning leads, workforce leads, Mental Capacity Act leads, social workers, occupational therapists, GPs, independent care providers and their employees.
- Healthwatch Bradford and District, and voluntary, community and social enterprise (VCSE) sector organisations
- People using services, their families and carers at the Carers' Resource, Age UK, a Black and Minority Ethnic forum and a care home.

We reviewed six care and treatment records and visited nine services in the local area including acute hospitals, intermediate care facilities, care homes and a hospice.

## The Bradford context

### Demographics

- 13% of the population is aged 65 and over.
- 67% of the population identifies as White.
- Bradford is in the top 20% bracket of most deprived local authorities in England.

### Adult Social Care

- 88 active residential care homes:
  - One rated outstanding
  - 42 rated good
  - 29 rated requires improvement
  - Four rated inadequate
  - 2 currently unrated
- 43 active nursing care homes:
  - 18 rated good
  - 14 rated requires improvement
  - Three rated inadequate
  - Eight currently unrated
- 70 active domiciliary care agencies:
  - 38 rated good
  - 18 rated requires improvement
  - 14 currently unrated

### GP practices

- 82 active locations
  - Three rated outstanding
  - 75 rated good
  - Two rated requires Improvement
  - One rated inadequate
  - One currently unrated

### Acute and community healthcare

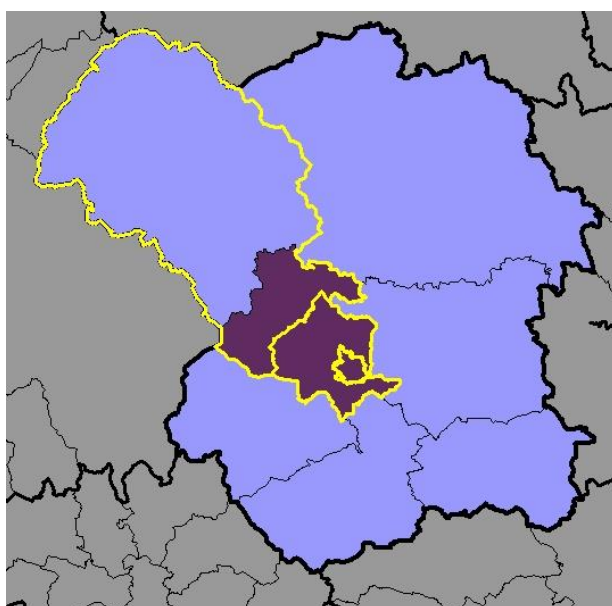
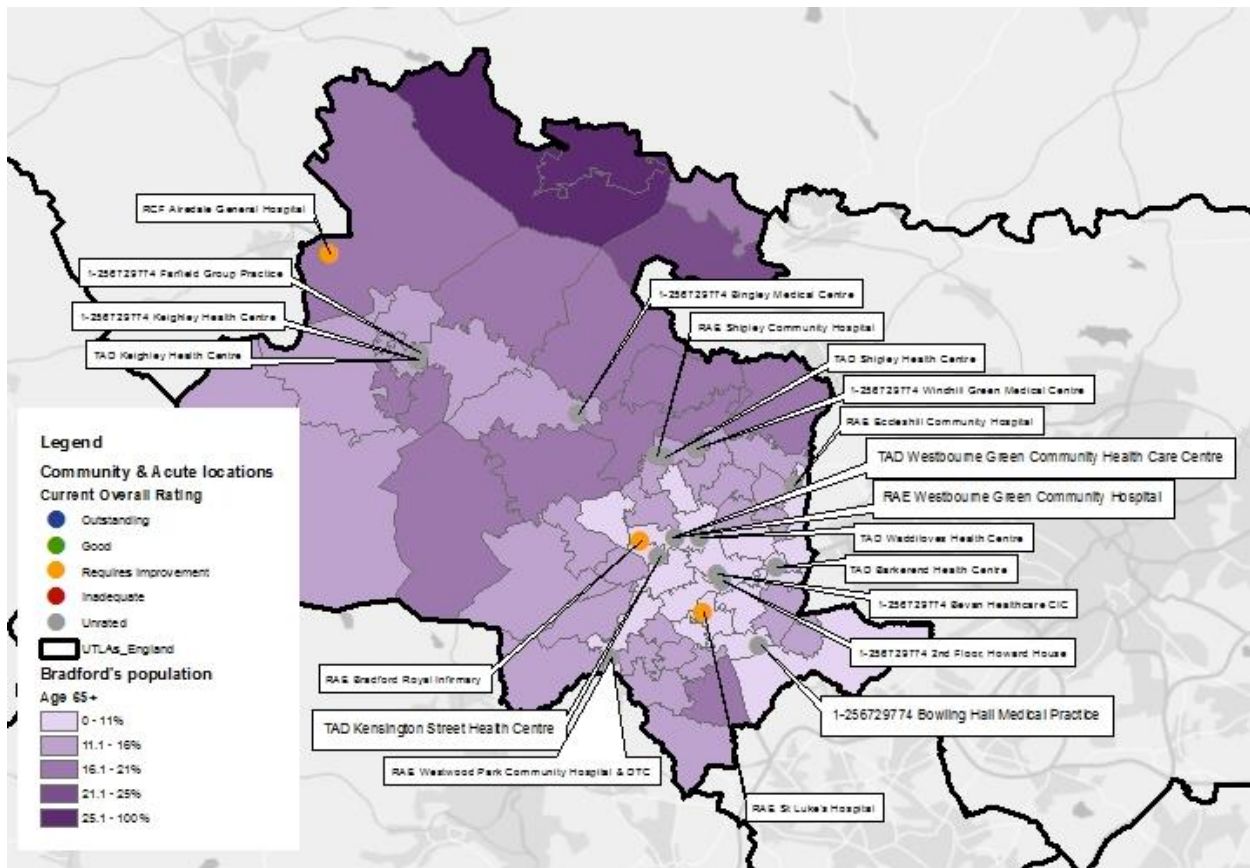
Hospital admissions (elective and non-elective) of people living in Bradford are found at the following trusts:

- Bradford Teaching Hospitals NHS Foundation Trust
  - Received 66% of admissions of people living in Bradford
  - Admissions from Bradford made up 88% of the trust's total admission activity
  - Rated requires improvement overall
- Airedale NHS Foundation Trust
  - Received 22% of admissions of people living in Bradford
  - Admissions from Bradford made up 63% of the trust's total admission activity
  - Rated requires improvement overall

Community services are provided by:

- Bradford District Care Trust
  - Rated requires improvement overall
- Airedale NHS Foundation Trust, via the Airedale Collaborative Care Team and Community Therapy Services

*All location ratings as at 08/12/2017. Admissions percentages from 2016/17 Hospital Episode Statistics.*



Map one (above): Population of Bradford shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Bradford.

Map two (left): Location of Bradford within the West Yorkshire STP. The Airedale, Bradford Districts and Bradford City CCGs are also highlighted.

## Summary of findings

### **Is there a clear shared and agreed purpose, vision and strategy for health and social care?**

- There was a clear shared and agreed purpose, vision and strategy described in the Happy, Healthy at Home plan which had been developed by the system. This was articulated throughout and at all levels of the system. We found that the majority of staff across the system, including adult social care, primary and secondary care sectors, and the voluntary sector were committed to the vision, although some areas acknowledged that there was still work to do to embed the supporting culture. Some of this was related to the interface of health and social care and there was a will to work towards pulling this together. There had been positive development around the Health and Wellbeing Board extending its membership to wider parts of the system, including housing, the VCSE sector, police and fire services.
- We saw that system leaders across health and social care were compassionate and caring. They were clear that the needs of the person sat at the heart of their strategy and vision. They recognised that individuals living in Bradford had different needs, goals and aspirations, and also recognised the differences in geographical communities; system leaders encouraged the development of communities to build support around the person.
- The next steps for the system will be to translate the vision into detailed modelling and then operational practice. The challenge will be to ensure the translation of the vision is in a common language that is understood by all partners.

### **Is there a clear framework for interagency collaboration?**

- There was a defined system-wide governance arrangement that pulled the system together and a clear architecture for development and roll out of the transformation of services in line with the plan. There was a clear locality structure emerging which included the VCSE sector as equal partners but there was still more work to do regarding the alignment and integration of frontline delivery of services. We saw evidence of joined up reporting through the reporting framework including the Health and Wellbeing Board from a health and finance perspective, but there was a challenge in doing this when each organisation has separate reporting frameworks. There was more work to be done to finesse this, but it was clear that the system was on a journey to achieving this.
- At an operational level, there was more work to be done to embed integrated working through integrated commissioning and funding. Much of the success of this depends on high trust relationships and the clear and strong commitment of leaders to the strategic vision.

System leaders need to consider how this is secured so that in the event that changes in leadership occur, the systems are in place to continue with the good work that has been built around strong relationships. There is a risk that in the event of significant unforeseen challenges that different parts of the system retreat back into their own organisations.

- The system needs to continue to build on relationships throughout all levels and consider how the independent provider market is engaged as equal partners.
- There were structures in place to discuss and negotiate commissioning intentions however we were aware that the partnership could be tested by a number of challenges including budgetary pressures within the local authority. Our observations were that Bradford had a good infrastructure through the Integration and Change Board (ICB) and Executive Commissioning Board (ECB) to enable early discussions in this regard.
- Although frontline staff found that sharing of information was still an occasional barrier, we also found that some of the information sharing processes were well developed. There were clear advantages where GPs, the mental health and community trust, and one of the acute trusts had a shared IT system. Although one of the trusts did not share the same system we saw that there were workarounds in place to manage this.
- Integration was ongoing and planned with some effective practice where multidisciplinary teams could access SystmOne. However, we did find some outdated practice such as using a fax machine for communication across the system. It was time consuming for staff to complete paper forms and where people needed re-referral, these forms would need to be completed on each occasion.

### **How are interagency processes delivered?**

- We found some good joined up interagency processes, particularly the Bradford Enablement Support Team (BEST) for reablement and the MAIDT (multi-agency integrated discharge team). The MESH team (the medicines service at home) was a further example of innovative practice. The intermediate care hub was the first point of contact to enable people to receive step up care or support when their needs changed and they were living at home. There was also good use of the VCSE sector to deliver services in equal partnership with health and social care staff.
- There were different ways for people to access services and they might be confused by different pathways into services. There were a number of 'single points of access' for example mental health first response, the EDT access team, the intermediate care hub, and the community nurse team. These areas would benefit from being brought together as a single network and system leaders have recognised this.

**What are the experiences of frontline staff?**

- Despite pressures on the workforce owing to difficulties around recruitment across health and social care, the workforce managed the flow through the system well and we saw that referrals, assessments and delivery of services were timely.
- Staff we spoke with were committed to improving outcomes for people and developing their strength-based approach. We saw good evidence of prompt responses in our case files. We found that staff were involved in developing the workforce strategy which would enable them to contribute to and to buy in to the system vision.

**What are the experiences of people receiving services?**

- People who lived in Bradford were supported to live in their own homes and their communities for as long as possible. They received holistic assessments of their care that took into account all of their social and health needs based around their strengths. Where possible, the provision of virtual wards meant that people could receive consultant-led medical care at home rather than in hospital.
- People were supported to live independently in a community-based support system. For example, we heard about a person who lived on their own and would visit particular shops and premises in their local area. Through the use of community connectors, there was a whole community support system put in place whereby local shops and services knew the person, and knew who to contact and report to if they had concerns about the person's wellbeing. This meant that they could continue to do the things they enjoyed in life and reduced the risk of social isolation. However, people who were not eligible to receive funding for services had difficulties finding support and navigating through services.
- People were able to access help and support to stay safe in their homes through the use of technology and telecare systems. People in some care homes had access to clinical assessment via video link with the Digital Care Hub. Where additional support was needed referrals were made to the appropriate service to visit them in the care home, for example GPs, community teams and out-of-hours services. This meant that there was less disruption to their lives particularly if they had needs associated with dementia and could find changing environments stressful.
- Although 87% of GPs provided partial access to extended provision which meant that people could access pre-bookable appointments, some people we spoke with told us that they could not get GP appointments when they needed them. This meant that they were more likely to attend A&E if they were anxious or unwell.

- People did not have to stay in hospital longer than they needed to. There was good support to enable them to return home safely. The provision of a retainer to domiciliary care agencies to hold packages of care meant people had continuity of care and did not have to wait for a new package to be commissioned upon their discharge from hospital. System leaders told us about successes in terms of reducing length of hospital stays and we saw that there was focus on getting people home as soon as possible.
- However, the experience of some people on their pathway through hospital was difficult. We heard that some people did not feel listened to when their needs were assessed or that the views of people who knew them best were considered. Despite a good ethos of not moving frail or elderly people through the hospital, we heard examples of this continuing to happen and some people we spoke with told us that this could be distressing.
- People felt supported by the Home from Hospital service managed by Carers' Resource which was a positive initiative supporting people out of hospital. We heard that it was responsive and was an important factor in enabling people to feel confident and secure on their return home.

## Are services in Bradford well led?

### **Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?**

*As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.*

*We found that that there were strong relationships across the health and social care system, which meant that all parts of the system were committed to the delivery of the Happy, Health at Home vision. There were high levels of trust and commitment between system leaders and elected members. We saw that there was a strong and compassionate approach to delivering better outcomes for people who lived in Bradford and a culture of seeking best practice and continuous improvement. The involvement of wider stakeholder groups such as the Voluntary, Community and Social Enterprise (VCSE) sector services, GPs and housing teams in the design of services ensured that there was a joint focus on prevention and keeping older people in their own homes for longer; however independent care providers were not yet partners in shaping the future of services.*

*There was still some work to be done around embedding joint arrangements. There was potential for pressures such as budget constraints or changes in leadership to impact on the delivery of transformation.*

### **Strategy, vision and partnership working**

- There was a clearly articulated vision for people living in Bradford which was subscribed to by staff across health and social care and at all levels of the system from leaders through to frontline staff. There were clear strategic and organisational threads running through from the West Yorkshire and Harrogate Sustainability and Transformation Partnership (STP) to the Happy, Healthy at Home plan which is the Bradford District and Craven plan borne out of the STP, down to the Bradford District Plan. The plan had been adopted by the Health and Wellbeing Board and replaced the strategy that was in place from 2013 to 2017. The vision of Happy, Healthy at Home was reflected throughout and was recognised by all parts of the system including the VCSE sector. The positive approach to developing a sustainable health and care system was not just narrowly linked to health and care service and budgets, but linked to wider economic growth. This recognised that regeneration, and tackling wider determinants of health were critical to long term sustainability.
- The Happy, Healthy at Home vision was underpinned by a number of joint strategies, such as Home First and Healthy Bradford with the focus on ensuring that people could stay healthy at home for as long as possible. System leaders told us that plans had been underpinned by the Joint Strategic Needs Assessment and the new joint health and wellbeing strategy which would deliver on the vision. The health and wellbeing strategy that was available to the public on the local authority website was out of date (covering 2013 to 2017); however the Health and Wellbeing Board had agreed an updated strategy which articulated the joint vision for Bradford. We saw that the iBCF plan and the social care precept planned expenditure had been used to align funding to the strategy with person-centred outcomes. System leaders were able to demonstrate in their Q3 iBCF return where improvements had already been made through the alignment of the funding streams to the strategy and vision.
- Other external agencies also commended the work that had been undertaken in the joined-up development of system plans. For example, NHS England described the senior leadership in Bradford as flexible and proactive in terms of meeting people's needs. We saw that the Chief Executive of Public Health England had visited the local authority shortly before our review and referred to "a sea of good practice", particularly around the work that health and social care partners had undertaken to identify the priority outcomes for people living in Bradford.
- We saw that system leaders, including elected members, were compassionate and focused

on improved outcomes for people while managing the realities of pressures on funding. When we spoke with system leaders they were often able to describe anecdotal examples and case studies while they were talking about their vision and plans which showed that they kept the person at the heart of their planning. Our relational audit (responded to by 168 people working across the health and social care system in Bradford) found that people had mixed views of relationships in the system, with more positive scores against statements around acknowledging and appreciating each organisation's contribution and investment in a shared purpose. However; when we spoke with frontline staff we sometimes heard that they did not feel that they were equally valued with colleagues working in other sectors.

- There was a clear organisational structure being developed to further the strategy. Two accountable care programme boards had been developed. In the Bradford district, north, south and central locality hubs would sit beneath the Bradford Accountable Care Partnership with 10 communities sitting below those. The Airedale, Wharfedale and Craven Accountable Care Partnership had three localities sitting directly below it. The VCSE sector was seen as an equal partner in the development of these plans as system leaders understood and valued the role that it could play in supporting communities around the preventative agenda.

### **Involvement of service users, families and carers in the development of strategy and services**

- We found that Bradford was a system that focused on the person at the heart of the journey. Healthwatch Bradford and District led on much of the engagement with people in Bradford around the development of services. In November 2017, they published The Big Conversation report following a series of events such as focus groups, public events, and face-to-face and online surveys. This was an opportunity for local people to have a say about what mattered to them in terms of the health and social care priorities, which services they felt worked, and which needed development. It was not clear how many of the respondents were people over the age of 65. Healthwatch Bradford and District were positive about their engagement with system leaders. They were able to sit on the Health and Wellbeing Board, the A&E delivery board and felt that they had good access to system leaders. They felt listened to and that system leaders were open, transparent, listened to feedback and acted upon it.
- There were other forums for older people to feed into the development of services. For example, system leaders told us that 8,500 people had been invited to participate in the development of person-centred care in the Home First strategy. However, some system leaders acknowledged that they needed to ensure that they were not developing services around assumptions of different community needs.
- Representatives of the VCSE sector sat on the People's Board, and members of the

People's Board sat on the boards of governing bodies so that there was an upward flow of feedback and information. The Bradford Assembly enabled VCSE providers to meet and discuss the planning of services and support, however we found that smaller organisations in the VCSE sector and the people they represented did not always feel engaged. Some of these we spoke with were not aware of the assembly and this meant that there were potentially missed opportunities for these smaller groups to enable the voices of the people they supported to be heard.

### **Promoting a culture of interagency and multidisciplinary working**

- The Health and Wellbeing Board promoted interagency working and collaboration. It had recently refined its terms of reference to include “mutual accountability between strategic partnerships for the delivery of [their] goals in the District Plan and Health and Wellbeing Strategy”. Common goals and measures between strategic partnerships, and a plan to develop a common data set would further embed this culture.
- We saw that interagency working was embedded in Bradford and there were many examples of how this supported people to stay well in the community and to leave hospital promptly. Planning for winter pressures had included multiple agencies and staff across the health and social care sector. For the winter of 2017/18 a single joint plan had been produced rather than a joint submission of individual system plans. We heard from staff that they felt that they worked well together, particularly when there was a crisis. There were high levels of trust and leaders were willing to flex resources promptly to support each other in times of pressure.
- Frontline staff told us during our review that an increase in networking had shifted the culture and helped staff to move away from a blame culture. However, one of the lowest scoring statements in our relational audit was “People take organisational risks where this has the potential to serve wider system goals, without fear of criticism or failure”.
- Staff told us shared working meant that they could have strong and open discussions, which enabled problem solving and they knew which experts could support them with advice. This had reduced the need to escalate issues. Sharing of some budgets had supported these processes. For example, the CCGs funded a purpose-built area in A&E to help speed up processes, where a consultant and health care worker began investigations and tests prior to the person being moved further into the department. Therefore, when people were moved, for example into minor injuries, test results should be back for the clinicians to see and to support diagnosis. Although it had taken time, system leaders had worked hard to develop relationships between the VCSE sector and the GP federation to develop joint working around self-care and prevention.

- The STP had created further opportunities for interagency working. The West Yorkshire hospitals created an association of acute trusts which meant that there were opportunities to learn from each other and share best practice. Although we heard that it had taken time and trust to build relationships between organisations that had previously worked in competition with each other, relationships had developed to a point where they could jointly start to look at issues such as their estates strategies.
- Providers and frontline staff in the residential and domiciliary care sectors told us that they did not feel valued as partners in planning and discussion regarding people's pathways of care. Very often these were people who could be strong advocates for people who could not representative their own views and needs. Enabling independent provider staff to have a voice in interagency and cross sector working could benefit other aspects of commissioning including stabilising and improving the quality of the market.

### **Learning and improvement across the system**

- There was a positive culture of continuous learning, self-reflection and seeking best practice. Learning was shared across the system. We saw that in areas where system leaders were already successful, such as the good performance with regard to delayed transfers of care, they still continued to actively seek ways to improve. Leaders engaged with experts from outside the region to develop their own learning at leadership and operational levels.
- Winter planning had been developed based upon learning from the previous winter. A comprehensive review of winter 2016/17 was submitted to the urgent care programme board in August 2017. It identified pressure points in the system and included a detailed analysis of impacts such as delayed transfers of care. The report made a series of recommendations for implementation in the 2017/18 winter plan. We saw that many of these formed part of the Bradford Home First strategy and the BCF plan, such as the increased support for the homecare market and the use of the VCSE sector to support work on ill-health prevention.
- System leaders continued to evaluate hospitals stays and look at options for improving people's experiences of discharge from hospital. The Public Health Team undertook a survey of people in acute hospital or intermediate care beds looking at the person's capacity and cognitive impairment and testing whether the hospital admission could have been avoided. They found about 13% of admissions could have been avoided and 27% of people surveyed could have benefited from an intermediate care option. They also found that although people from Black and Minority Ethnic (BME) communities were proportionately represented in terms of admissions, they were under-represented in terms of take up of intermediate care so there were opportunities for system leaders to build on this information for further improvement.

- Although work was regularly evaluated, much of the practice we saw around the improved funding for homecare agencies and the work around the Home First strategy was relatively new and was yet to be evaluated. In the iBCF Q3 report the system was able to report improvements regarding residential care placements and reablement. It was too early to measure the impact of support from initiatives such as BEST, which provided short-term support to avoid admissions and facilitate discharges from hospital although leaders told us that early indications were positive.
- There were opportunities to learn when things went wrong. For example, the medicine safety group included representation from hospital trusts, the CCGs and a Local Pharmaceutical Committee representative. This group ensured that lessons could be learned and shared this with relevant stakeholders through newsletters.

### **What impact is governance of the health and social care interface having on quality of care across the system?**

*We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.*

*We found governance arrangements were uncomplicated with clear lines of accountability. The structures in place enabled integrated working across health and social care with support from political members and external stakeholders. There were robust risk-sharing processes and a shared view and responsibility of risk. Information governance was well-developed. Telecare, telehealth and other digital solutions were being developed with a long-term aim of people being able to manage their own information. However, while many developments were proceeding at pace and appeared to be having a positive impact which was being evaluated, system leaders needed to be able to challenge themselves to ensure that developments continued in line with the joint vision.*

#### **Overarching governance arrangements**

- The Health and Wellbeing Board had the overarching strategic leadership of the health and social care system in Bradford. System leaders described their governance arrangements as “strong” with “high-level political ownership and scrutiny”. The Board was chaired by the leader of the council and comprised stakeholders from across the system including the VCSE sector, the police and fire services, housing teams and Incommunities (the social care housing provider).
- Although there were three CCGs covering the Bradford District area, there was one overarching chief officer which ensured that the CCGs were strategically aligned. This also meant that people living in Bradford did not need to navigate different systems. However, the

areas they covered had different demographics and by keeping them as separate entities they were better able to report on and respond to the needs of people in their area.

- There were clear lines of accountability through the Executive Commissioning Board (ECB) and the Integration and Change Board (ICB). The ECB was chaired by the local authority Strategic Director of Health and Wellbeing and had responsibility for the operational delivery around the implementation of integrated commissioning and the BCF. The ICB was chaired by the local authority Chief Executive and managed the strategy around transformation. There were joint posts that linked across health and social care. For example, the Strategic Director of Partnerships was employed through the CCG and was the senior responsible officer for the prevention and self-care agenda. The Programme Director for the ICB was a jointly funded post.
- However, one of the challenges to system partners was around holding each other to account. Relationships and trust among leaders were strong but there was no form of self-auditing in place at the time of our review to ensure that outcomes for people were embedded. This needed to be in place to ensure that a change in leadership would not impact on the processes or on delivery of the strategy.

### **Risk sharing across partners**

- The A&E delivery board had oversight of performance and risk across the system. This board was chaired by the Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust and undertook the assurance of service delivery and performance. Providers and commissioners worked through the A&E delivery board to ensure that escalation plans were aligned. The board also monitored progress in relation to winter resilience and the delivery of the high impact changes, from the national model for the management of transfers of care.
- We saw that risks, particularly around winter pressures, were shared across the system. We saw ANHSFT's January 2018 winter update which it presented to the board. It showed that despite "unprecedented" pressures in the preceding weeks, performance had improved on the previous year and commended the work of staff teams.
- There was a BCF risk log in place and this linked to the CCGs' and the local authority's corporate risk registers. This included an honest assessment of progress in some areas needing further development for example trusted assessors and the consistent application of policies around patient choice.
- A system progress report against the Health and Wellbeing plan was submitted in February 2018 that measured outcomes against targets and reported on risks against a range of health and social care metrics and described what systems were doing to improve

performance and mitigate against risks. The Health and Wellbeing Board scrutinised dashboard performance against the locality plan. It was effective in having standing items such as workforce development and budget review which meant that wider risks were continuously monitored.

- More work was needed to identify emerging risks in the independent care sector. We saw that systems had been put in place that identified which services needed support however this was predominantly based on findings from CQC inspections and system leaders needed to ensure that health and social services partners were working together to share information and manage emerging risks.

### **Information governance arrangements across the system**

- Information governance arrangements and digital interoperability were well developed across health systems in Bradford. System leaders described themselves in the response to the SOIR as “one of the first digital health economies” through the use of integrated records, telehealth and telecare. In 2016 a Digital2020 Board was formed “where leaders from across the health and care system committed to promote and implement the innovative use of technology and data”.
- GPs, social workers, and the community and acute trusts could access information through access to SystmOne. Information governance and data protection issues were resolved through the application of honorary contracts so that staff across the health and social care system could access the necessary records. However, the systems were not yet embedded and there had been some difficulties around information governance with regard to the supplier and NHS England. System leaders anticipated that these would be resolved before the end of 2018 and “two-way information sharing” would be in place. Frontline staff we spoke with also told us that co-location of teams meant that information could be shared more easily.
- Some work was being trialled at the time of our review that enabled domiciliary care workers to share information with people, their families, GPs and social workers through a hand-held tablet kept in the person’s home. We saw how this could be effective in providing reassurance for people who used services and their families, for providing information to health professionals in an emergency and for enabling care agencies to be person-centred and responsive to people’s needs.

## **To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?**

*We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.*

*We found that there was an integrated workforce programme in place to deliver the strategy and that system leaders were committed to developing a workforce that was aligned to the vision of integration in localities. There were difficulties recruiting staff however there were innovative solutions being developed to attract young people to the sector such as the Centre of Excellence. There was more work to be done to support the independent social care sector and the VCSE sector to reduce staff turnover and vacancies.*

### **System level workforce planning**

- System leaders had a focus on developing a workforce that could deliver on the integrated strategic vision. The local authority senior leadership team had a clear vision of enablement for people using services and the role of social workers as advocates for clients within a clear legislative context. The community health trust told us that their workforce was aligned to the strategic system wide vision. For example, the clinical team was involved in the out of hospital programme, and the trust board was also signed up to the vision. When the planned localities are in place, district nurses will be embedded into specific populations and be better able to understand the asset based approach.
- The Integrated Workforce Programme Board was chaired by the Medical Director of ANHSFT and led on the delivery of the workforce strategy across the system which was supported by an integrated workforce programme. There was a shortfall of available staff and to manage this, in line with the strategy, they were looking at “blended” roles combining health and social care. Although there were some jointly commissioned staff in post, workforce leads told us that there was still work to do around “future proofing” and changing the workforce to fit around an asset based approach. There was some frustration that national education systems still supported training that encouraged future jobseekers to choose between health and social care career pathways rather than encouraging integrated development at the early stages of people’s careers.

### **Developing a skilled and sustainable workforce**

- Recruitment and retention across the system was a challenge. For example, pharmacy leads told us that despite there being a school of pharmacy in Bradford, they experienced difficulties recruiting band 6 professionals. Analysis of electronic staff record data between July 2016 and June 2017 showed that the turnover rate of nursing and medical staff was higher in both acute trusts than the England average.

- There was a proactive approach to developing the local workforce to attract young people into the health and social care industry, through apprenticeships, an industrial centre of excellence and the West Yorkshire excellence centre. Workforce leads were working with providers to develop the prospectus for development and training to grow a workforce that was aligned to their vision. International recruitment for GPs had been approved for Bradford and Kirklees. Leaders were also considering associate nurse roles and consideration was being given to attracting people who were new to the employment market but who had experience of providing care in their own communities.
- Analysis of workforce estimates from Skills for Care showed that recruitment and retention was a particular issue for providers of adult social care services. Turnover of social care staff had increased in line with the England average and in 2016/17 was at 27.8%, however this was higher than the average of comparator local authorities. Vacancy rates had increased steeply between 2015/16 and 2016/17 from 5.6% to 9.1% and were above national and comparator averages.
- System leaders recognised this as a risk to the stability and quality of services. They felt that there were opportunities through the workforce programme and working with agencies such as Skills for Care to support more people in domiciliary care and care home settings to complete the right qualifications. Workforce leads had identified providers' reluctance to release staff for training and system leaders needed to find ways to address this.
- VCSE providers also had difficulties retaining staff. They felt that some of this was a consequence of uncertainty around contract arrangements which meant staff would be attracted away to positions that appeared more secure.
- Overall Bradford is within the 20% most deprived local authorities in England; however within the local authority area levels of deprivation vary, with the most deprived wards centred around the urban areas of Bradford city centre and Keighley town. In less affluent areas CQC inspectors felt that workforce was more of an issue in terms of quality and recruitment of staff. In addition, staff in these areas felt less valued by health professionals. There was a risk to people living in care services as the difficulty in recruiting qualified staff led to a lack of clinical oversight. This was reflected in the CQC ratings of nursing homes where 7% of services were rated as inadequate and only 42% were rated as good, compared similar areas where 3% were rated inadequate and 59% rated good.

**Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?**

*We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.*

*We found that system leaders had taken an innovative approach to supporting the VCSE sector in the formation of a formal alliance which would bring more stability to the sector and enable them to work closely together to develop their preventative agenda. They had also used funding to stabilise the homecare market and the success of this was reflected in very few delayed transfers of care. The GP alliance was supportive of the commissioning shift towards preventative services and engaged with the VCSE alliance.*

*However, system leaders needed to take a more robust approach to contract management and oversight, particularly with regard to the independent provider market as overall the provision of care was not good and people were required to pay a top up if they wanted better quality care. The commissioning of fifteen-minute care visits meant people sometimes had a poor experience and there had been an increase in medicines errors.*

**Strategic approach to commissioning**

- Commissioning plans were developed in line with the Happy, Healthy at Home vision, underpinned by the transformation towards localities. System leaders told us in the response to the SOIR that the Joint Strategy Needs Assessment (JSNA) informed their planning alongside more detailed and focused pieces of work such as their dementia needs assessment and winter resilience work. They told us that the JSNA enabled them to identify priorities for commissioning based on evidence and need. We saw that there was a JSNA for older people with a number of analyses sitting below this such as dementia and hospital admissions.
- We saw that work was ongoing to implement commissioning plans in line with the strategy. Health and social care partners were working together to align their commissioning intentions. System leaders told us that Bradford had a long history of involving the voluntary sector in strategic planning and that the VCSE sector played a vital role in the provision of services for older people. Frontline staff told us that advocacy services have been recommissioned to build an asset based approach.

**Market shaping**

- Partners we spoke with recognised that there were significant challenges in the domiciliary

care and care home sectors and system leaders recognised that the market was fragile. There was a previous history of poor partnership working with the sector. Steps had been taken to address this in the homecare sector through the iBCF uplift in order to retain supply and capacity.

- Although the strategic vision was directed at keeping people at home for as long as possible, so that people would only need to move to a care home if they had multiple needs that could not be managed at home, there was a shift in provision in the independent sector from nursing home to residential provision. Our analysis showed an 18% reduction in nursing home beds between April 2015 and April 2017 in Bradford; a greater reduction than in 14 of its 15 comparator areas, while the England average was a reduction of 2%. Over the same time period there was an increase of 13% in residential care beds. Commissioners were unable to identify the reasons for this although there was some speculation that it might be related to the difficulty in recruiting qualified staff. The market in Bradford had been difficult with a larger number of smaller providers however system leaders need to find a way of taking a strategic position so that they can anticipate and manage market changes. The local authority told us that in terms of their commissioning they had reduced the use of residential beds by 10% in a period of 10 months; this was supported by ASCOF data which showed a downward trend in the rate of long-term admissions to care homes for older people between 2013/14 and 2016/17. While this tied in with their strategic intentions, there was a greater risk of failure in the market as providers moved away from the nursing home market. This also placed a greater burden on system resources such as community nursing.
- System leaders recognised this and told us they had begun a major programme to tackle market issues, however they were in the first year of a three-year plan. The first step had been fee increases and retainers to help maintain capacity and build trust. There was work underway to clarify the type and volume of services needed which included a focus on in-house beds for short term care. There was a need to establish a fair price across the sector. We found that if people living in Bradford who received local authority funding wanted to be placed in a service rated as good by CQC, they would be required to pay a top up fee. This was confirmed by system leaders and also by our data which showed that 30% of care home beds in Bradford were partly self-funded compared to 13% in similar areas and an England average of 9%. This meant that there was a barrier for some people to receiving care from good services and a disincentive to services to improve if they did not attract funding from the local authority. Although Bradford had a significantly lower rate of delayed transfers than comparator areas or nationally, it had a slightly higher rate of delayed transfers resulting from the person or their family's choice. The quality of available social care services may have contributed to this.

### **Commissioning the right support services to improve the interface between health and social care**

- Support and funding was given to the VCSE sector to enable the formation of a VCSE alliance as a legal entity. This was developed to support the VCSE sector to play a part in market development. System leaders told us that there had been some good work around self-care as a result of this and that there had been reductions in A&E attendance and in GP attendances. A number of VCSE organisations were getting reduced funding and system leaders recognised the need to stabilise the sector in order to support their agenda of self-care and prevention.
- The VCS Alliance, following receipt of funding from the CCGs was established as a legal entity; the CCG recognised that in order for the system's integrated vision to be realised they would need to invest in the voluntary sector to mobilise. As a legal entity, the VCS Alliance became an equal partner and has been able to take on contracts for the delivery of services and support members through the process. However, there was a need to ensure that the wider VCSE sector was engaged with opportunities. We found that there was continued uncertainty for VCSE providers. For example, a large VCSE provider managing an important contract to support people living with dementia did not know in February 2018 whether the contract would be renewed in April.
- System leaders had been bold in making the decision to use funding to pay a 30-day retainer to homecare providers when people were admitted to hospital. Early indications showed that this had been effective and delays attributable to social care or people waiting for care packages were minimal. This was also a person-centred approach as it allowed continuity of care for people and served to stabilise the domiciliary care market.
- However, domiciliary care providers felt that the commissioning of 15 minute visits meant that their support was very task orientated with a focus on people's ill health rather than an enablement approach. In addition, they felt it had led to an increase in safeguarding referrals for medicines errors. This was reflected by CQC inspectors who told us that when they found breaches in the Health and Social Care Regulations, these were often around the administration of medicines.

### **Contract oversight**

- The management and monitoring of contracts was underdeveloped particularly with regard to residential provision. This was across both health and social care commissioning. We found that commissioners tended to be reactive and responded when things went wrong or services failed however there were not robust mechanisms in place for monitoring the quality of services in a way that would provide early warnings and enable proactive management.

- The quality of domiciliary care, residential and nursing home care services in Bradford was poorer than other areas. This has a big impact for people, as domiciliary care and residential care providers have a significant role in determining the quality of life for people who receive their services, whether they are being cared for in their own home or if they have moved into the residential service which has become their new home. The Care Act guidance<sup>1</sup> describes the role of the local authority as critical to achieving high-quality, personalised care and support through its commissioning and its broader understanding of the market. As at December 2017, less than half (42%) of the nursing care homes in Bradford that had received a CQC rating had been rated as good compared to 59% across comparator areas and 62% nationally. There was a greater disparity with residential care services with 48% rated as good compared to 72% across comparator areas and an England average of 75%. Analysis of re-inspections as at December 2017 showed that, the ratings of 16% of adult social care locations deteriorated, compared to 13% across comparator areas and the England average of 12%. The independent provider market had not been an integral partner in the system and this impacted on the ability of the system to shape the market around local needs and the quality of the lives of people who live in Bradford.

#### **How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting peoples' independence?**

*We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high-quality care and promote people's independence.*

*We found that resources were targeted at promoting people's independence and preventing hospital admissions. System leaders were able to agree joint priorities around the use of the iBCF that aligned to their overall strategy and felt assured that their spending was targeted on these priorities. However, although the impact was clear in terms of numbers of people flowing through the system without delay, more work was needed to evaluate the outcomes for people.*

- Money from the iBCF had been invested in extending capacity in the homecare market and enabling providers to offer a competitive wage. In addition, the social care precept was used to increase funding to homecare providers to stabilise the sector. System leaders had agreed to focus on reablement to assist people out of hospital and reduce the likelihood of readmission. Analysis of Adult Social Care Outcomes Framework (ASCOF) data indicated that this had been effective.

---

<sup>1</sup> <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-4>

- System leaders reported in their iBCF return that the iBCF grant demonstrated “protection of services for the residents of Bradford”. They stated that the allocation of iBCF monies had enabled frontline services to respond to the pressures in the system over the winter period. Their own data showed that during December 2017, there were only three people delayed for a total of six days where the delay was the sole responsibility of social care.
- The Public Health team was looking at what they could commission together with the VCSE sector as there were programmes that duplicated. There was a commitment to looking at how they invested in the VCSE sector however there needs to be support for VCSE organisations to become stronger at evaluation and building sustainability.
- We did not get a clear sense of how quality outcomes were tested across the system. Although data indicated that the system was working effectively in terms of flow, there were not measures in place to ensure that people also had a high quality experience of care.

## Do services work together to keep people well and maintain them in their usual place of residence?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in their usual place of residence**

### **Are services in Bradford safe?**

*With their focus on keeping people Happy, Healthy at Home, system leaders understood that people needed to feel safe. There were services in place to ensure that people felt safe and protected from harm through the use of telecare equipment and support from community navigators. Risk stratification systems had been developed and the rate of attendances at A&E for people over 65 was in line with the England average. Leaders were seeking to improve and were evaluating this work.*

*There was innovative work underway to identify people who might be at risk, working with the independent sector, and the Medicine Service at Home ensured that people’s medicines were reviewed regularly and managed safely. However, the commissioning of fifteen minute visits by domiciliary care workers had resulted in an increase in medicines errors and safeguarding referrals related to this.*

- There were systems in place to ensure that people could be protected from avoidable harm

in their own homes. For example, there was support to ensure that people's medicines were managed safely through the Medicine Service at Home (MESH). This service ensured that people who were at risk owing to the number of medicines they were prescribed or other identified risks had their medicines reviewed. The MESH service was under contract to undertake 6000 reviews and was able to undertake reviews in people's own homes. The service could be easily accessed by GPs, secondary and community care providers as well providers of domiciliary care. This meant that there were regular reviews and checks in place for people who might receive medicines for different conditions that could have contra-indications, and that medicines were managed safely. System leaders told us that although the MESH service had initially been costly, it was being utilised to its full potential and had resulted in long-term gains; one of which had been a reduction in the prescription of sedative medicines.

- However, the commissioning of 15-minute homecare visits compromised the safety of medicines administration. Domiciliary care agency staff and VCSE workers told us that because they needed to be fast, staff had to work in a very task orientated way. Often, they were the only person that the person using the service would see in a day, and they experienced difficulties with managing medicines and supporting the person in such a short time frame. This had led to increased numbers of medicines errors and related safeguarding concerns.
- The Safe and Sound service could be accessed by anyone who was assessed as "needing help to feel safer, more protected and independent in their own home". People living in Bradford and needing this support could refer themselves for an assessment, or the referral could come through the GP or health services. The service provided a pendant for people to get support in the case of a fall or other emergency, and there was also support for a wider range of issues that might concern people who feel vulnerable such as help dealing with bogus callers and medicines reminders.
- There was a safeguarding adults policy in Bradford that sat within a wider partnership. The West and North Yorkshire and York Safeguarding Adults Project Group set out their multi-agency policy and procedure in December 2015 which described the framework for how agencies should respond to allegations of abuse and neglect. Bradford's Safeguarding Board described its own vision as "Making Safeguarding Personal" supported by six principles. The first two principles were empowerment and prevention, which reflected the local focus on prevention. At the time of our review, we were told that this policy was due to be refreshed.
- System leaders were looking at a range of ways to identify people who were frail, had complex needs or were at risk of deterioration in their health or social care situation. GPs

identified the top 2% of patients considered to be at risk and some ensured that regular reviews were offered by a practice nurse or advanced nurse practitioner (ANP) to support them to avoid hospital admissions. Further work was underway through ANHSFT which was looking at using risk stratification to proactively identify people with complex needs and build a model of support around them. They described one person who had had multiple admissions owing to an exacerbation of a physical illness. This person also cared for their spouse. An ANP worked with the person to build a plan for the maintenance of their physical condition and a community navigator through Age UK supported them with plans around their low mood and sense of responsibility as a carer. The community navigator supported them to obtain a mobility scooter and also an afternoon of support per week for their spouse. This meant that the person felt that they could safely resume social activities and be assured that their loved one was safe. They had subsequently only had one hospital admission within a twelve-month period. However, system leaders felt that this community model could be further developed as the rate of referrals was lower than expected. At the time of our review this was being evaluated.

- There were other innovative ways of working with partners to ensure that people who might be at risk or living with conditions that could make them feel vulnerable were identified and safeguards put in place. For example, the Public Health team had started to work with the local water supplier, to maximise opportunities to share data so that support could be targeted. These suppliers would have information about people who might have mobility problems or require support to maximise their benefits. In return, the local authority could share information about people who might need additional assistance with things like bins. With this awareness, suppliers could be partners in flagging risks or concerns. The work was in its early stages and stakeholders were looking at how this could be developed further and in line with regulations around information governance.

### **Are services in Bradford effective?**

*System leaders were designing integrated health and social care systems that reflected their strategic vision and their focus on enabling people to remain in their chosen home for as long as possible. There was a focus on enabling people to be part of their communities and reducing social isolation. Work was underway to ensure that people from harder to reach communities were able to access services at an earlier stage. Information technology and information sharing was well-developed with IT systems in place to facilitate this. However, there was still work to be done to fully embed this across health and social care. The health and social care workforce collaborated around the needs of the person requiring services and the redesign of the locality based model recognised that primary care was often the doorway to services for people. Staff across the health and social care system were committed to making this work however there was a need to ensure that the knowledge and support of care staff in the independent sector was equally valued.*

- The Public Health team was focused on promoting the health and independence of people so that they could remain at home. They were maximising opportunities around housing and recognised that people had very different needs and were looking at ways to meet these. This work was linked to one to one support and signposting offered by community connectors. The community connector service enabled people to access support and information in their own local communities, which reduced social isolation as people could be part of their communities and remain confident in their own homes. There was work underway to include community connectors from an Eastern European background as health and social care leaders had identified that people from these backgrounds did not engage willingly with preventative social care services which meant that they were more likely to start using services when they were at crisis point. An event had also been scheduled to be held in February 2018, shortly after our review, in which health and social care staff in Bradford with an operational or strategic role were invited to a conference to further develop and improve the local response to people from these communities.
- We heard from people we spoke with, and saw from case studies, that people's needs were assessed holistically to support them to remain independent for as long as possible. We saw that multidisciplinary meetings were based around the person's needs. However, ASCOF data showed the percentage of older people accessing long-term social care support who were receiving direct payments to enable them to manage their own care packages was very low at 5.7% in Bradford in 2016/17 compared to the average across comparator areas (17.8%) and the England average (17.6%) and had declined slightly over the previous two years. This shortfall had been recognised by system leaders and work was underway to address this. A partnership group had been set up with a group of voluntary organisations to look at direct payments, funded care and the development of Individual Service Funds (ISFs). The work around ISFs was still at an early stage but it was being developed alongside independent providers with support from the Association of Directors of Adult Social Care (ADASS) and Think Local Act Personal (TLAP). Conversely, the rate of direct payments for NHS CHC per 50000 adults across Bradford CCGs was above the England average in Q1 2017/18 and the rate of personal health budgets was broadly in line with the England average
- Systems were designed around a philosophy of "asset based community management". This meant that, in line with the preventative agenda, systems were designed so that people could have as much control as possible over their own care. This was known in Bradford as "assisted self-care"; for example, people were able to refer themselves directly to a physiotherapist without having to go via a GP. The Public Health team were leading on work around warm homes, targeting their support on where the greatest need was, however there were concerns raised by people we spoke with about the impact of reduced funding in this

area and that some people may have risks to their health because of a lack of heating or hot water. There was a district nurse complex health team and a long-term conditions team to help people to avoid admissions. Their focus was on people who were at home and unable to access GP or other services.

- Care homes in Airedale had commissioned a GP provider to undertake regular ward rounds. We were told that this had reduced hospitals admissions. Our data showed that people living in care homes in Bradford were less likely than those in similar areas to attend hospital with avoidable conditions such as urinary tract infections and decubitus ulcers (pressure sores). However, although they were in line with comparators around pneumonia and other lower respiratory tract infections, they were higher than the England average. Work with GPs was being developed more widely through the Primary Care Home model (PCH) which linked GPs to the localities in Bradford. The PCH was being designed to work across the health and social care sector as well as the VCSE sector built around primary care hubs, as it was recognised that people often first came into contact with health services through their GPs.
- These plans were well developed with the full support of the GPs who understood their roles as an integral part of the community based model and as sitting at the heart of an integrated care model. The commitment to supporting GPs to undertake this work had been reflected in the average GP funding per patient which our analysis showed had been higher in 2014/15 and 2015/16 than similar areas and the England average.
- System leaders ensured that staff across health and social care understood the vision of Happy, Healthy at Home, and were embedding the skills required to support this through their workforce development. Staff were receiving training on new ways of delivering on personalisation agenda. System leaders told us that staff were encouraged to “change the conversation” and identify more empowering support for people. There was also training for staff around support offers such as “virtual wards” which enabled people to receive medical care at home and encouraging staff across health and social care to consider alternatives that would enable and empower people to remain in the setting of their choice. Training around dementia care planning had been implemented across health and social care, and mental health staff and occupational therapists supported extra care housing staff with training.
- However, although staff were willing to work in new ways, we heard from many groups of frontline staff and leaders that workforce capacity was an ongoing issue. Frontline staff that we spoke with understood that sharing information and collaborative working improved outcomes for people, however care workers in the independent sector did not always feel that their roles were respected in the same way by health professionals and that this led to missed opportunities for sharing important information about the people for whom they provided care.

- Although systems for sharing information were not yet fully embedded across Bradford, they were well developed. We saw systems in place to support information sharing and collaboration between care workers, GPs and social workers which also included families and people using services. A system was being trialled at the time of our review with 150 people receiving care in their own homes, which enabled them to hold their own care packages on computer tablets in their homes. They could use this to review their care plans, raise concerns and receive live notifications, for example if their care worker was running late. GPs could access the information if needed and people would not have to tell their story repeatedly. There was a single IT system in place used by GPs, BDCFT, ANHFST and at the A&E department of BTHFT. This facilitated better information sharing and where the A&E department could access GP records, symptom management could be put in place reducing the need for hospital admissions.

### **Are services in Bradford caring?**

*There was good support for people who used services and their carers to be involved in discussions and planning their care. However, for people who lacked the capacity to make decisions, consideration was not always given to their holistic needs and the wishes of their family members. A new team had been implemented in the local authority to provide support and advice to partners and we saw evidence of the success of this team, however further work was needed to embed the principles of the Mental Capacity Act across the system.*

*Carers received support and advice and there was further work going on to ensure that people who cared for others were identified and receiving support. The commissioning of short visits meant that care workers could not always support people in a kind and caring way as they often did not have time to have meaningful conversations with them or deliver the care in the way that they needed it.*

- We saw from case studies we looked at and heard from people we spoke with that people were at the centre of their care and support when services were being put in place. There was evidence that assessments were undertaken holistically by multidisciplinary teams and that the assessment reflected people's choices and cultural preferences. Assessments included family members and there was input from voluntary organisations. System leaders were further developing a needs assessment which would bring information and resources together and enable plans to be developed around wider determinants than the person's health needs.
- Some frontline staff felt that there was sometimes a tendency to see a person as a "diagnosis" rather than a person. This was being addressed by system leaders and would require a cultural shift. For example, district nurses had received training to have more holistic and empowering conversations with people to identify their needs and goals.

- The electronic system that was being piloted with domiciliary care agencies would enable domiciliary care workers to share information electronically with people who use their services, their families and their GPs in an emergency. This enabled people to be involved in managing their own care packages and with permission, families could access care records to share information or provide assurance. This meant that family members who did not live close by could, with permission, access records to get assurance around issues such as whether their loved ones were having their medicines on time or eating well.
- We saw that people were involved in making decisions about their care however work around the Mental Capacity Act 2005 (MCA) needed to be further embedded. We found that staff in the health sector and the social care independent sector did not fully understand the MCA and there was a risk that people's wishes could be disregarded by staff who were risk averse. There had been a significant backlog of Deprivation of Liberty Safeguards (DoLS) awaiting authorisation and a team of best interest assessors with an MCA lead had been established. This had been successful and the team's role had extended into advisory and training, supporting partners and providers with advice regarding the law, ensuring that people's rights and wishes were understood and respected in accordance with the MCA. For example, we heard about a couple who had been separated when one had been placed on anticipatory medicines which are given to people who are at the end of life and placed in a residential setting. However, the person had recovered but remained in the care home. The best interests assessor was able to establish that the person's own home had not been considered as an option for them to receive care and, although their condition meant that they could not verbally express themselves, they were able to demonstrate their objection to the care setting. The person's spouse also clearly wanted them home however health services had struggled with supporting the family to make a decision based on their wishes rather than their medical needs. Through the proper application of the MCA and the DoLS process this person was enabled to return to their own home.
- We saw from case studies we looked at and people we spoke with that there was good support for carers offered by the Integrated Carers Service which was commissioned through Carers' Resource. Carer drops-ins were arranged to offer support to people and an opportunity to discuss any concerns. In addition to the drop-ins, carers could call into the centre at any time if they needed any help. This helped to build up relationships and trust and provide people with an advocacy service if needed. Staff were very knowledgeable and showed compassion when speaking about their roles and responsibilities. They stated there were lots of unidentified carers and they were working on trying to identify more. Public engagement events were held and GPs were supporting the service in trying to identify where there was need. Carers were able to have a wellbeing review and the resource centre liaised with other organisations to ensure that carers had the support they needed such as support with benefits.

- ASCOF data for 2016/17 showed that the proportion of carers who were satisfied with their experience of care and support was slightly below the England average at 37.4% (England average 39%), however the proportion of carers aged 65 and over (who are more likely themselves to be caring for older people) that were satisfied was slightly better than the England average at 42.1% (England average 41.3%).
- The proportion of carers who reported in 2016/17 that they had as much social contact as they would like was higher in Bradford than the England average, both total and carers aged 65+.
- We saw that staff respected people's individual cultural and religious needs. However, the commissioning of home care services did not always enable staff to deliver care in a kind and compassionate way. We heard that fifteen minute visits were being commissioned and this meant that staff were often rushed. Domiciliary care staff and VCSE providers told us that home care was provided in a very task orientated way owing to the short visits. They told us that care could be provided without the care worker talking to the person as they would need to focus on issues such as checking medicines. An example was given of a visit from a care worker who was supposed to provide lunch for a person and ran out of time, serving the meal partially frozen.

### **Are services in Bradford responsive?**

*There was a wide range of services for people living in Bradford to support them through the health and social care interface. These services were joined up across health and social care and there was a holistic approach to managing people's care pathways. There was a focus on enabling people to receive support in their usual place of residence through the use of telemedicines, the Bradford Enablement Support Team, a 'virtual ward' and the complex care team.*

*The VCSE sector was valued and played a significant role in supporting people with low level needs that enabled people to live as independently as possible and avoid hospital admission. Health and social care professionals were proactive in linking people to services including VCSE services around social prescribing. However, there were multiple ways of accessing services which people found confusing and could result in missed opportunities for people. People who were not eligible for local authority funding had particular difficulties with accessing information and support.*

- We were told that systems were in place to enable people to access services easily. There was a single point of access through a call centre taking up to 200 calls a day for health and social care. Local authority leaders told us that this reflected the principle of 'home first'

agreed in the Happy, Healthy at Home strategy. However, we found that there were multiple 'single points of access' for a number of services such as the mental health rapid response service and the community nursing team, which could be confusing. At a forum we attended with people from BME communities, everyone we spoke with felt there was not enough information available in regard to contact numbers of services that may be able to help.

- There was a need to ensure that all people received the same level of support to access information about services, regardless of whether they were eligible for funded support. People we spoke with in focus groups told us that there were not the same levels of support for people who were able to fund their own care. For example, one person we spoke with told us that their parent was living with dementia and needed to fund their own support. However, owing to their condition they were unable to arrange this. Although they had assets through their property they did not have the means to maintain it, and were found without heating or hot water. In addition, owing to their anxiety levels, they were contacting emergency services throughout the night.
- System leaders valued support from the voluntary sector and recognised the important role they played in enabling people to stay happy and healthy at home. Carers' Resource had a point of contact that people could call for support with practical problems. If Carers' Resource could not provide support they would signpost people to relevant services and they also confirmed that very often they had to help people navigate through the system. This meant that people had different experiences of services. One person we spoke with described difficulties in finding out how to access equipment and adaptations at home; not knowing who to contact and not feeling listened to had impacted their confidence. However, another person who was living abroad had raised concerns through the contact centre about an older family member which resulted in the person's boiler system being repaired so that they had access to heating and hot water and were less likely to become unwell through poor living conditions.
- VCSE providers told us that there was good low-level preventative support available for people, for example lunch clubs and checks on people living alone. This was often managed within communities and providers felt that this was well managed in Bradford. When people were diagnosed with dementia, they were signposted to Age UK for support and we were told that professionals engaged well with this service. An organisation was commissioned to provide the community connector service and evaluation undertaken in January 2017 showed that 82% of contacts were related to anxiety, low moods and social isolation. Their own data over the period of March to October 2017 also showed a reduction in GP appointments and A&E attendances. However, only 26% of people using the service at the time of the evaluation were aged 65 and over and there was more work to be done around targeted support for older people.

- Access to GPs and district nurses was variable. We heard in particular, accessing a GP out of hours could be difficult. Analysis of data from September 2017 showed that 1.3% of GP practices across Bradford local authority offered full provision of extended access to pre-bookable appointments on weekday mornings, evenings and over weekends although we were told that there were plans in place to develop this. Across comparator areas, 43% of GP practices surveyed reported offering full provision and across England the percentage was 30%. Patient weighted analysis of provision of extended access to GPs showed fewer registered patients in Bradford could access pre-bookable GP appointments outside of core contractual hours (37%) than across comparators (64%) or England (55%).
- Domiciliary care providers told us that in some areas, an inability to get a GP or district nurse to attend a person at home for an issue such as a suspected urinary tract infection meant that they would need to rely on emergency services. Although the majority of people we spoke with felt that when they were able to see their GPs, they were listened to and received the support that they required, there were some examples of older people feeling that their age was a barrier to being heard. We heard from one person who had supported an individual as an advocate. Both the advocate and the individual they supported felt that the GP did not listen to them when they attended with an infection. Following a hospital admission, the person had required life-altering surgery. While we were not shown evidence that the wrong decisions had been made, the person was left feeling that if they had been listened to, they would have had a better outcome.
- There was good access to occupational therapy support and domiciliary care providers were able to refer directly which reduced delays for people waiting for these services.
- ANHSFT provided telemedicines through its Digital Care Hub. Their telehealth service won a national award in December 2017 and supported 500 care homes across the country, 48 of which were in Bradford. The telemedicines service enabled care homes to seek advice via remote video consultations and helped to prevent hospital admissions. For people who were at the end of their lives, a 'Gold Line' gave 24-hour access for people to receive urgent support and advice in their own homes so that they could die in their preferring setting.
- There were other arrangements to ensure people could be assessed and seen in their usual place of residence. A 'virtual ward' enabled people to receive consultant led care at home and was of particular benefit to people living with dementia who would experience less stress and confusion being cared for at home. This was developed through BHTFT and was a joined-up approach to care involving the hospital, community services, primary care services and adult social care. Staff we spoke with were proud that this initiative had won the 'Improving Value in the Care of Frail Older Patients' category at the Health Service Journal (HSJ) Value in Healthcare Awards in May 2017.

- Community matrons received additional training to support families around particular needs such as respiratory issues which could have a wider impact on a person's health. They would also liaise with the intermediate care hub and the virtual ward to support people to stay at home. However, some staff raised concerns that there was a bigger cohort of people whose level of support had not yet tipped into the group of people identified as high risk, and that these people probably has less proactive management of their conditions.
- The Bradford Enablement Support Team (BEST) was a local authority led service which provided short-term support for people at home to help prevent hospital admissions. The service was inspected by CQC in March 2017 and rated as good overall. We found that assessments were person-centred and our inspectors reported that "there was an exceptional promotion of maintaining good health and continued support for people who used the service throughout their care and afterwards". During our review, we were given an example of a carer who had gone into hospital. The BEST was able to provide support to their family member who was living with dementia. This gave comfort and assurance to the carer, and the family member did not have to leave home and receive care in another setting while their carer was unwell.

## Do services work together to manage people effectively at a time of crisis?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management**

### **Are services in Bradford safe?**

*When people were in crisis and required clinical interventions, there were systems and process in place to ensure that they were safe. Staff across all sectors received regular training and there was a culture fostered through daily meetings that enabled staff in the acute setting to raise concerns, confident that they would be acted upon. Staff did not always understand issues such as self-neglect and the MCA which could impact on the safety and liberty of people using services. Although acute trusts did not always meet the target for A&E waiting times, their performance was usually better than the England average. However national information returns about bed occupancy levels were found to be incorrect which meant that we could not assured that these were being safely managed.*

- There were arrangements in place to ensure that risks were managed when people were in crisis and required hospital support. At one hospital, we were told that there was a "safety huddle" twice daily which staff told us was an opportunity to escalate any issues of concern.

Staff were confident that these concerns would be listened to and acted on. Both acute trusts and BDCFT reported in the annual safeguarding report for 2016/17 that awareness of safeguarding had continued to be a focus for staff training. System leaders at BDCFT told us that they were considering how to collect learning from issues of concern that had been raised and which did not meet the threshold for safeguarding investigations but which they felt could contribute to learning and safer practice.

- System leaders at ANHSFT told us they had done a lot of work on patient flow and as part of the 'safer' tool were analysing the time that the person spent in hospital, taking into account best practice literature and learning from outside the area. They were encouraging a mind shift among clinical and healthcare professions prompting them to ask questions such as "why a hospital bed and why not the person's own bed?". This was aimed at preventing the rapid muscle loss and mobility difficulties that can occur when older people are unable to get out of bed. Staff were to encourage people to get dressed, mobile and eating well. Systems and processes were being put in place to drive this forward in a way that would ensure buy-in from staff. This was a proactive way of driving a cultural shift.
- More work was needed on training health and social care staff in the MCA, where there was a potential impact on the safety of people lacking capacity and living in Bradford. For example, there were some older people who undertook activities which could be considered unsafe, for example the hoarding of papers in their homes which provided fire and falls hazards. Sometimes there was little support for these people as their behaviour was described as "a lifestyle choice". However, it was not clear that meaningful discussions were held to enable people to understand the risks and to make informed decisions. Wider discussions needed to be held around the safety and quality of housing and whether the "lifestyle choice" was in fact a result of other issues, for example people being unable to take bins out and being too embarrassed to ask for help.
- When people needed to attend A&E, there were services in place to identify people who had complex needs and could be supported to avoid a hospital admission. The frail elderly team saw people arriving at A&E at both hospitals very rapidly and could arrange services to get them home without an admission.
- Both of the main acute trusts had met the 95% A&E waiting times target in 2014/15 and ANHSFT had also met the target in 2015/16; however, during 2016/17 there was a decline in performance but ANHSFT continued to perform better than the England average during 2016/17, with 91.2% of people seen within four hours, compared to the England average of 89.1%. BTHFT was performing slightly worse than the England average with 88.5% of people seen within four hours.

- National guidelines suggest that optimal bed occupancy levels in hospitals are no more than 85%. It is recognised that hospitals with average bed-occupancy levels above 85% risk facing regular bed shortages and that the quality of care may be compromised. NHS trusts are required to submit a quarterly return to NHS England. Over 2016/17 and in the first quarter of 2017/18 these returns showed that bed occupancy levels at ANHSFT were generally in line with the optimal level and below the England average. However, data submitted about the bed occupancy levels for BTHFT showed they were extremely low with the average for Q1 2017/18 at 62%. We found that this data was incorrect and system leaders told us during the review that their daily reports showed the bed occupancy levels were above 90%. The Winter Review Report for 2016/17 showed that last winter bed occupancy levels at BTHFT were at 94.8% and at ANHSFT they were at 94.6%.

### **Are services in Bradford effective?**

*System leaders had supported the development of services at the hospital 'front door' aimed at reducing admissions. Although the data had yet to demonstrate whether these were effective, they streamlined the process for people ensuring that they could be seen by appropriately skilled staff. There were some innovative approaches such as specialist waiting areas for people living with dementia, or who had mental health needs, to reduce the levels of stress they might experience in an unfamiliar environment.*

*Health and social services staff were co-located on wards which meant that discharge planning could be put in place earlier and with a holistic approach to people's needs. Although training on dementia had been rolled out, this was yet to be fully embedded in practice by all staff. Further work was also required to roll out the 'red bag scheme' to reduce the likelihood of losing important information that people brought into the hospital with them.*

- The CCGs had provided funding to the hospitals to put systems in place to ensure that people who arrived at A&E were seen by the right person. Streaming at the Bradford Royal Infirmary was effective in diverting 25% of people attending A&E away from the department into the GP led unit. There were processes for triaging people before admission to A&E which enabled staff to send people to the correct area in the department. The design of the department ensured that people could move through it in a smooth and logical way, making best use of space and resources and staff available. At Airedale General Hospital, a Frail Elderly team supported the medical assessment unit with the goal of ensuring as many people as practicable could return home on the same day. Both hospitals had quieter areas designed for people who lived with dementia or mental health needs and were awaiting treatment which meant that they were less likely to become distressed.
- There was a specialised ward for people with orthopaedic fractures which ensured that people with a fracture could go straight there avoiding A&E. This structure also recognised

that people had different needs at the different stages of their journey; for example, a surgeon would undertake the operation but older people would be cared for and supported by a geriatrician.

- There was other work underway to develop the skill mix of staff and ensure that the flow into and through acute services was more effective. Funding to alleviate winter pressures had been used to support an advanced paramedic role in the ambulance service however at the time of our review this was yet to be rolled out. Ambulance staff were able to make referrals to the MAIDT to avoid admissions. There was good work around empowering clinicians to be less risk averse including use of senior clinicians on the diagnostic unit. A liaison psychiatrist was available to attend A&E when required to undertake assessments and there was a social worker based in A&E which meant that when older people attended A&E their needs could be assessed holistically taking into account both health and social care needs. However, our data showed that these initiatives were yet to make an impact. Although the rate of attendances at A&E of people aged over 65 was very slightly below the England average, the rate of emergency admissions once people presented at A&E was higher than the England average with 27,899 admissions per 100,000 population aged 65 plus in Bradford between September 2016 and August 2017 compared to the England average of 25,009.
- Social workers were co-located within hospital wards which enabled a multidisciplinary approach to care and discharge planning. Meetings to support people with dementia were multi-organisational. There was joint working with neurology and there was a joint tender between health and social care underway at the time of our review for stroke care following discharge from hospital. Training had been rolled out across the hospitals so that staff could better understand the different needs of people who were living with dementia and who could often only express themselves through behaviour rather than verbally. The CCGs were supportive of this approach and the dementia lead had put templates and support in place for hospital staff. However, system leaders had further work to do to ensure that this was embedded in practice. We heard from people whose family members were living with dementia and had had a difficult experience. Two people told us about their family members being moved around hospital wards without discussion or notice which could be distressing for people who struggled to understand new environments.
- Although there were examples of collaborative working on the wards, the sharing of information required further development. ANHSFT used SystmOne which could be accessed by other partners such as GPs and social workers. However, we found that the 'red bag' scheme had not yet been rolled out. This scheme ensured that when people were admitted from care homes, their information travelled with them in a safe and secure way. Care home providers told us that information was often lost in transit to and from the hospital

and there had been instances of important documentation such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms going missing.

### **Are services in Bradford caring?**

*Although people received care that was assessed in a holistic way, there were missed opportunities to enable people and their families to voice their needs about their own care. There were some good practices to support the dignity and wellbeing of people using services such as the Butterfly Scheme for people living with dementia. However, families and care workers were not routinely involved in discussions about people's preferences and needs.*

- Although there were systems in place to ensure a holistic approach to managing people's needs when they were in hospital, staff did not always ensure that the person was at the centre of their care and support planning. Some staff told us that legal literacy around MCA and human rights needed to improve and could be a block in the system. They felt that there was a challenge in getting colleagues across the system to see that their role is beyond the physical repair of the person. This was reflected in feedback we received from a wide variety of sources, from people who used services, from residential and domiciliary care providers and from VCSE staff. However, members of the local authority's MCA team felt that there was increasing awareness across the system. There was a retendering process underway to bring the advocacy service together and this would see improvements in support for people as it had previously been commissioned through a number of agencies.
- We heard that when people were in hospital, communication with families and care workers was sometimes poor. When a person was taken to hospital or another setting, domiciliary care workers told us that they were not routinely notified that a person had been admitted or asked for information about how to manage their needs. In most circumstances, if people had the support of family members this would not be a concern. However, if a person lived on their own, the lack of information sharing could have an impact. We heard one example of where a care worker had to initiate their emergency plan as the person they supported had not responded. This resulted in the police breaking the door while the person had been safe in hospital.
- ASCOF data for 2016/17 showed that compared to similar areas, a higher proportion of carers in Bradford felt involved or consulted in discussion about the person they care for than the England average. However, when we spoke with people, we found that families were not always involved in discussions about a person's care, when very often their information could be important. For example, we heard from a family member whose parent had been admitted to hospital as an emergency. They were told to wait in a corridor outside their parent's room while they went through the admissions process and staff were dismissive of the family member's attempts to share information. Not only was this distressing for the

family member, it put the person at risk as they were living with dementia and had some specific needs which they could not communicate. However, when the person's family member subsequently raised a complaint about the treatment they and their parent had experienced, they told us that complaints staff had been compassionate and caring in their response.

- ANHSFT subscribed to the 'Butterfly Scheme'. This involved training for staff in the support of people who lived with dementia and there were 'Butterfly' champions on every ward. There was a member of Carers' Resource who visited the hospital regularly to provide support to people and their families. These initiatives ensured that the hospital stay was less distressing to people who were living with dementia.

### **Are services in Bradford responsive?**

*People who were in crisis and had to wait for support from emergency services told us that they often had to wait for long periods of time. Although work was underway to increase the skills of paramedics, people were still more likely to be taken to hospital if an ambulance was called. However, there were systems in place to support people in crisis in a wide variety of ways, rather than relying on traditional hospital bed care. Virtual wards enabled people to receive medical consultant-led support in their own homes and there was a good join of up the different initiatives such as the reablement team with community health teams and the virtual ward which enabled services to be wrapped around the person. There was very good support for people who were at the end of the lives as, with training, families were empowered to support their loved one so that they could die in their preferred place.*

- There were systems in place so that if a person was in crisis their care could be managed in the setting that was best suited to their needs. There was a multi-agency intermediate care hub that enabled people to be assessed so that they wouldn't be admitted through A&E by default. Through this people could access beds in a social care setting or nursing home, or an intermediate care bed in hospital. There was also a First Response Mental Health service that people could access in the community if they were in crisis, however residential care providers felt that the service was not always able to respond in a timely way and people sometimes reached crisis point before support was put in place.
- In focus groups, people using services and independent providers told us that they often had to wait a long time for an ambulance. Some people told us they had waited in excess of four hours. Our analysis showed that the proportion of 999 calls attended by Yorkshire Ambulance Service NHS Trust that did not result in transport to hospital between August 2017 and July 2017 was consistently below the England average. The ambulance service was encouraging the take-up of a programme for paramedics which would increase their skills and enable them to treat more people in their own homes. Residential care providers

told us that they undertook falls assessments prior to calling emergency services to reduce the burden on services and support their residents to stay out of hospital if possible.

Domiciliary care providers told us that sometimes they would need to wait with their clients for an ambulance for up to four hours. This increased the risk to the person waiting for support and for other people the care agency supported as it created difficulties providing staff for other people waiting for care.

- We heard that in Airedale, technology in the form of video consultations could be used when people became unwell so that they could be supported to receive treatment in some care homes. People could also be admitted directly to an assessment ward if this had been arranged by a GP. However, we were told that this was not always effective, for example a care home provider told us that on one occasion they had tried to arrange for the admission of one of their residents and were told that the ward was full which meant that the following day the person attended A&E.
- System leaders told us about safeguards in the system to support the families of people when they reached crisis point for example putting care support in place for an individual when the carer became ill. The BEST team was able to provide support seven days a week and 24 hours a day to ensure that people who were dependent on carers could receive support if their carer was in hospital.
- The virtual ward was well-established following its implementation in 2015. There was joined up work across the system to enable people to receive consultant-led care in their own homes. The virtual wards were monitored in the same way as hospital wards and there was support around managing long-term conditions such as COPD. The virtual ward also worked with the rapid response social care reablement team who were able to assess people within a two-hour time frame. For example, we heard that during our review a person had been visited by a physiotherapist and an occupational therapist so that the person who had been in crisis did not have to be admitted to hospital.
- At peak times district nurses visited hospital wards to assess whether people receiving care in hospitals could be discharged to receive care in their own homes. This initiative followed learning from a previous year when services were at crisis point. System leaders learnt that hospital staff were not always aware of the level of support that could be offered by district nurses in the community. By having these conversations on the ward and enabling clinicians to be assured about the management of people's care, people were able to be discharged from hospital earlier.
- We saw that hospitals recognised the importance of promoting wellbeing on the ward so that people's physical health did not deteriorate owing to lack of activity. People were

encouraged to get dressed and to be active where possible. However, there were some missed opportunities to promote independence such as enabling people to administer their own medicines. This would support them to regain their independence and enable them to manage their medicines following discharge from hospital without requiring support to do so. This was not routinely encouraged as staff were under pressure and it was quicker for them to administer medicines themselves.

- There was very good wrap-around support for people who were at the end of their lives and their families. In addition to the Gold Line, which provided advice and support 24 hours per day, families could be trained in the administration of anticipatory medicines. This meant that families could support their loved ones to be comfortable at the end of their lives and if they were in pain or distress they would not have to wait for support from healthcare staff.

## Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence**

### **Are services in Bradford safe?**

*There was good partnership working with the VCSE sector to enable people to return home from hospital safely. This ensured that people had safe and warm homes to return to and that their ongoing needs were assessed and supported. This would reduce the likelihood of people returning to hospital. People were able to return home sooner which meant that they were less vulnerable to hospital acquired infections or reduced mobility. However, further development of hospital discharge processes was needed, particularly around communication with care agencies and the management of medicines.*

- There was good use of interagency working and the VCSE sector to ensure that when people were discharged from hospital, their discharge was managed safely. The Home From Hospital service was led by Carers' Resource and supported people to return safely to their own homes. This involved ensuring that people were returned to a safe and secure environment and supported assessments for ongoing care and treatment. The team undertook an initial checklist of immediate practical things to ensure the person had food and heat.
- The Home from Hospital team also sought advice from professionals such as dieticians to

make sure that the hampers they provided had nutrients required to support recovery and then in turn helped volunteers to have conversations with the person about nutrition and hydration. The initial work would be followed up by further assessment of need for services such as befriending, support with benefits as well as practical health issues such as sight, hearing and dentistry.

- The Home From Hospital service provided information to people to promote their ongoing safety. For example, at the time of our review they were supporting people with awareness about postal scams as they had identified this as a risk.
- However, there were some gaps in the system that impacted on the safety of a person's discharge from hospital. VCSE providers found that there were some risks to people who were being discharged as hospital services did not always check that support was in place for people to return home, for example if people told them they received homecare they did not ensure that care providers were aware that the person was leaving hospital. This reflected what we were told by domiciliary care providers who said that hospital staff did not always check with providers that the package of care remained in place. The payment of a 30-day retainer to domiciliary care providers meant that people could have consistent care providers following discharge from hospital however people did not always understand when the period had ended and there was a risk that hospitals could send people home without a care package in place.
- Independent domiciliary, residential and nursing care providers told us that they routinely experienced problems with medicines when people were discharged from hospital into their care. Sometimes information about medicines was not sent home with the person as well as other important information such as DNACPR information. Occasionally medicines would be sent on to a person in a taxi several hours after they had left hospital. Care and hospital staff we spoke with shared these concerns and felt that the system would benefit from a universal approach on discharge medicines management. Discharge planning that included pharmacy staff in a timely way would reduce some of the risk. One person we spoke with had waited for medicines for more than four hours in a discharge lounge with their parent who had been placed on a fast track end of life care pathway. During this four-hour period staff did not check the person to see if they required food, hydration or pain relief.
- Analysis of stays in hospital for older people living in Bradford showed performance was better than the England average. Our analysis showed that in Bradford, a significantly low percentage of older people admitted as emergencies stayed in hospital longer than 7 days. This meant that people living in Bradford had a lower risk of developing infections and reduced mobility associated with longer hospital stays. The rate of emergency readmissions of older people within 30 days of discharge from hospital in Bradford had fluctuated around

the England average in recent years but was generally lower than the average across comparator areas.

### **Are services in Bradford effective?**

*There was good integrated multi-agency working to support people on their return home from hospital. For planned admissions, there was advance discharge planning in place. Health and social care staff worked collaboratively to share information, however some systems were still paper based and relied on out of date technology. While arrangements within health and social care systems for discharging people from hospital were effective, domiciliary care and care home providers did not always receive the right information in a timely way to help them support people when they were admitted or returned to the service.*

- There was a holistic approach to managing people's needs when they were discharged from hospital. The community connector service managed by a VCSE organisation ensured that there was social prescribing so that people could get a wider range of support on their return home. They liaised with health and social care agencies to manage practicalities such as dressing changes and benefits advice. People who went into hospital for elective surgery were identified at an early stage so that discharge planning could be put in place for their return home. This meant that people could have more choice and control over their care and support planning.
- Services were designed to support the flow through the system from hospital to home. The MAIDT worked collaboratively with health and social care staff to create fast and effective discharge plans. They undertook daily visits to wards to support the discharge process, and complex discharge team meetings with multidisciplinary working were held twice weekly and allowed for complex discharges to be effectively managed. At the time of our review the MAIDT was a relatively new service, but staff felt that it was already having positive impact. System leaders were working on developing this further, looking at how to move to more asset based approaches to assessment and practice building on people's strengths and abilities as they returned home.
- The multidisciplinary approach to discharge meant that people who returned home from hospital were supported by a workforce who had the right range of skills, including those in the VCSE sector. Staff we spoke with felt that they worked well with other multidisciplinary professionals and had built up relationships with them across the system which enabled them to discuss people's issues and resolve them as a team.
- Although health professionals and social care professionals had shared access to information through SystmOne (apart from BTHFT which only utilised this in A&E), information sharing on discharge from hospital was problematic, particularly when care home

providers and domiciliary care providers relied on the information. A trusted assessor model had not been implemented and there was a lack of trust from providers which needed to be overcome in order to manage this. Some providers felt that information provided when people left hospital was not always correct.

- Information we gathered from 18 registered managers of adult social care services regarding the flow of information on discharge from hospital suggested that receipt of discharge summaries in Bradford is mixed and when they are provided, they are usually in paper format with secure email or shared electronic systems rarely or never being used. Responses also indicated that the timeliness, accuracy and comprehensiveness of discharge summaries varied. One respondent noted that issues around confidentiality needed to be improved to enable better information sharing. This could be supported by consent arrangements with people using services.
- We found that although there was good collaborative working between staff this wasn't always supported with the best use of technology. For example, we found that the MAIDT relied on paper form filling which was then shared with colleagues via fax machine. This made the process onerous and time consuming and there was a risk that information could go missing. This was raised as an issue by staff but we also saw a particular example where a person who was due for a 'fast-track' discharge as they were at the end of their life, had their discharge from the ward delayed as the fax machine had broken.

### **Are services in Bradford caring?**

*We saw that when people returned from hospital to their home or a new place of residence, they were supported in a way that centred on their needs. People who received care at home could usually continue receiving care from providers who had previously provided their care and understood their needs. There was support from the VCSE sector to help people adapt to new conditions and build care and lifestyle choices that recognised their strengths and wishes.*

- When people returned home, there were services in place that ensured that their care was coordinated around their needs. The complex care multi-agency partnership was a multidisciplinary health-led team that comprised medical and nursing staff as well as psychology, therapy, personal support navigators and carer support navigators. People who would benefit from this support were identified either at home or hospital. Five support navigators worked alongside the clinical team. They coordinated follow-up services and tried to prevent readmission, providing wrap-around care to these people that followed them on their journey. Life preferences and choices were discussed with people using services and their relatives to manage their expectations and carers were given support.
- Staff we spoke with felt that there was still work needed to address people's

expectations and choices about new care settings, including enabling “honest” conversations with people and their families. This was flagged as issue across the West Yorkshire STP footprint. System leaders were working with NHS England to seek best practice that would enable them to better manage this as sometimes people could remain in hospital longer than they needed to, owing to disagreements about subsequent care settings.

- We saw that there was good support for people to make decisions about their future plans, particularly when the illness that had led to the hospital admission resulted in significant life changes or the person needing a new place of residence. We saw an example of a person who was living with dementia and their spouse wanted to support them to make a decision to return home. This was reviewed with a social worker and the best interests team. Staff noticed that, although the person could not express their feelings verbally, when they returned home on visits, they were more settled. At the time of the review steps were being put in place for the person to return home on a permanent basis.
- We saw examples of support from the VCSE sector that enabled people’s choices to be placed at the heart of care planning. For example, the Age UK support for people who were diagnosed with dementia provided a person-centred approach to people whose lives were undergoing change. One person they supported had been discharged from hospital following a chest infection. They had been diagnosed with multiple sclerosis and were registered blind. The support worker discussed the impact of their condition on their lifestyle and together they planned ways to maximise the person’s independence through the installation of equipment in their home. There was also district nurse put in place for support with catheter care. This meant the person was less reliant on their spouse with increased independence, dignity and quality of life.
- System leaders had used iBCF funding to pay a retainer to homecare agencies when a client required hospital treatment, for a period of up to 30 days. This was welcomed by care agencies and people who used their services as it meant that people could have continuity of care from care workers that they trusted. It alleviated the stress that some older people might experience with building new relationships, and allowed them to continue being cared for by people who had been providing personal care, sometimes for long periods before they went into hospital.

### **Are services in Bradford responsive?**

*There were a number of systems and options in Bradford to support people to return to their usual place of residence when they were fit to be discharged from hospital. We saw that reablement was effective as people were less likely to return to hospital within 91 days than people who lived in similar areas. People’s future care needs could be assessed and considered once they were out of hospital and joint working between the health and social care*

*and VCSE sector meant that a single assessment could be undertaken. However, if people were unable to return to their own homes and needed nursing or residential care, their choices were limited by a lack of quality provision. This meant that people might be starting a new phase of their lives in services that needed to improve.*

- There were systems in place to enable services to respond to people's needs following a period of crisis so that services could be delivered in the setting that was best for the person. The Care @ Carers' Resource service could be contacted by staff in A&E to support people to return home if their discharge from hospital took place between 9am and 8pm. The service could provide up to ten hours of care while other services were put in place and was linked to the Home from Hospital team which was also managed by Carers' Resource. There was also support from the Virtual Ward. This wraparound support was put in place around a single assessment which meant that people did not have to repeatedly tell their story to multiple agencies.
- The case studies that we looked at showed that arrangements for discharging people from hospital were timely and effective with involvement from families and the person's needs being considered in a holistic way. Discharges from hospital were supported in a variety of ways that fitted around the person. For example, the frail elderly team supported the discharge of around 66 people per month and had extended to a seven-day service. We saw that 22% of discharges following emergency admissions of older people occurred at weekends which meant that people who were found fit for discharge from hospital at a weekend did not have to wait until the following Monday before they could go home. Bradford discharged a higher percentage people from hospital at weekends than any of its comparator areas.
- The BEST provided reablement for a period of up to six weeks for people who were discharged from hospital. Analysis of ASCOF data showed that the proportion of people aged over 65 who were discharged from hospital and received reablement was, at 2.6% in 2016/17, slightly lower than the England average of 2.7% and lower than the average across comparator areas of 3.6%. However, this figure had been increasing in Bradford over the previous five years. Where older people did receive reablement services in Bradford they were effective, as a higher percentage (87.8%) were still at home 91 days after their discharge from hospital, compared to comparator areas (78.4%) and the England average (82.5%).
- The BEST also supported the discharge to assess process which was recognised as good practice in the high impact change model. It enabled people to make decisions about their future care outside of the hospital environment. We saw from data supplied by system leaders that, on an average day, 250 people were supported by the BEST.

- The system had made budget provision to ensure continuity of care for people returning home within 30 days of admission which meant they had the benefit of continuity of care from their usual domiciliary care provider as a retainer was paid to safeguard existing arrangements. In addition to the improved outcomes for people in respect of continuity of care support and relationships, it also meant that people were less likely to wait in hospital while a care package was recommissioned.
- The focus on packages of care in the community, intermediate care and the use of the VCSE sector meant that fewer people were delayed in their discharge from hospital. Our analysis showed that the number of people who stayed in hospital longer than they needed to was significantly lower than comparator areas and the England average. In Bradford, the average number of delayed days per 100,000 population aged 18+ between July and September 2017 was four, compared to 11 in similar areas and the England average of 13. The rate of delayed transfers in Bradford had been significantly lower than the England average in each month of our analysis from June 2015 to September 2017.
- We heard from people we spoke with that although people didn't stay longer in hospital than they needed to, sometimes delays happened because people being cared for could not agree on a residential service. The quality of care home services in the Bradford district was poorer than in similar areas and the England average. This limited people's ability to choose good care, particularly as people who wanted to receive care from a provider that was rated as good would be required to pay a top up even if they were entitled to social care funding. Of the seven residential services that were owned by the local authority, only two were rated as good. There was a risk of poor outcomes for people who had to choose new homes and live their lives in a setting that had CQC had identified as requiring improvement.
- We heard from social care providers that patient transport was not always effective and that people could experience delays and missed appointments. On the day of our visit to an extra care service someone had been waiting from 6am for transport to a 7.30am outpatient appointment. By 8am the transport had not arrived and this missed appointment could cause delays and risks to the person's health.
- Although system leaders told us that they needed to improve the timeliness of continuing healthcare assessments, we saw that across the three CCGs, assessments were completed in a more timely way than the England average.

## Maturity of the system

### What is the maturity of the system to secure improvement for the people of Bradford?

- There was a clearly articulated vision for the transformation and development of services for people living in Bradford. This vision could be articulated by system leaders, elected members and frontline staff. There was a well-developed joint strategy which was aligned with commissioning intentions. Delivery had begun on a number of strategic strands around helping people to avoid hospital admissions and to facilitate early discharge and progress could be measured by agreed metrics and results.
- The high level of trust between leaders in the system meant that their ability to have honest conversations was one of their drivers for success. These relationships had developed and improved over time, and leaders who joined the system had shared values which enabled continued success.
- There was a transparent and uncomplicated joint governance structure in place which enabled shared processes and decision making. The Health and Wellbeing Board was mature and had overarching oversight of the delivery of the transformation plan with operational, strategic and performance management boards sitting below it. This enabled elected members and people living in Bradford to hold leaders to account. The structure of the boards and the sub-groups sitting below it meant that there was shared decision making and accountability across health and social care and the VCSE sector was valued as an equal partner.
- There was a culture of trust between system leaders and improved relationships among frontline staff. There was a strong focus on collaborative working to meet the needs of the population and leaders needed to extend this work to build relationships with providers in the independent sector.
- Leaders worked collaboratively to shape the care market so that it would be sustainable and meet the needs of the local population. Although there had been some innovative and courageous funding decisions to build stability in the homecare market, there was still more work to be done to develop the quality of services and encourage the shaping of the independent care market to be able to support those with more complex needs.
- Resources were used collaboratively and targeted at high-risk cohorts to prevent crises and protect the wellbeing of people living in Bradford. We saw that planning of expenditure

around the BCF and the social care precept was designed to facilitate the smooth and prompt flow of people through health and social care services. It enabled integrated working and supported the development of a community led model. We saw that leaders were willing to make investments in structures and systems that support people who were at higher risk of needing services and were assured that this would produce long-term gains.

- Although there was a system-wide approach to workforce development, there were pressures across the system. Through the integrated workforce plan, system leaders had begun to look at shaping the workforce to support an integrated system. However, this work was at an early stage. System leaders were exploring ways of developing the local workforce to build career pathways for health and social care staff and reduce the workforce shortages in the system.
- Shared records and information governance was well developed in Bradford as information could be accessed across most primary and secondary healthcare and social care services. There were some barriers which were being addressed and there was a digital roadmap in place to describe this. There were innovative digital solutions in use to reduce the need for GP and hospital attendances. Further development was required around the design of some processes which relied on outdated methods for communication.
- The focus on prevention underpinned the strategic vision for Bradford through the Happy, Healthy at Home agenda. There was evidence that pathways across primary, community and secondary care supported the wider objectives of health maintenance and this would be further developed with the implementation of locality models. GPs, health and social care staff and VCSE providers worked together to support people to stay healthy and independent for as long as possible.

## Areas for improvement

**We suggest the following areas of focus for the system to secure improvement**

- System leaders need to address issues around quality in the independent social care market with a more proactive approach to contract management and oversight.
- Building on good relationships that exist between stakeholders such as VCSE organisations and GP alliances, this needs to be extended to the independent care sector.

- Leaders need to ensure that outcomes are person-centred and caring in line with the vision and strategy.
- NICE guidance<sup>2</sup> recommends that, apart from some exceptions, domiciliary care visits should not be shorter than half an hour. The commissioning of 15-minute domiciliary care visits needs to be reconsidered as concerns had been raised about the provision of care being task focused rather than person-centred and leading to an increased risk of medicines errors.
- There needs to be clearer signposting systems to help people find the support they need, particularly for people who funded their own care.
- Although good work was in place with the local authority MCA and best interest assessment team, system leaders need to ensure that staff in health services and independent social care provider services have a better understanding of people's rights and are able to understand the lifestyle choices that people make. System leaders need to address the fact that some people's experience is not consistently good and person-centred.
- There is potential to build primary care capacity and to maximise the impact of the primary care home model; the commissioning approach to primary care needs to maximise the outcomes from the two at scale GP models emerging in Bradford
- Although information sharing and governance was well-developed, system leaders need to consider how to streamline processes when people are discharged from hospital with less reliance on paper based systems.
- Medicines management when people have left hospital needs to be improved to reduce the time people have to wait for their medicines and to ensure that social care providers and people returning to their own homes have a clear understanding of the medicines they have been prescribed.

---

<sup>2</sup> <https://www.nice.org.uk/guidance/ng21/chapter/Recommendations#delivering-home-care>



Clive Kay  
Chief Executive Officer  
Bradford THT

Sent via email: [clive.kay@bthft.nhs.uk](mailto:clive.kay@bthft.nhs.uk)  
CC: ExecutiveOfficer@bthft.nhs.uk

Clive Kay, Chair of West Yorkshire &  
Harrogate Cancer Alliance Board &  
Amanda Bloor, Commissioning SRO  
of West Yorkshire & Harrogate Cancer  
Alliance Board  
c/o Wakefield CCG  
4th Floor, White Rose House  
West Parade  
Wakefield  
WF1 1LT

15<sup>th</sup> May 2018

Dear Clive

### **WY&H Cancer Alliance Board – Place-based Representation**

At the May meetings of the WY&H Joint Committee of CCGs and WYAAT CEOs there was agreement to restructure in order to strengthen the Cancer Alliance Board to enable it to set the strategic direction for cancer on behalf of the WY&H Health and Care Partnership. This includes taking responsibility for delivery of the WY&H Cancer Delivery Plan. We are writing to ask you to jointly consider and nominate a representative from your place to be a member of the WY&H Alliance Board.

The reshaped Alliance Board will be responsible for:

- Recommending the overall objectives of the Alliance to the WY&H System Leadership Executive Group;
- Providing a mechanism for joint action and joint decision-making for those cancer-related issues that are best tackled at scale;
- Overseeing prioritisation, deployment and assurance of resources specifically allocated to the Alliance (core team allocation and cancer specific transformation funds)
- Supporting the development of robust local partnership arrangements in each place to deliver person centred, integrated care to people affected by cancer
- Developing and implementing a mutual accountability framework for cancer which provides a single, consistent approach for assurance and accountability between alliance partners
- Adopting an approach to making collective decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours for the Partnership, keeping improved patient outcomes and experience at the heart of decision-making.

In practice, implementation of national cancer policy and delivery of cancer related operational standards happens in place. However, as we are increasingly being assessed externally as a

system-wide partnership it is crucial that we work together and support each other to reduce inequalities, maximise our performance and the resources at our disposal (especially where these are linked e.g. Cancer Transformation Funding) and deliver the greatest health gains for our populations. To work in this mutually accountable and supportive way our Alliance Board requires a more robust connection into place, and between place-based leads and Alliance level policy and project activity.

We therefore ask you to confer with your fellow local sector leaders to jointly nominate a representative who can fulfil the following:

- Attend Alliance Board with the knowledge and support of all sector leaders in their respective place;
- Working within the principles of integrated care systems be able to take an holistic view of your place-based cancer strategy and its delivery;
- Be briefed to contribute to meaningful discussion on delivery of local cancer plans, performance, risks, issues and mitigation.
- Be sufficiently senior and actively engaged in the cancer agenda to shape Alliance recommendations with confidence and provide assurance and accountability for delivery of agreements in place through strong local governance arrangements.

We are keen that the Board membership does not become too large to fulfil its remit effectively. However, if you feel strongly that the membership brief cannot be fulfilled by a single individual from your place then please let us know and we will try to accommodate. For your information we attach at Appendix 1 and 2 current and proposed membership including proposed 'sector' representation.

Occasional absence is inevitable. However, please do not nominate people who are unable to commit to regular attendance and will routinely send deputies as this will defeat our purpose. Replacements will be sought for anyone missing 3 or more meetings within a 12 month period. WY&H Cancer Alliance Board meets every two months. We plan for the first meeting of our reshaped Board at the next meeting **on Wednesday 4 July 14.00-16.00hrs** at a venue to be confirmed.

Please can you provide written confirmation and contact details for your chosen representative to [WYandH.CancerAlliance@wakefieldccq.nhs.uk](mailto:WYandH.CancerAlliance@wakefieldccq.nhs.uk) by Friday 8<sup>th</sup> June.

Yours sincerely



pp

Clive Kay  
Chair  
West Yorkshire & Harrogate  
Cancer Alliance Board



Amanda Bloor  
Commissioning SRO  
West Yorkshire & Harrogate  
Cancer Alliance Board

## PM speech on the NHS: 18 June 2018

### Introduction

I want to speak today about the future of our National Health Service. There is no place more fitting to do so than here at the Royal Free.

More than one hundred years before the NHS was conceived, the surgeon William Marsden discovered a young girl dying on the steps of St Andrew's Church in Holborn but could not find a hospital prepared to take her in. He was determined this should not happen again.

So he set up the Royal Free to provide healthcare for anyone who needed it, free at the point of use, regardless of background or income.

A century later this principle of fairness became the defining creed of our National Health Service.

From life-saving treatment to managing a life-changing condition - whoever we are, whatever our means, we know the NHS is there for us when we need it.

It was there for me when I was diagnosed with Type 1 diabetes. I will never forget the support - not just of my GP and consultants - but also the clinical nurse specialists attached to my local hospital. Their advice was critical: enabling me to adjust to the new treatment regime, to manage my condition, and minimise the impact it has on my life.

I would not be doing the job I am doing today without that support.

But as Prime Minister, I don't just get to see how the NHS helps me. I see how it helps other people when they need it most.

I will never forget visiting the Royal Manchester Children's Hospital in the aftermath of the Manchester Arena attack.

There, in the face of the very worst that humanity can do, I witnessed first-hand, the very best.

Doctors and nurses working 24 hour shifts to treat the injured.

And surgeons who were off-shift, dropping everything to come in and perform life-saving operations.

In every instance, I was struck not only by the medical expertise of the staff, but the compassion with which people were treated. Alongside the horror and anger over what had happened, I felt once again that deep sense of pride we all share in our National Health Service — and a humbling gratitude for the incredible people who work within it.

This is our National Health Service.

This is the model of healthcare that reflects our values as a people.

Our shared belief that no-one should face illness or injury alone.

That no-one should be denied medical treatment because they cannot afford to pay for it.

And that this great national institution that is there for us from cradle to grave should remain in public hands...not just now, not just for the next seventy years, but forever.

So today, as it approaches its 70th birthday, I want to talk about how we preserve those values of fairness on which our NHS was founded whilst building the NHS of the future; ensuring that it will be there for our children and grandchildren and beyond, just as it has been there for us in the past.

## **Our record**

The NHS was the crowning achievement of the post-war Labour Government. It is why, in the Members' Lobby of the House of Commons, Attlee stands alongside Lloyd George, Churchill and Thatcher as one of the four great 20th Century Prime Ministers.

But the NHS does not belong to a single political party.

The coalition government that led the country through the Second World War proposed the idea.

It was born of a national determination that the country we would build after the ravages of war should be a fairer and more civilised nation.

A nation where the giant evils of squalor, ignorance, want, idleness and disease should be tackled by collective effort.

There was a cross-party consensus on the core principles that underwrite our NHS.

In its 70 years it has been under the stewardship of Conservatives for 43 years – and Labour for 27 years.

And throughout that time its core values have endured.

When we took office in 2010, we recognised its unique importance.

At a time when we had to make difficult decisions on government spending in order to deal with the deficit left by to us, we protected and prioritised the NHS with real terms increases in spending each and every year.

That investment has delivered significant improvements for patients.

Clinical outcomes are better for almost every condition, with for example 7,000 more people alive today due to improved cancer survival.

The number of staff recommending the care of their own organisation in the 'friends and family test' has never been higher.

We are leading one of the largest expansions of mental health services anywhere in Europe.

And last year independent experts rated our NHS as the best and safest health system in the world for the second time running.

But it is also true that because of the difficult decisions we had to take to fix our public finances, the increases in NHS spending in recent years have been lower than the NHS has seen in the past.

And over the same period the demands on our health service have grown.

Much of this growth is a consequence of other welcome developments.

As we grow wealthier as a nation it is natural that we would want to spend more of our national income on being a healthier nation too.

Medical research and scientific discoveries mean there are more and better treatments available.

And we are living longer than ever before, but that often means people living with multiple complex conditions.

Other causes of the increase in demand are more concerning.

Malnutrition has given way to obesity as the great threat to our children's healthy development.

Our mental health is under growing pressure in modern society.

Research shows that loneliness is as damaging to our physical health as smoking 15 cigarettes a day.

The internet has brought countless opportunities, but we are only beginning to understand the risks it might also pose to our mental wellbeing.

So for reasons good and bad, the NHS is facing rising demands for more treatment, for more people, for longer and for ever more complex care.

This has meant that despite more funding, more doctors and more nurses, and great progress on treatments, our NHS is under strain.

Our NHS staff are rightly proud of what they do, but they worry that their current workloads are not sustainable.

But it is not just a question of money.

Patients admire the NHS, especially when it responds to an emergency like a heart attack. But when they try to book an appointment with a busy GP, or get some help for a relative with multiple conditions, too often they can be frustrated by a complex, hard to navigate system.

We have hospitals that are world leading for patient care, but others that lie too far behind the best.

As the NHS approaches its 70th birthday, it is the right moment to look again at how we secure the future of the NHS: now and for generations to come.

## **Long-term funding**

Let me start with funding.

It is clear that more money is needed to keep pace with the growing pressures on the NHS.

But it is not just a question of more money this year or next. To meet these pressures and deliver the world-class care that we all want and expect, the NHS needs to be able to plan for the future with ambition and confidence.

Over the last seventy years increases in health funding have often been inconsistent and short-term – creating uncertainty over what the funding position will be in as little as two years' time.

This has led to a system of planning from one year to the next, preventing much needed investments in technology, buildings and workforce.

We cannot continue to put a sticking plaster on the NHS budget each year.

So we will do more than simply give the NHS a one-off injection of cash.

Under our plan, NHS funding will grow on average by 3.4 per cent in real terms each year from 2019/20 to 2023/24. We will also provide an additional £1.25 billion each year to cover a specific pensions pressure.

By 2023/24 the NHS England budget will increase by £20.5 billion in real terms compared with today. That means it will be £394 million a week higher in real terms.

So the NHS will be growing significantly faster than the economy as a whole, reflecting the fact that the NHS is this government's number one spending priority.

This money will be provided specifically for the NHS. And it will be funded in a responsible way.

Some of the extra funding I am promising today will come from using the money we will no longer spend on our annual membership subscription to the European Union after we have left.

But the commitment I am making goes beyond that Brexit dividend because the scale of our ambition for our NHS is greater still.

So, across the nation, taxpayers will have to contribute a bit more in a fair and balanced way to support the NHS we all use.

We will listen to views about how we do this and the Chancellor will set out the detail in due course.

We should be clear that we are only able to make this funding offer because we have managed the public finances responsibly.

It is because of our balanced approach: to reduce debt as a share of GDP, to keep taxes as low as possible – and to invest in our public services.

So we will stick to our fiscal rules, reduce our debt but prioritise our NHS within public spending.

We also know we need to improve social care and continue to support prevention and public health, both for the benefits they bring in themselves and to relieve pressure on NHS care.

So we will come forward with proposals to put social care on a more sustainable footing. And we will set out budgets for both social care and public health as part of the forthcoming Spending Review.

But equipping our NHS for the future is about more than what we put in. It also depends critically on what we all get out.

In 2002, the then Labour Government significantly increased NHS funding, but much of this did not go on directly improving patient care.

That cannot happen again.

So in return for this increase in funding, the government will agree with the NHS later this year - a ten year plan for its future.

This must be a plan that ensures every penny is well spent.

It must be a plan that tackles wastes, reduces bureaucracy, and eliminates unacceptable variation, with all these efficiency savings reinvested back into patient care.

It must be a plan that makes better use of capital investment to modernise its buildings and invest in technology to drive productivity improvements.

It must be a plan that enjoys the support of NHS staff across the country – not something dreamt up in Whitehall and centrally imposed.

But NHS leaders at national and local level must then be held to account for delivering this plan.

This includes ensuring that over the medium term no NHS organisation is in financial deficit.

And it includes getting every part of the health service back on the path to delivering core performance standards so patients are never left waiting when they most depend on the NHS, whether that's for life-saving emergency care or treatment for cancer.

## **Vision**

The founding of the NHS was remarkable because it changed the nature of healthcare as we knew it.

We now have the opportunity for a similarly profound transformation.

At its heart it is about building an NHS around the needs of the patient. Taking the principle that the NHS provides care no matter who you are or what your means and transforming it into the principle that everyone deserves the right care, in the right setting, at the right time.

To do this we need to break down the barriers between providers so that staff and patients are empowered to work together across organisations - so that we have a health and social care system that addresses your physical, mental and social care needs together, not as separate problems to be dealt with in isolation.

We will need a workforce that is empowered to deliver the best possible outcomes, flexible enough to adapt to new models of care and valued for their commitment to our NHS.

We have the opportunity to lead the world in the use of data and technology to prevent illness, not just treat it; to diagnose conditions before symptoms occur, and to deliver personalised treatment informed not just by general understanding of disease but by your own data including your genetic make-up.

If we want not just to cope with an ageing population, but thrive too, we will need a renewed focus on prevention.

And finally we will not have succeeded in building the NHS of the future unless we recognise the importance of looking after our mental health, just as much as our physical health, and we put the resources in to mental healthcare to make that a reality.

So these are my five priorities: Putting the patient at the heart of how we organise care; a workforce empowered to deliver the NHS of the future; harnessing the power of innovation; a focus on prevention, not just cure; and true parity of care between mental and physical health.

I know that all of this is possible because much of it is already happening in parts of our NHS right now.

## **Sharing best practice across the NHS**

Indeed, the NHS we want to build for tomorrow can already be found in the very best of the NHS today.

We see it in the Royal Marsden Hospital and its academic partner, the Institute of Cancer Research, ranked as one of the top four centres in the world for cancer treatment.

We see it in innovative examples of integrated care – like in mid-Nottinghamshire where teams of different professions and staff from the NHS and Local Authority have worked together to reduce hospital admission by 6 per cent and care home admission by 20 per cent.

We see it in new models of social prescribing - like in Somerset where over 400 local care providers and volunteers are working together to support those whose health is being affected by loneliness.

We see it in outstanding NHS leaders who are using their expertise to improve other organisations – just as David Sloman and the team here at the Royal Free have been doing with Barnet and Chase Farm; and now with North Middlesex.

At its best the NHS is world class. But for decades it has been a challenge to spread that best practice.

When I brought together some of the most outstanding NHS leaders, they told me why.

Those who were innovating felt they were going against the grain. They described the competing incentives that lead to negotiations between different organisations at every step, and business cases and templates that seem to put process ahead of patients.

Those who were taking on struggling trusts said their organisations were not compensated for their effort and wasted too much time on reporting.

As one Chief Executive put it – sometimes you can spend so long reporting and providing assurance about the organisation you are trying to help, that you don't actually have time to do the work that's needed.

So a critical part of the long-term plan for our NHS must be to change this.

As Nye Bevan said at the Second Reading of the NHS Bill – our intention is that "...we should universalise the best, that we shall promise every citizen in this country the same standard of service."

Our long-term plan must empower NHS leaders to spread the very best of the NHS to every part of the country.

It must properly recognise and reward those who do so and hold those responsible for poor performance to account.

It must also make it easier to break down the barriers between different organisations to deliver integrated patient-focused care.

So people don't feel like a pinball in a machine, bounced from one part of the system to the next, re-explaining to the next healthcare professional what they had just said to the previous one.

And so they don't end up stuck in hospital when they could be better cared for in the community or at home; or waiting to see a GP when they could be at a pharmacy or getting help over the phone or online.

For example, as many as one third of people in hospital stay longer than they need to medically because they can't get the care they need in the community in time.

Yet for people aged over 80, 10 days of bed rest in hospital leads to the equivalent of ten years of muscle ageing. Ensuring people get the right care in the right place at the right time is not just about what is most efficient for the NHS. It is fundamental to the quality of care.

### **Building the workforce we need for the future**

To deliver such a transformation right across the NHS, we must invest in the workforce to deliver it.

Our NHS staff are the lifeblood of our NHS.

They care for a million new patients every 36 hours.

They are the doctors and nurses who look after us – not only with clinical expertise but with compassion.

They are the researchers and pioneers at the cutting edge, creating new NHS treatments.

They manage the GP surgeries, outpatient clinics and operating theatres that we all rely on.

And they will bring about change if they are empowered - and if we have enough of them with the right training and the right skills.

Today there are nearly 42,000 more clinical staff working in our NHS than there were in 2010.

But to those working tirelessly on the front line, too often it doesn't feel like that.

Growing demand and increasing complexity have led to a shortfall in staff. So our ten year plan for the NHS must include a comprehensive plan for its workforce to ensure we have the right staff, in the right settings, and with the right skills to deliver world class care.

Recruitment takes time. Students entering medical school this autumn will not become consultants until the early 2030s. So we will consider proposals from the NHS for multi-year funding for training places.

We will also need to create a more flexible workforce: with new routes into medicine and healthcare - building on the work to create new apprenticeships and the Nursing Associate Programme - and more diverse roles with the right skills to enable the holistic care we want to see.

More immediately we will act to increase the number of trained healthcare professionals in those areas of the NHS that are experiencing the greatest pressures.

So we will look at how we can support those with clinical training who are no longer in frontline roles, to return to patient care in some way.

And we are taking doctors and nurses out of the Tier 2 Visa Cap with immediate effect.

But the long-term plan also needs to do something more fundamental to make sure we train enough of our own people to work in our NHS and ensure we do enough to keep them.

It cannot be right long-term to rely so heavily on highly qualified health professionals from parts of the world where they can be desperately needed.

To do that we need to make careers in the NHS more attractive.

We need to recognise that today working practices in the NHS have not caught up with modern lifestyles.

Think of the nurse working beyond his shift for the fifth day in a row who can't pick up his children from school.

Think of the junior doctor with limited choice about where and when she works who has to alter her plans because rotas are changed at the last minute without her having any say.

Many people working in our NHS will look at the flexibilities their friends and families enjoy and see that their own jobs don't offer anything like the same.

And the same is true of career development.

Too often this is based around an assumption that people will want to do the same type of job for most of their career. For some that might be right, but others would embrace opportunities to learn new skills, take on new roles with new types of responsibility.

To change this, the long-term plan must fundamentally reset the deal between the NHS and its staff.

It is right that we lifted the pay cap and made a significant pay increase a core part of the new offer to over a million NHS staff.

But we must also take better care of staff and offer greater flexibility over where they work, when they work and what they can do.

We must do more to support the development of staff and provide meaningful opportunities to move between different organisations and into new roles.

And above all we need to listen to what staff themselves say about the support they need as they continue to deliver world class care in ever more complex clinical environments.

These things are often just as important as pay.

In short, we need a workforce strategy to make the NHS not just one of the world's largest employers but one of the very best.

### **Embracing the opportunities of technology**

New technologies are making care safer, faster and more accurate, and enabling much earlier diagnosis.

They are enabling greater self-care with new devices that give more independence to those managing different health conditions.

And they are transforming how we engage with the NHS so we can get the advice we need, when we need it and in the way we want to receive it.

Just last week, I hosted over 180 tech entrepreneurs and investors in Downing Street to celebrate London Tech Week.

It was fantastic to see some of our leading artificial intelligence technology in action.

This included a programme called Xim's Lifelight, which is trialling the use of a webcam to detect early warning of health problems.

I am determined to position the UK at the forefront of the revolution in Artificial Intelligence and other technologies that can transform care and create whole new industries in healthcare, providing good jobs across the country.

This is why we identified AI and responding to our ageing society as two of the Grand Challenges in our Industrial Strategy.

Our first two missions within those Grand Challenges are to use AI to diagnose at least 50,000 more people with cancer at an earlier stage within 15 years; and to give people five more years of healthy, independent, living by 2035.

And all of this underpinned by the additional £7 billion we have allocated to research and development.

There are already devices that combine with smartphones to enable sophisticated home self-care and remote monitoring.

From blood pressure cuffs to smart inhalers and remote sensors that can detect changes in heart rhythm and track them on your phone.

Systematically implementing digital innovations with the strongest evidence base will have a transformative effect.

I have seen the beginnings of that myself.

As a Type 1 diabetic, I have recently changed the way I monitor my blood sugar so I don't need to prick a finger for blood so often.

And when I attended the Juvenile Diabetes Research Foundation awards earlier this year, I heard about an artificial pancreas in development that could dispense altogether with the need for multiple daily insulin injections.

We also need to invest in technology to improve the way care is delivered.

This includes pioneering the further development of a vast array of apps which allow people to access health support online, by email, by phone or face to face depending on what they need, what they want, and what is convenient to them.

Put simply, our long-term plan for the NHS needs to view technology as more than supporting what the NHS is doing already.

It must expand the boundaries of what the NHS can do in the future, in the fastest, safest and most ambitious way possible.

### **A renewed focus on the prevention of ill-health**

My next priority for the ten-year plan is to create a renewed focus on the prevention of ill-health.

Whether it is cancer, heart disease, diabetes or a range of mental illnesses, we increasingly know what can be done to prevent these conditions before they develop – or how to ameliorate them when they first occur.

This is not just better for our own health, a renewed focus on prevention will reduce pressures on the NHS too.

As a government, we are committed to national action where we believe this can help people to make healthier choices.

That is, for example, why we published our world leading childhood obesity plan in 2016 and why we will be taking this further in the coming weeks.

But I want our long-term plan for the NHS to help every individual at a more personal level.

For we can increasingly use world-leading expertise in genomics to understand the risks to our own individual health.

And we can draw on cutting edge technology to monitor a condition and identify the actions we can take to remain healthy.

For example, NHS England, Public Health England and Diabetes UK are creating apps and wristbands that will help those at risk of type 2 diabetes prevent or delay the onset of this disease.

This is just the beginning of what can be possible.

Over the next decade, I want the NHS and its partners to develop ways to deliver much more personalised health information and advice to each of us - delivered in the way we choose to receive it.

### **Improving access to good mental health services**

The long-term plan must also address an issue which is a personal priority for me - mental health and its place at the heart of our NHS.

We all know someone that has been affected by mental health problems - a family member, a colleague, a friend.

But when the NHS was established seventy years ago mental health and mental illness were not well understood.

It was not something that people talked about.

And so as the NHS has grown mental health was not a service that was prioritised.

Yet it is estimated 1 in 4 of us has a common mental disorder at any one time.

The impact of mental illness is vast, from the devastating effects it can have on people's lives, to the productivity of our national workforce.

And with young people spending more time online and on social media - there are severe strains on their mental resilience and rising rates of mental health diagnoses in children and adolescents – as I heard here today in this very hospital.

Thousands of professionals deliver vital mental health services every day in our NHS - but for too long we have accepted that if you have a mental illness too often you will not receive the same access to care as if you have a physical ailment.

And that must change.

To transform how we look after our mental health, we will need to look beyond the role of the NHS so everyone plays their part – whether it is schools or the criminal justice system, private sector employers or social media companies.

And we need to change how we view mental illness - so improving our mental wellbeing is seen as just as natural and positive as improving our physical health.

Thanks to the efforts of so many across society, that change is beginning and the stigma and discrimination around mental health are now reducing.

But as more people are rightly coming forward to seek help, so NHS mental health services are struggling to cope with this additional demand.

The Five Year Forward View for Mental Health set a number of priorities – including perinatal and children's services, crisis care and psychological therapies – and backed them with additional funding. And there has been encouraging progress: for example, over 7,000 additional women accessed the expanded specialist perinatal services last year.

But we still have a long way to go.

Too often we hear that, in spite of the best efforts of staff, people are unable to access the support they need.

So we must improve.

This means that rather than just trying to catch up with the rest of the NHS, the long-term plan must contain proposals for mental health that are even more innovative and more ambitious.

This could include attracting more of the best graduates into the mental health professions; or finding new ways to provide joined-up care in the community, or helping people to manage their conditions so they do not reach a crisis point.

It must be supported by sustained investment that reaches the frontline of mental health services and staff.

And for too long we have had one expectation for minimum waits and eligibility for care when we have a physical condition; and another entirely in mental health.

So the long-term plan must move us towards new clinically defined access standards for mental health that are as ambitious as those in physical health.

## **Legislation**

As the NHS steps up to develop this ten year plan – I will do everything possible to support it.

That means more than providing the multi-year funding I have offered.

It also means removing any barriers that hold back progress.

I believe that right now, parts of our regulatory framework might be doing just that.

The intentions behind the creation of the internal market in the early 1990s were right.

It is right that those commissioning health services should be close to the populations they serve. They understand the specific needs of the people in their area – and they can choose the providers and services that best meet those needs.

It is also right that the best providers should have greater autonomy than those that are struggling. This drives innovation in care that would otherwise not happen.

But I believe that, as our NHS evolves, and delivers more joined up care across different services, we should make sure the regulatory framework keeps in step and does not become a barrier to progress.

So I think it is a problem that a typical NHS Clinical Commissioning Group negotiates and monitors over 200 different legal contracts with other, different, parts of the NHS.

It is too bureaucratic, inhibits joined up care, and takes money and people away from the front line.

So where legislation is making it harder for professionals from different parts of the NHS and different Local Authorities to work together – we should be prepared to change it;

Where it is resulting in overly bureaucratic processes – we should be prepared to change it;

And where it is making it harder to hold NHS leaders accountable for delivering better outcomes for people – we should be prepared to change it.

However, as we do this, I believe that any legislative proposals 'should be led by the health and care community' as recommended by the Health and Social Care Select Committee.

We must learn the lessons of the past and not try to design or impose change from Whitehall.

So as the NHS develops the ten year plan we will consider any proposals from the NHS on where legislation or current regulation might be creating barriers. And where we feel that action is required we will look to build the broadest possible consensus in parliament – so we truly create an environment in which the NHS can get on with delivering the long-term plan.

Similarly, as the NHS develops the priorities and outcomes the long-term plan will deliver, we would like clinicians to confirm the NHS is focused on the right targets - for both physical and mental health - which incentivise the best care and outcomes for patients, and have the broad support of our health professionals.

## **Devolved administrations**

Finally, I have focused today on the NHS in England because that is the responsibility of the UK government.

It is the devolved administrations in Scotland, Wales – and when sitting again, Northern Ireland – which have responsibility for the NHS in their parts of the UK.

But because the UK Government is increasing NHS spending in England, extra money will go to Scotland, Wales and Northern Ireland under the Barnett formula, which ensures every part of the UK gets a fair share of public spending.

While it is up to the devolved administrations to spend the money as they see fit, I believe everyone in the UK should benefit from this extra funding for the NHS.

So I urge the devolved administrations in Scotland and Wales to use this money to improve the NHS – and to develop their own long-term plans for NHS Scotland and NHS Wales.

This way the vision I have set out today can benefit the whole United Kingdom.

## **Conclusion**

The National Health Service is not the property of any one party or government.

The clue is in the name – it belongs to the nation.

Over seventy years, it has been held in trust by each generation for the next.

But those seven decades have not been years of stasis.

They have been years of constant evolution and growth.

Each generation has had to play its part in helping the NHS to meet the changing needs of the people it serves.

The values and principles of 1948 remain indelible, but how we make a reality of them in the modern NHS of 2018 has changed beyond recognition from the starched caps and bedsteads of post-war Britain.

The NHS that celebrates its 100th birthday in 2048 will be able to achieve things which today we can scarcely imagine – but only if we, at this moment, take the action necessary to secure the NHS's future.

That is what the long-term plan for the NHS will do.

It will ensure that our NHS does indeed remain -

There for everyone.

Free at the point of use.

With high quality care based on clinical need, never the ability to pay.

A National Health Service that is there for each one of us.

That is our mission.

Let us work together to deliver it.

So that together we can secure this great national inheritance for generations to come.