BOARD MEETING

29 June 2017

Paper Title:	Bradford Provider Alliance Memorandum of Understanding
Section:	Public
Lead Director:	Medical Director
Paper Author:	Dr Andy McElligott, Medical Director
Agenda Item:	**15**
Presented For:	Approval

1. Purpose of this Report:

The purpose of this paper is to present to Board the final draft of the Bradford Provider Alliance Memorandum of Understanding for approval.

2. Summary of Key Points

The development of a Bradford ACS is an important plank of our local Sustainability and Transformation Plan.

The first steps have taken the form of 'structured collaboration', initially for a new, end-to-end diabetes pathway, and latterly for 'out of hospital' care.

A vital element of structured collaboration has been the formation of a Bradford Provider Alliance (BPA). The membership 'rules' of the BPA are now set out in a Memorandum of Understanding (MoU).

The MoU will sit alongside the Alliance Agreement which the Trust signed in April.

The ambition of local health and care partners is to move from alliance contracting to a single, unifying, outcomes-based contract for the majority of health and care provision from April 2020.

3. Board Consideration

Board is asked to consider

- The content of the MoU and whether BDCFT can become a signatory without further modification of the agreement.

4. Financial Implications

None

5. Legal Implications

The MoU is not legally binding

6. Assurance

	Assurance provided?
Board Assurance Framework	Yes: Strategic Risk 2.1 [If local health and care leaders do not develop a plan for sustainable health provision then individual organisations may fail with potential to destabilise the whole system]
CQC Themes (see below)	Yes: well led
NHSI Single Oversight Framework	No

This paper provides assurance in relation to the following CQC Themes:

Well led:	The leadership, management and governance of the organisation make sure it's providing high-quality care that is based around individual needs, encourages learning and innovation, and promotes an open and fair culture.

7. Previous Meetings Where the Report Has Been Considered:

Audit Committee		Quality & Safety Committee		Remuneration Committee		FB&I Committee	
Executive Management team	✓	Directors Meeting		Chair of Committee's Meeting		MH Legislation Committee	

8. Risk Issues Identified for Discussion

None

9. Publication Under the Freedom of Information Act

This paper has been made available under the Freedom of Information Act

10. Recommendations:

That the Board formally approves the Bradford Provider Alliance MoU and, in so doing, agrees that BDCFT becomes a signatory to said MoU

Bradford Accountable Care System

Background

The vision set out in the Bradford District and Craven 5-year forward view (2014-19) was *"to create a sustainable health and care economy that supports people to be healthy, well and independent".* Three years on, we now have a place-based plan that is one element of a broader Sustainability and Transformation Partnership (STP) for West Yorkshire and Harrogate. A key aspect to achieve our local vision is the creation of two accountable care operating models – one across Bradford and the other across Airedale, Wharfedale and Craven – using the right drivers to make the right things easier to do, e.g. one budget for one contract, incentivised to prevent ill-health, with a common approach to quality improvement in treatment standards.

The vision expressed in the West Yorkshire and Harrogate STP articulated a range of proposals. Those which particularly relate to the development of an accountable care system (ACS) include:

- Every place will be a **healthy place**, focusing on **prevention, early intervention and inequalities**
- We will work with local communities to build **community assets** and resilience for health
- People will be **supported to self-care,** with **peer support** and technology supporting people in their communities
- Care will be **person centred,** simpler and easier to navigate
- There will be **joined-up community services across mental & physical health and social care** including close working with voluntary and community sector
- In some areas local services will evolve into **accountable care systems** that collaborate to keep people well
- We will move to a **single commissioning arrangement** between CCGs and local authorities and have a stronger West Yorkshire and Harrogate commissioning function
- We will always **actively engage people** in planning, design and delivery of care

For commissioners and providers, the collective challenge is to move from a complicated system that is delivered via multiple activity-driven contracts with organisations operating largely in isolation, to a simpler system with fewer outcome-based contracts across groups of providers designed with individuals at the centre of their care.

The formal journey towards the establishment of an ACS in Bradford began in October 2015 when the two Bradford CCGs launched a structured collaboration process for the provision of diabetes services.

The structured collaboration was established within a strategic context of Bradford having comparatively poorer outcomes for comparatively higher spend (2010/11 National Diabetes Audit Report).

The stated intention of the CCGs was to place a single, 10-year contract for an end-to-end, integrated diabetes service, across Bradford and that this exercise would be a precursor for a 'complex care' structured collaboration (again resulting in a single contract) and the eventual establishment of a Bradford ACS whereby a single, outcomes-based contract would be placed relating to the entirety of health and care needs for the population.

In response to the structured collaboration process, local providers of health and social care formed the Bradford Provider Alliance (BPA) and this now includes BDCFT, BTHFT, Bradford Care Alliance (BCA – a community interest company of which all Bradford GP practices are members), the Local Authority (as provider) and Bradford VCS Alliance Ltd (a not-for-profit company of which many local VCS organisations are members).

Bradford CCGs supported the BPA with non-recurrent funding and, latterly, have seconded some senior managerial resource which signals the direction of travel towards a smaller, more strategic commissioner and, potentially, a legally-constituted provider vehicle responsible for large, accountable care contract(s).

The BPA established an Integrated Management Board (IMB) which is now chaired by the BDCFT Medical Director. Membership is derived from the executives of the constituent organisations.

Governance and Contracting

The overall responsibility for directing and leading the development of a Bradford ACS now rests with the newly-formed Bradford Accountable Care Board (BACB), of which the Chief Executive and Medical Director are members. The BACB is a co-operative body, whose membership is drawn from the executives of Bradford-based commissioners and providers. It has no delegated powers of its own.

The response to local structured collaborations has been for the BPA and commissioners to work together to develop an 'alliance contracting' approach; this approach is underpinned by formal documentation / agreements which require sign-off by the Boards / Governing Bodies of the parties to those agreements.

The relevant documents for consideration / sign-off by the BDCFT Board are the **Alliance Agreement (AA)**, which also sets out the Terms of Reference of the BACB and the **Memorandum of Understanding (MoU)**.

The AA was signed by BDCFT, in April, following Board approval.

The MoU is not a legally binding document. It is a formal business document used to outline an agreement made between the various provider entities and sets out how the various partners of the BPA will work together to deliver their obligations as set out in the AA.

In line with the AA, the MOU will expire on 31st March 2019, and will thereafter be subject to annual review. Any partner may exit the MoU by giving 6 months' notice in writing to the other partners at any time.

Schedules, relating to each workstream set out in the AA, will be added as and when service contracts are signed.

The MoU is attached below as Appendix 1.

Recommendations

That the Board formally approves the Bradford Provider Alliance MoU and, in so doing, agrees that BDCFT becomes a signatory to said MoU.

Appendix 1

Bradford Provider Alliance (BPA)
Draft Memorandum of Understanding (MoU)

1 Purpose of the MoU

A Memorandum of Understanding (MoU) is a formal business document used to outline an agreement made between two or more separate entities, groups or individuals. The main purpose of the Bradford Provider Alliance MoU is to establish an agreed framework and a written understanding of the agreement between the named parties.

This document serves as a high level MoU between the parties and will be added to during the course of development towards appropriate contracting arrangements and to enable progress towards an accountable care system through the addition of schedules as agreed with the mutual written consent of all parties. The schedules are a scheme specification which set out the arrangements for an individual scheme agreed by the parties to this MoU to be included under this agreement.

2 General

This MOU is not a legally or contractually binding agreement; its principles are generic and describe how the providers that are party to the MOU will work together. It describes a consensus between the organisations that enables the Bradford Provider Alliance to take a common approach and commitment to embedding agreed guiding principles, behaviours and ways of working, as required to become an accountable care system by 2021. Until a legal framework is agreed and signed by all parties the individual organisation governing bodies remain ultimately accountable for their individual contracts.

3 The parties agreeing to this MoU are:

- Bradford Care Alliance CIC Ltd,
- Bradford District Care NHS Foundation Trust,
- Bradford Teaching Hospitals NHS Foundation Trust,
- Bradford VCS Alliance Ltd,
- City of Bradford Metropolitan District Council.

4 Term

The MOU will commence when on the 1st July 2017 and will expire when superseded by another agreement by the parties. It will be subject to formal annual review and additions in-year in the form of schedules to the agreement may be included as agreed by all parties. Any partner may exit the MOU by giving 6 months' notice in writing to the other parties at any time.

5 Function of the Bradford Provider Alliance (BPA)

To develop and deliver an accountable care system across the health, care and support services that delivers high quality, cost effective services that improve the wellbeing of the population of Bradford and delivers efficiencies.

6 Bradford Provider Alliance MoU

In entering into this MOU, the parties are taking a step towards the establishment of an Accountable Care System (ACS), linked to new models of care set out in the Five Year Forward View and Bradford District and Craven Health and Wellbeing Plan, through the integrated delivery of services in accordance with the proposed Alliance Agreement. This memorandum is not a legal contract.

7 BPA Guiding Principles, Behaviours and Ways of Working

The Parties agree to the following principles in relation to the provider alliance arrangements and the performance of this MOU:

- At all times to act in good faith towards each other and within the principles and behaviours identified within this MOU
- To act in a timely manner and recognise the time-critical nature of the service developments and respond accordingly to requests for support accepting competing pressures
- For the Parties to be accountable by taking on, managing and accounting to each other for performance of the respective roles and responsibilities set out in this agreement
- To communicate openly about major concerns, issues or opportunities and support each other in finding system solutions relating to the agreement
- To learn from best practice of other development of new models of care and the introduction of novel and complex contracts; and to seek to develop as an alliance to achieve the full potential of the relationship
- To share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost
- To adopt a positive outlook and to behave in a positive, proactive manner
- To act in an inclusive manner in regards to collaboration with people
- To adhere to statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, data protection and freedom of information
- To manage internal and external stakeholder relationships effectively
- To focus on people's care, quality and experience while seeking the best value for money, productivity and effectiveness
- To work toward a reduction in health inequality and improvement in health, care and support and well-being

- To promote use of innovation in identifying solutions for achieving an ACS
- Be committed through engagement and co-production with people to redesign care to achieve an ACS
- Notify any other relevant parties of any issues or complaints about the services described within the schedules of the MOU, and seek to resolve those issues bearing in mind the behavioural commitments described in the MOU
- No risk sharing arrangement shall take place between the partners without an express written agreement to that effect

8 Responsibilities of All Parties

Responsibilities of each of the parties are to:

- Work within the principles, behaviours and ways of working identified within this MoU
- Provide resources to support the progress towards an ACS as agreed by all parties
- Provide resources to support the development of the provider alliance where required
- Provide direction on key issues and areas of focus for the development of the ACS
- Fully participate in the Bradford Provider Alliance Integrated Management Board and any other relevant delivery arrangements to implement the agreed new models of care as described in the MoU schedules
- Disclose to each other the full particulars of any real or apparent conflicts of interest in connection with this MoU

9 Schedules

As described in Section 1 schedules may be added to this MoU in-year and during the course of development towards appropriate contracting arrangements and to enable progress towards an accountable care system as agreed with the mutual written consent by all parties. The schedules are a scheme specification which set out the arrangements for an individual scheme agreed by the parties to this MoU to be included under this agreement.

Schedule 1 is the Terms of Reference for the BPA Integrated Management Board. The provider organisations (parties to this agreement) have established the Integrated Management Board to enable the parties to work collaboratively to deliver more integrated services to improve care for people. The terms of reference for the IMB set out accountabilities, responsibilities and arrangements for the IMB.

Schedule 2 – Dispute Resolution Procedure to resolve issues to the parties mutual satisfaction so to avoid all forms of dispute or conflict in performing their commitments under this MoU.

Schedule 3 – Policy for the management of conflicts of interest

Schedule 4 is the Integrated Diabetes Service Model. This describes the scope and current delivery baseline for a unified diabetes service.

Schedule 5 - It is the commissioners stated intent that a range of activity generally described as “out of hospital services” will be agreed and Phase 1 service specifications developed and agreed by September 2017, with Phase 1 contract arrangements in place by April 2018. If this is agreed this it will be added as Schedule 5.

Additional schedules to enable progress towards an accountable care system may be added as agreed by all parties and could include; risk and reward share and staff aligned to undertaking work for Bradford Provider Alliance.

10 Intellectual property rights

Any intellectual property rights created in the course of the establishment of the new models of care, or any aspect of the ACS, should vest in the Party whose employee created them if intellectual property can be attributed to an individual. No risk sharing arrangement shall take place between the partners without an express written agreement to that effect. It is accepted through working in partnership in the spirit of this agreement intellectual property rights may not be attributable to an individual.

11 Charges and liabilities

Parties will each bear their own costs and expenses incurred in complying with their commitments under this MoU, including those associated with their employees or agents who are participating in managing and delivering the various elements of the new models of care.

12 Sharing of information and conflicts of interest

The parties shall deal with and share all information relevant to the schedules in an honest, open and timely manner, in accordance with the operational and service specifications in the NHS supply contract(s), and comply with data protection and information governance requirements.

12.1 The Parties will all follow their own organisational conflict of interest policies – Schedule 3.

All parties will

- disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this MoU or the performance of the Services as set out in Schedules (see Section 9), immediately upon becoming aware of the conflict of interest whether that conflict concerns the Party or any

person employed or retained by them for or in connection with the performance of the Services;

- not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other parties) before they participate in any decision in respect of that matter;
- and use best endeavours to ensure that their representatives on the IMB and work-streams also comply with the requirements of this Section 12.1 when acting in connection with this MoU or the performance of the Services.

If there is:

- any uncertainty or a lack of consensus between the Parties regarding the existence of a conflict of interest under Section 12.1.
- any query or Dispute as to whether any Party is put in a position (or will be) of conflict under Section 12.1.

which cannot be resolved with recourse to the protocol referred to Section 12.1, any Party may refer the matter for resolution under Schedule 2 (Dispute Resolution Procedure).

13 Dispute, problem and complaints resolution

The parties agree to adopt a systematic approach to problem resolution which recognises the principles, behaviours and ways of working set out in Section 7 above.

If a problem, issue, concern or complaint comes to the attention of a party in relation to the way the alliance arrangement is operating or the associated work-streams (identified in the supporting Schedules – Section 9) which relate to the BPA principles or any matter in this MoU and is appropriate for resolution between the providers such party shall notify the other parties and the parties each acknowledge and confirm that they shall seek to resolve the issues by a process of discussion.

If any party considers an issue identified in accordance with the above to amount to a dispute requiring resolution in accordance with the dispute resolution procedure (Schedule 2) and such an issue cannot be resolved within a reasonable period of time, the matter shall be escalated to the IMB which shall decide on the appropriate course of action to take.

If any Party receives any formal inquiry, complaint, claim or threat of action from a Third Party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the delivery of any work-streams identified in the supporting Schedules (Section 9), this shall promptly be referred to the IMB. Such referral shall not prevent the Party from responding as it considers

appropriate.

The Parties shall each publish, maintain and operate a Complaints Procedure in compliance with the relevant law and mandatory guidance. In the event that any Party receives a complaint that relates to any of the services set out in the supporting Schedules – see Section 9, then all the other Parties shall co-operate through the IMB for the purposes of investigating that complaint.

14 Monitoring and Review

There will be a process for monitoring and review of this MOU in-year through the addition of schedules as agreed by all parties, with a formal review at least annually, and this will take place through the Bradford Provider Alliance Integrated Management Board. This will be used to shape the development of and support the BPA going forward.

15 Termination and withdrawal

Termination of this MoU shall not affect any rights or liabilities of the Parties that have accrued prior to the date of termination.

15.1 Mutual termination

Subject to the general principles set out in the MoU the parties may unanimously agree, in writing, to terminate the MoU in whole or in part at any time.

15.2 Withdrawal in part

Subject to the general principles set out in the MoU the parties may unanimously agree, in writing, to terminate the MoU in whole or in part at any time by:

- Giving the other parties not less than 6 months written notice

16 Notices

Any notices given under this MOU shall be in writing and shall be served by hand, post, E-mail by sending the same to the address of the relevant organisation.

By post shall be effective upon the earlier of the actual date, or five (5) days after mailing;

By hand shall be effective upon delivery;

By email shall be effective when sent in legible form subject to no automated response being received.

17 SIGNATORIES

The signatories to this MOU are:

On behalf of Bradford Care Alliance CIC Ltd:

Name: .....

Role: .....

Signature: .....

Date: .....

On behalf of Bradford District Care NHS Foundation Trust:

Name: .....

Role: .....

Signature: .....

Date: .....

On behalf of Bradford Teaching Hospital NHS Foundation Trust:

Name: .....

Role: .....

Signature: .....

Date: .....

On behalf of Bradford VCS Alliance Ltd:

Name: .....

Role: .....

Signature: .....

Date: .....

On behalf of City of Bradford Metropolitan District Council:

Name: .....

Role: .....

Signature: .....

Schedule 1

Bradford Provider Alliance

Integrated Management Board

Terms of Reference

Establishment

The provider organisations (as listed at Annex A (the "**Parties**") have established the Integrated Management Board (the "**IMB**") to enable the Parties to work collaboratively to deliver more integrated services to improve care for patients and service users. In the short term the activities of the Board will be focused around the establishment of the Provider Alliance and the "structured collaboration" process for the new diabetes service in Bradford.

A statement of principles dated July 2016 and signed by the Parties (the "**Statement of Principle**s") sets out the principles which will apply to the operation of the Alliance Integrated Management Board

Aim and Purpose of the Integrated Management Board

The main roles of the IMB are:

- to provide a forum for discussion and decision making in respect of improving the quality and efficiency of the provision of the Services for patients and service users across Bradford
- to set the vision and have strategic oversight over the development of the Provider Alliance in Bradford
- to have strategic oversight and key decision making on the development of a new service pathways for Bradford
- to engage constructively and collaboratively with key stakeholders, including commissioners and other third parties
- to keep their respective governing bodies informed and to deliver internal communications as required, and to secure the necessary internal approvals as appropriate

The IMB shall carry out its role in accordance with the:

the key objectives of the Alliance Board (the "**Key Objectives**");

the Statement of Principles; and

these Terms of Reference.

These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the IMB and have been agreed and ratified by the Parties.

Further details of the remit and role of the IMB in respect of the Project are set out at Annex B.

Appointment of Party Representatives

Each of the Parties has appointed 2 individuals to represent them at meetings of the Integrated Management Board ("**Party Representatives**"). The initial Party Representatives are set out at Annex A.

The IMB should consist of Representatives who can offer a balance of skills, including: Finance, Clinical, Governance, Operations, HR

The Parties may remove or replace their respective Party Representatives at any time by notice to the other Parties.

Any Party Representative may appoint an alternate Party Representative to act on their behalf ("**Alternate**"). An Alternate will be entitled to attend, be counted in the quorum and make decisions at any meeting at which the Party Representative appointing them is not present and do all the things which their appointing Party Representative is entitled to do.

The IMB will ensure that the list of Parties and Party Representatives at Annex A of these Terms of Reference is updated from time to time to reflect any appointments to and removals from the Alliance and the Integrated Management Board.

Meetings and Proceedings of the Integrated Management Board

Frequency of Meetings

The IMB shall hold meetings monthly, or more frequently as is deemed appropriate by the Parties in all the circumstances.

Chair

The IMB members shall appoint a chair to oversee meetings of the IMB (the "**Chair**").

The Chair will be from with the parties of this alliance and will be rotated on a 6 monthly basis – the next date for review will be November 2017.

1.1 The Chair will act as facilitator and advisor to the IMB

4.5 In the absence of the Chair then an alternate or deputy Chair may be appointed by a majority vote of the IMB. References to the Chair in these Terms of Reference shall be taken as references to the alternate or deputy Chair where applicable.

Special Meetings

A special meeting may be called at any time by the Chair or by any of the Parties Representatives upon not less than 7 clear working days' notice being given to the Party Representatives and the Chair of the matters to be discussed.

Quorum

No business shall be transacted at any IMB meeting unless a quorum (as set out in paragraph 0 below) is present.

Attendance by at least 3 Alliance Parties is required to be present, and so a minimum of 3 Party Representatives plus the Chair to be quorate.

4.7 For matters requiring Alliance Parties to vote, then all Alliance Parties are required to be present, and so a minimum of 4 Party Representatives plus the Chair to be quorate.

Additional Attendees

The IMB may invite such persons as it thinks fit to meetings but such invitees shall not count towards the quorum for the meeting and shall not be entitled to vote.

The Programme Director will routinely attend IMB meetings

Minutes

The Integrated Management Board shall keep minutes of the proceedings at meetings of the IMB and circulate drafts of the same within 3 working days of such meeting. Such minutes shall be approved by the IMB at its next meeting.

Flash reports from each workstream should also be sent to the IMB for information.

Minutes of Progress Review Meetings with the CCG should be sent to the IMB for

Information and discussion as appropriate

Voting

A resolution put to a vote of the IMB meeting shall be decided on a show of hands. On a show of hands, each Alliance Party/organisation who is present at such meeting has one vote. The Chair will work to establish unanimity as the basis for decisions.

At present, the Alliance is not a legal entity. Through consensus the IMB aims to agree recommendations for each respective organisation to submit to its own approval process as appropriate.

Conflicts of Interest

6.1 All Organisations and their Representatives shall proactively declare any interests in any matter coming before the IMB, ideally before the meeting, but certainly during a meeting if a conflict of interest becomes evident. Such member must provide the Chair with such details as are necessary for the other Parties to decide whether or not to authorise the conflict and allow such Representatives to participate on the matter.

Workstreams

The IMB may appoint Representatives or such other persons who they may select from time to time to establish Workstream Groups required to meet the Key Objectives and deliver a Programme of Work. Each Workstream Group shall establish its own terms of reference that act in accordance with these Terms of Reference, the Statement of Principles and any instructions of the Alliance Board. Workstreams will report to the IMB on their activity as set out in their respective terms of reference agreed by the IMB.

On the establishment of a Workstream, the IMB shall agree the:

membership;

lead for the workstream

objectives and the timescales in which those objectives should be met; and,

the financial and non-financial resources to be provided to each Workstream, including the level of engagement required from the Alliance partners to enable the workstreams to conduct its business.

Progress Review Meetings

Bi monthly Progress Review Meetings will be held with the CCG. The IMB shall appoint up to 4 Representatives to attend Progress Review Meetings. Representatives shall normally be: IMB Chair, Programme Director, Workstream leads for each of the Diabetes and OD workstreams

10.2 The Programme Director will draft the agenda for Progress Review Meetings, to be approved by the IMB Chair and CCG lead

11 Administration

The Alliance Board meetings will be administered by [admin support]. The Programme Director will draft the agenda for approval by the Chair. All agenda items and relevant

papers will be published 3 working days prior to Alliance Board meetings. [admins support] will maintain minutes of all meetings and a log of decisions made.

12 Review

These Terms of Reference for the IMB will be reviewed at least annually by the Parties and may be reviewed before that date to reflect changes in national or local policy or guidance as required.

Last review date: April 2016 – to be reviewed June 2017

Annex A

Membership

The Parties to the Alliance and their appointed Representatives are as follows:

Party	Representative
Bradford Teaching Hospitals Foundation Trust	**Clive Kay (Chief Exec)** **John Holden (Director of Strategy)**
Bradford District Care Foundation Trust	**Nicola Lees (Chief Exec)** **Andy McElligott (Medical Director)**
Bradford Care Alliance CIC Ltd	**Catherine Dymond (Managing Director)** **Richard Haddad (Director)**
Bradford Metropolitan District Council	**Lynn Sowray (Assistant Director, Operational Services)**
Bradford VCS Alliance	**Helen Speight** **Jen White**

Annex B

Alliance Board Responsibilities

The Alliance Board shall have the following responsibilities:

1. conduct the business of the IMB and develop the Alliance in accordance with the terms of reference and the Statement of Principles and work towards achieving the Key Objectives;
2. seek to determine or resolve any matter referred to it by any Party on a “Best for Service” basis
3. take responsibility to make unanimous decisions, and as a last resort to use agreed mechanism for conflict resolution
4. to ensure representation for each Alliance Party at IMB meetings such that quoracy is achieved
5. setting boundaries for the Programme of work and ensuring appropriate programme governance and assurance
6. appoint Party Representatives or such other persons who the IMB may select from time to time to establish task and finish groups for the work-streams required to meet the Key Objectives and deliver the Project (“**Task and Finish Groups**”);
7. determine the resources to be contributed by each of the Parties in respect of establishing Task and Finish Groups and/or the Project; and to review spend levels vs budget
8. review and approval of outputs from work streams
9. monitor the Alliance’s performance and progress against the Key Objectives and agreed Programme Plan;
10. to fully participate in Progress Review Meetings with the CCG and the structured collaboration process
11. strategic Risk Management
12. managing interdependencies and conflicts between organisations and within their own organisations; acting as an escalation / resolution vehicle as and when necessary
13. managing consistency of communications across the Alliance, and ensuring delivery of communications within their own organisations
14. Review and update these Terms of Reference from time to time and at least annually

Schedule 2

Dispute Resolution Procedure

1 Avoiding and Solving Disputes

1.1 The Parties commit to working cooperatively to identify and resolve issues to the Parties mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU. Accordingly the Parties will look to collaborate and resolve differences under Section 13 (Dispute, problem and complaints) of this MoU prior to commencing this procedure.

1.2 The Parties believe that by focusing on their agreed BPA principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the BPA.

1.3 The Parties shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this MoU or the operation of the BPA (each a '**Dispute**') when it arises.

1.4 In the first instance the Programme Group relevant to the particular Service area in dispute shall seek to resolve any Dispute to the mutual satisfaction of the Parties. If the Dispute cannot be resolved by the local Programme Boards within 10 Business Days of the Dispute being referred to it, the Dispute shall be referred to the Integrated Management Board for resolution.

1.5 The Integrated Management Board (IMB) shall deal proactively with any Dispute on a Best for Local Population basis in accordance with this MoU so as to seek to reach a unanimous decision. If the IMB reaches a consensus that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice.

1.6 The Parties agree that the IMB, on a Best for Local Population basis, may determine whatever action it believes is necessary including the following:

(a) If the IMB cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and

(b) The independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the IMB to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure and, subject to the terms of this MoU, the procedure of the IMB at such discussions;

(iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Business Days of the independent facilitator being appointed; and

(v) have its costs and disbursements met by the Parties equally.

(c) If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 2 and only after such further consideration again fails to resolve the Dispute, the IMB may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

Schedule 3

Policy for the management of Conflicts of Interest

All parties will follow their own organisational conflict of interest policies – refer to Section 12.1 of this MoU.

Insert each organisational policy

Schedule 4

New Diabetes Model for the Population of Bradford

Executive Summary

The Bradford Provider Alliance's Vision Statement is to deliver an "Accountable Care System" across the health and wellbeing sectors which will deliver high quality services, financial stability and will improve the wellbeing of the local population.

Bradford City and Bradford District CCGs have recently embarked on a 'structured collaboration' process with all providers involved in the delivery of the Bradford diabetes pathway to develop a new -and more integrated -service for diabetes, that will commence mobilisation and implementation from April 2017 onwards. To encourage the required level of integration, one single contract will be awarded to an alliance of providers involved in the provision diabetes care. This is an important first step in the development of an accountable care system across Bradford, and there is potential for further services to be added as the Alliance demonstrates a collaborative approach and a successful delivery track record.

The Bradford Provider Alliance has been developing a new and improved model of diabetes care for the population of Bradford over the last 9 months (June – Feb 17). This document outlines our approach, the current service model, and the subsequent new model of care and associated benefits and outcomes anticipated which has been co-produced with key stakeholders. Primary care has been involved in the co-design of the diabetes model of care, currently the Bradford Care Alliance Community Interest Company (BCACIC) is an alliance of 64 out of 67 GP practices.

Doing Nothing is Not an Option

Bradford City CCG has the highest diabetes prevalence in England (9.7%) and Bradford Districts is 20th highest (7.7%). Currently, 28,500 people aged 17+ are registered with diabetes and if current trends continue: +11,500 new cases of diabetes expected in 2026: average increase of 1150/yr. We also know there is:

- Low uptake of structured education for both individuals at high risk and those with diagnosed diabetes
- High DNAs across the whole of the pathway – resulting in poor outcomes
- High spend, poor outcomes

The system cannot afford to do nothing, hence the case for change and need to implement a new model of integrated care.

The vision for the Integrated Diabetes Model

The vision for the service is that it will encompass the entire end-to-end disease pathway and patient journey, from primary prevention through to acute intervention. This new service model will therefore need to adopt a 'whole systems' approach -and will require significant levels of collaboration and integration between providers to ensure a seamless and joined up service. Taking and end-to end pathway approach enables the further harnessing of the impact and lessons taken from recent initiatives, such as the Bradford Beating Diabetes programme, and to adopt them as part of the mainstream approach to the prevention and management of diabetes in Bradford.

Opportunities

- Early identification of those at risk through Bradford Beating Diabetes (BBD) programme have been offered referral into a national prevention programme to postpone or prevent diabetes
- Early identification of those with diabetes (previously undiagnosed) and management results in less severe complications which are associated with poorer management
- 10 year contract being offered with savings being reinvested into primary prevention – commences 1st April 2017
- Diabetes is the early adopter of the New Model of Care, next will follow with Complex Care (many patients with diabetes have complex co-morbidities which impact on their lives)
- Agreed a series of outcomes across the pathway including patient reported outcomes

How we have development the new Model of care

A structured approach has been used to bring together a range of both quantitative and qualitative methodologies to develop a clear understanding of current provision and has led to the development of a new and improved model that will impact on the quality of diabetes care offered to the whole population of Bradford.

The focus in phase one has been:

- Engaging with key stakeholders
- Development of an activity and finance model to illustrate a 'do nothing option' and also to demonstrate the impact of the new model of care on the current patient flows, and shifts in activity over the 10-year contract.
- Gain clinical consensus of the issues to be addressed and resolved, and therefore the development of a more integrated approach to a model of care
- Explore willingness of providers to collaborate further and to work differently on potential new clinical service options
- Development of a service model that has included a wide-ranging number of stakeholders from all provider

Our approach included representatives from a wide range of organisations, a range of professional groups, and patient representatives. The stakeholders involved included:

- Clinical and operational staff from Bradford Teaching Hospital Foundation Trust (BTHFT)
- Clinical and operational staff from Bradford District Care Foundation Trust (BDCFT)
- Commissioning and finance staff from the Bradford CCGs
- Clinical leads from the CCGs
- Members of the Bradford Alliance Integrated Management Board (IMB)
- City of Bradford Metropolitan District Council
- Bradford Care Alliance CIC Ltd which represents 64 out of 67 general practices across both Bradford District and City CCGs.
- Local voluntary sector representatives
- Born in Bradford
- Patient representative
- CCG Patient engagement lead

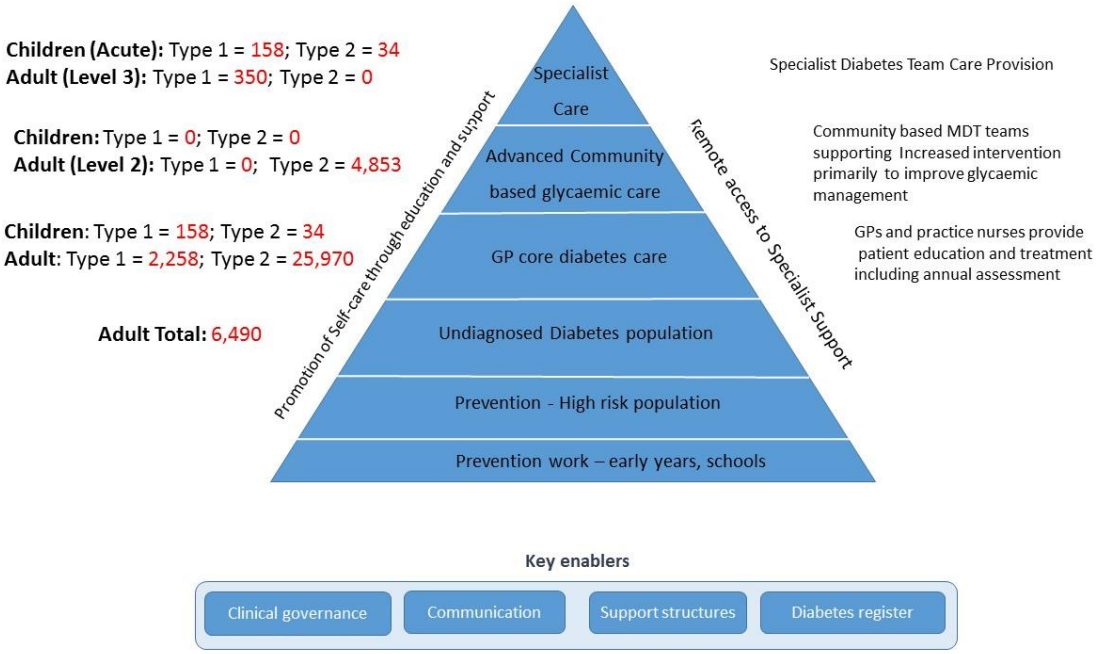
New Model of Diabetes Care

It is very clear that self-care and self-management, based on personalised care planning and the effective delivery of structured education, and person empowerment, are central to the way in which outcomes can be optimised for people with diabetes and other long-term conditions. The individual must be the starting point for any decisions about their care. This is central to the proposed model of care in Bradford, this linked with a need to reduce the prevalence of diabetes

over the contract term to ensure services are able to cope with the demand and subsequently required capacity in the system.
While good diabetes care today will avoid the development of the long-term complications of diabetes in the future, many people are already living with the microvascular and macrovascular complications of diabetes, such as blindness, kidney failure or heart disease. People with diabetes may also have one or a number of other long-term conditions, such as chronic obstructive pulmonary disease (COPD), anxiety or depression. An integrated holistic approach to diabetes care is therefore required to reduce the burden on the Bradford health system.
Health promotion and prevention schemes will need to be leveraged as optimally as possible to reduce the risks within the Bradford population in relation to the development of diabetes. Some of these approaches and interventions will need to be diabetes specific, but others will be part of the wider public health agenda and schemes which aim to reduce health risks and influence lifestyle changes to impact across a number of potential long term conditions being developed, such as cardiovascular and other long-term conditions.

The integrated diabetes service model for Bradford is outlined in the diagram below.

Figure 1 – Integrated Diabetes Service Model



The overall aim of this new and improved integrated model is to provide a seamless and integrated model of care and support for all diabetic people in Bradford. This will need to ensure a co-ordinated and fully integrated delivery model that ensures that people are seen in the most appropriate element of the service, and facilitated to return to the lowest level of intervention and support as quickly as is clinically appropriate. This will require the provision of a single point of access for diabetes care, with this being via the remote access function that ensures a seamless delivery of care and support equitably across Bradford. This approach will ensure a comprehensive range of high quality, cost effective, integrated health services for people with diabetes and their carers.

To achieve this the Provider Alliance will deliver on the following broader aims:

- management of diabetes/Impaired Glycaemic Control
- reduced ill-health and complications due to diabetes

- an excellent patient experience of care and support
- patients will be empowered and confident in how to self-care and self-manage
- services are high quality and safe, with an equity of access
- to reduce the incidence, prevalence and impact of diabetes in Bradford across the term of the contract
- to influence the local Bradford health promotion and prevention incentives to ensure that diabetes is one of the conditions that is considered as part of the development and delivery of schemes to support lifestyle changes and potential to reverse the impact of health conditions

The general principles for the integrated diabetes model of care are as follows:

- to influence the population to reduce the incidence of diabetes over the 10-year contract
- to engage people through person-centred practice, and asset-based approaches to enable behaviour change and reduce the risk of type 2 diabetes
- effective communication enables individuals to identify their strengths, assess their needs, and develop and gain the confidence to self-care and self-manage
- for individuals to have appropriate/consistent information and to understand the range of options available to them.
- developing skills and confidence in understanding the impact of increased weight and the increased likelihood of diabetes through supporting self-care mechanisms
- individuals are enabled to access support networks
- individuals are able to make lifestyle changes that positively impact on themselves and their families
- services will be responsive to the needs of individuals and offer a seamless service across the range of interventions and treatment appropriate to their clinical presentation
- individuals will be confident in knowing who is supporting them and coordinating the care that they may require
- individuals are supported in the lowest intensity tier of the service as possible according to their clinical presentation
- basic diabetic care will remain the responsibility of the patient's registered General Practice (funded via GMS and QOF)
- optimal use of technologies to enhance the delivery of the new service model

Transition to New Model of Care

Bradford City and Bradford District CCGs have recently embarked on a ‘structured collaboration’ process with all providers involved in the delivery of the Bradford diabetes pathway to develop a new -and more integrated -service for diabetes, that commenced mobilisation and implementation from April 2017 onwards. To encourage the required level of integration, one single contract will be awarded to an alliance of providers involved in the provision diabetes care. This is an important first step in the development of an accountable care system across Bradford, and there is potential for further services to be added as the Alliance demonstrates a collaborative approach and a successful delivery track record.