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Report of the Clinical Accountable Officer to the meeting of the Health and Wellbeing Board to be held on 23rd July 2013.

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Subject:

Integrated Care for Adults Programmes in Airedale, Wharfedale and Craven and Bradford

Summary statement:

This paper describes the progress made on achieving the integration of health and social care services across Bradford District, seeks a mandate to proceed at scale and at pace and support the pioneer application.

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NHS Airedale, Wharfedale and Craven Clinical Commissioning Group, on behalf of the Chief Officers of the Clinical Commissioning Groups.
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Portfolio:

Adult Social Care

Overview & Scrutiny Area:

Health and Social Care

Beacon Authority
2009-2010 Positive engagement of older people
2006-2007 Improving Rural Services: Empowering Communities

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Suzan Hemingway, City Solicitor

1. SUMMARY

- The Health and Wellbeing Board will hear a presentation providing a summary of the progress achieved to date on the Integrated Care for Adults programme which is developing integrated community-based health and social care services for adults
- The Board will be asked to formally support the application for partners to become health and social care integration pioneers
- A mandate will be sought from the Board to progress integration of health and social care services at scale and pace

2. BACKGROUND

Health, social care statutory and voluntary and community sector partners are engaged in a major programme to integrate health and social care services for adults. The programme has two distinct geographical centres:

- Airedale, Wharfedale and Craven
- Bradford

The main ambitions of the programme are common to both:

i. To join up services around the needs of the person
ii. To reduce costs associated with avoidable unplanned admissions to hospital and to long-term residential care and redirect savings to community-based care
iii. To increase community-based capacity and capability to support more people with more complex needs
iv. To use rehabilitation and reablement services to enable people to have the best possible outcomes in terms of their health, wellbeing and independence

Our vision, signed up to by partners in early 2012 is to achieve the

Right care, right place, first time:
By joined up services to enable people to regain and keep their optimal health, well-being and independence.

Joined up community health and social care services will be delivered by Integrated Community Teams in communities which have an average population of c.33, 000 people. Within these geographical communities, the GP practices, community health and mental health services, social care services and the voluntary and community sector will work together to coordinate the care of the most vulnerable people and their carers.

Some specialist services will continue to be delivered on a CCG-locality basis or across the whole of the district for example some of the specialist nursing services such as Tissue Viability.

The link between community and hospital services is critical to get right to ensure that people are only admitted to hospital or residential care when they really need to be (particularly in their last days of life) and to ensure that discharge arrangements are as smooth and successful as possible.

Acute trust partners are key to this programme and are focusing their attention on their services which are particularly relevant to keeping people in their own homes. Both acute trusts have developed intermediate care services that provide short-term, intensive and

rehabilitative support to keep people at home when they become unwell or to support them after discharge from hospital. The Airedale Collaborative Care Team (ACCT) is well established and is expanding to incorporate social care home care reablement (intermediate care) services. It already has an integrated team of health and social care professionals operating successfully as a single team.

In Bradford, the Bradford Teaching Hospital has successfully piloted a virtual ward in the Autumn/Winter of 2012 focused on preventing readmissions and supporting discharges home. This year, this is being expanded to provide a fully integrated intermediate care service comprised of specialist nurses, geriatricians, therapists, social workers and reablement staff. This team will link directly with their community-based counterparts in the Integrated Community Teams to ensure a smooth hand-off between intermediate care services and mainstream community-based services.

This programme links closely with the council's Great Places to Grow Old programme and partners are actively exploring opportunities to establish joint community-based intermediate care facilities in Saltaire and Keighley.

We recognise that the system infrastructure is critical in supporting integrated care and we have a number of projects to deliver this:

i. Estates

We have done initial mapping of the entire estate across the NHS and Local Authority, using a recognised and powerful mapping tool called SHAPE. This enables us to understand what estate is where, what it is used for, the potential for enhancing the resource or disposing of tn and identifying locations for co-locating services around the needs of local communities.

SHAPE allows us to map demographic and health data geographically against current estate, for example we can see where the highest population of people with COPD live and look at whether relevant support services are in the right place. This tool is incredibly important to enable partners to achieve the best possible use out of their most valuable capital resources. Further detailed data cleansing and analysis is required.

ii. Organisational development and communications

We have appointed a lead for organisational development to work across all organisations to support managers and staff to make the necessary changes in culture and work practices that will make integrated care work.

iii. Integrated care record

We are developing an integrated care record shared across health and social care and based on the same IT system (SystmOne). This is a critical part of the infrastructure to enable truly coordinated and person-centred care to be delivered. Bradford will be unique nationally in achieving this.

iv. Predictive risk stratification

We have commissioned and implemented a predictive risk stratification (PRS) tool in General Practices. This tool uses health unitisation data to stratify each practice population in terms of their relative risk of admission to hospital over the next 12 months. This enables Integrated Community Teams to have a greater insight into which people in each community are most at risk and therefore act proactively to keep those people well and at home.

v. Community profiles

We would like to develop detailed community profiles to enable services to have detailed intelligence on local need, resources and challenges. Community profiles will enable evidence-based commissioning to take place at a very local level, responding much more directly to local need. It will enable more detailed and accurate resources allocation for each community.

Additional resources will be required to achieved this detailed piece of work.

vi. Financial flows

To achieve more community-based provision of services within a reducing financial envelop, we will need to take a whole system view and move resources around that system, e.g. from hospital care to community-based care. Evidence from elsewhere (Kings Fund, 2013) indicates that achieving integrated care may cost more initially, particularly while services have to double run as capacity and capability is increased in the community.

We would like to consider alternative payment methods that can incentivise and support integrated care.

Chief Finance Officers are engaged in this work at the Bradford and Airedale, Wharfedale and Craven Transformation and Integration Groups.

We have recently submitted an Expression of Interest to become one of ten health and social care pioneers nationally. Competition is fierce and we would like the support of the Health and Wellbeing Board in pursuing our ambitions to achieve integration of health and social care services at scale and pace regardless of whether we are identified as one of the national pioneers.

The Expression of Interest is appended to this document.

A full governance structure is in place, led by the Transformational Change Board.

3. OTHER CONSIDERATIONS

The main focus for this Board is to provide a mandate to local health and social care organisations to implement integrated care for adults at scale and pace. All partners recognise the complexity of the programme and have committed to deliver its ambitions.

The current focus is on the integration of adult services in recognition of the magnitude of the task. We will also consider the integration of children's services via the Children's Trust arrangements and ensure that these programmes are linked to facilitate better transition between services and a true whole system approach for all of the District's citizens.

4. OPTIONS

4.1 No integration of services

Services could remain in their current configuration with no attempt to integrated care around the needs of individuals. There is strong public opinion that health and care services should be more joined up and this option is therefore not recommended.

4.2 Small scale collaboration

Opportunistic collaboration of services wherever the opportunity arises. The opportunity to do this already exists, and this demonstrates that left alone, most staff will remain focused on the needs of their own organisation rather than that total needs of communities. Small scale collaboration will not have the impact on the quality of care required and will not enable community-based capacity and capability to be increased. This option is therefore not recommended.

4.3 Full scale integration of services at scale and pace

To have the impact that is required, it is necessary to use the integration of health and social care services as a mechanism to reorganise services to provide as much care as possible at home, or in a community setting. By supporting more people, with more complex needs at home, supporting people to self-care and intervening more proactively, integrated care will be a major part of the sustainability of the local health economy.

This needs to be put in place at scale and at pace to achieve the required impact and this is therefore the recommended option.

5. FINANCIAL & RESOURCE APPRAISAL

All statutory health and social care partners in Bradford District are under immense financial pressure to deliver safe and high quality services to meet the needs of the citizens of the District. Need is high and increasing as a result of high levels of deprivation and poor health.

This programme will achieve small efficiencies as a result of integrating services and the main outcome will be increased quality of care for people. However, where we expect more significant gains to be achieved is through preventing people's needs escalating unnecessarily and requiring avoidable high levels of care, whether that is by way of an admission to hospital, admission to long-term care or significant health and care packages at home.

This programme is therefore a major plank of the sustainability plans of the local NHS and social care services.

6. RISK MANAGEMENT AND GOVERNANCE ISSUES

Governance arrangements are being put in place to ensure that the new model of integrated care delivery is safe for service users and staff. Information governance arrangements are also being established to enable safe and secure sharing on relevant information.

7. LEGAL APPRAISAL

Not applicable at this stage.

8. OTHER IMPLICATIONS

8.1 EQUALITY & DIVERSITY

A full equality impact assessment will be undertaken in due course.

8.2 SUSTAINABILITY IMPLICATIONS

Not applicable

8.3 GREENHOUSE GAS EMISSIONS IMPACTS

Not applicable

8.4 COMMUNITY SAFETY IMPLICATIONS

Not applicable

8.5 HUMAN RIGHTS ACT

Not applicable

8.6 TRADE UNION

Not applicable at this stage. There are no current plans to change the employment of terms and conditions of staff.

8.7 WARD IMPLICATIONS

Not applicable

8.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

Not applicable

9. NOT FOR PUBLICATION DOCUMENTS

None.

10. RECOMMENDATIONS

10.1 To note the progress to date regarding the integration of services for adults

10.2 To provide a mandate to local statutory health and social care organisations to drive forward integration of care at scale and pace

10.3 To approve formal support of the Expression of Interest to become health and social care integration pioneers and the model of integration described within it

10.4 To provide a mandate to statutory partners to develop community profiles

11. APPENDICES

11.1 Expression of Interest to become Health and Social Care Integration Pioneers
11.2 Presentation

Bradford health and social care integration pioneers expression of interest

Health and social care partners in Bradford, Airedale, Wharfedale and Craven

28th June 2013

Parties to the Expression of Interest

NHS Bradford Districts Clinical Commissioning Group	Helen Hirst, Chief Officer
NHS Bradford City Clinical Commissioning Group	Helen Hirst, Chief Officer
NHS Airedale, Wharfedale and Craven City Clinical Commissioning Group	Dr Phil Pue, Clinical Chief Officer
Craven District Council	Paul Shelvin, Chief Executive
City of Bradford Metropolitan District Council	Tony Reeves, Chief Executive Janice Simpson, Strategic Director - Adult & Community Services Kath Tunstall, Strategic Director of Children's Services Anita Parkin, Director of Public Health
Airedale NHS Foundation Trust	Bridget Fletcher, Chief Executive
Bradford Teaching Hospitals NHS Foundation Trust	Bryan Millar, Chief Executive
Bradford District Care Trust	Simon Large, Chief Executive
Bradford HealthWatch	Andrew Jones, Managing Director
Bradford Voluntary and Community Sector Assembly	Natasha Thomas
NHS England Area Teams	Alison Knowles, Director of Commissioning
Bradford Health and Wellbeing Board	Cllr Green, Leader of the Council
North Yorkshire County Council	Helen Taylor, Corporate Director Health and Adult Services
Local Medical Committee	Dr Shaun Millns-Sizer, Chair – Bradford and Airedale branch

Bradford, Airedale, Wharfedale and Craven's expression of interest for health and social care integration pioneers

Introduction

Bradford, Airedale, Wharfedale and Craven are good places to be and we want to make them even better. We are demonstrating how the whole system of health and social care can be transformed. We are eager to share this nationally and go even further. Our starting point is simplifying a complex system by integrating care around people rather than organisations. Evidence tells us that integration provides the platform for achieving better care in every arena, including the frail elderly, children with complex needs, urgent care, end of life care and for people with long-term conditions. Alongside earlier, preventative interventions, we are creating a powerful combination that with have a real impact on people's health and wellbeing. Throughout the bid, for ease of reading, we refer to Bradford, Airedale, Wharfedale and Craven as 'Bradford'.

Here we demonstrate the successes we have achieved so far in integrating services for adults. Our ambitions are immense and know no boundaries - we are ready to create a new health and social care landscape and become one of the first to adopt integration in its fullest sense. Becoming part of a national partnership would enable us to deliver this and to influence national policy.

Bradford has a large geographic footprint incorporating significant deprivation, some affluence, urban, rural and city living. Services are commissioned and provided to a population of 605,000 by NHS England, three Clinical Commissioning Groups, three local authorities, 85 general practices, two acute foundation trusts, one mental health, learning disability and community services trust (applying for FT status), and a wealth of voluntary sector organisations.

We are changing the health and care landscape and have big ambitions for Bradford.

Our programme is well established, commencing in 2011 with strong leadership from system leaders, particularly clinicians, and commitment and energy from all staff. Most importantly it is built on the views of the users of our services. Integrated care is happening on the ground and supporting people to remain at home. We are delivering real benefits for people through grouping a whole range of health and social care community services around clusters of GP practices to line up services to keep people at home.

Our impact is tangible as for the first time in years, non-elective admissions are reducing due to a wide array of different approaches to the delivery of care. In 2012/13, emergency admissions reduced by 21% and we can attribute around 7% of the reduction to better integration. Bradford Council is the best performing council in the region for not delaying discharges. Practices are leading much of this work: 19 Bradford practices are directly engaged in designing and delivering integrated care with partners, covering 30 % of the population. In Airedale, Wharfedale and Craven, all 17 practices are engaged covering the whole population. We have aligned funding and incentives (CQUINS, DES, reablement and social care funds) to drive change coherently.

We have aligned our Integrated Care Programme with our Urgent Care Strategy. Better and joined up care at home and coordinated intermediate care services in the form of virtual wards aim to prevent avoidable admissions to hospital or get people home as fast and successfully as possible. We know that the absolute number of people over 80 years old in Bradford is predicted to double over the next 20 years and that 40% of all admissions are non-elective. Admission to hospital may treat the immediate problem, but over 35 per cent of older people admitted to hospital are discharged in a poorer functional state than when they were admitted and so there are good health, as well as economic, reasons for avoiding admission.

Our whole system is lined up. We will go further and challenge national and local policy and systems that prevent full integration of services and militate against shifting even more capacity and capability into the community from secondary care services.

Our vision: right care, right place, first time

Again and again people tell us how much better their lives would be if they didn't have to repeat their story to every care professional who visited their house; if the nurse and the social worker talked to each other about their care; if the GP knew they had been discharged from hospital and needed a visit; if the hospital had been able to arrange a social care assessment they would have been able to send them home; if their carer had been able to access some local support they wouldn't have had to give up work. People constantly told us that care was badly coordinated. This is what one man told us:

> ***'There are people in different places ... but there was no-one drawing it together, drawing together packages of care and communicating with each other across the organisations'.***

Our vision is that these stories are a thing of the past. That the people living in Bradford who need care and access to services are able to live better, longer and happier lives and can have it in a way that makes a difference and keeps them as independent as possible.

This won't happen unless we fundamentally change how the organisations in Bradford who provide and commission care and services work together. We have a set of principles that guide us on the journey to working better together:

- Working better together is first and foremost about what is best to add value for the people we care for
- We will improve the quality of care and support available
- We will look for improvement through the eyes of the people we care for and the staff providing the care
- There will be no blame or scape-goating of or by individual organisations – we're in this together, working as a whole system
- We will continue to create a culture of trust, openness and transparency, including demonstrating a collective stewardship of resources
- We will put the interests of the people we serve ahead those of our individual organisations
- We will share our learning from working together with one another, and others as well as learning from elsewhere and will share our learning more widely
- We will build on existing work that has established strong foundations for integration e.g. Airedale and Craven Collaborative Care Teams, Bradford Virtual Ward, Integrated Care test-sites
- We will collectively agree our future priorities as a whole system
- We will adopt a positive mind-set – 'we can, we will'
- Our clinicians, social care professionals, managers and others will work together to make change happen
- We commit to working at pace, to achieve rapid progress, make decisions and see them through

Time and again the patients and public tell us how much better their lives would be if they saw right person to help them, to help get the right care when the need it. People's lives would be much better if they didn't have to repeat their story to every care professional they saw. Carers often shoulder the burden of downfalls with the health and care system.

Our response is integration, but that is often small scale pockets of `good' - we want it to be big, systemic and our default model of care. We are determined and will ensure that we find a way over, through or round any obstacle that challenge our ambition to integration.

We have all heard and read about international and national models of integration – all established to address similar issues to the ones Bradford is currently facing. Demographic pressures, financial challenges, fragmented care with a poor patient experience, outcomes that are difficult to assess and quality of services that are not always the best that can be achieved. From Jönköping in Sweden to Torbay, they have all responded to such pressures by developing their own version of integrated care with different successes – what they have all achieved is a realisation of their collective vision to organise and deliver improved quality care and services around the needs of those who require it. This is where Bradford aims to be: focusing on joined up and evidence-based pathways, achieving continuous quality improvement through shared learning, boosting frontline staff skills, maximising the benefits of technology enablers such as SystmOne, telemedicine and telecare and putting in place incentives to make the system better.

Whenever we talk about integration people think organisational form, buildings, co-located staff, but we want to break out of this mould and transform and integrate services to address our shared problems of inefficiency, variable quality of services, significant inequalities in health and access to care and services irrespective of organisational boundaries. We don't yet have all the elements of that model on our collective page, but this is where becoming a Pioneer will help us access support to deliver our model at scale and pace across a whole range of areas.

We have senior buy-in and a commitment to work together better to describe this model and put it in place – we accept this will include testing and changing the system to allow front line staff to work in an integrated way and deliver care around the needs of patients. We have an established programme of transformation and integration for adults which is a template for taking the model above and beyond our current achievements and successes. This needs to go further to achieve the 'can do' approach to shaping and informing national and local policy which sometimes stands in our way. We have staff including practitioners and clinicians at the heart of shaping and delivering our transformation and integration programme. We know we need to go further, faster and we are making changes on sharing records and information, sharing skills and developing their skills, improving when and how we communicate, and working through joint solutions on the problems to delivering integrated health and care services.

We're really good at engaging people in our developments but we want to make the involvement of local people much deeper – they should be able to recognise this as their vision too and be part of delivering it.

Patients and the public share their views with us and tell us what they would like to see. We want the patient and public voice to help us design and deliver the solution, and embed expert patient and co-production approaches. This isn't about listening just at the beginning; this is direct involvement in shaping and delivery the solution.

Our collective vision was built on public opinion and developed through a number of workshops involving service users, practitioners, managers and clinicians. It was signed up to by partner organisations in early 2012:

Right care, right place, first time: joined up services to enable people to regain and keep their optimal health, well-being and independence.

We have adopted the National Voices narrative and definition of integration and use it to shape the changes we are making. The Bradford vision is consistent with it and reflects our commitment to re-organise services around people and not organisations. We will work with people to test the 'I' statements and bring them into practice to deliver better coordinated care.

We recognise the need to deliver ambitious goals and strengthen public engagement. This is an important area for us to progress further with national input to achieve exemplar status. Our innovative approaches for public engagement and the range of people actively involved does not fully represent the rich mix of our population in terms of ethnicity, age, rurality, city living and deprivation or reach those who are seldom heard.

The public and stakeholders need information to understand the complex nature of Bradford's health and care economy and the changes that will be required in the future to sustain it. They need to be part of helping create and delivering the message, as well as the potential delivery solutions. An on-going dialogue is underway so we can engage people as integration develops.

The partners

This Expression of Interest is evidence that partners in Bradford are both committed to and capable of delivering a new model of health and social care which will become standard and are ready to embrace the major benefits and opportunities that becoming Pioneers will bring.

Partners to this bid are: NHS Airedale, Wharfedale and Craven Clinical Commissioning Group, NHS Bradford City Clinical Commissioning Group, NHS Bradford Districts Clinical Commissioning Group, City of Bradford Metropolitan District Council, North Yorkshire County Council, Craven District Council, Bradford Teaching Hospitals NHS Foundation Trust, Airedale NHS Foundation Trust, Bradford District Care Trust, Voluntary and Community Sector Assembly, HealthWatch, NHS England Area Teams.

We have a proven track-record of partnership working and there is full engagement and support from statutory organisation leaders, Health and Wellbeing Board and Health and Social Care Overview and Scrutiny Committees and a strong desire and intent to integrate care and support for the local population. The Health and Wellbeing Board is driving integration as a means of reducing health inequalities and the delivery of its Joint Health and Wellbeing strategy. Formal sign up to this EOI will be achieved by the HWB at its meeting in July 2013. Councillor Green, Chair of Bradford and Airedale HWB has already provided a statement of support for this Expression of Interest.

There is explicit commitment to the transformation and integration of health and social care services and we have put strong governance arrangements in place to deliver integration:

- A Transformational Change Board (TCB) is in place reporting to the Health and Wellbeing Board, connecting senior leadership from NHS providers, NHS commissioners and Local Authority commissioners and providers to ensure alignment of their respective strategies. The TCB has explicitly committed to integration of health and care services and to this Expression of Interest
- Airedale, Wharfedale and Craven Clinical Commissioning Group crosses three local authority boundaries (Bradford, Craven District and North Yorkshire County Council), and there is alignment in the intention of the three Health and Wellbeing Boards concerned. This allows models to emerge and be tested in both rural and urban areas.
- There is an explicit commitment to integration of services in the Bradford District Health and Wellbeing Strategy
- Front-line health and social care professionals are directly involved in designing and leading integration
- Involvement from the outset of patients groups and many groups representing communities of interest
- Dedicated commissioner leadership including CCG Board members responsible for the delivery of integration
- A programme management office and organisational development leadership
- Dedicated provider leadership across the system to implement change within and across organisations

With three Clinical Commissioning Groups and the complexities of cross-local authority boundary working, the leadership priority is to think strategically as a whole system, beyond organisational boundaries and to predict and manage the impact of change. Underpinning TCB are two Transformation and Integration groups (TIG) one in Bradford and one in Airedale. These groups oversee the Urgent Care and Integration of Health and Social Care programmes. Membership includes Directors from across the system including Directors of Finance.

TCB recognises that to achieve what is best for local people it will need to take a long, hard look at the commissioning and provider landscape across the District. TCB have worked with the King's Fund to explore the impact of change on organisations.

Our current transformation and integration programme

Our programme integrates care both horizontally across community health/mental health services, primary care and social care and vertically between community and hospital services. It is a whole-system programme of integration which ensures that people who use services do not see the artificial barriers between them wherever they are in the system. They are entitled to a holistic service, oriented around meeting their whole range of needs (including their mental health) and not around the needs of the various organisations involved. They also require modern methods of communication and treatment. In Airedale, Wharfedale and Craven in particular, telemedicine in the form of video conferencing between patients in the community and secondary care clinicians, is helping to avoid admissions, reduce length of stay and reducing the need for visits. Across the District, telecare is widely available, and we are keen to embed all forms of electronic assistive technology into mainstream care where it can make a difference.

Bradford's health and care economy is under significant challenge and through our vision and programme of transformation and integration system leaders all agree to deliver better outcomes for local people and to create a sustainable model of care.

The current programme relates to all adult services, including community-facing hospital services, engaged in supporting people to remain at home, and to regain and retain their health, wellbeing and independence. The emerging service model removes distinctions between services (whilst preserving specific skills) and focuses on whatever the person needs to prevent acute care, long-term residential care or unnecessary dependence on the health and social care system. We recognise that housing is key and has to be capable of meeting changing needs and be an asset not a problem.

Using outcomes frameworks (Adult Social Care, NHS and Public Health) we will assess the impact on outcomes for patients with our whole systems dashboard. This will show shifts in the whole system in terms of activity, cost and quality of service. We expect to see activity increasing in the community, and reducing in secondary care as the location of care delivery shifts towards community settings. Costs need to follow activity to make this sustainable and quality outcomes maintained at the very least and enhanced wherever possible.

The local health and care economy

The local NHS, in common with the national picture, is not expected to have its budget cut – but will have to cope with increased demand for its services with very little additional growth in its budget. The local health economy predicts it will need to make annual efficiency savings in excess of 4% over the next 4 years which equates to over £160m.

For the Local Authority, in the last three financial years Bradford Council has had to find in excess of £100m of savings and a similar amount is assumed over next three. Integrated care will allow Councils to make best use of their resources to support the increasing numbers of people needing support and care.

Given the scale of these pressures, the efficiency requirements and the implications of this week's Spending Review, it is clear that this economy-wide approach is necessary to ensure financial sustainability for the future. We are undertaking a three-staged approach for the delivery of these targets:

- driving efficiencies to eliminate costs that do not contribute to the delivery of front line services
- optimising spend and delivery quality; eliminating activities that are unaffordable or low priority
- shifting care into more cost effective settings and redesigning the way health services are delivered, including their interaction with social care services.

Our business case for integration, whilst under development, leads to early indications that by better management of long term conditions, reducing avoidable non-elective admissions and re-admissions and promoting more prevention, a significant amount of resource could be redirected across the system and deployed elsewhere. It is not expected that this will generate cash releasing efficiencies, but will allow us to use our resources more efficiently to meet some of the increased demographic growth for services. We have calculated we spend £25m on long term conditions (COPD, neuro-degenerative diseases and heart failure/heart disease), ambulatory care sensitive conditions and other conditions that could be treated in a primary/community setting that should not require a hospital admission. Our ambition is to maximise the opportunity available from service integration and to direct our resources accordingly to ensure optimum outcomes are delivered in the most efficient and cost effective way. By improving outcomes for people and reducing duplication, resources go further.

It is not expected that this will generate cash releasing efficiencies, but will allow us to meet some of the increased demographic growth and shift resources around the system. For example, the Airedale Collaborative Care Team (integrated intermediate care) avoided 442 hospital admissions in 12/13. This equates to around £337,688 in savings available for reinvestment in community services.

Work needs to take place to determine how the payments system will work and would form a key part of a pioneering approach. As an early test-bed for this we have a commitment to work collaboratively with providers and are currently exploring how a more risk based approach to contracting can work. We have a track record for putting in place a transformational reserve to pump prime investment to enable our vision for integration to be implemented 'further, faster'. We will continue utilising CCG non-recurrent funds over this year and the next to drive forward this strategy. In addition we have jointly agreed plans to use our CQUIN investment in NHS contracts, reablement funding and NHS funding for social care to push forward this agenda.

Our successes to date

'...It's what kids today call a 'no brainer!' It's so obvious to keep patient central, share ideas and resources...' [Nurse Practitioner]

We have a clear vision of joining up care for local people so that they get the right care in the right place, first time. The simplicity belies the enormous complexity of lining up the strategic intent of health and social care organisations, with

their own business imperatives and competing organisational priorities. All recognise their mutual dependency and the need to operate as a whole system to remain viable. The programme includes:

1. joining up health and social care services around the needs of the person in the community and in hospital
2. reducing costs associated with avoidable unplanned admissions to hospital and to long-term care
3. increasing community-based capacity and capability to support more people with more complex needs at home
4. using rehabilitation and reablement to enable people to have the best possible levels of health, wellbeing and independence
5. integrating IT systems and estates to provide the infrastructure for integrated, community-based care

We have started with adult health and care services. Integration is the platform for improving all services and our Pioneering approach

The focus is currently on adults, but these aims are equally applicable to the integration of all health and care services as a standard model. Our ambition is to use the framework developed around adult services as the basis to integrate other areas of health and care including children's services and urgent care.

Integrated community teams

Our basic model is one of all health and social care community services grouped into common geographical communities, each covering an average population of around 33,000 people. Social care services, community health services and GP practices are clustered into the communities and are part of the integrated multi-agency offer, which together are responsible for meeting the health and care needs of the local population, including mental health needs and particularly those associated with dementia. General practice acts as a source of continuity across primary, community and secondary settings and they are leading integrated care in Bradford, supported by the Directed Enhanced Services scheme for risk stratification and care management and a local contract which builds on this for practices, which we will implement from October 2013.

Core components include:

- Predictive risk stratification, which in combination with clinical insight, enables teams to identify people at high risk of an unplanned admission (89% of practices have this in place, and growing)
- Active case management supported by a patient-accessible integrated care record across health and social care
- The development of 'self-care packs' to support people take control of their own care
- Services organised into 'communities' with a common geography, grouped around clusters of practices
- Rapid access to assessment and diagnosis and optimum community-facing step-up and step-down bed provision
- Clinicians and practitioners working across secondary and community care boundaries, e.g. geriatricians, social workers
- A rehabilitative approach to achieve optimal levels of health, independence and wellbeing
- Shifting the balance from step-down care to step-up care
- Voluntary and community sector embedded in integrated care teams
- Governance arrangements and operational protocols for joined up working

Vertical integration between community, intermediate and acute care services

We are also seeing major shifts in secondary care in line with this programme. The Chief Executive of Airedale NHS Foundation Trust talks of 'turning the hospital inside out' to become more community facing. Bradford Teaching Hospitals NHS Foundation Trust has reviewed their strategy and is now much more concerned with community-based health care.

The whole ethos of our programme is optimisation of people's health, wellbeing and independence through a preventative and rehabilitative approach. Both acute trusts have established virtual wards as the mechanism to deliver the intermediate care tier of services. The focus is shifting to 'step up' to prevent avoidable admissions through intensive multi-disciplinary support. The Airedale Collaborative Care Team has substantially reduced admissions from intermediate care beds to long-term care from 11% in 2010/11 2.7% in 2012/13. The Bradford virtual ward has reduced demand in acute elderly inpatient beds and the number of readmissions.

Local authority home care reablement services have a successful record of returning people to independence and avoiding the need for on-going care. 27% of people using these services become fully independent and 28% need a reduced level of support. These services are integrating into the virtual wards to provide expertise in reablement and

additional capacity and capability needed to support people. The voluntary and community sector provide a 'home from hospital' scheme to support people practically immediately after discharge. Secondary care and community-based care are beginning to become vertically integrated, but we know that it is a major challenge to achieve this and see it embedded as a whole system.

We have implemented a predictive risk stratification tool in our practices. We know that detailed information on population risk, and the intelligent use of this to implement preventive interventions is a fundamental part of the system to improve outcomes for patients with long term conditions. Our plan is to extend the tool to incorporate data from social care to build a richer profile of risk.

Once we have a collective understanding of who is at risk, we can be more proactive and support people better. The support is multi-disciplinary and multi-agency, including voluntary and community sector support with person-centred interventions including clinical, social and self-care support, coordinated by an active case management approach and joined-up care planning.

Telecare, telemedicine and telehealth has a lot to offer as part of the whole system of joined up care. We will embed these into mainstream care delivery. Where telemedicine video conferencing is used in care homes locally, we have seen very significant reductions in A&E attendances and admissions to acute care.

Telehealth, telecare and telemedicine options will be included amongst the options for care plans, supporting people to take a proactive approach to their own care and providing reassurance for carers.

Our focus is on the most vulnerable which is often, but not exclusively the frail elderly with multiple problems. Our programme focuses on all adults and predictive risk stratification supports early identification of people who could benefit from proactive care and a joined up response. Our virtual wards have been established in recognition of the need to bridge the gap between hospital and home, ensuring people receive the best intensive support and rehabilitation to regain their independence.

We recognise that carers are a central force in shifting more care into community settings. Getting it right for carers is key to the success of integrated care and we are commissioning an integrated health and social care service for carers so it is simple to access, consistent across the District and supports carers as well as we possibly can.

End of life care is part and parcel of integrated care. The virtual wards support people to die in their place of residence and to prevent unnecessary admissions at the time of death by providing expert medical assessment. Advance care plans will become part of the person's integrated care record (where appropriate). We are developing wrap-around social care support to provide the additional capacity needed at home or in care homes to enable people to die in the place of their choice.

Communicating and involving

We have communications plans, tools and techniques in place to support the integration agenda across agencies and geographic boundaries. We recognise the importance of staff as the closest point of contact with local people and are working with them to ensure that patient stories, views and experiences are routinely fed in from day-to-day contact. Front-line staff are leading the implementation of integrated care on the ground.

We have an on-going dialogue with local people, including Patient Participation Groups, and will continue to use existing channels such as local media, newsletters, web and digital media, community engagement and networks. We respond to local views and tell people what is happening as a result. People want us to focus on helping them to keep well and supporting them at home, rather than treating them once they have become ill or incapacitated. They feel very strongly about care being joined up across health and social care services.

In addition to this, we are working with HealthWatch and other health and social care and voluntary sector partners as a pilot site in the Building Health Partnerships programme, to strengthen the health and wellbeing hubs; and develop community health maps which provide a comprehensive directory of local health, social care, and voluntary services.

We will continue to ensure that we use innovative approaches to engaging with our diverse communities and are currently setting up a Google+ virtual network to enable patients and clinicians to raise issues and discuss topics and solutions in a safe way.

There will be difficult conversations to be had with the public and politicians as we put this in place. As services grow in communities, hospital beds will need to reduce. Resources will need to be moved around the system to achieve the right care in the right place, first time. The public need to be confident that this represents an improvement in services and not a reduction.

We'd like support around the best way to have difficult conversations with the public

Fundamental to the success of this transformation programme is the investment we will make in ensuring our development activity focuses on equipping and inspiring all stakeholders, teams and professionals to build and embed a system of integrated care. Our approach to organisation development includes:

- Undertaking organisational and team diagnostics to establish readiness, capability and capacity in and development of effective integrated care provision
- Engaging leaders, clinicians and managers to build commitment, and ownership of this agenda across all systems
- Facilitating big and small conversations with stakeholders which will support the creation of a culture of cooperation and coordination between health, social care, public health and the voluntary and community sector
- Establishing frameworks and improvement activities which will support the development of sustainable high performing integrated locality teams.
- Building resilience and sustainability across teams through system and team coaching, knowledge transfer and creating formal and informal systems to share lessons learnt across the programme
- Delivering communication and engagement plans that ensure that the voice of the patient is at the centre
- We have made excellent progress on personalisation of social care services and we are also a personal health budget pilot site. This is an opportunity to significantly impact on how health and social care is delivered and to provide new levels of patient empowerment.

Developing the infrastructure

This is a whole-system programme in response to public demand, and we have described how delivery of care is being joined up around the needs of local communities. However, integration of staff and services won't be sustainable without the system infrastructure that underpins it. We are in the process of putting the following in place:

- An integrated care record across health and social care, children and adult services, operating from the same IT platform (SystmOne)
- Shared approach to estates across the system, supporting co-location of staff and more efficient use of our buildings
- Shared care and treatment facilities across health and social care, linked with new extra care housing
- Information sharing agreements
- A sustainable approach to payment for services across the whole pathway of care – hospital to home
- Better approaches to joint commissioning
- Information sharing agreements and consent processes

We would like support to get the most out of freedoms and flexibilities

We have not yet addressed how we will utilise our commissioning and procurement strategy to deliver the changes needed. Nor have we fully explored innovative ways to utilise existing freedoms and flexibilities, other than those strategies set out earlier. With support, we can become a national champion in using freedoms and flexibilities to deliver change.

We have a track-record of partnership arrangements between the NHS and local authority and have used national funding to drive integration including integrated community equipment services, integrated approach to carers support services including breaks and training, intermediate care beds, social care reablement services due to be integrated into virtual ward arrangements, 7-day hospital-based home care managers and social workers.

In addition, reablement funds have enabled us to put in place other parts of an integrated care system including early supported discharge schemes, OT in A&E to prevent avoidable admissions and expansion of virtual wards combining secondary, community and social care expertise.

We're using the CCGs 2% non-recurrent reserve to support providers and the voluntary and community sector to test out innovative ideas and to invest in new services, allowing for some double-running as other services are in the process of being decommissioned or moved from acute to community settings.

Our plans for the future: how we will go further, faster

We have described the significant changes to care that we have already achieved and demonstrated that we have the leadership and capability throughout the system to continue on this journey. The next section describes our big ambitions and how the Pioneer scheme can support us. Specifically, over the next twelve months, we will:

a) Understand how to delegate the total NHS and care budget as close to local communities as possible
b) Establish deep involvement of the public and service users in changes to the way we deliver services locally
c) Establish locality management and delivery of health and care services, delivered in defined local communities
d) Expand integrated health and social care intermediate care services delivered as virtual wards
e) Commission joint intermediate care facilities with an explicit focus on rehabilitation and reablement as part of the local solution to keeping people in their own community and avoiding unnecessary admission to care or hospital
f) Speed up access to clinical assessment using virtual ward approaches to avoid admit to assess approaches
g) Deploy new approaches to whole system commissioning
h) Implement new funding and payment models: whole pathway tariff development across secondary, rehabilitation and social care services, incentivising care around the needs of the person
i) Shift funding around system from acute to community-based services without destabilising providers to create community-based capacity and capability to deliver more care at home
j) Develop collaborative approaches to the recognition and treatment of mental health problems where they are associated with the physical health of the individual to enable holistic care
k) Harness the intelligence gathered by the police, fire service and other agencies that have high volume of visits to the homes of vulnerable people and families. They have a significant potential to identify risk in those people that possibly not yet known to health or social care services
l) Apply this framework for integration across the whole spectrum of children's services, building on work already in development in response to the Children and Families Bill
m) Move towards a joint health and social care information system maximising the benefits of a single shared record for patients and staff
n) Increase social care capacity in social work, occupational therapy and support staff, strengthening their impact in integrated community teams
o) Move to 24/7 availability of care

This will put our vision in place and by 2016 the local health and care landscape will be completely transformed. An avoidable admission to hospital or long-term care will be a sign of system failure. People won't notice which organisation provides their support because services are wrapped around the needs of local people in local communities.

We would like the support that being a Pioneer will bring to help us tackle the challenges and blocks in the local and national system that make achieving these things difficult in the extreme. We have the leadership and organisational capability to achieve this, demonstrated by what we have achieved so far. Pioneer status will help us move faster and more effectively. We want to influence national policy and show how it can be done in a real place with real people.

We are fully committed to actively sharing every lesson from the implementation of our programme of integrated care and have put (or are putting) the following in place:

- communications and engagement work stream and appointment of an organisation development lead
- a rolling programme of stakeholder engagement and learning events at district, provider and team level
- development of peer to peer promotion and building and growing on our existing pool of advocates
- Build up opportunities to describe our journey and to share our story through learning networks, forums a quarterly newsletter which is disseminated across all stakeholder organisations.
- Establish systems to share lessons learnt and transfer knowledge

We have a strong track record in sharing learning at a national and international level. We have done presentations this year at the NHS Confederation Conference and the Kings Fund Integrated Care Summit. We want Bradford on the national map as a place that is making change happen.

Building up the evidence

Our programme is supported by our interpretation of the evidence. We are maximising or use of a number of high value interventions which include:

- Risk stratification and predictive modelling
- Self-care at scale
- Active case management and multi-disciplinary planning
- Frailty approach in secondary and primary care, focusing on multi morbid patients.
- Addressing systemic under-implementation of high value clinical interventions
- Telehealth, telemedicine and telecare
- Hospital at home-type interventions (our virtual wards)
- Early senior review in A&E to reduce A&E conversion to admission
- Standardised discharge process

We'd like to grow our own evidence and will evaluate the impact of our programme on the health and wellbeing of local people

We fully commit to work with national partners to develop and test new measurements of people's experience of integrated care.

We fully commit to participate in a systematic evaluation of progress. In addition, we are building the evidence base locally. Throughout we will undertake careful evaluation and system monitoring. We will seek to evaluate the quantitative and qualitative benefit of our work – focused on those that are recipients of interventions, compared to those who aren't considering the health and social care system as a whole.

Conclusion

We can deliver because we already are. Integration is happening on the ground. Leaders are leading it. Staff are making it happen. The money is being lined up and the infrastructure of an integrated system is being put in place. The future viability of the local health and care economy is at stake and we have to do this. Your support will help us make this happen faster.

Bradford has many health and social challenges and the economic downturn is pervasive having a direct impact on the health and wellbeing of the population. We have a rapidly growing population and significant poverty and deprivation and hospital and care home costs will rise by at least a third over the next decade.

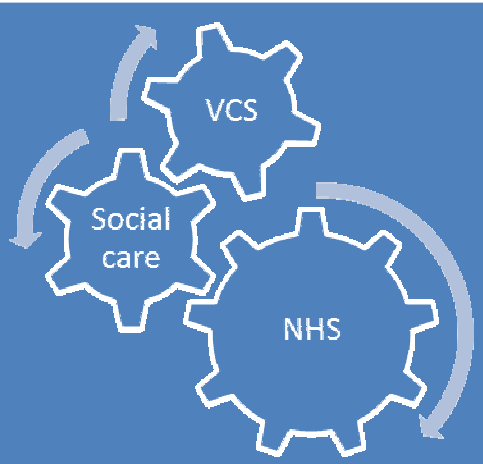
Commissioner and providers alike recognise that social and welfare needs seriously impact on the health and quality of life of our population, and identified the need to make radical changes to the way health and social care services were delivered in Bradford. We know that many people end up unnecessarily in hospital or care homes, particularly the frail and elderly and that the outcomes for people as a result of this were poor.

We fully recognise the implementation of our vision may destabilise one or more of our providers. We have discussed that with the senior leadership teams of all the providers concerned at a facilitated workshop with the Kings Fund. We gave a collective commitment to continue to drive forward this strategy because we all believe this is the right thing to do for local people and we will not let organisational form become a barrier to change. We gave a commitment that should this happen, we would address the consequences but that the needs of the patients would be paramount and continuity of services would override these concerns.

We recognise that the impact of change will be determined by our degree of ambition and commitment and our commitment is unquestionable from CEOs to front-line staff. We recognise the need for pace, scale and accelerated delivery and already have plans in place.

Pioneer status will provide the national support to address hugely complex and sensitive issues such as exploring economic viability of the health economy in its current form and considering alternative models such as integrated care organisations. The scope and ambition will provide a foundation to roll out integrated care to incorporate children's services in the longer term, giving local people a truly joined up health and care system.

Bradford is a good place to live and we are making it even better.



Joined up care in Bradford

Right care, right place, first time

The context: why we need to do this

- More people, more complexity, less money
- Efficiency targets for all partners
- Inefficient and uncoordinated response
- Continued need to improve quality and safety
- Infrastructure isn't joined up (IT, estates etc)
- Too many avoidable 'events'

Most importantly....

People tell us that
health and social care
don't talk to
each other or
work together

the experience…

Community mental health teams

GP

Warden

Vol & Community sector

Housing services

Discharge team

General practice

District nurse

Vol & comm sector

Housing grants

Physio-therapy

Community Matron

Podiatrist

Out-patients

Equipment services

Social worker

Practice nurse

Health OT

Home care

LA OT

Heart doc

Diabetes service

Falls service

Telecare

Memory assessment

Community health services

Local Authority

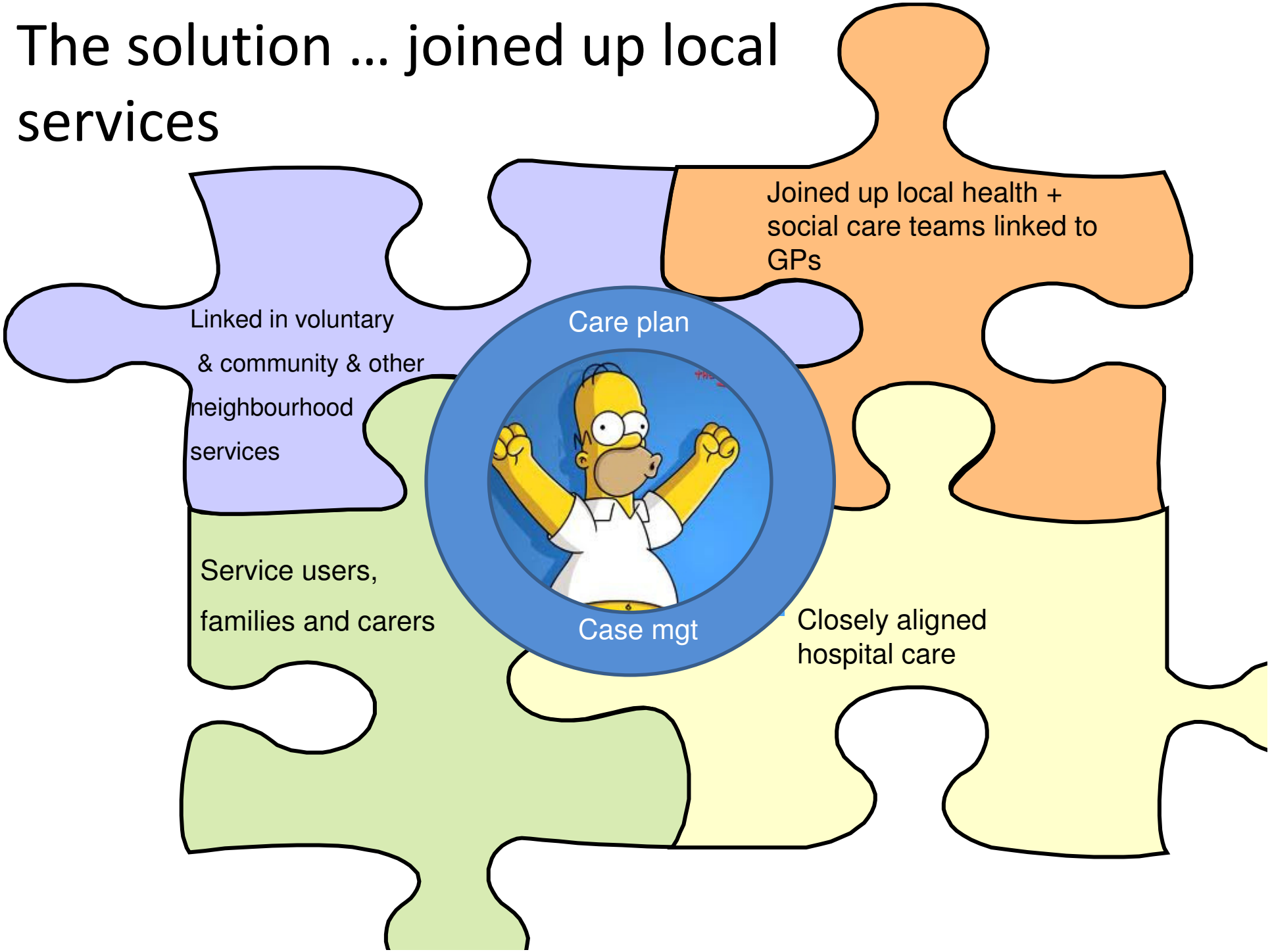
Housing agencies

Secondary care

Voluntary & Community sector

Primary care

The solution … joined up local services



Main aims:

1.Join up services around the needs of the person

2.Reduce costs associated with non-elective admissions and long-term care and redirect savings to community-based care

3. **<u>Increase community capacity and capability</u>**

4. Use rehabilitation and re-ablement to enable people to have best possible levels of health, wellbeing and independence

Tiered service model

1. Integrated community teams

   SW, DN, VCS, GP etc

   based around groups of GP practices

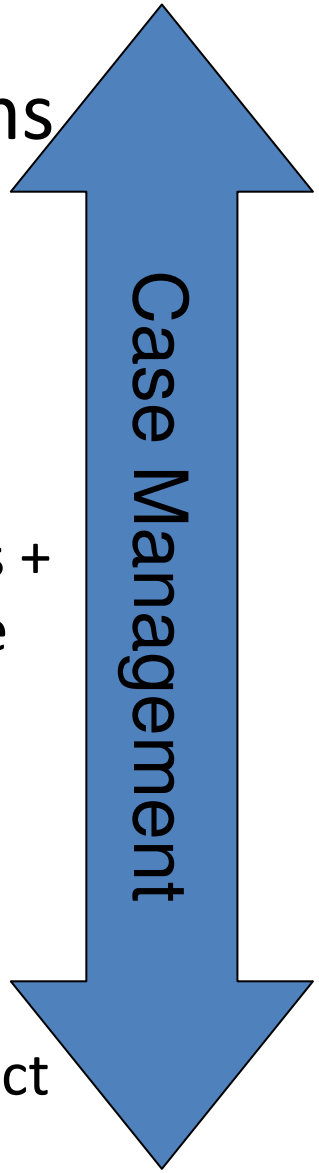
2. Intermediate tier

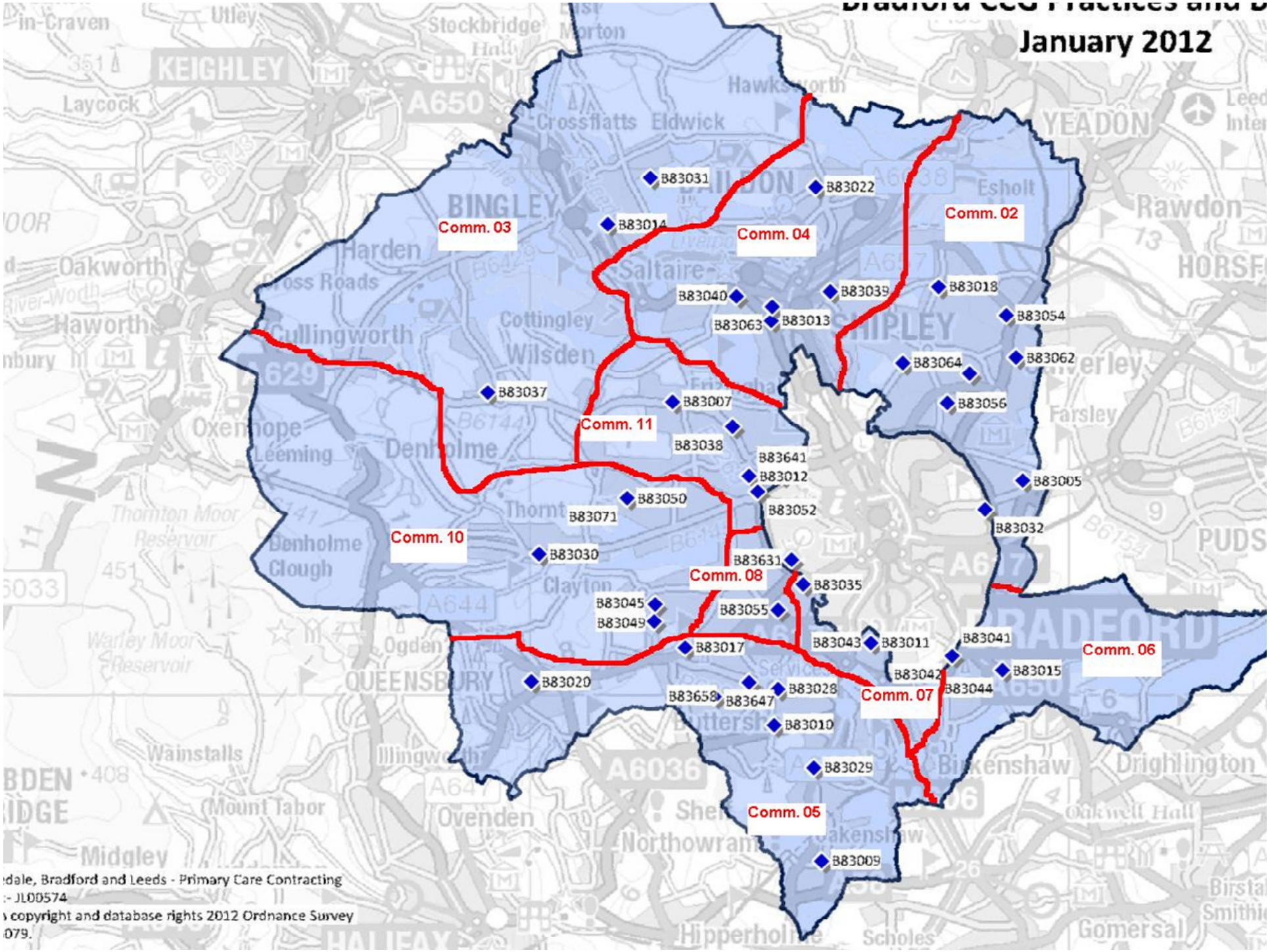
   A virtual ward preventing admissions + supporting discharge with home care enablement, therapists, geriatrician, nurses

   Across whole CCG area

3. District level

   specialist services across whole district

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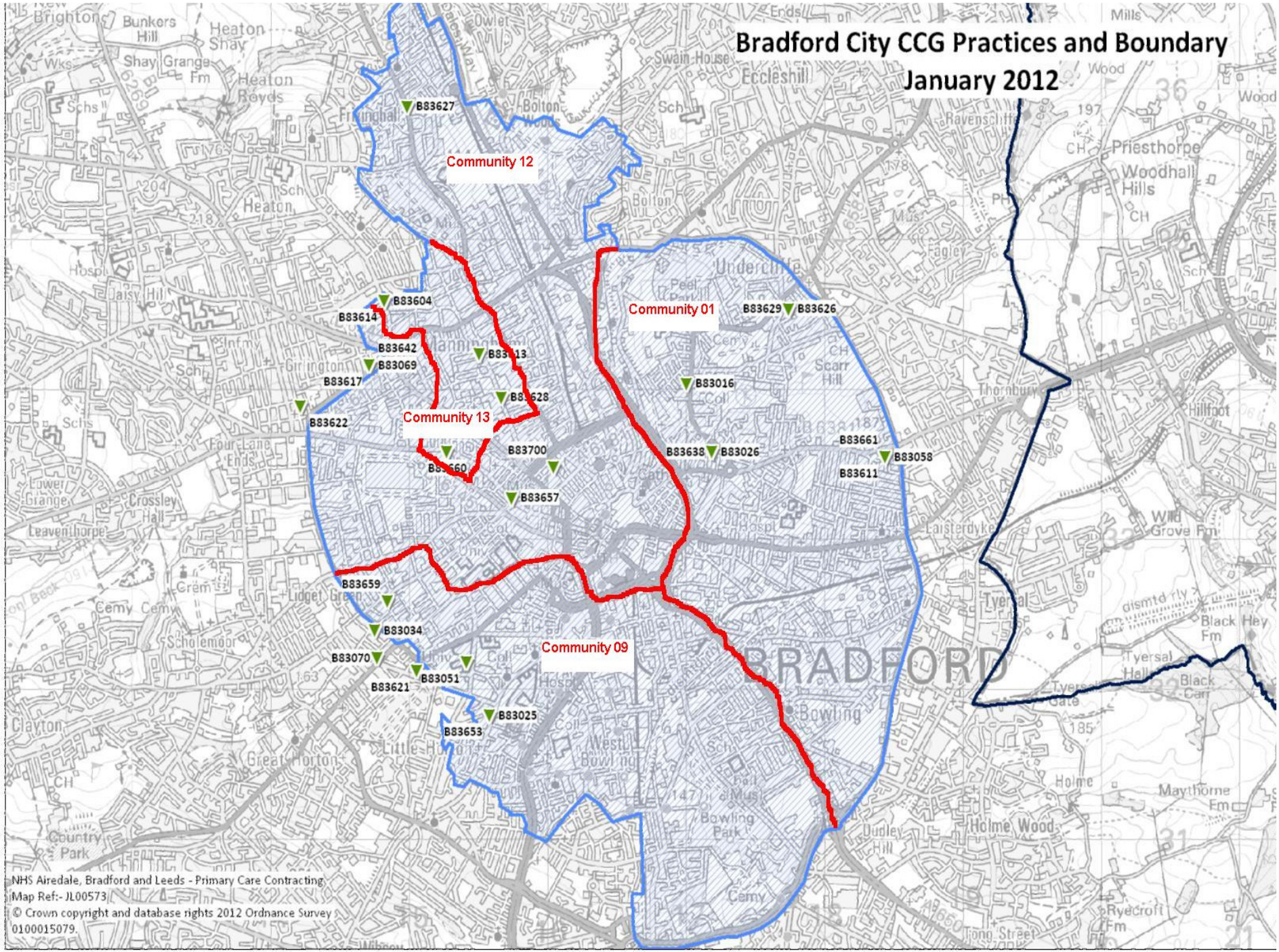
Bradford City CCG Practices and Boundary
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NHS Airedale, Bradford and Leeds - Primary Care Contracting
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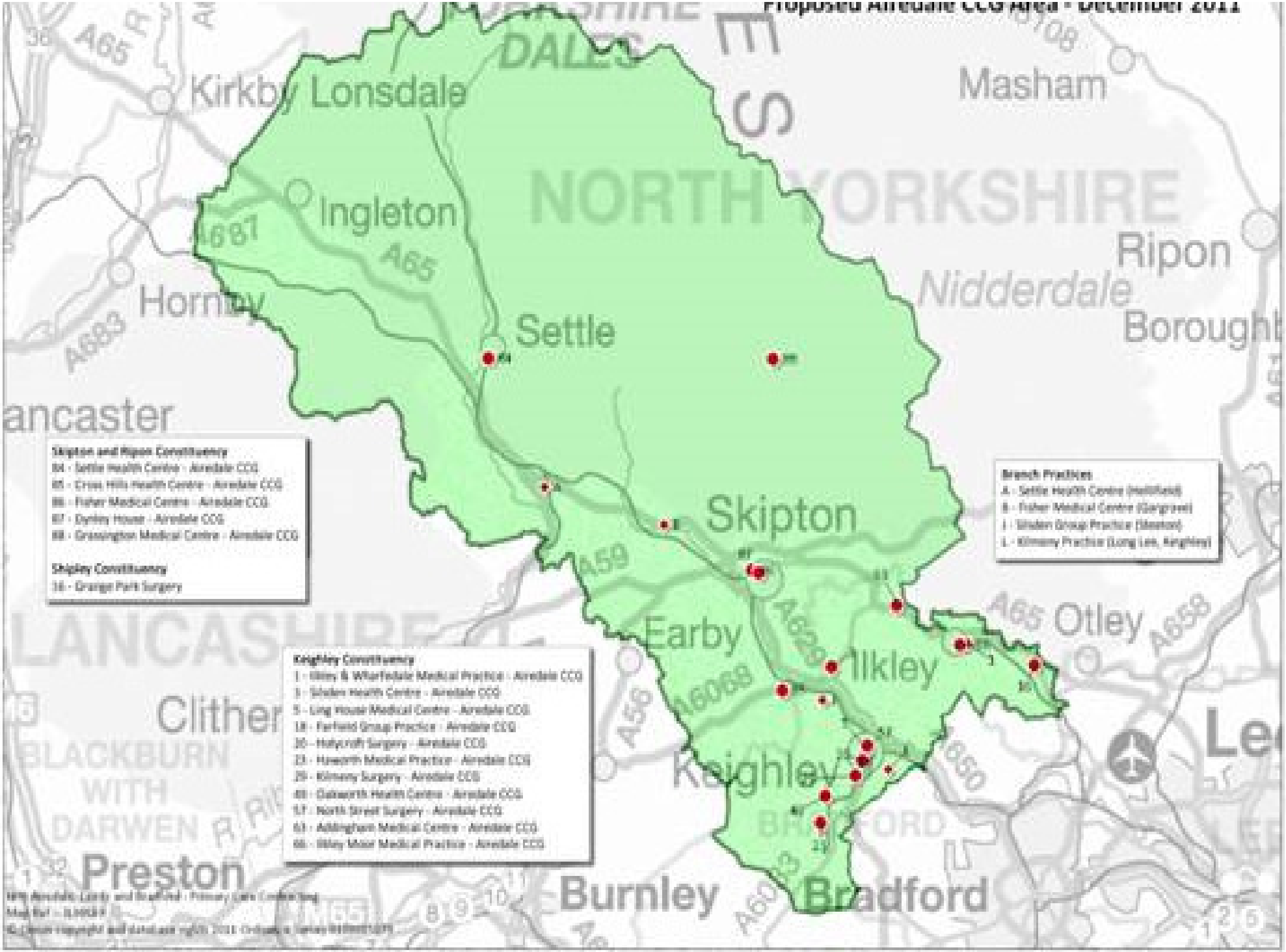

Proposed Airedale CCG Area - December 2011
Kirkby Lonsdale
DALES
Masham
NORTH YORKSHIRE
Ingleton
A65
A683
Hornby
Settle
Ripon
Nidderdale
Skipton
A59
Earby
Ilkley
Otley
A65
A658
A6068
Clitheroe
Keighley
BLACKBURN WITH DARWEN
Preston
Burnley
Bradford
Skipton and Ripon Constituency
84 - Settle Health Centre - Airedale CCG
85 - Cross Hills Health Centre - Airedale CCG
86 - Fisher Medical Centre - Airedale CCG
87 - Dyslley House - Airedale CCG
88 - Grassington Medical Centre - Airedale CCG
Shipley Constituency
16 - Grange Park Surgery
Keighley Constituency
1 - Ilkley & Wharfedale Medical Practice - Airedale CCG
3 - Silsden Health Centre - Airedale CCG
5 - Ling House Medical Centre - Airedale CCG
18 - Fairfield Group Practice - Airedale CCG
20 - Hallyroth Surgery - Airedale CCG
23 - Haworth Medical Practice - Airedale CCG
29 - Kilnsey Surgery - Airedale CCG
49 - Oakworth Health Centre - Airedale CCG
57 - North Street Surgery - Airedale CCG
63 - Addingham Medical Centre - Airedale CCG
66 - Ilkley Moor Medical Practice - Airedale CCG
Branch Practices
A - Settle Health Centre (Hellifield)
B - Fisher Medical Centre (Giggleswick)
I - Silsden Group Practice (Steeton)
L - Kilnsey Practice (Long Lee, Keighley)

Where are we so far?

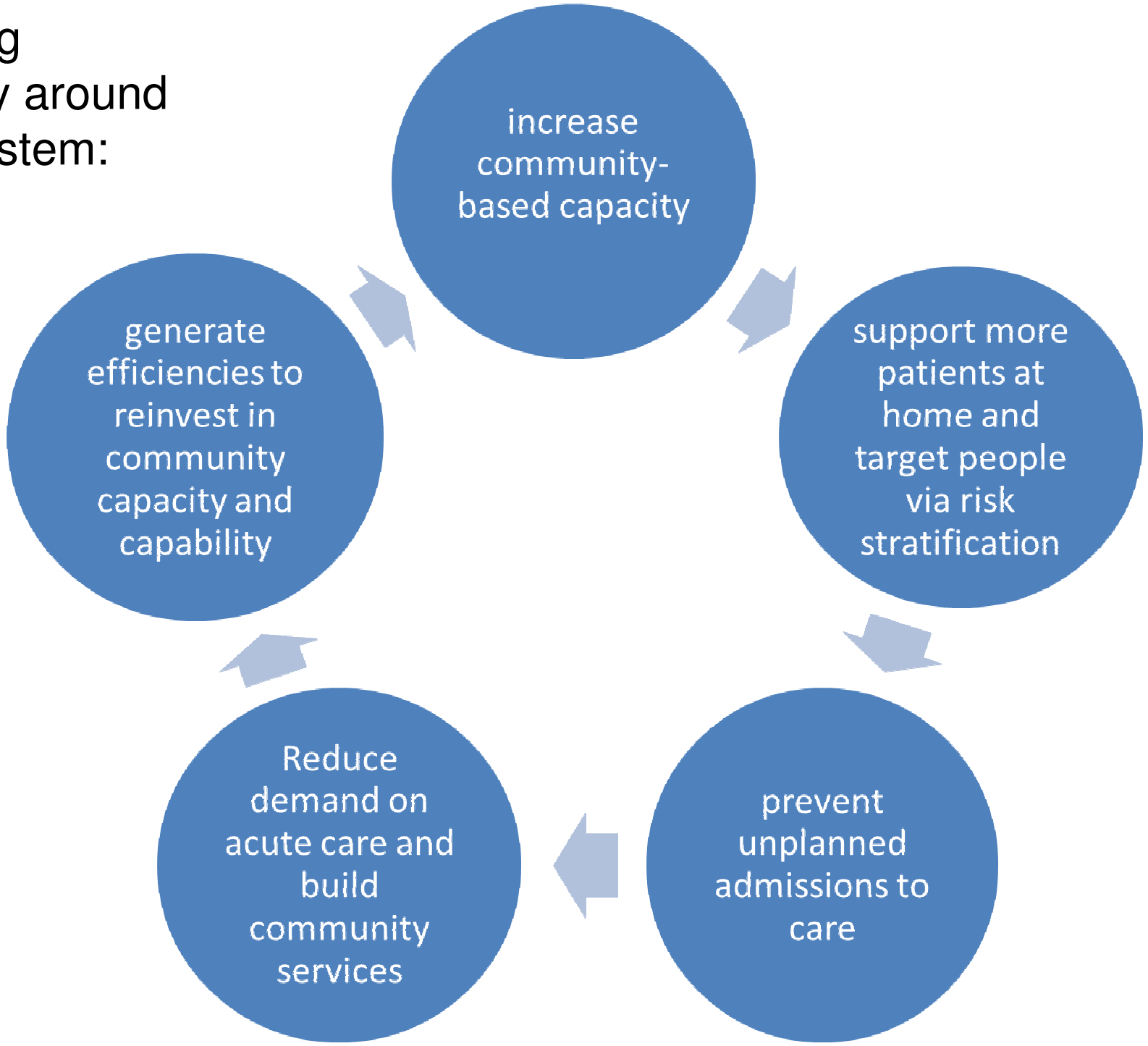
- Airedale, Wharfedale and Craven: whole area roll out
- Bradford: four test sites (19 practices and 30% of population) and rolling out to whole District this year
- Multi-disciplinary/agency working is functioning better
- Creating a better response for people and thinking about different solutions
- Predictive risk stratification in (nearly) all practices
- Starting to identify people who could benefit from a more joined up approach
- Starting to develop joined up assessments and care plans
- Operational protocol and a blueprint done
- Bradford Virtual ward and Airedale Collaborative Care Team expanding and integrating with social care

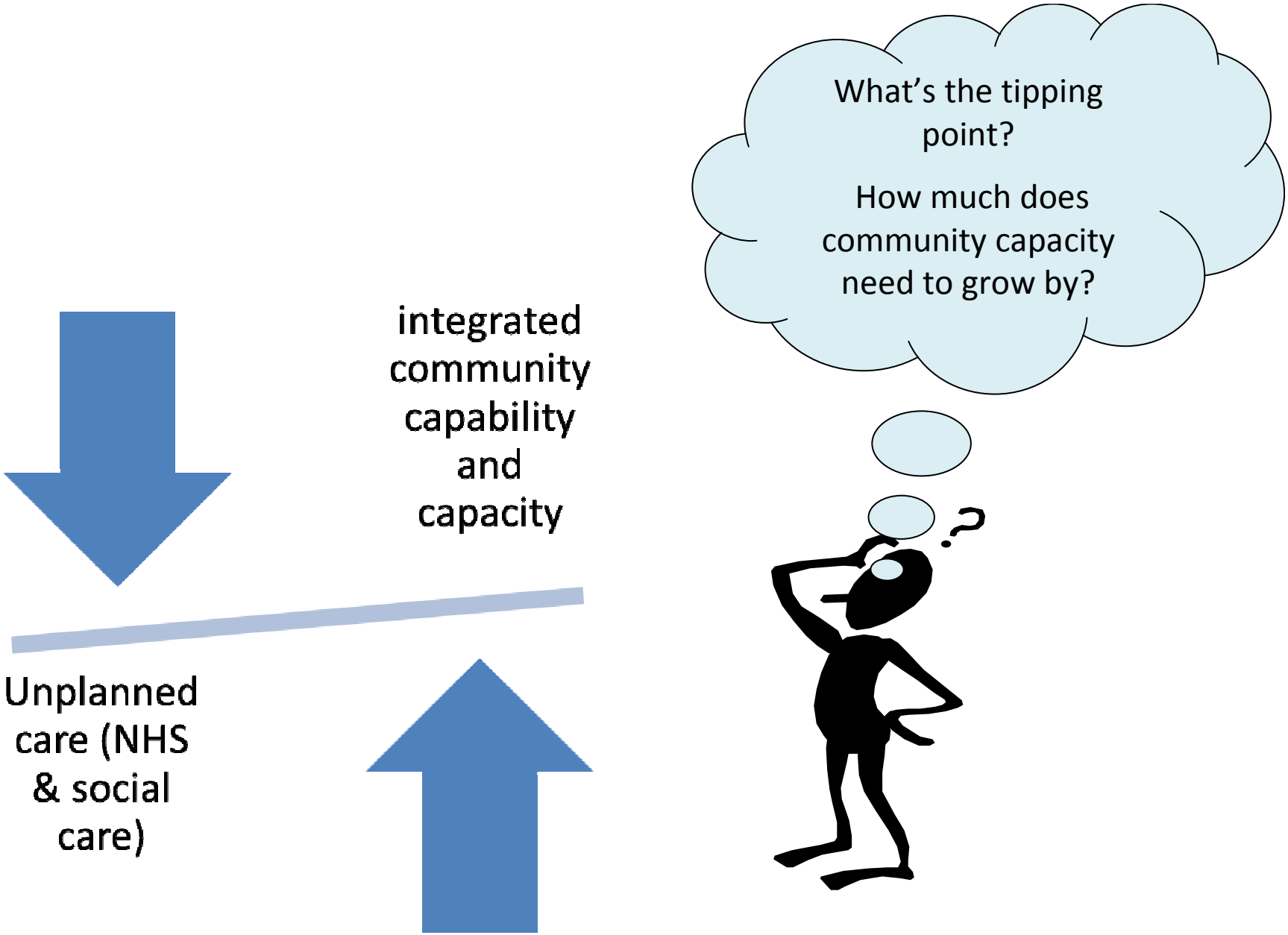
King's Fund core components of successful integrated care strategy: how are we doing?	
Defined populations	Yes
Aligned financial incentives	Some: CQUINS, DES, reablement, NHS funding for social care
Shared accountability for performance	Dashboard; separate performance regimes Not lined up in contracts
Information technology	Integrated care record in development; social care shift to S1; predictive risk stratification
Use of guidelines/shared protocols	Protocol and 'how to' blueprint
Collaboration of clinicians and managers	Yes
Effective, enduring and inspiring leadership	Yes, and mandate sought from HWB to move at scale and pace
A collaborative culture	Yes – increasingly
Multi-specialty groups	Yes
Real patient and carer engagement	Some through PPGs. Need to be better at this
Relentless focus on quality	Not as a whole system

Things to make some decisions about...

- Whole system skill mix across organisations
- A manager responsible for health & social care in each community
- A budget for each community
- Blurred roles and skill sharing
- An integrated patient record system
- Commissioning a whole system
- Deep and meaningful patient involve
- Soft stuff: culture change
- 7 day working
- Moving money around the system

Moving money around the system:




What's the tipping point?
How much does community capacity need to grow by?
integrated community capability and capacity
Unplanned care (NHS & social care)

Where does it need to go next?

- Implementation at scale and pace: whole district
- Commission community nursing better
- Bring more practices in
- Implement active case management to coordinate care
- Joined-up assessment, care planning & care record from a single IT platform
- Skill sharing and role blurring
- Expansion of the virtual wards (intermediate care) to prevent avoidable admissions and faster access to clinical assessment
- Integrate end of life care
- Support self-care better and embed in practice
- Increase the influence of local people
- Understand the detailed profile of each community, to:
  - Commission more responsively to local need
  - Understand the total resource

Are we making a difference?

From this...

'There are people in different places ... but there was no-one drawing it together, drawing together packages of care and communicating with each other across the organisations'.

To this....

"I now know there's all that support I can have ... it's supportive, it's reactive and it's value for money"

And this....

' It's been a life saver... it's having a network of people who care, and they do'

And this...

"…It's what kids today call a 'no brainer'! It's so obvious to keep the patient central, share ideas and resources…"