

# **Report of the Airedale, Wharfedale & Craven, Bradford City and Bradford Districts CCGs to the meeting of the Health & Wellbeing Board to be held on 29th July 2014.**

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**A**

**Subject: Bradford District & Craven 5 Year Forward View**

## **Summary statement:**

NHS England guidance clearly articulated the need for CCGs to work collaboratively across a wider health and care footprint to develop 5 year strategies. As a result, Airedale, Wharfedale and Craven, Bradford Districts and Bradford City CCGs jointly submitted to NHS England a 5 year forward view for the Bradford District & Craven health and care economy on June 20th.

This paper describes the development of the 5 year forward view document, the key focus areas and the next steps. The full document is attached as an Appendix.

Whilst the Health & Wellbeing Board has been fully engaged in the process, timescales for submission did not permit formal sign off and this is still required in line with NHS England guidance.

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**Overview and Scrutiny:**

**Health and Social Care**



## 1. SUMMARY

On December 20th 2013, NHS England published planning guidance, which set out its proposals for how the NHS budget is invested in order to secure sustainable models of care over the next five years. The guidance included a requirement for NHS commissioners to work together to co-design a five year strategy on a wider health and social care economy footprint, that sets out a clear plan on how commissioners, local authorities and NHS providers will work together to deliver services over the next five years within financial constraints.

The 5 year forward view for the Bradford District & Craven health and care system is designed to deliver our collective vision to create a sustainable health and care economy that supports people to be healthy, well and independent. It describes how health and care services for the people of Bradford District & Craven needs to change over the 5 years from 2014 to 2019, and how we envisage this will be achieved.

While it comes at a time of unprecedented prolonged financial challenge to the health and social care sector, twinned with rapidly rising demand, it also represents a huge opportunity to create a system that operates in a way better suited to the 21st century and we need to move from looking at how we merely address the financial challenge in the system to looking at how we collectively utilise available resources in a more efficient way.

This paper describes the development of the 5 year forward view document, the key focus areas and the next steps. The full document is attached as an Appendix.

The Health & Wellbeing Board is recommended to approve this submission as a footprint of the transformation needed across the health and care system in order to deliver our shared vision.

## 2. BACKGROUND

Work on the system wide vision has been led by the Integration and Change Board (ICB) in conjunction with the Bradford Health & Wellbeing Board (HWBB). Across Bradford District and Craven the ICB, made up of chief executive and senior director level representation from commissioner and provider bodies, and chaired the CEO of City of Bradford Metropolitan District Council, is responsible for driving integration and transformation from a system leadership perspective.

Building upon the 'Better for Bradford, Airedale, Wharfedale and Craven' work, through a number of development sessions, the concept of a 'Bradford District & Craven Mutual' has been explored, where organisational boundaries and structures don't create barriers for change. This work has identified a number of challenges which must be overcome in order to ensure a sustainable health and care system moving forwards. A set of values and principles, in order to work as a whole system in the delivery of our vision over the next 5 years, has also been agreed and signed up to by stakeholders.

Following on from a joint HWBB and ICB session in late May, ICB organisations were tasked with developing a document which would outline how Bradford District & Craven



could create a sustainable health and care economy that supports people to be healthy, well and independent. Using detailed Public Health analysis and a range of feedback from the citizens of Bradford District and Craven, which outlined the case for change, the following 5 key areas for development were identified:

- Promote self-care and illness prevention and improve the general health and wellbeing of the population of Bradford District and Craven;
- Transform primary and community services and place the patient at the centre of their care;
- Implement a 24/7 integrated care system across health and care economy;
- Develop and deliver a sustainable system wide model for urgent care services; and
- Develop and implement a system wide model for delivery of planned care interventions.

We will also look to commission on a wider footprint, where there are advantages to this approach and are already working in partnership with other CCGs to develop plans on a West Yorkshire footprint for paediatric, stroke, cancer and emergency care services.

To move from vision to reality will require efforts behind the scenes. Different organisations will need to integrate how they work around an individual's needs. Clinicians will need to explore how closing the gap between primary and secondary care could be best achieved. Staff will need retraining as we move to more generic roles which focus more on an individual's whole needs, working collegiately with other professions too as they organise their services in a different way, with care at home being the preferred option where it is safe to do so. New technologies will be needed to improve access to real time information and to bring services closer to home. We have identified the need to employ the following enablers in order to deliver our vision effectively:

- Deploy new approaches to whole system commissioning and new payment models to incentivise care around the needs of the person in the community;
- Embed electronic assistive technology;
- Establish effective engagement and co-production of services with service users and staff;
- Workforce transformation;
- Medicines optimisation; and
- Utilisation of assets.

We are aware that the development of this document is only the first step in delivering a truly transformed health and care system in 5 years' time and that there is still much work to do. There is a need to model the impact of our 5 new models of care and we are working collaboratively with our Commissioning Support Unity (CSU) and Ernst & Young to do this work. We have also identified a need to incorporate more of the broader health environment within our vision and will work over the coming few months to further develop and refine our models of care.

Whilst developing this strategy, a number of gaps in our governance arrangements have been identified. Specifically, we have identified the need for a cross organisational



programmes to develop our planned and self-care models and a stakeholder wide group to lead the development of our workforce transformation.

The aim is to have robust transformational change programmes in place and a refreshed 5 year forward view document by September.

### **3. OTHER CONSIDERATIONS**

It is recognised that there is still work to be done on defining how we deliver our vision for Bradford District and Craven, but the importance of this being a true system wide vision, with sign up from all stakeholders, cannot be underestimated. The work of the 'Bradford District & Craven Mutual' will therefore continue over the coming few months.

### **4. FINANCIAL & RESOURCE APPRAISAL**

We currently have a successful system, delivering all financial and operational targets and have always done so. However, we recognise that existing service models and patterns of spend are not sustainable in the context of future demographic and financial pressures. Initial estimates suggest the overall financial challenge to the health and care system over the next 5 years will have totalled £364m.

We have estimated that £197m of resource releasing savings need to be achieved from a health perspective by commissioners and from providers' internal efficiency savings plans by 2018/19. The Local Authority, a key partner with whom we have strong joint commissioning arrangements, face similar financial challenges with savings requirements of £167m over the next 5 years.

Through the implementation of our 5 year vision, we expect to create, with our partners, a health and social care economy which is able to meet the needs of our population whilst remaining financially sustainable. We have commissioned Ernst and Young to model the impact in more detail and the effect of some of our proposed interventions.

Whilst it is not possible yet to fully quantify the impact our vision will have on the sustainability of the system in 5 years' time, it is clear that there is still work to be done to fully address the potential financial impact. To create a truly joined up health and care system, we need to move away from viewing the financial challenge as a gap to be filled, to looking at how we collectively spend available resources in a more efficient way.

### **5. RISK MANAGEMENT AND GOVERNANCE ISSUES**

We have designed a governance structure that will underpin the implementation of our key priorities. The HWBB is responsible overall for governance.

We acknowledge that there are significant risks in relation to delivering our vision for health and care services over the next five years and we will use the governance framework outlined in the 5 year forward view document to mitigate and manage these risks.



## **6. LEGAL APPRAISAL**

No legal issues arising

## **7. OTHER IMPLICATIONS**

### **7.1 EQUALITY & DIVERSITY**

No issues identified

### **7.2 SUSTAINABILITY IMPLICATIONS**

Not applicable

### **7.3 GREENHOUSE GAS EMISSIONS IMPACTS**

Not applicable

### **7.4 COMMUNITY SAFETY IMPLICATIONS**

No issues identified

### **7.5 HUMAN RIGHTS ACT**

No issues identified

### **7.6 TRADE UNION**

No issues identified

### **7.7 WARD IMPLICATIONS**

None identified

### **7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)**

None identified

## **8. NOT FOR PUBLICATION DOCUMENTS**

None

## **9. OPTIONS**

There are no options resulting from this report for consideration by the committee



Suzan Hemingway, City Solicitor



## **10. RECOMMENDATIONS**

The Committee is asked to formally ratify the 5 Year Forward View (2014-19) for Bradford District & Craven Health & Care Economy and note the further steps identified.

## **11. APPENDICES**

- Appendix 1 5 Year Forward View (2014-19) Bradford District & Craven Health & Care Economy
- Appendix 2 Plan on a Page
- Appendix 3 Key lines of enquiry

## **12. BACKGROUND DOCUMENTS**

None



# 5 Year Forward View (2014-19) Bradford District & Craven Health & Care Economy



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## Introduction

On December 20th 2013, NHS England published planning guidance, which set out its proposals for how the NHS budget is invested in order to secure sustainable models of care over the next five years. The guidance included a requirement for NHS commissioners to work together to co-design a five year strategy on a wider health and social care economy footprint, that sets out a clear plan on how commissioners, local authorities and NHS providers will work together to deliver services over the next five years within financial constraints.

This document is the 5 year forward view for the Bradford District & Craven health and care system. It's designed to deliver our collective vision to create a sustainable health and care economy that supports people to be healthy, well and independent. It describes how health and care services for the people of Bradford District & Craven needs to change over the 5 years from 2014 to 2019, and how we envisage this will be achieved. While it comes at a time of unprecedented prolonged financial challenge to the health and social care sector, twinned with rapidly rising demand, it also represents a huge opportunity to create a system that operates in a way better suited to the 21st century and we need to move from looking at how we merely address the financial challenge in the system to looking at how we collectively utilise available resources in a more efficient way.

In order to deliver the ambitions of this plan we will need to shift activity and resources into different parts of the system and we therefore recognise the importance of a breadth of ownership of the plan, both in its creation and implementation. We have, therefore, worked to co-create these plans by involving the people and organisations who have an important stake in the delivery and performance of local health and social care. This has included hospital, community, mental health, primary care, voluntary sector, Healthwatch, public groups and social care partners amongst others. It is also critical to the success of the plans and vision we have, for the public and patients to be central to their conception, development and implementation and we have therefore used public and patient feedback, to shape the design and delivery of services around patients.

Airedale, Wharfedale and Craven  
Bradford Districts  
Bradford City

*CCGs working together*



Bradford District   
Care Trust

Bradford Teaching Hospitals   
NHS Foundation Trust

Airedale   
NHS Foundation Trust

  
England

City of Bradford Metropolitan District Council

[www.bradford.gov.uk](http://www.bradford.gov.uk)

# The Current Health & Care Delivery System

## Airedale, Wharfedale & Craven CCG

- 17 member practices
- 156,000 patients with 1% annual growth in total population
- 14% South East Asian
- 23% of population aged 65+ and 30% forecast to be 65+ by 2021
- 78.3 / 82.3 year life expectancy for males / females
- Approximately two thirds of the population live in the Bradford authority boundary and one third in the North Yorkshire authority boundary
- Top causes of death: cardiovascular, respiratory disease & cancer
- Budget £188m, £1,189/head of population

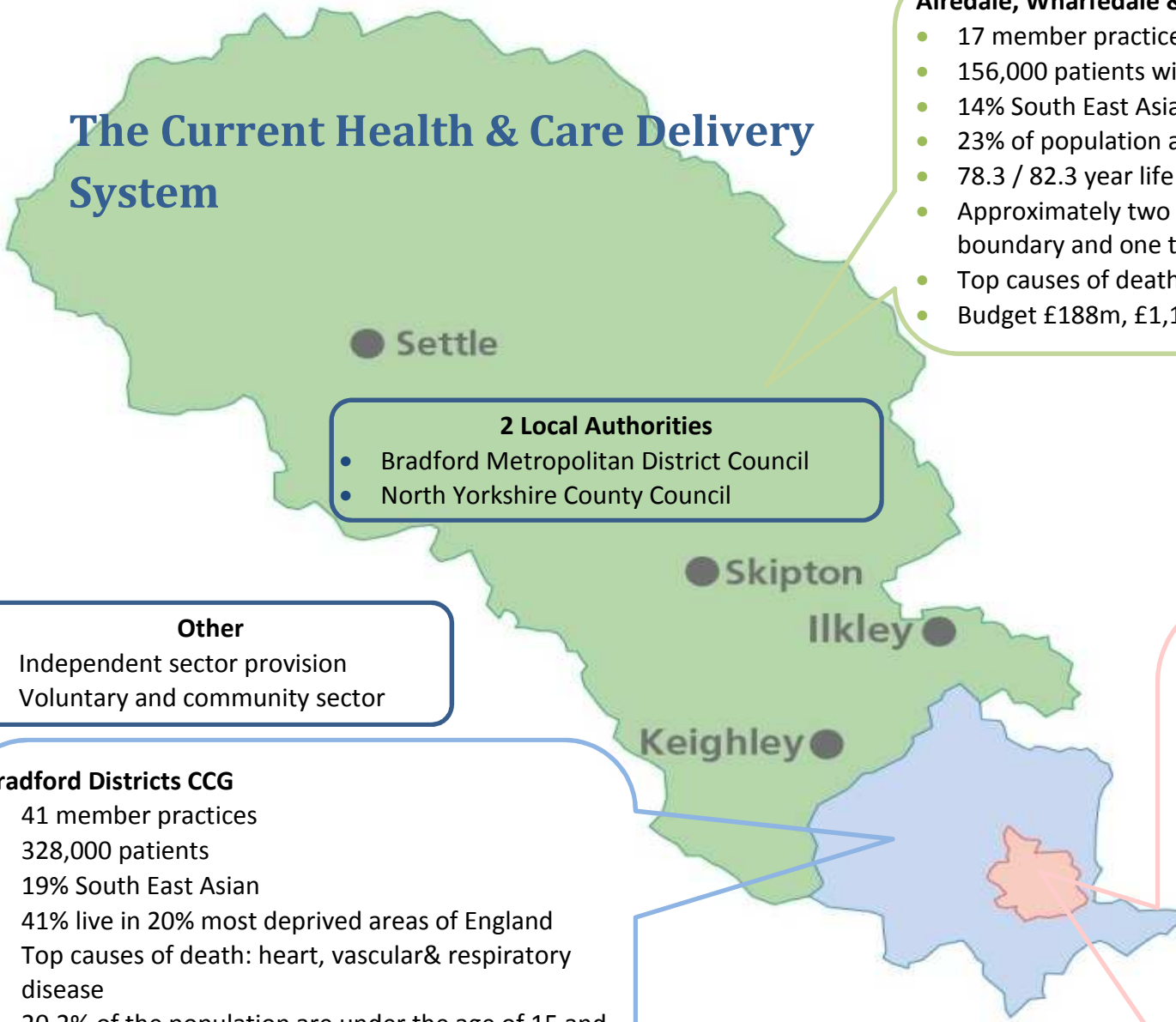
- ### 2 Local Authorities
- Bradford Metropolitan District Council
  - North Yorkshire County Council

- ### 4 NHS Trusts
- Airedale Hospital Foundation Trust
  - Bradford Teaching Hospitals Foundation Trust
  - Bradford District Care Trust
  - Yorkshire Ambulance Service

- ### Other
- Independent sector provision
  - Voluntary and community sector

- ### Bradford Districts CCG
- 41 member practices
  - 328,000 patients
  - 19% South East Asian
  - 41% live in 20% most deprived areas of England
  - Top causes of death: heart, vascular & respiratory disease
  - 20.2% of the population are under the age of 15 and 6.9% are 75+ (forecast to increase by 1.5% by 2020)
  - 78.0 / 82.2 year life expectancy for males / females
  - Budget £398m, £1,182/head of population

- ### Bradford City CCG
- 27 member practices
  - 118,000 patients
  - 75% South East Asian
  - 80% live in 20% most deprived areas of England
  - Top causes of death: heart, vascular & respiratory disease
  - 26.3% of the population are under the age of 15
  - 79.3 / 82.0 year life expectancy for males / females
  - Of all the local authorities in England and Wales, Bradford experiences the 2<sup>nd</sup> highest number of infant deaths
  - Budget £116m, £952/head of population



Bradford District and Craven has a large geographic footprint incorporating significant deprivation, some affluence, urban, rural and city living. Our population is one of the most diverse nationally and significant health inequalities still exist across the different areas of the district.

The health and care delivery system of Bradford District & Craven comprises 3 Clinical Commissioning Groups (CCGs), two local authorities and four main NHS providers. Although statutory organisations in our own right, the three CCGs have a commitment to collaborate and this was seen as one of our strengths during the CCG authorisation process. This means that we work together to secure the best possible, integrated and efficient services for people in the Bradford District and Craven area.

As well as buying health services, we work with other partners to help us achieve our objectives. We work collaboratively with Bradford Metropolitan District Council (BMDC) and North Yorkshire County Council (NYCC) to support them in their role as providers of health and care services for the local population, particularly around Public Health responsibilities (sexual health, school nurses, weight management, drug and alcohol support, stop smoking, emergency planning and accident prevention) for which they now have responsibility. Our local authorities also provide a number of different services to residents. Adult Social Care provides advice information and sign-posting to other services for the total population but its core focus is on adults with 'eligible support needs'. This includes older people, people with a learning disability, physical disability, sensory impairments, mental ill health and substance misuse issues. The wider local authority is a major contributor to the total Health and Wellbeing of the population through the provision of Housing, Leisure, Recreation and Environmental Services.

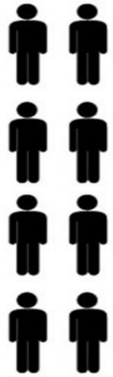
Bradford Teaching Hospitals Foundation Trust (BTHFT) and Airedale NHS Foundation Trusts (AHFT) provide primarily acute and secondary care services, Bradford District Care Trust (BDCT) are the main provider of community and mental health services and Yorkshire Ambulance Service (YAS) provide urgent and emergency medical care to people who call 999. There is also a well-developed market for elective and community care from independent sector providers including Yorkshire Clinic, Yorkshire Eye Hospital and a number of GP practices and a wide range of services provided by Voluntary and Community Sector (VCS) organisations.

CCG representatives are members of the local Health and Wellbeing Board (HWBB), which brings together key decision makers from the NHS, BMDC and the VCS to set a clear direction for the commissioning of healthcare. NHS England, who is now responsible for buying primary medical services (GPs, dentists, opticians and pharmacies), high security psychiatric services, health services for prisoners, specialised services, some public health services and some health services for the armed forces, is also represented on both the HWBB and on a number of local health and care system wide commissioner groups.

The independent public watchdog, Healthwatch, is a key partner in helping us to plan services. The organisation aims to give people and communities a stronger voice to influence and challenge how health care services are provided. The service records issues about health and care services to help address concerns and make improvements and offers a signposting service for local people. The district is covered by 2 Healthwatch groups: Bradford and District and Healthwatch North Yorkshire.

# Our Case for Change

## Current State



### Our Population

- People are living longer but a significant proportion live their lives in poor health
- The population is growing - the last ten years alone the population has grown by 11%
  - 23% increase in the number of 0-4 year olds
  - 26% increase in the number of 55-59 year olds
  - 17% increase in the number of over 85s
- 31% of the population- live in areas included in the 10% most deprived in England
- Almost 38,000 children live in relative poverty; that is 27% of the population aged 18 years and under
- Significantly higher level of adults with learning disabilities than England average

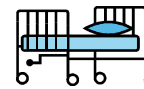
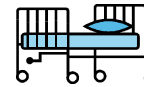
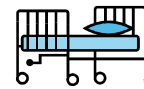


### Wider determinants of health

- 27% of Bradford households have an annual household income less than £15,000. In some areas of the district the proportion is as high as 40%.
- 10% of houses in the district are overcrowded and 12.6 % of all households live in fuel poverty
- 5.5% of 16-18 year olds are not in education, employment or training
- Educational attainment is improving, but remains lower than England
- Significantly higher levels of unemployment can impact upon physical and mental wellbeing



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### Long Term Conditions (LTCs)

- Treatment and care for people with long-term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure
- People with LTCs now account for approximately: 50% of all GP appointments; 64% of all outpatient appointments; and over 70% of all inpatient bed days
- More and more people live with more than one LTC
- 80,000 of people have been identified with hypertension, 40,000 with asthma, 34,000 with depression, 28,000 with diabetes and 21,000 with coronary heart disease. The actual number of people who have these conditions is likely to be higher than recorded
- About 1,000 people a year or 3 people every day experience a stroke
- 25% - 50% of people with high blood pressure do not have their blood pressure adequately controlled. 1/3 of patients with diabetes have poorly controlled blood pressure, resulting in potentially avoidable hospital admissions.

### Lifestyle Factors

- 12% of the population aged 17+, are registered as obese
- 22% of children are overweight or obese when measured in Reception, 35% in Year 6
- Obesity levels are highest in some of the more deprived wards
- 1 in 5 adults still smoke. Inequalities remain: 1 in 3 routine and manual workers smoke
- 10% of young people are regular smokers by the time they reach Year 10, 32 young people aged 11-15 years old take up smoking every week
- 19.3% of drinkers drink more than the recommended safe limits. Hospital admissions due to alcohol related harm increased by 34% between 2008 and 2011
- More disadvantaged groups are more likely to have a cluster of unhealthy behaviours



### Spend

- Each year we spend around £932 million on health services for the population
- The local authority spends around £1.2 billion each year
- Each year we spend around £160 million on social care for adults across the district



### Health & Social Care Use

- Over 12,400 older people need assistance in maintaining independent living. A further 8,200 people require help with one or more activities of daily living
- One in ten people provide some level of unpaid care
- 2,400 people received short-term support by way of rehabilitation and re-ablement last year. Each year 11,500 people receive longer-term services – 8,500 at any one time
- 1,940 people are supported to live in residential or nursing homes
- 90% of patient contacts with the NHS occur in primary care
- There are more than 190,000 A&E attendances each year at the two hospital trusts.
- Historically non-elective (unplanned) admission rates have increased year on year
- Significantly higher levels of adults and older people using secondary mental health services than England average
- Significantly higher levels of self harm than England average



## Future State



### Our Population

- The population by 2019 it is expected to increase by 7%
- Fast growing age groups between 2001 and 2019:
  - 37% increase in the number of 0-4 year olds
  - 39% increase in the number of 25-29 year olds
  - 42% increase in the number of 55-59 year olds
  - 44% increase in the number of over 85s

### Lifestyle Factors

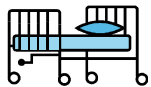
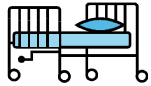
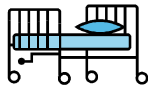
- It is difficult to predict how people's attitude to their health and behaviour will change over the next 5 years. Current trends suggest a growing socio-economic divide as those who are better off take on board health messages and adopt healthier lifestyles and those from more disadvantaged backgrounds do not
- Smoking rates are falling, albeit slowly. If current trends continue by 2019, 1 in 6 adults will still smoke
- Without additional action to tackle alcohol misuse, the % of drinkers drinking more than the recommended safe limits may rise to 25%. Hospital admissions due to alcohol related harm will increase by as much as 60%
- Some predictions suggest that by 2019 1 in 3 adults will be obese. This may result in more than 30,000 more cases of diabetes, and more than 30,000 more cases of heart disease and stroke



### Wider determinants of health

- Independent research suggests the economic downturn is likely to have lasting consequences on health and wellbeing. Much will depend on how the economic climate changes between now and 2019. Higher unemployment would continue to impact upon physical and mental wellbeing
- Work-related illness is decreasing, particularly among people with manual occupations – but the above could impact
- If we improved to Yorkshire and the Humber averages:
  - >3,000 households would be taken out of fuel poverty
  - We would save 112 excess winter deaths each year
  - 7,000 children will be taken out of poverty by 2019
  - An additional 800 children each year will achieve a good level of development at the end of reception
  - An additional 300 pupils will gain 5+ A\*-C grade GCSEs inc. English and Maths
- Improved housing conditions and greater access to green spaces should have a positive impact on health

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### Long Term Conditions (LTCs)

- The number of people living with more than one LTC is expected to continue to increase over the next 5 years. If current trends continue this will require an estimated £5m additional expenditure by 2019
- There will be an increase in people with identified to hypertension (83,000), asthma (43,000), depression (30,000) and diabetes (35,000)
- Between 30 and 35 strokes have been prevented in the last year alone through improved anticoagulation in patients with atrial fibrillation. If trends continue that's a potential 20% reduction
- If we reduced variation between the 3 CCGs in the % of diabetes with poorly controlled blood pressure, 1,000 additional patients would have their blood pressure controlled, potentially avoiding hospital admissions



### Health & Social Care Use

- Forecasts suggest an increase to around 3.5 million primary care contacts each year by 2019
- If current trends continue more people will require social care support. Between 13,000 and 14,000 older people will need assistance in maintaining independent living by 2019 and there is a growth in the number of children with disabilities needing support
- System change, supported by the Better Care Fund is expected to reduce the number of people in residential and nursing care homes by 9.73% each year over the next 2 years. But the impact on the number of people supported with short and long term packages in the community remains unclear
- If current trends continue, by 2019 there may be as many as 10,000 additional A&E attendances/year
- Without system change, un-planned admission rates are expected to continue to increase and could be as high as 12,930 per 100,000 population by 2019
- The number of older people living on their own will continue to increase, but the working age population is not expected to increase at the same pace as the older population. Will the working age population be able to care for older relatives?
- With an increasing older population we will continue to need more appropriate accommodation to support people to live independently in their own homes, meaning they are less reliant on health and care services.
- A growing number of older people and their families will fund their own care. The number of older carers will increase by up to 70%. 8,500 additional older people will require support with activities of daily living

### The Financial Gap



- Whilst responding to increasing demand we must make significant savings and continue to improve the quality of services and outcomes achieved.
- By 2019 demand for NHS services will outstrip supply (assuming funding and population changes at the predicted rate)
- Nationally it is predicted that £30bn of efficiencies will be required to ensure that the NHS can meet this demand and this translates broadly to £364 million for us if we include the anticipated reductions in local authority funding
- We have taken a strategic decision to focus our efforts on achieving the best quality and outcomes for our residents with the resources we do have and design a system that ensures the gap we envisage never materialises.



## What our Citizens Say

We are fully committed to engaging patients and the public in all aspects of our work and the Call to Action aims are synonymous with our vision to develop sustainable organisations. The Call to Action<sup>1</sup> programme has been embedded within our existing engagement programmes with an aim to use, develop and refine existing infrastructures. Patients and the public are involved in developing future service models through a range of engagement activities from individual patient stories to patient networks and events (Health and wellbeing hubs, Voluntary & Community Sector events, focus groups for diabetes, maternity, urgent care, youth services and mental health and joint events with the local authority).

"I think it is good that we get to speak and be involved directly. It means they hear what we have to say and the message is not mixed up. I can see a real commitment to want to listen and to make changes"

As part of our drive to collect insight and feedback from people who have used our services, we have also created a local Health Survey. The aim of this survey was to hear about their experiences of the local NHS services and ideas they may have on how we might improve them in the future. Our Call to Action work has also been supported by the Commissioning Support Unit (CSU), Bradford Council and HealthWatch. Through this engagement work a number of priorities for each CCG have been identified.

### Airedale, Wharfedale & Craven CCG

- More coordinated and joined up services
- Listening and communication skills from clinicians
- More focus given to healthy living/self care – included in this are health risks for younger people
- Isolation and loneliness both for older people and in rural communities
- Mental health services and dementia

### Bradford City CCG

- Mental health
- Heart disease and diabetes
- Loneliness (young people's isolation)
- Dementia
- Patient experience

### Bradford Districts CCG

- Heart disease and stroke
- Mental health
- Patient experience
- Loneliness (old age)
- Weight management and bariatric surgery.

"Involving communities in making services means that we will create and improve services that meet gypsy traveller needs and that is a good thing for everyone"

"We need to build awareness for professionals so they can learn more about us. We need to teach ourselves about the commissioners and service providers so we can challenge and change the systems together"

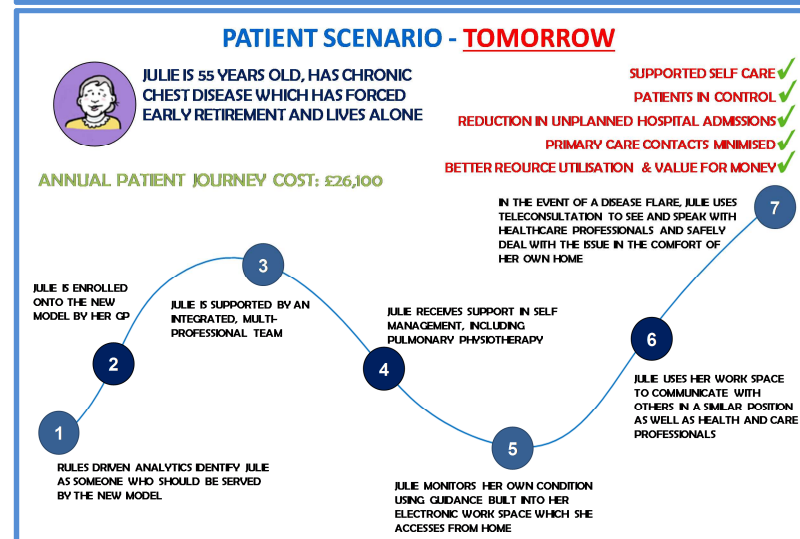
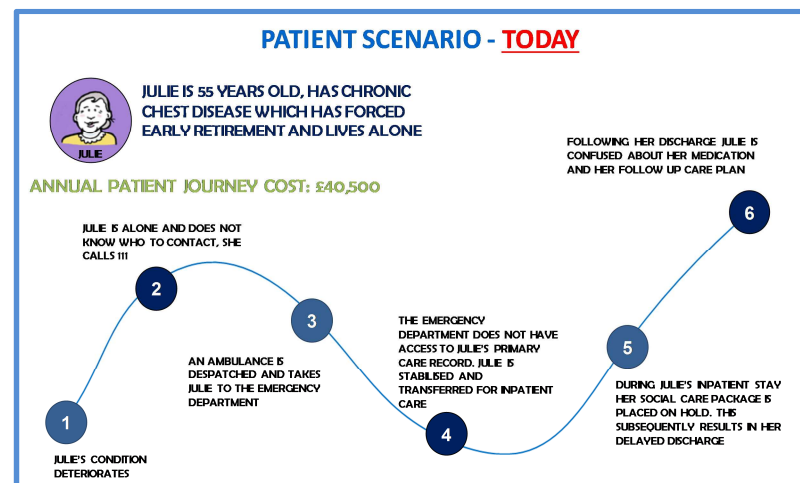
"It has been really good to meet different people from different communities – what I learned is that when we listen to each other's stories – our issues, our needs are not that different. There are so many commonalities between us that it felt like a joint cause to make services better and not a lone cause"

<sup>1</sup> <http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs-belongs.pdf>

## The Challenge for the system

This is a challenging environment for commissioning health and social care. Local demands on health and care services are increasing as people live longer with more complex long term conditions. Patient expectations continue to rise, and there is a universal drive to increase productivity and efficiency that necessitates radical changes in the way we deliver care, such as the move to 7 day services, all at a time of limited or no growth and significant financial challenge. To address the challenges in the system, we need to transform the way we deliver services to the local population in a way that places the patient at the centre of their care, encourages them to take responsibility for their long term health and reduces inefficiencies in the delivery system. However, delivering a system which moves us from our current state to our vision of tomorrow, in itself, is subject to a number of specific local challenges:

- The health and care economy financial challenge is estimated as £364m over the next 5 years
- Both patient engagement and involvement needs to be strengthened to understand and support the priorities for the system and own the interventions and new models of care
- The impact of NHS England's direct & specialist commissioning is unknown at this stage
- There is a lack of whole system commissioning
- There are significant workforce pressures moving forwards but we lack a coherent system wide workforce transformation strategy
- There is variability in access to primary care and inconsistent models of delivery
- As yet there is an unknown impact on organisation form as a result of changes to service models
- There is a lack of self care responsibility
- Delivery of A&E targets & sustainability of current urgent care system is a challenge
- Sustainability of clinical services may impact upon models of planned care
- There is often a focus on current operational delivery at the expense of planning for the future
- Population (carers, booming young & ageing population with geographic variation)
- Demand increasing despite community alternatives



# Improving quality and outcomes

The NHS Outcomes Framework describes the health outcomes required from NHS organisations under 5 domains. National data shows significant variability across the health and care economy in relation to these national outcomes and we are determined to reduce these inequalities for our population. We will develop a clear set of local metrics to support the delivery of each of our 5 new models of care. Delivery will be supported by a move towards more outcome based commissioning.

The following describes our current performance, our aspiration for 2018/19 and the new models of care which will help to deliver these aspirations.

## Domain 1: Preventing people from dying prematurely

### 1. Reducing the number of years of life lost due to treatable physical and mental health conditions

- The number of years lost per 100,000 population from amenable causes has reduced since 2003 (2,545 in 2012) but remains higher than the England average (2,001)
- By 2020 14.7% of the population forecast to be 65+

**Aspiration:** Reducing PYLL by between 9% and 18% by 2018/19

**Models of care:** 24/7 integration, self care & prevention, patient centred community and primary care

**Example local metrics:** See HWBB strategy

- Reduction in rates of smoking, obesity and alcohol related conditions
- Continued reduction in infant mortality rates
- Improve physical health of people with mental illness and increase access to psychological therapies
- Reduce mortality from CVD, respiratory disease and cancer
- Improved immunisation and screening uptake

## Domain 2: Enhancing quality of life for people with long term conditions (including dementia)

### 2. Improving health related quality of life for people with LTCs

- The health related quality of life for people with long term conditions (LTCs) has fallen from 71.6 in 2011/12 to 71.0 in 2012/13. Remaining below the England average of 73.1.
- People with complex conditions are living longer
- GP survey data suggests 65% of those with LTCs feel that they have had enough support from local services
- People are more likely to die at home than in hospital or in a hospice (22% in Bradford and 19% in AWC)

**Aspiration:** Improvement in EQ-5D score by between 0.04% and 1% by 2018/19

**Models of care:** 24/7 integration, self care & prevention, patient centred community and primary care

**Example local metrics:**

- Reduction in admissions for emergency care sensitive conditions
- Increase in % reporting sufficient level of support (GP survey)
- Improved dementia diagnosis
- Better management of diabetes (9 care processes)
- Better management of AF in primary care

### 3. Reducing unplanned hospitalisation

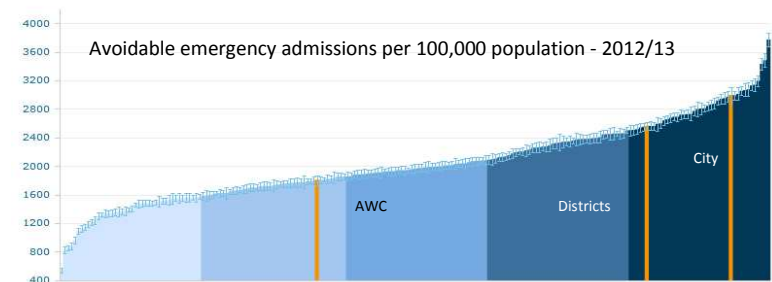
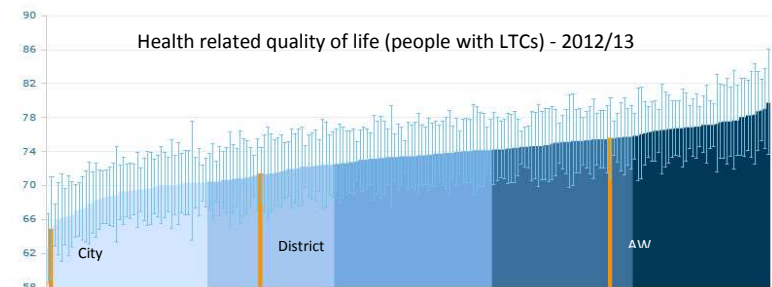
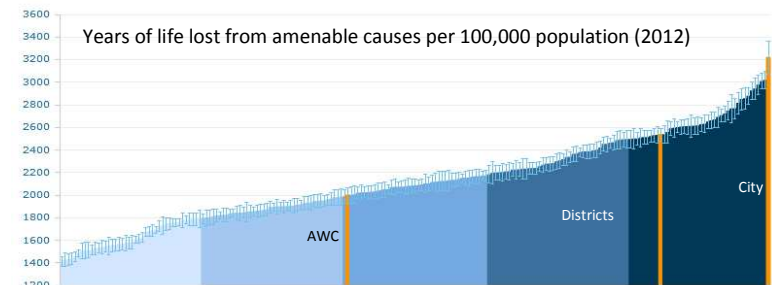
- In 2012/13 there were 1055.1 emergency admissions for chronic ambulatory care sensitive conditions, 339.1 emergency admissions for asthma, diabetes and epilepsy in under 19s, 1,440.1 emergency admission for acute conditions that should not usually require hospital admission and 451.0 emergency admission for children with LRTIs per 100,000 population compared to England averages of 826.8, 343.2, 1,214.2 and 373.6 respectively
- 40% of those attending A&E could be treated in alternative settings (Keogh)
- 64.4% of non-elective Children's admissions are for one day or less
- Emergency re-admissions continue to increase year on year

**Aspiration:** Reduction in emergency admissions of 15% by 2018/19

**Models of care:** 24/7 integration, self care & prevention, patient centred community and primary care

**Example local metrics:**

- Reduction in emergency admissions for specific conditions & age groups
- Reduction in A&E attendances
- Reduction in re-admissions
- Improved access to primary care



**Domain 3: Helping people to recover from episodes of ill health or following injury**

**4. Proportion of older people living independently at home**

- Locally 92% of people age 65+ discharged from hospital into reablement/rehabilitation services are still at home after 91 days (81.4 England) although only 1.8% of people age 65+ are discharged from hospital into reablement/rehabilitation services compared to 3.2% nationally
- 26.6% of Non elective admissions are over 65
- A&E attendances have increased by 13% between 2008/09 and 2013/14
- In 2013/14 93% of patients were still at home 91 days after discharge from a reablement or rehabilitation scheme

**Aspiration:** 95% by 2016/17

**Models of care:** 24/7 integration, patient centred community and primary care

**Example local metrics:**

- Reduction in permanent admissions to residential and nursing care homes
- Increase % of older people aged 65+ who were still at home 91 days after discharge from
- Increase in people supported with short and long term social care packages in the community, 65+ per 100,000 population
- Reduction in non-elective admissions per 100,000 population (65+)
- Reduction in delayed discharges

**Domain 4: Ensuring that people have a positive experience of care**

**5. Positive Experience of hospital care**

- Bradford Teaching Hospitals was rated as "average" for questions forming part of the 2013 inpatient survey
- Airedale NHS Foundation Trust was rated as "average" for questions forming part of the 2013 inpatient survey

**Aspiration:** Improvement ranges from 2.6% and 25% by 2018/19

**Models of care:** Planned care interventions, sustainable urgent care services

**Example local metrics:**

- Friends & family test
- Improved in patient experience
- Improved ability to meet and exceed nationally and locally agreed targets

**6. Positive experience of care outside the hospital**

- BDCT performance against the MH survey questions in 2013 was classed as "average" against other MH providers

**Aspiration:** Improvement ranges from 0.2% and 21% by 2018/19

**Models of care:** 24/7 integration, patient centred community and primary care

**Example local metrics:**

- MDT patient experience measure (2014/15 CQUIN)
- Improved access to primary care
- Improved patient experience of primary care
- Reduction in face to face follow up appointments

**Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm**

**7. Avoidable deaths in our hospitals**

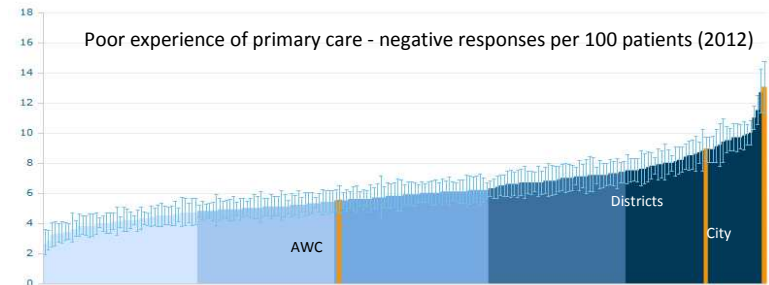
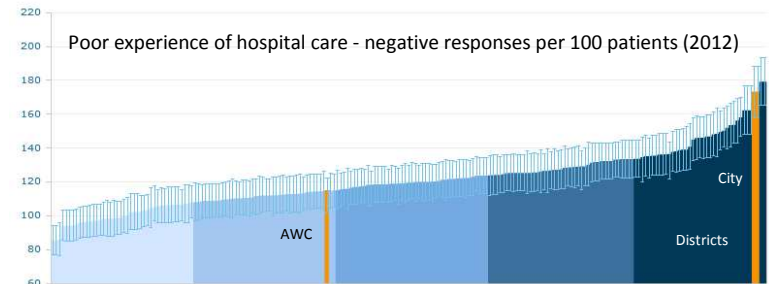
- Mandate to deliver 7 day working by 2015/16 supported by local CQUIN schemes
- 20% increase in Emergency HSMR at the weekend compared with during the week at BTHFT.

**Aspiration:** Zero HCAs

**Models of care:** Planned care interventions

**Example local metrics:**

- No hospital reported cases of Cdiff or MRSA
- Reduction in % community reported Cdiff cases
- Reduction in HSMR



## A System Wide Approach

Work on the system wide vision has been led by the Integration and Change Board (ICB) in conjunction with the Bradford Health & Wellbeing Board (HWBB). Across Bradford District and Craven the ICB, made up of chief executive and senior director level representation from commissioner and provider bodies, and chaired the CEO of City of Bradford Metropolitan District Council, is responsible for driving integration and transformation from a system leadership perspective.

Building upon the 'Better for Bradford, Airedale, Wharfedale and Craven'<sup>2</sup> work, through a number of development sessions, the concept of a 'Bradford District & Craven Mutual' has been explored, where organisational boundaries and structures don't create barriers for change. This work has identified a number of challenges to the system which must be overcome in order to ensure a sustainable health and care system moving forwards.

It is recognised that there is still work to be done on defining how we deliver our vision for Bradford District and Craven, but the importance of this being a true system wide vision, with sign up from all stakeholders, cannot be underestimated. The work of the 'Bradford District & Craven Mutual' will therefore continue over the coming few months.

### Values and principles

In order to work as a whole system in the delivery of our vision over the next 5 years, the following values and principles have been agreed and signed up to by stakeholders through the work of the HWBB and ICB:

- Working better together is first and foremost about what is best to add value for all the people of the district
- We will improve the quality of care and support available and look for improvement through the eyes of the people of the district and the staff providing the care
- We're in this together, working as a whole system and both risk and reward are shared
- We will continue to create a culture of trust, openness and transparency, including demonstrating a collective stewardship of resources, using all available assets in a shared way
- The system is wider than just our organisations and we will put the interests of the people we serve at the forefront of our decisions with the view that the people of the district are themselves an asset
- We will collectively agree our future priorities as a whole system;
- Our clinicians, social care professionals, managers and colleagues and partners will work together to make change happen
- We commit to working at pace, to achieve rapid progress, make decisions and see them through
- We will all communicate our shared values and principles in a consistent way

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<sup>2</sup> Better for Bradford, Airedale, Wharfedale and Craven: right care, right place, first time. An inter-agency agreement to deliver integrated care services in Bradford, Airedale, Wharfedale and Craven by 2016

## Our Vision

In light of our analysis of the current and future state of the health and care economy of Bradford District and Craven, the specific local challenges we face, and through listening to what our citizens say, we have set ourselves the following vision:

### **To create a sustainable health and care economy that supports people to be healthy, well and independent**

In order to achieve this vision we will, by 2019:

- Promote self-care and illness prevention and improve the general health and wellbeing of the population of Bradford District and Craven
- Transform primary and community services and place the patient at the centre of their care
- Implement a 24/7 integrated care system across health and care economy
- Develop and deliver a sustainable system wide model for urgent care services
- Develop and implement a system wide model for delivery of planned care interventions

The future state of our health and care economy will undoubtedly need to change in order to deliver our vision. Recent proposals to develop co-commissioning arrangements between NHS England and CCGs and the legislative reform order going through parliament provides for greater, formal collaboration between commissioners around their unit of planning. We have been exploring how to make more progress on joint commissioning between the CCGs and the Council in both adults and children's services and we are working with NHSIQ to develop our joint commissioning arrangements for children. In addition, work is underway on a West Yorkshire footprint to look at cancer, paediatric, stroke and emergency care.

Through the ICB development work we have acknowledged that provision should be driven by the needs of patients and not the configuration of providers. We are exploring capitation based budgets for defined communities and are exploring new models of contracting for services that incentivise a move towards a more patient centred approach. ICB have significant concerns about the future availability of an appropriately trained workforce and providers are considering where best to collaborate to secure the best service offer for the people of Bradford to mitigate the risk of workforce shortages.

We will need to become sophisticated commissioners, using data to understand our local needs and modelling the impact of interventions in a more intelligent way to drive commissioning decisions. Only when we are able to do this will we be in a position to use innovation underpinned by evidence to ensure radical and fast implementation.

One feature of the development of this strategy has been co-production between commissioners and providers. We want to explore how best to remove the barriers between commissioning and provision so that almost every penny is spent on services to patients rather than on managing the system.

## New Models of Care

It is acknowledged that we are not starting from a stationary position and our vision for the next 5 years will build upon current work already underway across the system. We are starting this journey with a strong foundation of clinical leadership and partnership working and already have a number of areas of success:

- Across the district we have 58 practices engaged with our atrial fibrillation programme to help prevent strokes. 330,000 patients have been included with 714 additional patients on Warfarin, resulting in 29 strokes avoided and 17 deaths prevented
- Across District CCG there are proactive multidisciplinary working in 9 integrated communities working across the whole health and social care economy and 338 at risk patients now have an Integrated Care Plan in place
- All 27 City CCG practices are actively participating in the Bradford Beating Diabetes project with 2,144 people (with known impaired glucose) having attended for risk assessment, of whom 1,859 have been offered a brief intervention and 528 new diabetics have been identified since November 2013. There has also been an improvement in the ongoing management of known diabetics in primary care with those receiving all 9 recommended diabetic care processes increasing from 40.2% to 63.6% in City CCG practices the past 12 months
- A new helpline across the district to improve healthcare for seriously and terminally ill patients who are at the end of their life has been launched across the health economy. The dedicated 'Gold Line' phone number provides help and advice, 24 hours a day, seven days a week, to patients and their carers, and supports them in their preferred place of care
- A pilot project to support patients with long-term conditions in Manningham through more joined-up care has proved a real success. The project looked at whether these patients could have been supported better to manage their long-term conditions with focused health and social care input – looking at the patient's family and support networks and their clinical needs. With the help of a community matron and a community coordinator, the practices worked with the patients over several months to see how different services could support them to stay well and independent
- Airedale's collaborative care team (ACCT) initiative was launched in 2008, and is now supported by the Craven Collaborative Care Team (CCCT), to establish an integrated care team tasked with preventing unnecessary admissions and facilitating efficient hospital discharge. At the heart of the CCT approach lies the principle that patients should only be in hospital when this is of clear benefit to them. Feedback from patients, carers and relatives has been extremely positive, with 100 per cent of patients for Airedale CCT and 98 per cent for Craven CCT reporting that the quality of services is "excellent" or "good" in the most recent patient satisfaction surveys.

The focus of our change programme over the next 5 years is to continue the shift of services and resources from unplanned hospital care to integrated health and social care delivered in community and primary care settings. It is also acknowledged that, whilst this strategy has been developed on a health and care economy footprint, there will be cases where the new models of care will need to be tailored to reflect the differing needs of the populations of the 3 CCGs.

## Promote self-care and illness prevention and improve the general health and wellbeing of the population of Bradford District and Craven

In Spring 2013, the Secretary of State for Health said: “Everyone should have the same opportunity to lead a healthy life; no matter where they live or who they are which is why we must continue to work to narrow the gap in health inequalities, local areas must work together to address the health needs of their population and make a real difference in tackling health inequalities.”

“Making simple changes to my medication and type of inhaler has enabled me to look after myself better, I feel I have my independence and that is important”

### Bradford City specific

Beating Diabetes, a major public awareness campaign on diabetes has been launched by clinical leaders in Bradford City. Helping to prevent people developing diabetes in the first place; and making sure those people with diabetes are looking after themselves and getting the right care and support, are the key aims of the campaign.

With over 7,500 diabetic patients in the City area, and an additional 5,700 people at moderate or high risk of developing the most common form of diabetes (Type 2), the CCG is launching a campaign to prevent diabetes becoming an inevitable part of many people’s lives.

An integral part of reducing inequalities and creating a sustainable health and care system is improving self-care with the aim of stopping or delaying people from needing to access long-term social care and health services and keeping people better for longer. The vision for self-care is to incorporate a preventative, early intervention approach, and to support people in being a partner in their own care to enable them to self-manage in the community whenever possible. A self-care week was held in November 2013 which focused on embedding support for self-care across communities, families and generations.

The Health Inequalities Action Plan for Bradford District and the Community Plan for North Yorkshire detail the areas of health inequalities where health and care services must work together to deliver improvements in living and working conditions, social and community networks and in promoting “good” lifestyle choices. Our existing self-care programme has prioritised the reduction in mortality from cardio-vascular, respiratory diseases and cancer, as these are our particular health challenges. There is also a focus on improved mental health support as a key factor in improving overall health and wellbeing. We have implemented a range of programmes such as X-Per patient, self-care packs, and community champions that support both social and health models of care with partners in health, social care and the third sector. This has given us a solid foundation for expanding our focus in this area.

### Bradford Districts specific

The CCG is developing an e-learning tool (VitruCare) which enables patients to jointly plan and take better control of their health

We recognise that self-care can only ever be developed as part of an overall strategy for producing healthy communities and the benefits it can bring in reducing health inequalities across these communities. Our priorities for the next 5 years in delivering our self-care strategy will be:

- Staying healthy: Education and promoting the use of technology such as health apps, forums, web literature (94% of adults own or use a mobile phone and 75% have broadband)<sup>3</sup>; use of services in the VCS such as community champions and village agents and; Self Care Week
- Minor ailments: Use of Pharmacy First, 111 and NHS Choices as alternatives to GPs and A&E and better self-management of minor ailments

“It is really important to understand information – not just receive it, I want to know about choices and options and supported to make decisions with someone who recognises my needs”

<sup>3</sup><http://media.ofcom.org.uk/facts/files/2013/07/fastfacts-a4.pdf>



- Early diagnosis for the well: Health screening and checks and risk stratification (linked to the enhanced primary care model)
- Management of long term conditions and following an acute illness: Reduction in waste in medicines through optimal patient usage, self-care packs and patient education (see above) and holistic planning
- Embedding the importance of enablement and locality focused co-production of services: Use of a more asset based assessment that promotes what people can contribute to their local communities and neighbourhoods rather than what they can't do

"I didn't think I could do an Experts Patients' course. I got so much support and that has been important. I feel so happy to have completed the course that I cannot describe it. I have grown in confidence to look after myself"



### The self-care continuum



jointly commissioned across health and social care.

We want to design our self-care agenda based on what individuals can and want to do as opposed to what they cannot do for themselves. Taking a preventative approach should be taking place alongside treatment and service provision at all levels, and involving patients in decisions relating to their health whenever possible. In addition, residents must be supported in caring for themselves and their families, and in using services appropriately and in taking more responsibility for their health. This is the underpinning principle to self-care.

Carers play a crucial role in supporting people to self-manage their health conditions, and our aim is to provide early support to carers in times of difficulty. A new carers hub model is in the process of being

#### Bradford City specific

Bradford City CCG has funded Partnerships for Wellbeing to deliver the Expert Patient Programme (EPP) courses to help people learn more about how to manage their health condition and stay well and in control. Local women who took part in a recent course are testimony to the positive impact it has had on their health, wellbeing and lives in general. One participant said "One of the things we learned was how to recognise the symptom cycle and how to break it. Now I know how to manage my condition because the course gives you the tools you need. I am just so much happier in myself."

We are committed to working with partners to deliver our joint Health & Wellbeing Strategy, which focusses on the wider determinants of health. The priorities for action in this Strategy have been grouped under the six policy objectives described by Marmot:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

#### AWC specific

Using non-recurrent funding, AWC has introduced health promotion managers in 2 of their local practices who will work with patients to look at their health and wellbeing. By sharing health information, they aim to improve communication to support self-care and encourage patients to lead healthier lifestyles

The population of children and young people is growing with over 140,000 children and young people under 19 years of age and just over 40,000 children 0-4 years. The focus over the next few years needs to be on prevention and early intervention in a child's life especially during pregnancy and the first few

years of life when most impact can be made to improve health and wellbeing outcomes (Heckman 2008<sup>4</sup>). Infant mortality, obesity, child poverty rates and school readiness aged 5 years are all worse than the national averages and in more deprived areas are significantly worse. Long term conditions prevalence such as asthma, epilepsy and neurodegenerative conditions are higher than nationally and the focus needs to be on reducing admissions and improved management wherever possible so children are healthier and able to attend school and ready to learn. The Children's Trust is the lead partnership working towards improving child health and wellbeing in the district. One of the three priority areas in the Children and Young People's Plan 2012-15<sup>5</sup> is child poverty, led by the Child Poverty Board. The Bradford Child Poverty Strategy 2011-14: Child Poverty is Everybody's Business<sup>6</sup> sets out how the district aims to alleviate the impact of poverty on children and ensure children living in poverty get the best start in life.

Bradford has been awarded £49m to help parents give their children the best start in life. The award comes from the Big Lottery Fund's A Better Start: Fulfilling Lives programme and will be spread over the next ten years. The successful programme will be led by Bradford Trident, and will involve a wide number of public, private, voluntary and community based organisations working together to support families. The programme will focus on three main areas of child development from pregnancy to three years of age.

Income inequality has been shown to underpin inequalities in health in general. Bradford District has greater levels of income inequality than many other parts of the country, and the gap between the most and least deprived parts of the district is greater than the gap in any other Local Authority area. In addition, welfare reform is likely to adversely impact those who are the most vulnerable. Therefore reducing income inequalities and the negative impact of relative poverty is particularly important. The Regeneration and Prosperity Partnership is the lead partnership working towards creating the economic, social and environmental conditions that improve quality of life for all, in line with the Bradford Community Strategy<sup>7</sup>.

Improved outcomes in mental health get people back to work, save benefits and add to general economic recovery. Mental health was a key theme identified through our engagement work. As part of our transforming mental health work we will review the levels of mental health intervention from self-care, through community provision to planned and acute interventions.

Improving illness prevention and improving the general health and wellbeing of the population will require close working with Public Health at both a local and regional level.

**West Yorkshire wide**

NHS England's (West Yorkshire) focus will be on:

- Maximising coverage of screening & immunisation programmes
- Improving access to programmes for at risk and vulnerable groups
- Delivering the best start to life for children aged 0 – 5 years & increasing the Health Visitor workforce
- Improving access to public health services in prisons
- Commissioning high quality effective public health services and

<sup>4</sup> James J. Heckman, "Role of Income and Family Influence on Child Outcome", Annals of the New York Academy of Sciences, 25 July 2008

<sup>5</sup> [http://www.bradford.gov.uk/bmdc/BCYPP/children\\_young\\_peoples\\_plan/young\\_peoples\\_plan.htm](http://www.bradford.gov.uk/bmdc/BCYPP/children_young_peoples_plan/young_peoples_plan.htm)

<sup>6</sup> [http://www.bradford.gov.uk/bmdc/BCYPP/children\\_young\\_peoples\\_plan/child\\_poverty\\_strategy](http://www.bradford.gov.uk/bmdc/BCYPP/children_young_peoples_plan/child_poverty_strategy)

<sup>7</sup> [http://www.bradford.gov.uk/bmdc/bdp/our\\_work/community\\_strategy](http://www.bradford.gov.uk/bmdc/bdp/our_work/community_strategy)

## Transform primary and community services and place the patient at the centre of their care

GP provision across the health and care system faces a range of challenges from: unwarranted variation in quality of care; ageing population; increase in co-morbidities; funding constraints; workforce changes; declining patient satisfaction; and variation in utilisation of secondary care. Whilst we have relatively high numbers of GPs per 100,000 population compared with the national average, in the City CCG area, just over 30% of practices are single handed practitioners. When Healthwatch started in April 2013 they went out to community groups and public events to talk about their work and how people could have their say on health and social care in the district. Wherever they went we asked the question, 'What one thing would you change about health or social care?' and found that the majority of what they heard back from people was about primary care services – particularly about accessing GP services<sup>8</sup>. Given all the challenges faced by general practice, NHS England (West Yorkshire) and the 10 CCGs have accepted that there is a powerful case for change and have agreed an ambition for general practice which is:

"My practice recently started a system where the doctor calls you to see if you need to come in or if he can give you advice on the phone. I like this because I know my doctor and it has made me feel connected and responsible for making my own decisions"

### To create and deliver a model of general practice across West Yorkshire which ensures all patients have timely access to high quality, safe services.

To create an environment which enables general practice to play a much stronger role, as part of an integrated system of out of hospital care, in:

- Proactive co-ordination of care, particularly for frail elderly people and those with long term conditions and complex health problems
- Shifting the balance of care from unplanned to planned
- Ensuring fast, responsive access to care and preventing avoidable admissions and ED attendances
- Preventing ill-health and ensuring more timely diagnosis of ill-health
- Involving patients and carers more fully in managing their own health and care
- Ensuring high quality of care, effectiveness, safety and patient experience
- Delivering primary care "at scale" where it supports safe and effective care

The Anytown<sup>9</sup> model suggests that reducing variability in primary care could deliver potential savings by 2018/19 of £12.5m across the health and care system. We understand the need to focus on core primary care as a driver of health improvement in a number of parts of the district and therefore recognise the importance that co-commissioning of primary care with NHS England will enable in terms of allowing locally driven improvement in quality, variability and patient experience.

"There is a GP practice in every community, it's never too far to get to and usually you can walk to a GP or a pharmacy so I think this is the best place to provide care – so that is where the improvements and money should be directed on to so they are better, have more appointments and even more services – like blood tests and clinics."

<sup>8</sup> Invisible at the desk - experiences of primary care in Bradford and District

<sup>9</sup> <http://www.england.nhs.uk/2014/01/24/any-town/>

Whilst our aim is to develop new models of enhanced primary and community services which place patients at the centre of their care, we acknowledge that there is variability across the system and a 'one fit all' model will not initially work, and therefore the pace of change from pure primary care to holistic community care systems will vary across the district and localities.

#### City CCG

Our focus will start with improving primary care quality and improving the offer to patients from a primary care service. This will include improving how patients access primary care for urgent care needs as well as the long term conditions planning and management, and the practices are exploring how to work better together to create models of care that enable them to do this.

Given our growing younger population, we need an equal emphasis in our out of hospital care strategy on this group as the over 75s. Our integrated care vision includes specific outcomes for children and young people and specifically those with complex health needs.

#### Districts CCG

Our out of hospital care strategy has three strands:

- To look at how practices work in defined communities of care for the most vulnerable, over 75's using multi-disciplinary team work with practices being accountable for care and potentially a move towards capitation based budgets for defined communities
- Improving the way primary care operates to deal more effectively with urgent care needs as well as provide continuity of care to patients with long term conditions
- To undertake more planned care procedures out of the hospital setting to improve access and waiting times

#### City & Districts CCGs

We will continue expansion of the intermediate care virtual ward in Bradford to include significantly increased capacity and availability of step-up, admission avoidance care. BTHFT, along with local health economy partners has developed the virtual ward as a mechanism to deliver intermediate care and reduce inappropriate hospital admissions. The virtual ward provides the means to bridge the gap between hospital and home, offering vertical integration between community, intermediate and acute care services. In the virtual ward a patient can remain at home and be visited by the relevant staff from BTHFT and partner organisations such as the local authority and local care Trust. This provides a joined up, holistic approach to care and helps to reduce avoidable admissions to hospital. In the event that patients have had to be admitted, the virtual ward can also be used to get patients home as fast and as successfully as possible.

We want to expand the diagnostic services available in community settings so that patients can have the majority of their needs met closer to home. Developing models of care closer to home will also address the need to reduce the reliance on long term residential and nursing care solutions and promote alternative housing solutions such as extra care housing, and promote enablement and intermediate care services across the whole system (including the independent sector) that support people (including those with dementia/ mental health needs) to live safely and with social interaction in their own homes for as long as possible and to end of life where possible.



#### AWC CCG

Modelling in AWC has identified that the most expensive 3% of patients account for 39% or £29m of primary and secondary care costs, with the next 10% accounting for 34% or £25m respectively. We believe this cohort of patients would be better served through a new model of care and we are currently actively exploring the two new models - Enhanced Primary Care and Extensivist.

Extensivists care for the highest need and sickest patients and work alongside networks of GPs providing enhanced Primary Care to other patients with multiple conditions including frail elders. The Extensivist model will support the 3% of patients who are intensive users of the current system, with each care team able to provide coordinated care to 3-500 patients, and each patient receiving highly personalised care, supported by a care navigator. The model drives significant improvements in the quality of care given to patients, with them empowered to make informed decisions and to support the management of their own condition(s) which improves their care experience. Hospital interactions are reduced by 20-25% through more proactive management of conditions and more care in the community or at the Extensivist clinic and a reduction in unnecessary emergency attendances reduces A&E attendances by up to 20%.

The Enhanced primary care system is made of up a large network(s) of GPs who care for 15-20% of the population with long term and multiple conditions. This is a team based approach, building on the current multi-disciplinary teams we have in place, and the patient will work in conjunction with their GP to ensure good management of their conditions. Patients cared for by an Enhanced Primary Care network typically have around 30% less A&E admissions and spend approximately 45% fewer nights in hospital. The model can lead to improved coordination of community, social and mental health care and significant improvement in outcomes with little change in budget. Although outpatient activity increases by 5-10%, to support improved chronic disease management, patients spend 25-30% fewer nights in hospital and experience less unnecessary emergency attendances. Reductions in the use of secondary care could initially deliver savings of up to £39m across the health system. The remaining 80% of the population will continue to be cared for under the existing primary care system.

## Implement a 24/7 integrated care system across health and care economy

We already have well established community multidisciplinary teams and recognise that these can be used to set the platform for future models of integrated working across health and social care. Our Better Care Fund (BCF) will be used to make a step-change in the capacity and capability of community services seven days a week. This will support the ambitions of our well-established programme of integrating health and care services and delivering more care at home. By doing this we will achieve:

- Better quality person-centred care and a better experience of care
- The right care in the right place, first time
- Maximised independence
- Reduced costs to the local health and care economy
- A turn in the curve on demand for acute care

Our starting point is simplifying a complex system by integrating care around people rather than organisations and increasing the availability of care at home, or closer to home that is capable of responding rapidly and supporting people with complex and urgent needs. This will enable us to reduce demand on secondary care acute services (particularly non-elective demand) and on permanent residential care. The programme is wide ranging however we can use the BCF to target the following priority areas for the health and care economy, achieve better outcomes for people and ultimately manage demand on the whole system more effectively:

- **Dementia:** Delivering an integrated and person/carer-centred system that is capable of supporting people with dementia and their carers to receive flexible care that maintains their dignity and supports them in a way that does not compound their disorientation and distress
- **Falls:** Achieving a whole-system and proportionate response to falls and investing in an integrated system of primary and secondary prevention that enables people to remain active and mobile
- **Maximising independence - Intermediate care, rehabilitation and reablement:** Creating a 7 day integrated system oriented around enabling people to regain and maintain their health, independence and wellbeing. This requires an enabling approach across all tiers of service from social care packages of care through to complex step-up arrangements to contain and manage escalating need
- **Self-care and prevention:** We need to make a step-change in the way primary, community, secondary care and social care enable and support people to manage their long-term conditions
- **Proactive care and continuity of care:** Through care coordination and case finding supported by predictive risk stratification and integrated care records. General Practice is at the centre of a joined up system of health and care, organised into 21 communities

Underpinning all of this is an infrastructure orientated around independence including community equipment, home adaptation services, telecare and telemedicine, VCS support and information.

“The importance of different organisations and departments talking to each other and providing a service that is easy to understand and access is essential for us to work on. By working together, we can make that happen”

“When you focus on the needs of me as a patient, it is easy to see how different professionals need to work together – naturally all the people rotate around me. It is much more difficult to do that when you start from one department to another”

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.

Our portfolio of transformation and change programmes is in place to ensure both health and social care services are fit for the future, by working together and creating an increasingly integrated single system of care. The further expansion of virtual ward activity, ambulatory care and other admission avoidance services will require increased levels of services being delivered by the local authority to provide those non-medical aspects of care and support essential to maintaining people at home. In 2014/15 and 2015/16 the level of funding will need to allow for the system redesign in the community. This will include the development and mobilisation of extra supported housing and purpose built step down/up intermediate care facilities across the district. There will be a need to ensure that enablement and occupational therapy capacity is adequate to meet increased demand arising from supporting increasingly complex situations in the community. Delays in securing specialist home nursing and daily living equipment and home adaptations compromise the ability to establish and maintain a person's care at home and are likely to precipitate the need for institutional care (hospital or permanent care).

#### **The 'Right Care' Vision for Integrated Care in Airedale, Wharfedale and Craven**

Our vision is of a health and social care system which empowers people to take control enabling them to set their own personal goals and to become the architect of their own support package with services which are responsive when people need care. We call this 'patient orchestrated care'. The care provided will be patient centred, coordinated and safe, meeting the needs of individuals at the right time. This presents an opportunity to rethink how we support people with long term conditions, our largest group of people requiring care. Right care enables people to become the architects of their own care services, across a range of clinical and care settings. Care will be integrated around the needs of the individual, not organisations, services will wrap around the person and be enabled by use of technology which will help accelerate achievement of personal goals. The individual is at the centre of everything we do, with combined health and social care integrated around their needs, not organisational needs.

We will make optimum use of the resources available thereby ensuring effective use of the financial resource. To do this organisations will change how they work together, to deliver healthcare and support in a joined up and seamless way and avoid passing people between professionals in a bureaucratic way. This will bring an end to often heard complaints, such as; "The nurse and the social worker never talk to each other, they both ask me the same questions and turn up at different

#### **AWC CCG specific**

AWC's strategic objective is to reduce the rate of unnecessary non-elective admissions by 15% over the next 5 years. Should the ambition be achieved, there is the potential to release funding for reinvestment in more community based holistic services.

#### **City & Districts CCG specific**

As a result of developing integrated care services, it is anticipated that there will be a 5% reduction in activity in Bradford across the acute sector, achieved mainly in care of the elderly services and through increased ambulatory sensitive care pathways. There are also opportunities to reduce hospital demand in Elderly Medicine and General Surgery. A 5% reduction in admissions in elderly medicine and general surgery could result in potential savings of £350k and £191k respectively. It is probably more likely that some admissions for elderly emergencies could be dealt with in a different way and treated at home/in a community setting through intermediate care approaches, as long as community-based alternatives are in place, it is safe and the patient and family/carer agree, than those for general surgery.

Our ambition is to move to a system of resource allocation across the whole health and care economy and collectively allocate resources at our joint disposal to maximise value for service users.

There are a number of areas not yet addressed for 7-day working which will need to be developed including 7-day diagnostics and assessment, medicines management to facilitate timely discharge and 7-day therapy services.

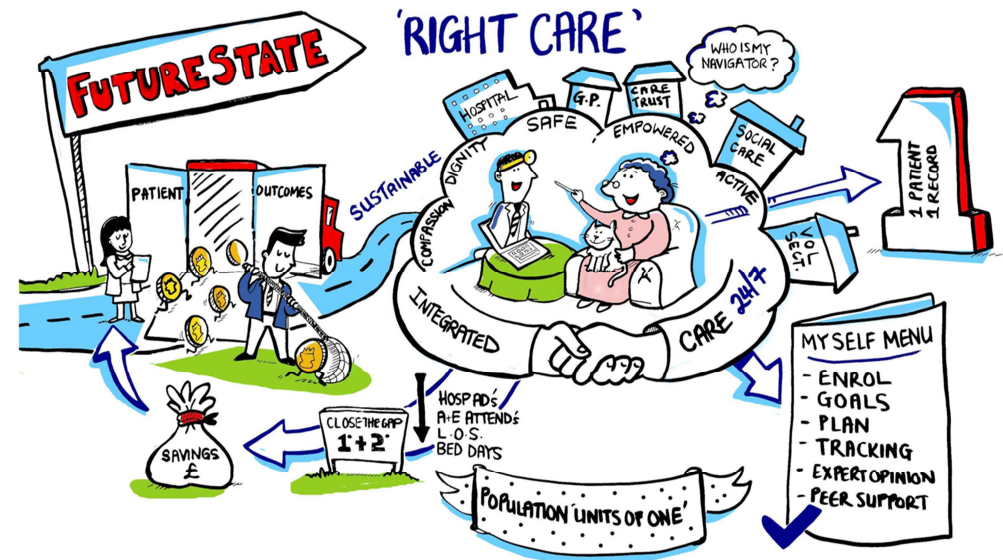
In implementing a 24/7 integrated care system across health and care economy, patients will see a noticeable change to .....

More integrated and effective working across partners is also a priority for the Children's Trust Board in the future, such as the rollout of universal Integrated Care Pathway (ICP) for early years services and the SEND pathway for 0-7 year olds with SEN and disabilities, which is focused on the development of the integrated service offer to families with a child with SEN or a disability.

Integrated working between Midwifery, Health Visiting and Early Years services, via the ICP, is being rolled out across the district and there is also a high focus on improving support and services in pregnancy and 0-3 year olds within the Better Start Bradford programme in three high-deprivation wards. This features pooled resources and co-location of services, with a strong community-lead aspect. The learning from this Programme will inform district approaches.

Integration of some commissioned funds to support Early Help to children and families is in development. It is intended to roll out integrated ways of working for early years developed through the Better Start programme District-wide where appropriate.

The Children's Trust is focusing on integration of strategic decision-making and service delivery, support to active and resilient families and communities leading to neighbourhood-based development and delivery of services in its development of the 2014-17 Children and Young People's plan over the summer of 2014.



## Develop and deliver a sustainable system wide model for urgent care services



The current urgent and emergency care system comprises a range of dedicated and professionally delivered services that are providing the residents of the local health and care system with a service that has a high overall patient satisfaction rating<sup>10,11</sup> delivering good patient outcomes and generally meeting most of its statutory targets. However, the evidence is clear that the system is being squeezed from all directions including tightening resources, increasing patient demands, and societal expectations of 365/24/7 right now access to services that meet their needs rather than those of the system.

“Learning more about the different urgent care services has been useful because I didn’t know so much was available”

In 5 years’ time our vision is to have a simple to navigate, sustainable and customer focussed high quality urgent and emergency care system providing 24/7 access that ensures patients are seen by the most appropriate health professional at the right time in the right setting. In order to achieve this we must:

- Improve patient experience through the creation of a patient friendly urgent and emergency care system that is open for business 24/7, easy to navigate, responsive to their needs and lifestyles, and treats them with respect and dignity
- Make primary care the default and first port of call for urgent care needs through clearly differentiated services with patients supported and guided through the system to find the right service for their needs
- Reduce the incidence for hospital based care through alternative comprehensive community based support and management of frail and vulnerable people and those with long term conditions, through increased use of technology to facilitate remote consultation and support, and ambulatory pathways that minimise the need for conveyance to hospital based services
- Deliver high quality and responsive hospital based emergency care through dedicated Major Emergency/Emergency Care Centres supported by real-time access to diagnostics
- Reduce the need for acute admission through alternative community based services provision and when admission is necessary, to improve the flow of patients through hospital based urgent and emergency care through enhanced provision and management of intermediate care services and beds
- Improve patient outcomes by ensuring that the patient is seen quickly by the right clinician/health professional first time, that the pathways between the different elements of urgent and emergency care are, seamless, efficient and user friendly, underpinned by effective sharing of patient data

In order to deliver the above we have identified 3 key work programmes.

**Access and Convenience:** It is clear from national and local surveys that access to primary care is an issue for some patients, and that the current services do not always align with people’s expectations or modern lifestyles. It is acknowledged that the current urgent and emergency care system can be complex and difficult to navigate. The goal of

“We usually come to A&E because, by the time we phone on the day, there’s hardly ever an appointment available at our usual GP practice. I phoned a few times today and we had to opt for coming here”

<sup>10</sup> Bradford Urgent Care Research: How patients use healthcare services in Bradford: IPSOIS MORI 2014

<sup>11</sup> Grassroots Patient Experience Report for Quarter 3 (2013-2014): AWC



this work programme is to ensure that the primary care system, defined as general, medical and dental practices, NHS111, pharmacies, optometrists, the Out of Hours GP service and walk-in provision becomes the first port of call for urgent care needs.

**Acute and specialist services:** Hospital based acute and specialist services should only be needed once a patient's condition cannot be managed in a home or community setting. Once the patient accesses these services they should be treated as quickly as possible, by the right clinician in a safe and appropriate environment. Access to the necessary diagnostics is critical to patient experience and outcomes, as is clear differentiation of these services to facilitate patient navigation. The intention of this work programme is not to close any hospital or A&E department but to ensure that their emergency services align with the emerging guidance from NHS England to deliver facilities that are able to receive a full range of emergency patients of all ages and which provide for the reception, resuscitation, diagnosis and if necessary onward referral of patients.

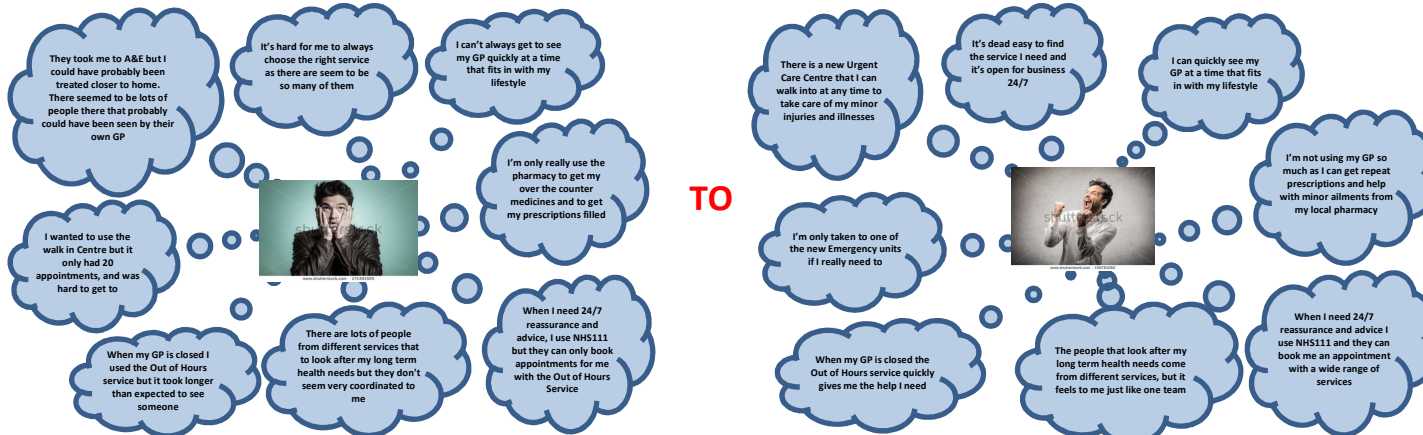
**Managing demand and flow through the system:** Self-care and improved management of long term conditions through proactive support and care delivered through multi-disciplinary teams has the potential to reduce the impact on the flow of patients into urgent and emergency care. Improved patient knowledge and the integration of services should deliver these benefits as people are cared for longer in their local environment rather than being regularly admitted to hospital for short periods of time.

We recognise that some elements are subject to national or regional (West Yorkshire) specifications, contracting and developments. In these cases, stakeholders will use their influence to shape policy and delivery to support delivery of this strategy. National examples include the move to 24/7 working and the NHS111 future specification, with regional examples being the West Yorkshire 2 year plan for developments in general practices, Yorkshire Ambulance Service, NHS111 and West Yorkshire Urgent Care.

**Mental Health Crisis Care Concordat**

- A single point of access into crisis care, with well-trained triage and tele-health workers who are supported by services which are available 24 hours a day, 7 days a week as they are for physical health crisis.
- Home treatment teams, so that when an individual is experiencing crisis, it is possible to reduce attendance at Accident & Emergency services and admissions to acute and mental health hospitals, where appropriate.
- High quality liaison mental health services for individuals who go to Accident & Emergency.

Whilst it is too early to fully quantify the financial impact, a more joined up urgent care system should allow us to stop the anticipated growth of 10,000 additional A&E attendances by 2019, a saving of circa £1m and the urgent and emergency care system will have changed from .....



## Develop and implement a system wide model for delivery of planned care interventions

Along with our scale of ambition for transforming urgent care services, improving self-care and delivering integrated services across health and social care, we are committed to developing a strategy for planned care (non-urgent services) as part of our overall system. With a move to delivering patient centred care in the community, there will inevitably be changes in what is delivered in traditional planned care settings.

Our vision is to develop models of planned care that deliver efficient, effective and high quality interventions (based on the latest available evidence where possible). Our level of aspiration is not limited to hospital based care and the new models of planned care will be a key plank within our fully transformed system, forming part of our collective programme of transformation.

Initial scoping suggests the areas we need to focus on are:

**Sustainable clinical services:** There is a need to develop a sustainable clinical services strategy to establish the appropriate service configuration for hospital planned care, assessing whether services should grow, maintain steady state, disinvest or partner and highlighting where we plan to develop existing services. Our local acute providers have already begun discussions.

**Commissioning on a wider footprint:** The CCGs collaboratively across West Yorkshire have committed to a number of work programmes which may impact upon in-hospital care in the following areas: stroke, cancer services and paediatrics<sup>12</sup>.

**Planned care delivered at scale:** We will look at providing planned care at scale where system wide efficiency can be achieved or inherent risks in sustainable delivery can be mitigated.

**Transforming diagnostics:** Achieving earlier diagnosis and treatments for patients will require improved access to leading edge, early diagnostics and detection services. A system wide review of current access to diagnostics will be undertaken.

**Managing demand:** We will look to better manage variability across primary care in the use of planned care services, and identify those services where there is limited clinical value for the local population.

**Use of technology:** We will look to utilise technology to manage demand on the system. We will expand the use of telephone and e-consultations to reduce the need for first outpatient appointments and use other technologies such as telemedicine and the telephone to reduce the need for face to face follow up visits.

**Increasing productivity:** Whilst both our acute hospitals have already implemented significant productivity

“Going into hospital is a frightening time, but you have a lot of people around you who are helping and very supportive, it’s when you come out that the real hard part starts and you want the help to stop you going back.”

### West Yorkshire wide

The West Yorkshire Commissioning Collaborative, representing all CCGs, has signed up to the following programmes of work on a wider West Yorkshire footprint:

#### Stroke

- Prescribing and management of anti-coagulation for known patients with AF
- Improving the management of patients with hypertension

#### Cancer Services

- Early Diagnosis - Awareness & Education
- Rapid Access to Diagnosis
- Smoking Prevention
- Survivorship

#### Paediatrics

- Care Closer to Home
- Configuration of Acute Services

<sup>12</sup> 10CC West Yorkshire Chapter

initiatives, national benchmarking data would indicate that there are still areas where savings can be made if both Airedale and Bradford Hospitals moved to upper decile of Trusts over the next five years.

**Re-design of outpatient services:** We need to review our current outpatient models to better utilise existing assets, encourage care for patients closer to home and make more effective use of clinical resource.

**Transforming mental health services:** We will continue to review our current planned care models of delivery for mental health services. This includes improving psychiatric liaison services and reviewing the needs of the population in terms of autism, children’s mental health services, eating disorders and rapid access to psychiatric advice. We are committed to achieving

Potential efficiency savings per annum (£m)	ANHST	BTHT	Total
Managing first to follow up ratios	3.0	10.4	<b>13.4</b>
Emergency readmission (14 days)	2.3	6.8	<b>9.1</b>
Outpatient appointment DNA	0.5	3.6	<b>4.1</b>
Pre procedure non-elective bed days	0.7	2.6	<b>3.3</b>
Pre procedure elective bed days	0.1	0.9	<b>1.0</b>
Increasing day surgery rates	0.1	0.4	<b>0.5</b>
<b>Total</b>	<b>6.6</b>	<b>24.8</b>	<b>31.4</b>

**BDCT Transformational Change programme**

- **Liaison psychiatry service:** Work with commissioners, local acute hospitals and primary care to develop a service which will provide a comprehensive range of psychiatric liaison specialties offered by a multi-disciplinary team. The service will operate 24 hours a day, seven days a week in acute settings to meet the needs of patients aged 18 or over and will also include elements to support primary care. The service will also offer educative and training components to a range of health professionals within the acute sector. The London School of Economics evaluation of the impact of a comparable within a health economy shows a saving of £4 for every £1 invested
- **Alcohol liaison:** Extend the alcohol care teams within acute hospitals, increasing the availability of more specialised interventions for people experiencing harm as a result of their alcohol misuse. National evidence shows that early intervention at key “teachable moments” proves effective in engaging individuals who may not have otherwise sought treatment for alcohol dependency. The implementation of alcohol care teams helps to improve clinical outcomes and patient experience and creates savings across the NHS by preventing alcohol related admissions and readmissions. There will be clearer connections with the Trust’s sizeable portion of the local alcohol services provision through diversion to community detoxification.
- **Dementia pathway:** Extend the current acute and care home liaison and memory assessment and treatment services. Local evaluation of current smaller scale services evidences the success of the Trust in reducing lengths of acute hospital stay and reducing the likelihood of admission or readmission to acute hospital, mental health inpatient wards and other residential settings

parity of esteem for mental health services and the people who use them by 2019.

**24/7 day working:** We will review current services and determine what 24/7 delivery for planned care means in the context of local health needs.

“The hospital staff on the ward were good but the nurses on the ICU were so busy and running around, they couldn’t give any real time or attention, it felt like they were always one step away. There could be different levels of staff to help with different tasks, so everyone can get the attention and care needed.”

## Enablers

To move from vision to reality will require efforts behind the scenes. Different organisations will need to integrate how they work around an individual's needs. Clinicians will need to explore how closing the gap between primary and secondary care could be best achieved. Staff will need retraining as we move to more generic roles which focus more on an individual's whole needs, working collegiately with other professions too as they organise their services in a different way, with care at home being the preferred option where it is safe to do so. New technologies will be needed to improve access to real time information and to bring services closer to home. We will therefore need to employ a number of enablers in order to deliver our vision effectively.

### Deploy new approaches to whole system commissioning and new payment models to incentivise care around the needs of the person in the community

We will look to commission on a wider footprint, where there are advantages to this approach. For example, we are already working on a West Yorkshire footprint to develop plans for paediatric, stroke, cancer and emergency care services.

The three CCGs are intending to submit expressions of interest to co-commission primary care with NHS England, but with slightly differing emphases. The differences reflect where each CCG is in respect of their out of hospital care strategies. For example, AWC CCG are clear that the intent is to try different financial models that fit with their plans for extended and extensivist models of care. City CCG is clear that improving primary care quality is the number one driver behind their proposal and that enabling different ways of achieving this may be facilitated by having a greater say in commissioning. Districts CCG is more concerned with aligning primary medical care delivery with integrated communities and facilitating the delivery of 'at scale' working in some areas. None of the CCGs intend to include General Ophthalmic Services in their request. Each CCG is clear that co-commissioning is not the end in itself but is an enabler to achieving better outcomes for patients.

A significant enabler for our strategy is to also critically review the payment mechanisms currently in operation across the various elements of health & social care. New models of patient centred care will require new methods of contracting and also new flows of money. The current mixed financial system of payment for service, tariffs, block contracts and capitation is currently seen as a significant barrier to transformation and has created perverse incentives and disincentives to different providers. There is a need to put in place financial solutions to incentivise everyone in all areas of health and

#### **AWC specific**

Our plan is to build on the initial financial and data analysis performed by Oliver Wyman in the AWC area, which highlights the small percentage of patients that are high users/costs to the local system. This takes into account all primary, secondary, community, prescribing, social care and mental health interactions to fully understand the financial and patient flows that our patients are currently navigated through and as a result the associated resource utilisation in finance terms. In doing this it will help determine the models of care that fit best for us that will generate the desired quality and efficiency outcomes. By understanding the information at patient, population and a whole system level it allows us to determine the true cost of care at patient level and allows opportunities to explore and enable different delivery of patient centred care. This will ensure best use of resource and realise efficiencies.

AWC envisage working with Oliver Wyman and our partners to have detailed segmentation of activity and financial data by the end of 2014/15. We also expect this financial strategy to cover all elements in the system not just CCG responsibilities. By submitting our expressions of interest to co-commission primary care and by further developing our joint work with our local authorities through the Better Care Fund, we will have knowledge of all activity and financial flows. In doing this we will be able to shadow operate different financial models in 2015/16 before agreeing proposals. An example we are looking to explore would be a weighted capitation system for enhanced primary care/extensivist models coupled with outcomes based contracts. Monitoring of the impact of new models at a patient level are key to understanding the impact they have and provide evidence that new models can deliver the financial efficiencies required over the next few years and help manage financial risk. Better alignment of patient data with financial information will be mean better decision making for commissioners, providers and patients.

social care to promote patient centred integrated care. Creating a balanced, sustainable health and social care system will require a new vibrant and flexible financial environment aligned with different methods of contracting and data flows to enable a more proactive preventative approach to care rather than responsive care that is currently commissioned.

Whilst we develop new payment methods and maximise the opportunities co-commissioning presents we will look to maintain the financial stability of all our partners, including the local authorities. In developing new care models we will look to minimise financial risk where possible and use the appropriate funds to manage the transition to new arrangements. The ability for CCGs to co-commission primary care with NHS England will give us the ability to think differently on all funding and quality aspects in our area. A core component for new models of care is the improved quality outcomes and the ability for providers in our system to have financial flexibility to make decisions with the associated financial risk to improve patient care. Current specific financial initiatives such as CQUINs, re-ablement, readmission, non-elective thresholds, local and national enhanced services and QOF, are potential barriers to integrated care. They can promote silo commissioning and perverse financial incentives to individual organisations but can also be enablers and opportunities if viewed and used in total for the same outcomes. The whole system spend on individuals is key and need to be considered to ensure we can think and provide care innovatively around the patient and not the providers.

The Better Care Fund will also be a key enabler in developing and enhancing our integrated model of care, being used to secure new service development and increase capacity in key health and social care services for local people within a reduced financial envelope. In 2014/15 we will allocate £23,718,000 to our Better Care Fund and in 2015/16 this will increase to £37,345,000.

Being a pilot area from 2013 for personal health budgets (PHBs) has meant we already have patients in receipt of full fund continuing healthcare (CHC) with such budgets. From October 2014 all patients in receipt of CHC have a right to request a PHB and we are making preparations to enable that process. This change is intended to give patients and carers greater control and personalisation when planning care for their continuing healthcare needs. The Department of Health has indicated that PHBs may be extended to other categories of patient from April 2015 and research is currently in progress around mental health and long-term condition PHBs at a few pilot sites around the country.

These innovations, combined with Section 26 of the Care Act 2014, which embeds the use of personal budgets for service users and carers by the Local Authority and the explicit encouragement to integrate 'other amounts of public money' mean the 'Integrated health and care, and integration of other aspects of public support are the long-term vision of the Government' will take a step nearer to fruition. Such flexibility regarding combining existing budgets to allow greater individual control and personalisation of assessed care needs is one of the key levers by which an integrated, seamless experience which can help to remove unnecessary bureaucracy and duplication in the delivery of care can be brought into being.

### Embed electronic assistive technology

New technologies are opening up opportunities to offer services in different settings and in different ways that meet new needs and are sustainable financially. The Anytown model suggests the following potential savings by 2018/19 through more effective use of telehealth/telecare:

#### City & Districts specific

We have recently commissioned a new telephone coaching service for patients with long-term conditions. The service, provided in partnership by Turning Point and Local Care Direct, aims to provide support and guidance to enable patients to manage their long term conditions and covers factors such as lifestyle change, medication management and access to appropriate services. It will be delivered by structured telephone calls with a trained healthcare professional. It can be a self-contained service or be used to supplement other forms of telehealth.

- Airedale Wharfedale & Craven CCG - £798k
- Bradford City CCG - £310k
- Bradford Districts CCG - £1.16m

We will build on current work to further develop the contribution that telemedicine, telecare and technology in general can offer in supporting people to receive care where they live. For example, we will move to creating an agile workforce, with the technology that enables staff to spend more time with patients.

**AWC specific**  
 We have commissioned a new innovative service from Airedale Hospital which provides ‘virtual’ rapid specialist opinion to patients in care homes (residential homes and nursing homes) and in their own homes. This means that through live on screen video link a consultant from the hospital can review a patient and provide care or advice, without the need for frail patients to be taken to hospital. We aim to expand this service with a particular focus on patients with heart problems and breathing difficulties. A similar approach is being taken for patients who are nearing the end of their life and wish to remain in their own homes rather than be admitted to hospital. Equipment is installed in patients’ homes so that they, and their carers, can access specialist advice from clinicians without the need to go into hospital.

We also have ambitions to become a fully digital health economy and we have been identified as one of three national accelerator sites (Safer Hospitals, Safer Wards Technology Fund) for the delivery of a cross-system integrated digital care record. The Council has committed to moving to a shared platform for an integrated health and social care record which will place us at the forefront of integrated records nationally. This work will ensure that clinical information can be shared between the different elements of the system, so that lack of patient information does not become a barrier to providing the best outcome for the patient.

### Establish effective engagement and co-production of services with service users and staff

We recognise that successful implementation of our strategy will require real engagement and co-production of services with service users and staff. There are many reasons for engaging with patients, users, carers, communities and the public<sup>13</sup> but the emphasis for our vision will be on two areas:

**Using engagement to develop better services that are built upon strong relationships and trust across all stakeholders:**

We will continue to listen to the population of the health and care system to make the most appropriate commissioning decisions for our population. Our communications and engagement strategies have been updated this year following local engagement and now reflect what is new and our aspirations for building strong platforms for patient and public voice. The strategies describe the engagement mechanisms we have in place to make sure that the patient voice is represented in commissioning decisions.

Our current communication and engagement infrastructure ensures that the following requirements are met: individual patient participation; community and public participation and; insight and feedback reporting. By developing different ways in which people living in the district can get involved in shaping the services, we will maximise the opportunities for participation.

Where we have specific service we were reviewing, we will continue to establish focus groups and events to hear patient views and design new pathways of care (previous pathways include diabetes and community nursing). We will use our websites and social media to share feedback more widely than those



<sup>13</sup> <http://engagementcycle.org/introduction-to-the-engagement-cycle/>

who attend events. Our integrated care work stream has patient representatives to support our service development and ensure we are upholding the duties in our own and in the NHS Constitution.

**District CCG specific**

The CCG has invested energy working with our young people’s network ‘Youth Fusion’ and as a result of this work we have two practices who are about to start a project funded from Healthwatch and Barnardos to improve engagement of young people with mental health problems in patient groups.

**District wide**

In order to improve transition between Children’s and Adolescent Mental Health (CAMHS) pathways and adult services, we have use some non-recurrent funding to enable Barnardos to develop a technology based signposting system

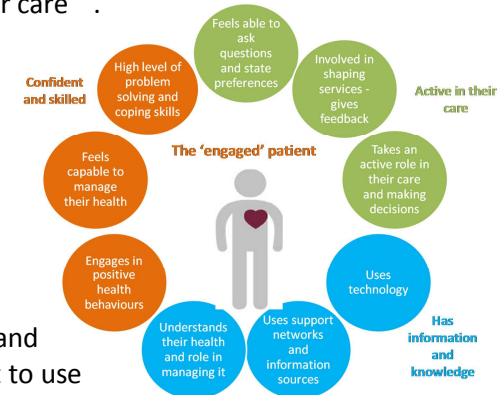
We have also used our local CQUINs to engage young people in the development of better CAMHS transition pathways.

Only through effective engagement will we be able to ensure that our citizens are partners in the delivery of our 5 year vision.

**Using engagement to improve knowledge of the appropriate use of services, promote illness prevention and better use of self-care:** The goal is to move from the ‘patients with a problem’ system, which is reactive and disease driven, where people play a passive role to one where the public are focused on managing their wellbeing throughout their life. The engaged citizen is active in their own and their family’s lifestyle choices and care. They actively seek relevant information and are knowledgeable about choices and the consequences of their choices and are active in their care<sup>14</sup>.

They:

- Have more positive experiences of care
- Have better clinical outcomes
- Have lower rates of hospitalisation
- Are more likely to attend screening programmes, check-ups and immunisations
- Are less likely to have unmet health needs
- Adhere to treatment and condition monitoring better



For example, to support our urgent care work, we will develop and implement a communication plan to engage and inform the stakeholder community; patients and general public about the services that are available to them, how best to use them and the benefits of self-care; health/social/community staff and stakeholders about the developments in the urgent and emergency care landscape and how to help patients navigate their way to the most appropriate service, and all relevant stakeholders during the detailed design of the work programmes.

**Workforce transformation**

The implementation of this strategy will raise a number of workforce issues as it will involve new ways of organisational and/or individual working, which in some cases may include new and emerging roles. We will develop a stakeholder wide workforce development plan that will firstly, define the resource

<sup>14</sup> [The Kings Fund \(2014\) Supporting people to manage their health: an introduction to patient activation](#)

needed to deliver the services including means to retain existing and attract new staff and secondly, working with Local Education and Training Board, ensure that staff have the necessary skills and knowledge to support the realisation of this strategy. New models of care will require staff who:

- Have the right skills to deliver new models of care
- Are empowered to impact care and have the capacity to do so
- Are able to practice to full scope of license/capability, while expanding the system role
- Have greater influence on patient outcomes through accountability
- Are enabled to think beyond the "job description"
- Can work across organisational boundaries

There are a number of national barriers to workforce transformation e.g. GP and Consultant contracts and Agenda for Change which our programme of work will need to address.

## Medicines optimisation

Medicines optimisation is a key enabler to delivering our new models of care. Patients are living longer with more complex conditions and it is known that:

- up to 50% of patients do not take their medicines as prescribed
- between 5-8% of acute admissions to hospital are due to medication issues
- medicines waste is a significant problem
- antimicrobial resistance is increasingly a worldwide problem
- use of compliance aids in order for patients to stay in own homes is a complex issue

Redesigning services for certain patients groups through joint ownership and partnership working between healthcare professionals, will result in significant efficiencies and improvement to patient care. A cross sector strategy joining primary & community care, secondary care, public health, the local authority, NHS England and community pharmacy needs to be developed over the next 5 years. This will look at:

- A joint approach with secondary care colleagues to provide a Bradford Health Economy Formulary, so all partners are using the most cost effective medicines for the best outcomes. This includes an antimicrobial strategy to reduce the risk of CDiff, MRSA and increased antimicrobial resistance
- Work with secondary care colleagues to implement NICE guidance, review Homecare policies and High Cost drugs to offer the community best value with optimal outcomes
- A joined up approach with other agencies, within all sectors, especially social care providers, to rationalise the use of compliance aids, to patients not the providers

Tackling the issue of waste is a national problem and as yet different strategies have been tried but none have been totally successful in reducing an untapped resource. Right Care analysis has identified the following top 3 areas where potential savings can be made if prescribing was in line with similar CCGs:



### **Airedale, Wharfedale & Craven**

- Endocrine, nutritional & metabolic £550k
- Circulation £333k
- Respiratory £225k

### **Bradford City**

- Endocrine, nutritional & metabolic £1.5m
- Respiratory £340k
- Musculo Skeletal £151k

### **Bradford Districts**

- Endocrine, nutritional & metabolic £581k
- Respiratory £503k
- Circulation £226k

The use of IT should provide a valued link between sectors, and provide information as to how best to improve medicines optimisation within the healthcare community. We will work with primary care providers on the better use of primary care prescribing and adopt a more joined up approach to prescribing across all organisations.

### **Utilisation of assets**

We will look to use all the assets of the health and care system in a more effective and joined up way. As a system, we have input our assets on the Strategic Health Asset Planning and Evaluation (SHAPE) application and we are using this in planning our future service delivery from both an asset and a workforce perspective. This will support co-location, joint workforce planning and integrated ICT systems. Over the longer term, we may look to establish an operational and commercial property strategy to ensure we optimise our financial efficiencies but we recognise the requirement to involve wider stakeholders in this approach.

We have previously worked collaboratively to review our support functions including communications, finance, HR, catering and cleaning, procurement and maintenance. The scale of the financial challenge and the commitment to the whole system approach provides us with the opportunity to refresh this work and identify areas to deliver efficiencies as well as provide effective support to our citizens around a coordinated service delivery model.

All 3 CCGs are writing their sustainability management plans supported by the CSU but in principle ensuring the best utilisation of our assets (estate and staff).

## Financial Sustainability

We currently have a successful system, delivering all financial and operational targets and have always done so. However, we recognise that existing service models and patterns of spend are not sustainable in the context of future demographic and financial pressures.

Initial estimates suggest the overall financial challenge to the health and care system over the next 5 years will have totalled £364m. We have estimated that £197m of resource releasing savings need to be achieved from a health perspective by commissioners and from providers' internal efficiency savings plans by 2018/19. This is as a result of the following factors:

- Limited increases in allocation as a result of national economic constraints and a national commitment to move all CCG's allocations closer to the target level for their population
- Demographic growth which shows an increase in the oldest members of our population, who are likely to be more frequent and more intensive users of health services
- An increase in the numbers and life expectancy of people with complex or multiple disabilities or conditions, who are also likely to have a higher level of need for health services
- The local effect of national economic constraints in areas which impact on health service use including Local Authority budget constraints and the adverse impact on the local economy of welfare reform

	System Wide Financial Challenge					
	2014/15	2015/16	2016/17	2017/18	2018/19	Total
<b>Local Authority</b>	£38m	£51m	£26m	£26m	£26m	<b>£167m</b>
<b>Health</b>						
NHS Providers	£32m	£25m	£26m	£26m	£26m	<b>£135m</b>
CCGs	£8m	£13m	£9m	£7m	£7m	<b>£43.5m</b>
NHSE Direct Commissioning	£3m	£2m	£2m	£2m	£2m	<b>£11m</b>
NHSE Specialist Services	£3m	£1m	£1m	£1m	£1m	<b>£7m</b>
<b>Total health</b>	£46m	£41m	£38m	£36m	£36m	<b>£197m</b>
<b>TOTAL</b>	<b>£84m</b>	<b>£92m</b>	<b>£64m</b>	<b>£62m</b>	<b>£62m</b>	<b>£364m</b>

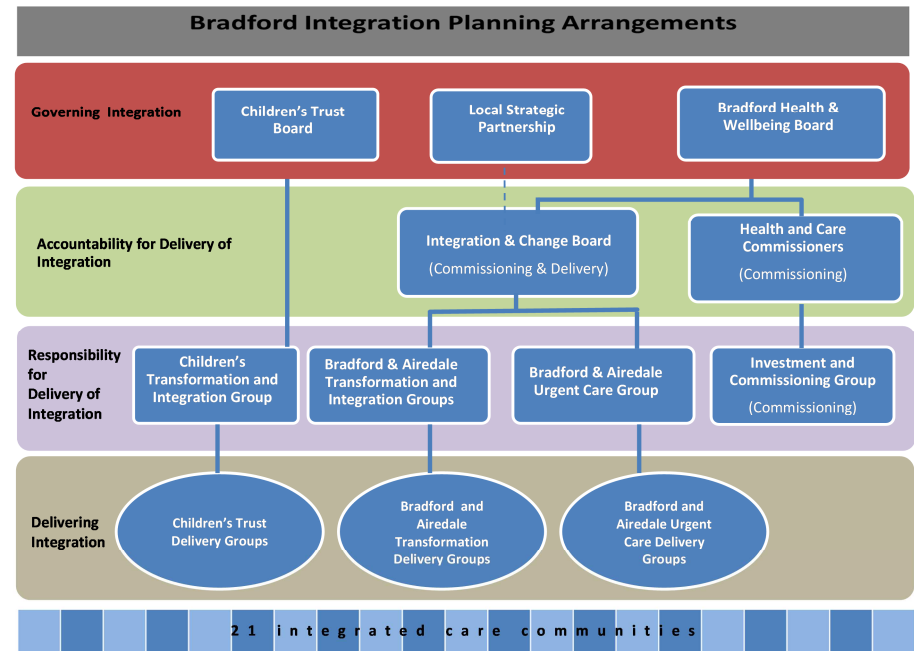
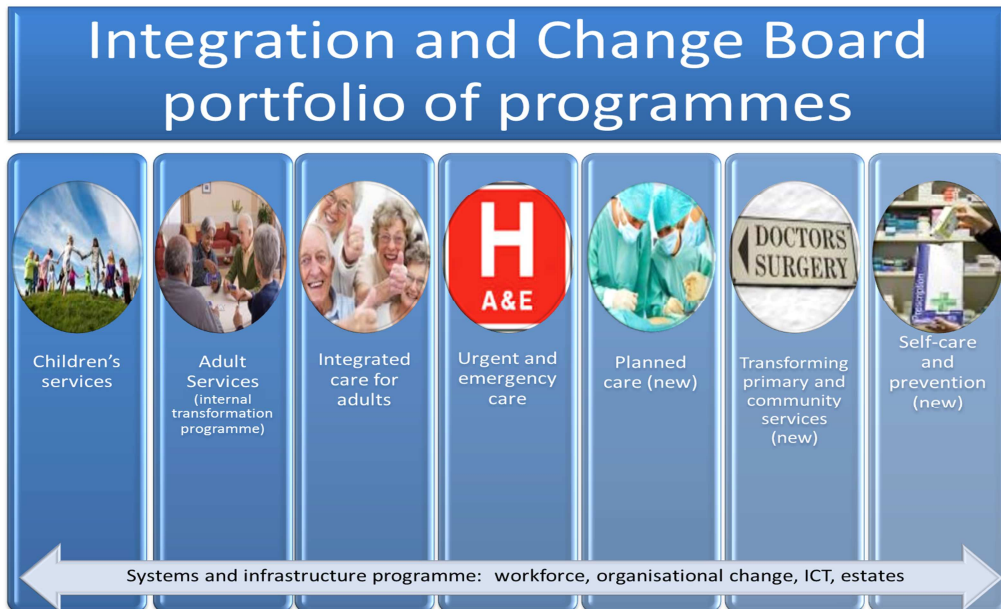
The Local Authority, a key partner with whom we have strong joint commissioning arrangements, face similar financial challenges with savings requirements of £167m over the next 5 years.

Through the implementation of our 5 year vision, we expect to create, with our partners, a health and social care economy which is able to meet the needs of our population whilst remaining financially sustainable. We have commissioned Ernst and Young to model the impact in more detail and the effect of some of our proposed interventions. Whilst it is not possible yet to fully quantify the impact our vision will have on the sustainability of the system in 5 years' time, it is clear that there is still work to be done to fully address the potential financial impact. To create a truly joined up health and care system, we need to move away from viewing the financial challenge as a gap to be filled, to looking at how we collectively spend available resources in a more efficient way.

# Governance

We have designed a governance structure that will underpin the implementation of our key priorities. The Health and Wellbeing Board (HWBB) is responsible overall for governance.

Whole system change is driven through the multi-agency, commissioner/provider Integration and Change Board (ICB) the Transformation and Integration Groups (TIGs) for both Airedale, Wharfedale and Craven and for Bradford, and through the District-wide Urgent Care Working Group. These are supported by a comprehensive programme management approach and a clear focus on identifying and mitigating system risks. A range of programmes are in place to deliver change and these are operated on a portfolio basis to ensure a whole system approach across urgent and emergency care and integrated care programme developments across primary, secondary, community, social care and the Third Sector. The ICB will oversee the different work streams within the scope of the 5 year vision and will be led by the CCG.



The adequate resourcing of this governance structure will be vital to ensure the successful delivery of our key priorities and other work streams that will evolve and develop in the future. Stakeholders acknowledge that support for this will need to be a community responsibility, shared across the health and care economy.

Whilst developing this strategy, a number of gaps in our governance arrangements have been identified. Specifically, we have identified the need for a cross organisational programme to develop our planned care vision and a stakeholder wide group to lead the development of our workforce strategy.

## Risks

We acknowledge that there are significant risks in relation to delivering our vision for health and care services over the next five years and we will use our governance framework to mitigate and manage these risks which include:

- The vision does not ensure the sustainability of our system - our economic and financial modelling has not yet presented a position whereby we can quantify the impact of our new service models to close the financial gap across the system and therefore further detailed work is required
- The approach to the specialised commissioning process impacts negatively on provider sustainability – NHS England specialist commissioning plans are not yet available and therefore their impact on the local system is currently unknown
- Funding issues regarding CCG primary care premiums remain unknown
- Capacity and capability of workforce is insufficient to deliver new models of care – we have identified the need to work collaboratively on system wide workforce planning and development
- Plan not delivered as governance process not robust enough to effectively monitor progress and risks – programme management approach being developed
- The rigidity of contractual models impact on delivery of new integrated community provision – develop new payment models and risk sharing approaches
- National requirements impact upon delivery of new models of care – there is currently a lack of flexibility regarding delivery of national targets which could impact upon the transformation of services
- Vision fails to be delivered due to ineffective engagement – engagement of citizens, staff and all stakeholders should be built into all our delivery programmes

## Next Steps

We are aware that the development of this vision is only the first step in delivering a truly transformed health and care system in 5 years' time and that there is still much work to do. There is a need to model the impact of our 5 new models of care and we are working collaboratively with our CSU and Ernst & Young to do this work. We have also identified a need to incorporate more of the broader health environment within our vision and will work over the coming few months to further develop and refine our models of care.

June 20 <sup>th</sup> 2014	Sign off of health and care economy 5 year view at ICB and submission to NHS England
July 29 <sup>th</sup> 2014	Sign off at Health & Wellbeing Board
June – Sept 2014	Modelling of potential impact of new models of care and refinement of or forward view
Sept 2014	Models of care further defined, robust transformational change programmes in place and refreshed vision document shared

## Appendix A – Associated Plans

NHS England (West Yorkshire)  
Strategic Framework for Action: General Practice in West  
Yorkshire 2014 - 2019



DOUBLE CLICK HERE

NHS England (West Yorkshire)  
Plan on a page - primary care & secondary dental



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NHS England (West Yorkshire)  
Plan on a Page – Public Health



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10CC West Yorkshire Chapter



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Health & Wellbeing Strategy



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Health Inequalities Action Plan



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Health Watch – Invisible at the desk - experiences of  
primary care in Bradford and District



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Better for Bradford, Airedale, Wharfedale and Craven:  
right care, right place, first time



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Better Care Fund



DOUBLE CLICK HERE

## Plan on a Page

The health and care economy in the Bradford District and Craven has agreed to deliver the vision of:  
**To create a sustainable health and care economy that supports people to be healthy, well and independent**

### Outcomes

1. To reduce the number of years of life lost due to treatable physical and mental health conditions
2. To improve the health related quality of life for people with long term conditions
3. To reduce unplanned hospitalisation
4. To increase the number of older people living independently
5. To improve patient experience of hospital care
6. To improve patient experience of primary and community care
7. To significantly reduce avoidable hospital deaths
8. To ensure the health system maintains a stable financial position by 18/19

### Challenges to overcome

- Health and care economy financial challenge estimated as £364m over the next 5 years
- Both patient engagement and involvement needs to be strengthened to understand and support the priorities and own the interventions and new models of care
- Impact of NHS England's direct & specialist commissioning is unknown at this stage
- Lack of whole system commissioning
- Lack of coherent system wide workforce strategy
- Access to primary care and inconsistent model of delivery
- As yet unknown impact on organisation form as a result of changes to service models
- Lack of self care responsibility
- Delivery of A&E targets & sustainability of current urgent care system
- Sustainability of clinical services
- Focus on current operational delivery at the expense of planning for the future
- Population (carers, booming young & ageing population with geographic variation)
- Demand increasing despite community alternatives

**Our new models of care (interventions)** to deliver the system objectives over the next 5 years are:

- Promote self-care and illness prevention and improve the general health and wellbeing of the population
- Transform primary and community services and place the patient at the centre of their care
- Implement a 24/7 integrated care system across health and care economy
- Develop and deliver a sustainable system wide model for urgent care services
- Develop and implement a system wide model for delivery of planned care interventions

**Enablers** required to deliver our vision

- Deploy new approaches to whole system commissioning and new payment models to incentivise care around the needs of the person in the community
- Embed electronic assistive technology
- Establish effective engagement and co-production of services with service users and staff
- Develop a whole system workforce planning approach
- Medicines optimisation
- Utilisation of assets

### The agreed governance arrangements include

- The Health and Wellbeing Board (HWBB) alongside the Children's trust board, is responsible for governance.
- The Integration and Change Board (ICB) reports to the HWBB.
- The Airedale Transformation and Integration Group (TIG), Bradford TIG, Bradford and Airedale Children's TIG and Bradford and Airedale Urgent Care Working Group (UCWG) are each accountable to the ICB.

### Measured using the following success criteria

- All health and care organisations report a stable financial position in 18/19
- Measurable improvement against the outcome ambitions
- No provider is under enhanced regulatory scrutiny due to performance concerns
- Our patients/citizens tell us their care is being delivered at the right time, in the right place, first time.

### System values and principles

- Working better together is first and foremost about what is best to add value for all the people of the district
- We will improve the quality of care and support available and look for improvement through the eyes of the people of the district and the staff providing the care
- We're in this together, working as a whole system and both risk and reward are shared
- We will continue to create a culture of trust, openness and transparency, including demonstrating a collective stewardship of resources, using all available assets in a shared way
- The system is wider than just our organisations and we will put the interests of the people we serve at the forefront of our decisions with the view that the people of the district are themselves an asset
- We will collectively agree our future priorities as a whole system
- Our clinicians, social care professionals, managers and colleagues and partners will work together to make change happen
- We commit to working at pace, to achieve rapid progress, make decisions and see them through
- We will all communicate our shared values and principles in a consistent way

## Key lines of enquiry (KLOE)

The following table template asks key lines of enquiry and contains space for the organisation to add their responses.

Segment	Key Line of Enquiry	Organisation response	Supported by:
Submission details	Which organisation(s) are completing this submission?	Airedale, Wharfedale & Craven CCG (AWCCCG) Bradford City CCG (BCCCG) Bradford Districts CCG (BDCCG)	
	In case of enquiry, please provide a contact name and contact details	Kerry Weir <a href="mailto:Kerry.weir@bradford.nhs.uk">Kerry.weir@bradford.nhs.uk</a>	
a) System vision	What is the vision for the system in five years' time?	To create a sustainable health and care economy that supports people to be healthy, well and independent	The plan on a page <i>"Our vision" in 5 Year Forward View (2014-19) Bradford District &amp; Craven Health &amp; Care Economy</i>
	How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically: 1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care 2. Wider primary care, provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent	Within the 5 year strategy (5 Year Forward View) we detail our New Models of Care to deliver items 1-5. Work on specialised services is ongoing across West Yorkshire in collaboration with CCG colleagues and clinicians. Citizen engagement is an enabler to the delivery of our strategy and we are clear that co-production is our ambition for the future. Please refer to the sections within the forward view for more detailed information.  The 3 CCGs have also commissioned, via the Commissioning Support Unit (CSU) a piece of economic modelling work. This work is being delivered by Ernst & Young (E&Y) and will be used to determine	See: <i>"The challenge for the system"</i> <i>"Promote self-care and illness prevention"</i> <i>"Transform primary and community services"</i> <i>"Implement a 24/7 integrated care system"</i> <i>"Develop and deliver a sustainable</i>

Segment	Key Line of Enquiry	Organisation response	Supported by:
	<p>and emergency care</p> <p>5. A step-change in the productivity of elective care</p> <p>6. Specialised services concentrated in centres of excellence (as relevant to the locality)</p>	<p>the baseline financial position and model the impact of the interventions for the next 5 years.</p>	<p><i>system wide model for urgent care</i></p> <p><i>“Develop and implement a system wide model for delivery of planned care”</i></p> <p><i>“Establish effective engagement and co-production of services with service users”</i> in the 5 Year Forward View (2014-19)</p>
	<p>How does the five year vision address the following aims:</p> <p>a) Delivering a sustainable NHS for future generations?</p> <p>b) Improving health outcomes in alignment with the seven ambitions</p> <p>c) Reducing health inequalities?</p>	<p>The system vision articulates the need to create a sustainable health and care economy whilst improving health.</p> <p>The potential financial gap for the health and care system as a whole has been estimated by the Directors of Finance as approximately £225m over the next 5 years. This baseline position and effect of our new models of care will be refined through the E&amp;Y modelling and further discussion. We will therefore have a much more robust, risk assessed position as this work progresses.</p> <p>The JSNA and Health and Wellbeing Strategy has been used to form the basis of this strategy. Our intention from the delivery of the models of care is to reduce health inequalities across our health and care</p>	<p>Please see <i>“The challenge of the system”</i> and those sections listed above in the 5 Year Forward View (2014-19)</p>



Segment	Key Line of Enquiry	Organisation response	Supported by:
	<p>Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?</p>	<p>economy.</p> <p>Airedale, Wharfedale &amp; Craven CCG (AWCCG)  Bradford City CCG (BCCCG)  Bradford District CCG (BDCCG)  City of Bradford Metropolitan District Council (CBMDC)  Bradford District Care Trust (BDCT)  Bradford NHS teaching Foundation Trust (BTHFT)  Airedale NHS Foundation Trust (AHFT)  NHS England</p> <p>Across Bradford District and Craven the Integration and Change Board (ICB), made up of chief executive and senior director level representation from the above organisations is responsible for driving integration and transformation from a system leadership perspective. This group had a development session in March where, under the concept of working together as the 'Bradford District &amp; Craven Mutual' (a concept with assumes that all organisations are in effect working together as directorates of a larger system wide organisation) identified the key challenges to ensuring a sustainable health and care system. These challenges are reflected in the draft required interventions. A further event took place on the 15<sup>th</sup> April with the Health &amp; Well being Board to finalise this area of work. The HWBB then tasked all partners to develop the strategy and the output of this work is the 5 Year Forward View.</p> <p>Whilst the strategy has been agreed by ICB in its current form, there is further work to be undertaken on</p>	<p>Please see 5 Year Forward View (2014-19)</p>

Segment	Key Line of Enquiry	Organisation response	Supported by:
		the new models of care to ensure the development of robust delivery plans.	
	How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	The BCF is a key enabler for ensuring delivery of the integration agenda which is an integral part of our strategy.	Please see “ <i>Implement a 24/7 in the 5 Year Forward View (2014-19) integrated care system</i> ”
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	<p>Key themes emerging from the Call to Action engagement work are:</p> <ul style="list-style-type: none"> <li>• Mental health &amp; dementia, heart disease &amp; stroke, cancer and diabetes;</li> <li>• Loneliness and isolation (younger people and old age);</li> <li>• Patient experience;</li> <li>• More focus given to healthy living/self care;</li> <li>• More coordinated and joined up services</li> </ul> <p>Our new models of care are based on what our citizens continue to tell us through our ongoing engagement work.</p>	Please see “ <i>What our citizens say</i> ” under <i>our case for change</i> and quote boxes throughout the 5 Year Forward View (2014-19)
	Is there a clear ‘you said, we did’ framework in place to show those that engaged how their perspective and feedback has been included?	All three CCGs have reported themes emerging from A Call for Action work and other engagement work to our clinical boards/executive group and governing bodies. We have a Grass Roots report which collates, themes and reports on information from a wide range of sources, along with a you said, we did section and is considered in various forms by our reference groups for patient and public communications and engagement, our quality committees and our governing bodies.	Please see “ <i>What our citizens say</i> ” under <i>our case for change</i> in the 5 Year Forward View (2014-19)

Segment	Key Line of Enquiry	Organisation response	Supported by:
		In terms of “you said, we did”, the CCGs have or are establishing website pages which will feed back details of individual consultations on services, engagement and feedback as well as case studies.	
a) Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?	<p>Using our JSNA and other data we have reviewed our current state in terms of the needs of our citizens and used this as the basis of development sessions with ICB and the HWBB to identify the opportunities and challenges which form the basis of our new models of care and the enablers. The majority of our planning work is supported by the data provided in the Commissioning for Value packs so this ensures we have a robust evidence base to continue with our stakeholder and citizen engagement.</p> <p>An estimate of the potential financial position for the health &amp; care system has been made. However, further analysis is underway using the E&amp;Y modelling work.</p>	Please see “ <i>Current State</i> ” in the 5 Year Forward View (2014-19)
	Do the objectives and interventions identified below take into consideration the current state?	See above	
	Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?	Yes. However, it is acknowledged that there may be further work to do in terms of operational planning once the 5 year strategy is finalised.	Please see “ <i>improving quality and outcomes</i> ” in the 5 Year Forward View (2014-19)
b) Improving quality and outcomes	At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the	<p>Please refer to “improving quality and outcomes” in the 5 Year Forward View (2014-19) for the detail.</p> <p>Other local quality improvement outcomes may well be</p>	Please see “ <i>improving quality and outcomes</i> ” in the 5 Year Forward

Segment	Key Line of Enquiry	Organisation response	Supported by:
	outcome ambitions?	identified as the modelling work is developed.	View (2014-19)
	How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?	<p>We have discussed this work in a range of forums to gain community views including:</p> <ul style="list-style-type: none"> <li>• Health and wellbeing hubs;</li> <li>• VCS events;</li> <li>• Attendance at various groups;</li> <li>• Online questionnaire;</li> <li>• Joint events with the local authority.</li> <li>• Public “Have your Say” events</li> </ul> <p>Clinical input has been sought from the CCG council of members meetings and clinical boards/executive group etc, whilst AWC have embarked upon a piece of work (Oliver Wyman) to look at the future system with GPs and Consultants.</p> <p>However, we acknowledge that there are still gaps across the system in terms of thoroughly engaging secondary care clinicians and that this will be need to form part of our further development of the strategy.</p>	
	What data, intelligence and local analysis was explored to support the development of plans for improving outcomes and quantifiable ambitions?	Local CSU reports which present analysis of outcome measures and key performance indicators, including local and national benchmarking, are reviewed on an ongoing basis throughout the year to inform CCG strategic planning. The CSU has also conducted an analysis of the Right Care metrics. The Right Care data and modelling work done by E&Y has provided	See: <i>“Promote self-care and illness prevention”</i> <i>“Transform primary and community services”</i>

Segment	Key Line of Enquiry	Organisation response	Supported by:
		<p>some detailed analysis to hold discussions as a whole system on the scale of change needed to meet our local needs.</p> <p>Data has been shared with ICB and HWBB and internally in each organisation about the ambitions and the deliverability of them.</p> <p>The work done in AWC with Oliver Wyman provided some intelligence to enable the CCGs to understand the wide scale impact of new systems of care and the principles of this work will be modelled across the system.</p>	<p><i>“Implement a 24/7 integrated care system”</i></p> <p><i>“Develop and deliver a sustainable system wide model for urgent care”</i></p> <p><i>“Develop and implement a system wide model for delivery of planned care”</i> in the 5 Year Forward View (2014-19)</p>
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	The joint HWBB strategy is based upon the JSNA work. As a health and care economy we have held planning sessions to ensure the work being undertaken does not miss any of the potential interventions.	Please see <i>“Current state”</i> <i>“Future state”</i> <i>“Improving quality and outcomes”</i> in the 5 Year Forward View (2014-19)
	How have the Health and well-being boards been involved in setting the plans for improving outcomes?	Please refer to the response to “A system vision” above	
c) Sustainability	Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	We are working hard to quantify the impact of our new models of care supported by the work undertaken by E&Y.	Please see <i>“Sustainability”</i> in the 5 Year Forward View (2014-19)
	Are assumptions made by the health economy consistent with the challenges	Yes, partners are signed up to the scale of the challenge and this has been consistent throughout all	

Segment	Key Line of Enquiry	Organisation response	Supported by:
	<p>identified in a Call to Action?</p> <p>Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates?</p>	<p>discussions and development work on the strategy.</p> <p>The outcomes are reflective of the submissions in the 2 year operational plans. We have concerns about our ability as a system to deliver the financial challenge and believe that only 50% of the identified gap is feasible.</p>	<p>Please see <i>“Future state”</i> and <i>“Sustainability”</i> in the 5 Year Forward View (2014-19)</p>
d) Improvement interventions	<p>Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the :</p> <ul style="list-style-type: none"> <li>• Overall aims of the intervention and who is likely to be impacted by the intervention</li> <li>• Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have</li> <li>• Investment costs (time, money, workforce)</li> <li>• Implementation timeline</li> <li>• Enablers required for example medicines optimisation</li> <li>• Barriers to success</li> <li>• Confidence levels of implementation</li> </ul> <p>The planning teams may find it helpful to consider the reports recently published or to be published imminently including</p>	<p>The full detail of each of our interventions and our enablers along with our aspirations, challenges and risks can be found in the attached strategy. There is work still to be undertaken by the health and care economy on the expected outcomes, investment costs and timeline.</p> <p>In summary, the following interventions have been identified:</p> <ul style="list-style-type: none"> <li>• Promote self-care and illness prevention and improve the general health and wellbeing of the population of Bradford District and Craven</li> <li>• Transform primary and community services and place the patient at the centre of their care</li> <li>• Implement a 24/7 integrated care system across health and care economy</li> <li>• Develop and deliver a sustainable system wide model for urgent care services</li> <li>• Develop and implement a system wide model for delivery of planned care interventions</li> </ul> <p>The following are the enablers we will need to employ to deliver our vision effectively:</p> <ul style="list-style-type: none"> <li>• Deploy new approaches to whole system</li> </ul>	<p>Please see <i>“The Challenge for the system”</i> <i>“New Models of Care”</i> <i>“Enablers”</i> <i>“Improving quality and outcomes”</i> <i>“Sustainability”</i> <i>“Risks”</i> in the 5 Year Forward View (2014-19)</p>

Segment	Key Line of Enquiry	Organisation response	Supported by:
	commissioning for prevention, Any town health system and the report following the NHS Futures Summit.	<p>commissioning and new payment models to incentivise care around the needs of the person in the community</p> <ul style="list-style-type: none"> <li>• Embed electronic assistive technology</li> <li>• Establish effective engagement and co-production of services with service users and staff</li> <li>• Develop a whole system workforce planning approach</li> <li>• Medicines optimisation</li> <li>• Utilisation of assets</li> </ul>	
e) Governance overview	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	<p>The agreed governance arrangements include:</p> <ul style="list-style-type: none"> <li>• Delivery Boards within each locality reporting to the local Transformation and Integration Groups (TIG). The TIG, alongside the Urgent Care Working Group is accountable to the ICB;</li> <li>• Integration and Change Board (ICB) that reports to the Health and Wellbeing Board (HWBB);</li> <li>• Alongside the Children’s trust board, the HWBB is responsible for governance.</li> </ul> <p>Representatives from our local voluntary and community sector sit on our Delivery Boards and at the HWBB.</p>	See “ <i>Governance</i> ” in the 5 Year Forward View (2014-19)
f) Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	<p>As part of the development of the BCF, an inter agency agreement is in place which sets out a range of values and principles applicable to the delivery of the strategy. These have been agreed and signed up to by ICB and the HWBB:</p> <ul style="list-style-type: none"> <li>• Working better together is first and foremost about what is best to add value for all the people of the</li> </ul>	Please see “ <i>A system wide approach</i> ” in the 5 Year Forward View (2014-19)

Segment	Key Line of Enquiry	Organisation response	Supported by:
		<p>district</p> <ul style="list-style-type: none"> <li>• We will improve the quality of care and support available and look for improvement through the eyes of the people of the district and the staff providing the care</li> <li>• We're in this together, working as a whole system and both risk and reward are shared</li> <li>• We will continue to create a culture of trust, openness and transparency, including demonstrating a collective stewardship of resources, using all available assets in a shared way</li> <li>• The system is wider than just our organisations and we will put the interests of the people we serve at the forefront of our decisions with the view that the people of the district are themselves an asset</li> <li>• We will collectively agree our future priorities as a whole system;</li> <li>• Our clinicians, social care professionals, managers and colleagues and partners will work together to make change happen</li> <li>• We commit to working at pace, to achieve rapid progress, make decisions and see them through</li> <li>• We will all communicate our shared values and principles in a consistent way</li> </ul>	