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Report of the Director of Adults and Community Services CBMDC and the Director of Collaboration NHS Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs to the meeting of the Health and Well Being Board to be held on 9th September 2014.

Subject: **G**

Health and Social Care Integration and Transformation

Summary statement:

The following report sets out the journey so far to integrate the health and social care systems across the Bradford, Airedale, Wharfedale and Craven Districts.

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Portfolio:

Adult Services and Health

Overview & Scrutiny Area:

Health and Social Care

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1. SUMMARY

The following report sets out the journey so far to integrate the health and social care systems across the Bradford, Airedale, Wharfedale and Craven Districts.

2. BACKGROUND

2.1 Joint commissioning

The Health and Wellbeing Board requested an update from Bradford and Airedale Collaborative Commissioners on joint commissioning, particularly in relation to commissioning from the third sector.

Partners in health and social care are experienced in joint commissioning, and the new landscape of CCGs offers further opportunities to extend this not only to provide economies of scale but to ensure consistency for both providers and citizens. The initial work commenced looking at the third sector in summer 2013. While a lot of preparatory work was undertaken by partners a combination of conflicting procurement requirements resulted in services being commissioned separately albeit in collaboration.

Health and social care partners are committed to delivering improved outcomes for our local population, and this will be the basis of future joint commissioning, this will move us away from commissioning by sector to commissioning based on health and social care needs.

2.2 Context

Joint/collaborative commissioning across health and local authority organisations has long been an agenda for Governments predating the current reductions in public sector funding. The increasing levels of demand for both health and social care services against this backdrop of real cuts in funding being made available make collaboration a necessity. Locally the net reduction in available funding to meet the health and social care needs of Bradford and Districts is in the region of £364 million over the next five years. This magnitude of change in funding coupled with the increasing demand and expectation from the public requires an equally seismic shift in how health and social care organisations respond.

The announcement of the Better Care Fund heralded as an enabler of greater collaboration between health and social care, is designed to force local partners to begin to think beyond the margins of the more traditional areas of collaboration, joint commissioning, winter pressure, planning and intermediate care. Health and social care communities have been challenged to develop models of delivery that transform the way services are organised., funded and delivered to better respond to the needs of individuals, provide 24/7 services, care closer to home and encourage the individual to take greater control of their health and wellbeing.

The Health and Wellbeing Board have endorsed the Local Health and Social Care 5 Year Forward View representing a fundamental building block in the delivery of a much more unified system where the citizen is the focus and care closer to home is the objective. There is agreement across the system to jointly commission services where this adds value and to this end plans are being put in place. Integrated health and social care teams are in development across the district. Progress towards a greater unified health and social care system is the end game. The journey necessitates an incremental approach. How far the system integrates will depend on the ambitions of the community.

2.3 Governance arrangements

Bradford and Airedale Health and Social Care have a relatively strong track record of joint commissioning arrangements in the areas of adults and children's services. The recent reforms and changes within the NHS and LA however slowed or even reversed progress. As both NHS and Social Care realign their commitment to joint commissioning it is important to clearly define the governance structures that will provide support, resilience and oversight.

The Health and Wellbeing Board is the highest level strategic forum where priorities for joint commissioning are decided and for ensuring consistency with the Health and Wellbeing Strategy.

Bradford and Airedale Health and Care Commissioners (BAHCC) is the forum which assumes responsibility for assessing the impact of any commissioning or decommissioning decisions taken by any stakeholder and considering the wider implications for local communities and providers. This group will take responsibility for driving the priorities set by the H&WBB and ensuring mechanisms are in place to deliver appropriate outcomes.

The Investment and Commissioning Group (ICG) is intended to be an operational decision making forum that has delegated powers from BAHCC to provide rigour and set parameters for joint commissioning arrangements to take shape and operate effectively. The monitoring and management of the joint commissioning arrangements will initially sit with BAHCC. Further operational task and finish groups that help to facilitate joint commissioning and sharing of service developments will be formed once the momentum for joint commissioning gathers pace.

2.4 Implementation

An area where we already jointly commission is integrated support for carers. It has been agreed that we will now develop joint commissioning arrangements for both children and adults in the areas of learning disability and mental health. Child and Adolescent Mental Health (CAMHS) is under discussion to identify the benefits of jointly commissioning services.

We are mapping out current commissioning and contracting resources across the local authority and clinical commissioning groups and have agreed to revise the roles of existing commissioning managers and/or recruit to vacant posts to explicitly describe how staff working in these posts will implement joint commissioning. We will be setting up hosting arrangements so that commissioning teams can be co-located where it makes sense to do so.

As far as possible, the work of joint commissioning will be carried out through forums that already exist (e.g. the transformation and integration groups that report in to the Integration and Change Board) rather than setting up more groups.

2.5 Expected impact

The essence of building a framework for joint commissioning is to create pathways of care that are built around the needs of the individual, their carers and family and not around the separate needs of health or social care organisations. For example, if an illness is prevented, a condition properly managed, a fall avoided, not only is that better care for the individual but it also means less pressure on the system. It also means that in developing services with patients 'for patients' and with service users 'for service users', the consultation/engagement can take place once instead of repeatedly with the various provider organisations engaging separately in their respective silos.

Bradford has some good examples of joint commissioning within health and social care. The joint commissioning of carers allows ease of access and provides a joined up suite of services.

The 3 main improvements stimulated by joint commissioning will be:

1. Services designed around the patient or service user that provide ease of access to services; improved patient/client experience, improved clinical governance and better social care outcomes
2. Speedier decision making for clients/patients who are vulnerable;
3. Improved responsiveness and higher quality of services

The systems changes brought about by joint commissioning begin with greater transparency, better sharing of information and working collectively to define and prioritise the needs of the local population. This will provide a framework where the main steps of the commissioning cycle, and in particular the health and social care assessment of the needs of the local population will be done jointly. The planning and implementation stages which range from designing new pathways and reconfiguring service specifications to aligning budgets and setting up contract management mechanisms will be carried out collaboratively. This joint arrangement will provide efficiencies in provider management, greater economies of scale with reference to the sharing of support systems and improved performance management and clinical governance.

A person-centred perspective of joint commissioning aspires to people experiencing one system of care and treatment, not several disconnected ones that create frustration and delay. It will enable local people to access joined up services through single routes of information, advice and referral. It will offer local people a journey across their respective pathway that enables them to find the best outcomes for themselves without fear of becoming lost or trapped across organisational or professional boundaries. It will allow people to become meaningfully involved in shaping their own experience of the system and linking in more directly with self-care, personal health budgets and social care budgets.

How successful the system changes are, will be measured through patient/user experience. This improvement will be captured through combined health and social care performance indicators. A further measure of success will derive from greater efficiencies and management of activity across the system.

2.6 Integrated Digital Care Record (IDCR) Programme

The joint Council/NHS Integrated Care for Adults Programme commissioned a report appraising the viability and solution options for creating integrated care records between Health and Social Care. The IDCR programme includes representatives from all partner organisations and supports organisational, system and Information Governance interests. The objective is to enable a shared record environment across the district in which information about an individual's interaction with primary, intermediate, secondary and social care will be accessible to all practitioners who have a legitimate relationship with that individual (given the individual has consented to share their care record). Some integration between electronic systems has already occurred, however, to truly integrate care it will require working at locality level, providing access to an IDCR at the point of care. City of Bradford Metropolitan District Council's contribution to the programme is a project to migrate social care records to SystmOne (which is being used as a hub to host the shared record environment). By selecting SystmOne, key data will be appropriately shared ensuring a high level of care and service is achieved and maintained for our patients/service users. As of 1st April 2015 CBMDC will adopt the NHS number as the primary case identifier.

How will this improve things for the people of Bradford?
Moving to a full IDCR will support delivery of integrated services and enable organisations to join up care around the needs of the person. A key requirement to meet our vision for integration is to ensure that patient information can be shared securely between partner organisations. An integrated electronic patient record will provide a central, shared and accurate record with the ability to operate anywhere across the health care community and the means to exchange real-time information in support of a person's overall care plan. This will enable Health and Social Care professionals to make more timely decisions, having a fuller picture of the care that a person is receiving. A considerable amount of time will be saved for practitioners by not having to chase information from other services about the care that is being

provided to an individual. This information will be readily available in the person's record. Having access to the right information at the right time enables more timely and appropriate response. It helps professionals' document handovers accurately and makes it easier to share information quickly across multi-disciplinary teams and with other providers. It will enable more integrated working practices/pathways to be developed across our health and social care settings. The subsequent alignment of assessment and care planning processes will, in turn, help increase the effectiveness and efficiency of service delivery and improve the patient/service-user experience.

The programme will enable us to integrate information that currently remains housed in unconnected silos across our organisations. Improvements in performance reporting through the use of a single system will enable us to establish/monitor benefits of changes in the system on an ongoing basis. A study; Kings Fund quoted (Ramsay, Fulop and Edwards 2009) has recommended that what should be measured should include:

- Impact on patient experience, including the development of 'markers' improved processes of care
- Impact on use of services, especially inpatient beds
- Impact on costs, and differentially on cost in different parts of the system
- Impact on health/social care outcomes, with markers developed

The future is about increased joint working across health and social care, with services wrapped around the user. Investing in technology and creating information systems that help professionals and individuals share information more easily also drives innovation and continuous improvement in care delivery. It enables completely different delivery models and creates new opportunities for cross-sector research.

2.7 IDCR Technology Fund

Wave 1
Funding has been awarded through the IDCR Technology Fund, a combined bid by Bradford District Care Trust (BDCT), Airedale NHS Trust (ANHST) and City of Bradford Metropolitan District Council (CBMDC) resulted in Bradford being identified as one of three national accelerator sites

Wave 2
A further application for funding has been submitted by partners in July 2014 the outcome of which has not yet been determined. The focus for this second application is to further the expansion of the programme across other areas.

2.8 Better Care Fund

The local health and care economy is required to develop detailed plans for the utilisation of its Better Care Fund. The outline plan submitted to NHS England on the 4th April set out the local proposals for the use of the BCF pooled budget to support transformational change and integrated care. We are now required to submit a fully worked up proposal to NHS England by September 19th.

The BCF covers the same footprint as the Health and Wellbeing Board and includes Airedale, Wharfedale, City and Districts CCG areas. Craven forms part of the North Yorkshire BCF plan.

By way of context it is worth reiterating the policy and funding assumptions that underpin the fund. Health & Social Care economies have been provided with an indicative minimum value of resources required to be pooled into the BCF. The value of the fund for Airedale and Bradford is £37.345m. Just under half of this money is expected to be pooled from existing 2014/15 services (reablement, social care grant, LA disabled facilities grant and carers support) which total £17.7m, and the remaining funding (£19.6m) will come from local CCG's redirecting funds from acute care into community based services to support and transform the system.

The broad aim set out by the Health and Wellbeing Board is to achieve a step-change in the capacity and capability of community services seven days a week, with a particular focus on:

- Dementia
- Falls
- Maximising independence (intermediate care, rehab and reablement)
- Self-care and prevention
- Proactive care and continuity of care

As the BCF forms part of the 5 year strategy planning process, it must not be seen as the sole mechanism to deliver change. The BCF requires the creation of a pooled budget to support integrated care. The list above reflects service areas where an integrated approach is particularly beneficial and necessary to make an impact.

New guidance on the BCF has highlighted that unplanned admissions are the biggest driver of cost in the health services that the BCF can affect. Our plans need to clearly demonstrate how they will reduce total emergency services, as this is seen as an indicator that health and care services are working together.

The most significant change in the policy is around the "new" resource. The national assumption set out an expectation that the NHS would be set aside £1.9bn in 2015/16 to be pooled into the BCF. Of this £1.9bn, £1bn would be dependent upon a set of performance metrics, although how this would work in practice was not clearly articulated. The new guidance clearly sets out how the performance element will work:

- £1.0bn will remain in the BCF BUT will now be commissioned by the NHS on out of hospital services or be linked to total emergency admissions.
- It will be paid into the BCF based on performance and solely linked to total emergency admissions and NOT the range of other metrics previously included in guidance.
- The expected minimum annual reduction in total emergency admissions is 3.5%
- The performance element will be released by CCG to the BCF based on quarterly performance.

- £0.9bn is subject to HWB discretion as per original plans.

- Revised BCF plans must clarify the level of protection of social care from their share of the £1.9b, including the relevant share of the costs of implementing the Care Act (£135m nationally)

2.9 Expected impact

- Outcome 1: People are supported to remain independent, delaying or reducing the need for care and support;

- Outcome 2: People receive the right care in the right place the first time, meaning that no-one is admitted to hospital unnecessarily or kept in hospital longer than necessary;

- Outcome 3: People have a positive experience of health and care services, with joined up and personalised services;

- Outcome 4: The cost of health and social care estate is reduced.

2.10 Working together to implement the Special Educational Needs and Disability code of practice: 0 to 25 years

The code of practice provides statutory guidance on duties, polices and procedure relating to Part 3 of the Children and Families Act 2014 and associated regulations. There is an expectation that a number or organisations, including local authorities, clinical commissioning groups, NHS service providers and schools will work together to ensure all children and young people are supported to achieve well in their early years, at school and in college and lead happy and fulfilled lives.

A programme board has been created with a number of project work streams established to support organisations to work together improve the experience of children and young people with special educational needs and disabilities (SEND). The programme board, with additional support from other work streams such as the health SEND working group will deliver this outcome by:

- Ensuring education, health and social care services work together to jointly plan and commission services for children and young people with SEND
- Making sure children, young people and families know what help they can get when a child for young person has special educational needs
- Giving children and young people and their parents more say about the help they can access
- The implementation of one overall assessment to look at what special help a child or young person needs with their education, health and social care needs, resulting in one plan for meeting these needs, which can run from birth to 25
- Making sure children, young people and their parents are fully engaged in the development of this plan
- Ensuring the provision of support if the child, young person or their parents wish to appeal about the help they are offered within the plan.

The expectation is that the implementation of the Code of Practice will lead to a children and young people experiencing a system which is less confrontational and more efficient. Their special educational needs will be picked up at the earliest point and support will be put in place quickly. Young people and parents will know which services they can reasonable expect to be provided and children, young people and parents will be fully involved in decisions about their support. The aspirations of children and young people will be raised through an increased focus on life outcomes, including employment and greater independence.

The local authority are required to publish the local offer of services for children and young people with SEND (both online and in other formats) and provide opportunities for feedback on these services which will be shared with relevant service providers and their commissioners.

2.11 Integration in Continuing Healthcare and personalised commissioning.

Integration of the assessment and review components of the Continuing Healthcare (CHC) process has been a long held ambition locally. Co-location of health and social care staff responsible for these two major elements within the CHC process has been agreed between both parties and planning is underway to achieve this by December 2014. The aim of co-locating staff is to improve the experience service users and their carers have of the CHC process by better co-ordination of assessments, more timely decision making and a more integrated approach to commissioning care packages between the two services. This is particularly pertinent as the NHS introduces personal health budgets in a similar vein to the Direct Payments scheme overseen by Local Authorities for several years now.

Being a pilot area from 2013 for personal health budgets (PHBs) has meant locally we already have patients in receipt of full fund continuing healthcare

(CHC) with such budgets. From October 2014 all patients in receipt of CHC will have the right to have a PHB. This change is intended to give patients and carers greater control and personalisation when planning care for their continuing healthcare needs. The co-location of staff and plan to integrate elements of the process and care package commissioning where it makes sense to do so, is a key element in our ambitions for patients and service users. Our aim is to reduce duplication of effort and information gathering, shorten decision making times and be able to react with better co-ordination when patient/service user needs change and care packages need to respond to reflect that change. The Department of Health has indicated that PHBs may be extended to other categories of patient from April 2015 and research is underway regarding mental health and long-term condition PHBs at 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 implementation. The flexibility created by 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 can help to remove unnecessary bureaucracy and duplication of effort in the delivery of care package

3. OTHER CONSIDERATIONS

Not applicable.

4. FINANCIAL & RESOURCE APPRAISAL

Not applicable.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Not applicable.

6. LEGAL APPRAISAL

Not applicable

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

The system changes described in this report relate to the total population of the Districts.

7.2 SUSTAINABILITY IMPLICATIONS

Not applicable.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

Not applicable.

7.4 COMMUNITY SAFETY IMPLICATIONS

Not applicable.

7.5 HUMAN RIGHTS ACT

Not applicable.

7.6 TRADE UNION

Not applicable.

7.7 WARD IMPLICATIONS

System changes District wide affecting all Wards.

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

Not applicable.

8. NOT FOR PUBLICATION DOCUMENTS

Not applicable.

9. OPTIONS

Not applicable.

10. RECOMMENDATIONS

10.1 The Board to comment on the progress made towards integration across Health and Social Care.

10.2 The Board to identify areas where the greatest efforts should be focused to achieve the most benefit for citizens'.

11. APPENDICES

None.

12. BACKGROUND DOCUMENTS

None.