**Purpose of the Report**

The purpose of the Chief Executive’s report is threefold, namely:

- to highlight key National and Local Health Economy developments that are of strategic relevance to the Foundation Trust and which the Board needs to be aware of;
- to bring together key messages from the Board papers into a single, high level assurance narrative; and
- to update the Board on key strategic and operational developments that I and the Executive Team are leading.

This month's report covers developments that have happened since the February Board of Directors meeting.

**Key points for discussion**

As usual there have been a number of significant national announcements and publications this month which are listed in the paper and summarised in Appendix 1. Of particular strategic importance to the Trust is the number of references again to the future provider landscape and the need for radical transformation.

Across the local health and social care economy planning activities are ramping up as partners get to grips with the Better Care Fund and arrangements for aligning 5 year plans. Directors will note the Bradford Health and Well Being Board’s decision to extend membership to one provider to represent all 3 NHS providers. Also attached to this month’s paper is the Better for Bradford agreement from the Integration and Change Board which all partners are taking through their respective Boards this month for approval and sign off.

For the Trust, in addition to the usual quality and delivery focus, the key item for discussion in the private session will be the finalisation of the Annual Plan submission to Monitor.

**Recommendations**

The Board is asked to receive and note the CEO update report and with reference to the Better for Bradford document consider whether it is happy to sign up to the partnership agreement.
1 National Developments and Publications

National developments I wish to bring to the attention to the Board this month are listed below with further details summarised in Appendix 1. At the Board of Directors meeting I will lead a discussion on the implications of the developments highlighted in terms of their potential strategic impact for the Foundation Trust.

1.1 Important Government Announcements
- Care Bill vote re hospital closure powers
- NHS Pay Announcement
- Expert group says to leave Francis constitution amendments until later
- Mid Staffs NHS Foundation Trust to be dissolved

1.2 Significant Publications
- Public Accounts Committee (PAC) Report on A&E Staffing
- Age UK Care in Crisis Report
- Care Quality Commission Hospital Inspection Report
- Secretary of State Report on Duty of Candour
- King’s Fund Making Our Health and Care Systems Fit For an Ageing Population
- King’s Fund Vision for Primary Care
- Labour Party, One Person, One Team, One System
- Monitor report on Foundation Trust Q3 Performance
- Monitor and NHS England may set acute providers different savings targets
- Monitor, NHS England and Trust Development Authority report of NHS Futures Summit
- NHS England Surgical Never Events Task Force recommendations
- NHS England Annual Staff Survey Results
- National Audit Office Report on Social Care
- NHS Confederation Ripping off the sticking plaster
- Royal College of Nursing Frontline First on nurse staffing levels

1.3 Consultations
- Department of Health on new criminal offence of wilful neglect
- Monitor and NHS England on new NHS payment system

1.4 In the news
- Final words from outgoing NHS Chief Executive, Sir David Nicholson
- CQC Chair on failing Trusts
- Hunt orders NHS to cut night bed moves
- NHS England on Care.data
- NHS England Executive Team Changes
- Ehealth Insider on Digital Maturity Review
2 Local Health Economy Developments

2.1 Bradford and Airedale

Health and Well Being Board (HWBB) Feedback

At this month’s meeting the HWBB considered the following items which are of relevance to Airedale:

- **ToR and membership of HWBB** - the members considered a number of options regarding changes to the membership. As the Board are aware the Bradford HWBB has not had provider representation thus far. The options paper included proposals for NHS provider representation – either a single CEO to represent all 3 NHS providers, or all 3 provider CEOs to have a place. Following lengthy discussion the HWBB determined that one CEO would be offered a place to represent all 3 NHS providers – the CEOs to agree who will represent. Whilst the move to have provider representation on the Board is welcomed, the three CEOs were of the view that all three should be included and had written a joint letter to the leader of the Council setting out our rationale. (Attached, Appendix 2)

- **Commissioning intentions update** – high level summary of CCG and Local Authority commissioning intentions which will inform their respective 5 year plans which providers are required to align with.

- **Better Care Fund (BCF)** – the HWBB is required to sign off the final version of the BCF to be submitted to NHS England at the beginning of April. A special meeting of the HWBB has been arranged for 1 April to review the final submission.

Integration and Change Board (ICB) Update

Health and social care partners are working together collectively to agree the 5 year strategy for Bradford, Airedale, Wharfedale and Craven following the decision by the H&WBB that the whole district be considered the unit of planning for planning purposes.

As a step towards this, members of the ICB have been working on an inter-agency agreement – *Better for Bradford*. The agreement document signals the direction of travel for our shared integration aspirations.

All ICB members have agreed to bring the latest version of the *Better for Bradford* agreement to their respective Boards in March for formal sign off. (Attached Appendix 3). Next steps will include developing specific measurable performance indicators that all partners will be held to account on.

**Recommendation**: the Board is asked to consider the attached agreement and confirm whether it agrees to sign up.

ICB partners are currently reviewing the role of ICB and, following a workshop earlier this month facilitated by Mike Farrar, are proposing to extend the scope of the ICB from the current focus on integration only to a much wider role, focussing more on transformation and change to ensure sustainability of services.

2.2 North Yorkshire

**Integration & Change Board (ICB)**

Partners in the North Yorkshire ICB are also working to complete their Better Care Fund submission to NHS England and also have a special Health and Well Being Board arranged for 1 April to review the final submission. Airedale is involved in the discussion and contributing to the plans.
2.3 West Yorkshire

i) Area Team Communication re strategy

Earlier this month all provider CEOs across West Yorkshire received a letter from Andy Buck, Director of the West Yorkshire Area, team summarising his understanding of the emerging NHS England strategy for the NHS and providing more detail about the progress CCGs are making towards responding to this strategy.

Focussing on strategy and planning for acute providers, Andy's view is four things stand out:
- the intention to create a new model of urgent and emergency care, with between 40 and 70 major emergency centres at the heart of urgent and emergency care networks;
- the drive towards seven day working;
- the intention to move towards between 15 and 30 centres of excellence for specialised services, with country wide compliance with service specifications; and
- the expectation that integrated services will lead to a reduction of 15% in emergency admissions to hospital.

With reference to financial challenge he confirms his assessment that the West Yorkshire challenge accumulates to £1.5 billion by 2020.

Clearly across West Yorkshire these intentions create both opportunities and challenges. Andy believes we have a big enough population to be able to continue to meet most needs here, in West Yorkshire, and to meet the rightly exacting standards being set. The creation, therefore, of a health system that has a first class urgent and emergency care network; has one of the best specialised services centres and networks; is confident about its provision 24/7; and sees a lasting reduction in avoidable admissions to hospital is therefore something he believes we could achieve.

ii) West Yorkshire Acute Provider Chief Executives

On 18 March I met up with Chief Executives from acute providers from across West Yorkshire to review challenges, explore opportunities and share experiences.

2.2 Stakeholder engagement update

Directors have continued their engagement activities with partners to further refine our Right Care vision to ensure alignment with integration plans across our local health and social care economies.

In addition to contributing to the development work of the ICBs and Health and Well Being Board, Trust Directors have contributed to organisational development reviews and strategic planning visioning for the local CCGs who have commissioned external support to help with their ongoing development.
3 Airedale Foundation Trust Update

3.1 Quality of Services

i) Care Quality Commission (CQC) latest intelligent monitoring report

The CQC published an updated intelligent monitoring report earlier this month for each NHS acute and specialist hospital. The report, the second since the new style hospital inspection regime was introduced last year, includes a range of tier 1 indicators relating to the five key questions the CQC ask of all services – are they safe, effective, caring, responsive and well-led? and are used to raise questions about the quality of care. The indicators are not used on their own to make judgements as CQC judgements are always based on the result of an inspection, which takes into account the intelligent monitoring analysis alongside local information from the public, the trust and other organisations.

This latest intelligent monitoring report presents the CQC’s analysis of the key indicators for Airedale NHS Foundation Trust. The CQC use a number of statistical tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator. In the report Airedale is deemed to have no risks or elevated risks.

NHS acute and specialist hospitals that have not yet been subjected to the new style inspection regime are assigned a risk banding – Directors will recall in the first intelligent monitoring report, published just prior to the Trust’s formal CQC inspection, the hospital was assigned a band 6 (lowest risk) rating. Those organisations inspected under the new regime are not assigned a banding in the report as the CQC provides its definitive judgements for each organisation through the new comprehensive inspections – Airedale hospital falls into this group.

Whilst the Trust has been assessed as no risk, Directors are in the process of reviewing the detail of the report to identify any areas for further improvement through our usual quality and safety assessment processes.

ii) Paediatrics Peer Review

This month the Paediatric Department was subjected to peer review. Informal feedback from the reviewers was that they found no immediate risks or serious concerns - the panel noted it was the first Paediatric service to have none under the new review process.

Positive feedback included:
- Overall it is a cohesive team, well led and committed to a delivering a quality service for the patient and their families.
- The 1st team in Yorkshire with a 24hr on calls service/helpline
- Mandatory training on the ward for nurses and doctors – this has not been seen anywhere else & is excellent.
- Impressed with the training done with schools and colleges

A small number of issues to consider:
- The policy for managing Hba1C needs to be reviewed to incorporate those with Hba1C >75 (currently 80)
- No cover for diabetologist
- Psychological services are very limited – 1 session per month, most areas have 4 – the team need to consider how the best practice tariff can support further sessions.
Airedale NHS Foundation Trust  
Board of Directors: 26 March 2014  
Title: Chief Executive’s Report  
Author: Ann Wagner, Director of Strategy & Business Development

A copy of the review panel’s formal report is expected shortly for factual accuracy checking prior to final publication. The full report and action plan in response will be subjected to usual quality, safety and governance assurance processes.

iii) Endoscopy JAG Accreditation

Following the JAG revisit to the endoscopy unit at Airedale General Hospital on 16 March, I am pleased to confirm that the endoscopy unit Airedale General Hospital has met all of the required JAG Accreditation standards and has been awarded full JAG accreditation for one year. Accreditation will be awarded annually following successful completion of an April census and submission of the Annual Report Card. Thereafter there will be 5 yearly JAG Accreditation site visits.

This is a fantastic achievement for the staff who have worked tirelessly to establish the new unit, which opened last year. I am sure the Board will want to join me in congratulating the team.

3.2 Month 11 Finance and Performance Update

i) Financial position

The overall position at the end of February was as follows:

- a surplus of £781,000 against a planned surplus of £403,000- £388,000 better than plan reflecting increased income from additional activity.
- EBITDA is £311,000 behind plan, offset by an improvement on depreciation relating to capital slippage. This position continues to deliver a Continuity of Service Rating of 4; and
- the cost improvement programme (CIP) gap for 2013/14 is £1,381,000. This is covered in full by the CIP contingency.

As previously reported, recurrently there is a CIP gap of £2.2m which is being addressed through the Trust’s Right Care Portfolio of Programmes as part of the annual planning process which the Board is actively reviewing to ensure a recurrent viable solution without adversely affecting patient experience. An update on the Right Care Portfolio Programmes is referred to later in this paper.

Further details of the month 11 financial position are included in the Director of Finance’s report.

ii) Performance standards

Accident & Emergency (A&E) 4 hour treatment time standard

Having failed the A&E standard in January the Trust’s performance improved during February with the A&E 4 hour wait standard being achieved (96%). However quarter 4 performance at the end of February stood just below the target at 94.9%. March has been a very challenging month with the department very busy and, despite best efforts, struggling to cope with the unrelenting demand. However performance at the time of writing this report has begun to improve with the current March position (@ 18 March) at 96.56%, 95.32% for the quarter and 95.71% for the year to date.

Hospital Acquired Infection Rates

- There has been one case of MRSA during February bringing the total to two cases for 2013/14
- There were no cases of C Difficile in February so the total number of cases for 2013/14 remains at 7. This is below our national target of 9 and de minimis of 12 applied in the Risk Assessment Framework.
Other Standards

For February the Trust achieved the required thresholds or was within de minimis limits for all other Monitor standards. We are currently forecasting an indicative Quarter 4 Amber rating for Service Performance.

Further details of the performance position for month 11 are included in the Director of Finance’s report.

3.3 Monitor Updates

i) Monitor formal review of Quarter 3 (Q3) 2013/14

Earlier this month we received confirmation from Monitor that following their analysis of our Q3 submission the Trust has been assigned a Continuity of Services Risk Rating of 4 and Governance Risk Rating of GREEN

A copy of the Monitor letter and high level summary review are attached for information (Appendix 4)

3.4 Annual Planning 2014/2015 to 2018/2019

As the Board is well aware, the Trust has been developing its two and five year plans in response to national policy and regulatory requirements, local commissioner intentions, stakeholder plans and Governor and member feedback.

A key item on the private agenda is the final draft of the 2 year Annual Plan for Board sign off for submission to Monitor. The Board will want to be assured that the Annual Plan and underpinning financial plan is in line with our strategy, meets the requirements of our commissioners and regulators, can be delivered safely and within the financial envelope and required efficiencies.

Once the Board has confirmed it is satisfied with the submission we will be communicating the key themes both internally and externally with stakeholders and the local community.

Work will also continue to complete the 5 year plan which is required by June. As part of the submission to Monitor, Trusts are required to complete and report on a self assessment regarding the strength of strategic planning. (Copy of section 7 of Monitor’s planning guidance has been circulated to Board Directors for information). The Board will want to reflect on the guidance in preparation for the next strategy day when Directors will be considering the self assessment return.

3.5 Right Care Portfolio: Programmes Update

The latest financial position of the Right Care Portfolio Programmes against their efficiency targets is as follows:

- **2014/15** - £5,031k identified against target of £7,290k (£2,259k gap). Recurrently this gap increases to £2,688k (identified £4,602k recurrently)
- **2015/16** - £5,716k identified against target of £5,090k (£626k better than plan). Recurrently this over identified reduces to £372k (£5,462k identified recurrently)
- In total £2,316k recurrent gap.
Together with the Director of Finance I am in the process of meeting with each Executive sponsor to review individual programme progress and plans to close the gap.

Currently Programme Teams are working to establish their programmes, in terms of the governance documentation that will be used to assure executive sponsors that each programme has been established correctly, has identified the benefits that it hopes to deliver, both financial and non-financial, and has the correct reporting lines up to the Right Care Portfolio Board. Programme Teams are also working to outline the activities that will need to be undertaken to deliver the identified opportunities, split out in terms of timescales for delivery, responsible owners and any linkages or interdependencies with other projects or programmes.

Each programme will also produce a Quality Impact Assessment which will be evaluated and signed off by either the Medical Director or the Director of Nursing to ensure that there will be no negative impact on the quality of our clinical services during the period that activity is on-going to deliver the identified opportunities.

The Portfolio Management Office is working to establish the structures that will be required to monitor progress and assure Executive Sponsors of delivery. Alongside this activity, the Portfolio Office is also working with colleagues from the Communications team to finalise the planned staff engagement sessions throughout the coming financial year, and generate a set of principles that will underpin the delivery of the Right Care vision, which are based upon feedback received from the open staff meetings held in January and February. These principles will be further tested with staff over the coming month to ensure that they are true to the original feedback, and colleagues feel that they can sign up to them. Once this process is complete the vision and principles will start to be communicated widely across the organisation, backed up by visuals (posters and other communications materials) which will be distributed across the Hospital.

3.6 Workforce

i) Staff Survey Results

The national annual staff survey results have been published. A paper summarising the key findings and how Airedale compares to the rest of the NHS is included in the Board pack.

Overall the report for Airedale is positive with many areas showing improvements on last time and our scores on staff engagement and recommending the Trust as a place to work or receive treatment improving on last time and being above average for acute trusts.

However there is no room for complacency as there remain issues for the Trust to focus including improving appraisal rates, addressing work pressures and satisfaction regarding communications between senior managers and staff.

Nick Parker, Head of Human Resources, will brief the Board on our plans to address these issues and how this correlates with other staff feedback we have received through our quarterly pulse surveys and staff listening sessions.

ii) Staff Recognition

This month I am delighted to bring to the attention of the Board two of our nursing staff who have achieved national and international recognition.

The first is Nona Toothill, Airedale Hospital’s urology specialist, who has been shortlisted for a national nursing award. She is one of three in the country competing for the Urology Nurse of the Year category of the British Journal of Nursing Awards 2014 and will take part in an award ceremony in London on 21 March.
The second is Jane Pearce, a member of Airedale Hospital community team who has secured international recognition as a specialist for multiple sclerosis (MS). Jane has just been awarded a certificate from the Multiple Sclerosis Nurses International Certification Board (MSNICB) after passing a stringent examination for all nurses worldwide who provide MS care. There are just nine people each year who sit the exam, part-funded by The International Organisation of MS Nurses (IOMSN) and the UK Multiple Sclerosis Specialist Nurses Association (UKMSSNA). Jane, has been a MS specialist nurse for eight years and is one of only 240 in the UK.

I am sure the Board will want to join me in congratulating Nona and Jane on their outstanding achievements which are a testimony of the calibre of nursing we have across the hospital and community teams.

### 3.7 Innovation recognised

As reported last month, Airedale featured significantly at NHS England’s EXPO event held in Manchester at the beginning of May. As well as leading seminars in the pop up university, and taking part in a number of panel discussions, Airedale’s Telehealth Hub featured in the Future Zone with our Immedicare Joint Venture partners Involve supporting us with live link ups to Hub nurses. The telemedicine service caught the attention of the BBC who featured Airedale on national breakfast TV with Tim Moffat interviewing Rebecca Malin, Deputy Director of Strategy and Business Development. This was followed the following day with a main feature on Sky News who filmed local Settle GP and CCG clinical chair Dr Colin Renwick in the Telehealth Hub.

The Trust has also been invited to contribute to a No 10/Cabinet office programme aimed at lowering the barriers to entry/growth for disruptive businesses and business models in the UK. One of the markets they are focusing on is Preventative and Personalised Healthcare and the use of electronic information and communication technologies to support healthcare when distance separates participants. The scope of the work includes Homehealth [telehealth, telecare], Telemedicine, Healthcare Applications and Smart Homes. Airedale has been asked to contribute to this due to our reputation in this field and profile raised through the NHS Futures event.

We have also been invited by Accenture to present at international events in Nice and Barcelona during April and May to showcase our telemedicine work and one patient one record developments.
Appendix 1

National Developments: Summary

1.1 Important Government Announcements

Care Bill vote re hospital closure powers
There is widespread media coverage of the final Parliamentary stages of the Care Bill, including the House of Commons vote on two clauses which relate to the powers and responsibilities of the Trust Special Administrator (TSA) and the health secretary in the event of provider failure. MPs voted against removing clause 119 of the Care Bill by 297 to 239, with the result that the TSA can make recommendations of change across health economies, including at organisations not directly within the Unsustainable Provider Regime.

NHS Pay Announcement
The Government has announced its plans for a two-year pay award for public sector staff, including those in the NHS. The Government’s rejected the recommendation from NHS pay review bodies for a one per cent uplift to all pay scales. Instead, the Government announced that only staff who won’t already be receiving an incremental increase will receive a one per cent increase, which they will get through non-consolidated payments. In 2015/16 the same approach will apply but with the non-consolidated payment being two per cent.

Expert group says to leave Francis constitution amendments ‘until later’
The Expert Advisory Group to the NHS Constitution has rejected the Francis report’s recommendation the document should be rewritten and has instead said the government should focus on making sure it was “publicised, embedded and applied”. The group was set up in late 2012 to take forward recommendations on the constitution made by the NHS Future Forum advisory group. It reported last week and recommended the government abandon its commitment to consult on amendments to the constitution suggested by Robert Francis QC, and instead recommended that the Department of Health leads work to embed the constitution and “leaves content changes till later”. The DH said the group’s recommendations had been accepted and it would work with NHS England on an awareness campaign in 2014-15

Mid Staffs NHS Foundation Trust to be dissolved
Health secretary Jeremy Hunt has announced that Mid Staffordshire NHS Foundation Trust is to be dissolved. Management of the trust’s two hospitals in Stafford and Cannock Chase will transfer to two neighbouring providers, and over a three-year period, specialist services including inpatient paediatrics and A&E will also move. In a written statement to the House of Commons, Mr Hunt said 90 per cent of patient visits would continue at the two existing hospitals. He also announced that the original recommendation of downgrading Stafford Hospital’s maternity unit to a midwife-led unit would be reviewed.
1.2 Significant Publications

**Public Accounts Committee (PAC) Report on A&E Staffing**
The Public Accounts Committee (PAC) report that says the NHS should consider paying A&E doctors more money in order to address a "chronic shortage" of medical staff in England, and there is "too much reliance" on temporary staff. The PAC says that hospitals are already struggling with poor outcomes and financial pressures and are finding it harder to recruit and retain staff. The report claims a lack of A&E consultants is preventing hospitals from tackling increasing numbers of emergency admissions, and A&E departments are too reliant on expensive temporary workers. The PAC expressed concerns that neither NHS England or the Department of Health has a clear strategy to tackle the shortage of A&E consultants.

**Age UK Care in Crisis Report**
The report claims that 'unprecedented' numbers of older people are being left to fend for themselves as a result of a reduction in social care. The 'Care in Crisis' report states that the reduction in social care has been happening since 2005, despite an increasing elderly population and hundreds of millions of pounds being transferred to social care from the NHS. The report welcomes the Government's Care Bill, which will introduce a cap on the cost of care and a deferred payment scheme intended to prevent people having to sell their homes to pay care bills.

**Care Quality Commission Hospital Inspection Report**
The CQC has published its assessment of the "proof of concept pilot" for its new inspections approach for acute trusts, whereby 18 organisations, including Airedale, were examined between September and December 2013. A report summarising their findings found that:

- there was a wide range of quality between hospitals: some were good or outstanding throughout, others had a number of poor quality services.
- in several hospitals there were marked variations between services – for example high quality maternity care but poor A&E services, and vice versa.
- in some hospitals there was variation within a service. This was particularly noticeable where one or two of the medical wards (especially in care of the elderly wards and on 'escalation' wards) were poor – what we call ‘worry wards’ – while others were good.
- two thirds were found to be underperforming in outpatient departments.
- accident and emergency departments are under “greater strain” than other hospital services, and are often experiencing long waiting times, overcrowding and staff shortages.
- critical care services – for patients with more urgent needs – were found to be of high quality and performing well, as were maternity services.
- many of the trusts were making a determined effort to improve care for patients with dementia. Several had created dedicated wards, with staff specifically trained in the needs of people with dementia. Some had created systems and pathways to identify patients with dementia so that they could give them the right level of specialist care.

The report also features good practice. Airedale is referenced on two occasions for good practice. Firstly under effectiveness for our telemedicine service for supporting...
patients with long term conditions and helping avoid hospital admission; and secondly under responsiveness for our volunteer feeding buddy scheme.

**Secretary of State Report on Duty of Candour**
A report by the president of the Royal College of Surgeons (RCS) and the chief executive of Salford Royal NHS Foundation Trust recommends that patients should have the right to be told about mistakes made in their care. Professor Norman Williams and Sir David Dalton were tasked by health secretary Jeremy Hunt to look at the threshold at which duty of candour - which applies to all health organisations - should be set. The review concludes that the duty should apply to "moderate harm" events, which are incidents that do not cause permanent harm but which most patients would regard as 'significant' events.

**King’s Fund**

i) *Making Our Health and Care Systems Fit For an Ageing Population*
The King’s Fund has warned that budget-squeezed health and care provision for a rapidly ageing population needs to change urgently. By 2030 one in five people in England will be at least 65 years old. The King’s Fund claims that health and care services have not kept pace with huge demographic changes. Its report argues that meeting these needs will require a “fundamental shift”. The fund envisages a future revolving around individual requirements rather than single diseases. A system that prioritises prevention and supports older people’s independence will also be key, . The report identifies nine care components that need improving. These include allowing older people to live well with stable long-term conditions; improving partnerships between the NHS and social care to enable patients to leave hospital quickly after treatment, with good community-based support; giving older people fast access to emergency care.

ii) *Vision for Primary Care*
This paper from the King’s Fund describes the current system of commissioning and funding general practice in England. It puts forward the case for a new approach that brings together funding for general practice with other financial resources. GPs could be given a role in co-ordinating other services, such as social care and mental health care. Ultimately the authors suggest ‘family care networks’ could be developed that provide all forms of non-specialist care.

The solution they propose would be to develop a new model to provide more integrated, consistent, locally-focussed primary care which dovetails more closely with other patient services.

This model would see GPs permitted to apply to commissioners for funding to co-ordinate whole patient primary care, by providing their own traditional services as well as using the services of social care or mental health care providers, health visitors, nurses, hospital services and other related forms of care as they see fit. Funding would be allocated using a population-based capitated contract.

Eventually, the authors envisage the emergence of ‘family care networks’, which would be able to provide most forms of care other than those requiring specialist expertise best provided in hospitals.
Labour Party, One Person. One Team, One System
The Independent Commission, led by Sir John Oldham, has published their report on Whole Person Care for the Labour party. The report sets out detailed recommendations to organise services around the needs of the person, built upon three themes: giving meaningful power to the people using the health and care system; reorienting the whole system around the true needs of the population in the 21st century; and addressing the biases in the established system that prevent necessary change happening.

The report brings together many of the well-rehearsed arguments for changing the NHS. It argues people’s care needs have changed faster than the system which cares for them, emphasising that people want better coordinated services and that older people particularly want a system that stands up for independence and against stereotypes.

The report also argues that most care is provided in the home, delivered by people themselves or their family. However, acute hospitals remain a “magnet” towards which people are drawn, combined with inadequate investment in community based services. It concludes the system is too fragmented and therefore needs to be reformed around the needs of individuals, not institutions, while acknowledging pressures being experienced in delivering care and support.

On provision the Commission makes the case for the next government facilitating the growth of new forms of coordinated provision. Commissioning based on achieving collective outcomes will require providers of care to work together. It cites a number of potential models including an accountable lead provider (such as the Alzira model in Spain) or alliance group of providers. This form of provision will need to move from being unusual to usual.

The report recognises that local flexibility will be essential to creating these arrangements, as no one model of care will be appropriate. It specifically recommends that regulators allow locally determined change to services, based on collaboration, not competition.

The importance of primary care to this new sort of provision is underlined, with the commission arguing the current model can be inflexible and inadequately connected to other areas. It is advocated that primary care will need to widen access to a broader range of professionals and services, while also making improvements to out-of-hours care and care continuity. The report points to primary care networks or federations, support partnerships or regional and national multi-practice organisations as potential models to be developed.

There is also an emphasis on self-management of long term conditions. The report advocates greater access to smart technology as a key form of support. In particular the report recommends the development of NHS Choices to create a personalised health hub that will enable families and friends to support each other through ageing and ill health.

This direction of travel means more care will need to be provided by community services, while recognising that local acute services will continue to be necessary, although different from the past. In particular, the “decoupling” of clinical expertise from hospitals is recommended, with the deployment of specialists into community-based organisations.
Monitor report on Foundation Trust Q3 Performance

Foundation trusts are performing well in providing quality services to patients in challenging economic times and are coping with winter pressures according to Monitor’s latest quarterly performance update.

The health sector regulator's latest quarterly report for October to December 2013 shows foundation trusts (FTs) are coping with winter pressures, as fewer missed the four hour A&E waiting time target than at the same period last year (28 compared to 32).

Foundation trusts have also met performance standards for all three elective waiting time targets. However more trusts breached the targets than both last quarter and the same period last year. There has also been an increase in the number of trusts breaching the target for cancer patients to start treatment within 62 days of referral by a GP.

Overall the 147 FTs (two-thirds of all NHS hospitals) are continuing to make a surplus (£135m so far this year). However, this is less than was planned (£173m) for this stage of the financial year. The number of trusts in deficit (39) is also more than expected (24), and almost double the same period last year (21). The combined deficit of these trusts (£180m) was higher than expected (£168m) but 60% is attributed to five organisations which are already subject to regulatory action by Monitor.

A further 17 trusts have very small deficits. Monitor's analysis shows that the fall in value of the surpluses across all FTs was more significant in eroding the sector's overall financial performance than the growth in the size of the gross deficit.

The report also shows that FTs have delivered efficiency savings of £867m so far this year, although this is 18% (£185m) behind what they planned at this stage.

Monitor and NHS England may set acute providers different savings targets

Monitor and NHS England are considering setting acute providers different efficiency targets based on their varying potential to achieve savings. The proposal was made in a document published by the two bodies last month, which says the organisations are considering “how to allocate financial risk optimally across the sector” so more risk is allocated to “those organisations best placed to manage it”.

Monitor, NHS England and the Trust Development Authority report of NHS Futures Summit

Monitor, NHSE and the TDA have published a call to action focussing on transformative ideas for the future of the NHS. The report follows the NHS Futures Summit held in November which was designed to spark debate about how the landscape of health and care providers could evolve over the next decade to better meet the challenges outlined in NHS England’s original Call to Action publication.

The report summarises the ideas discussed at the summit and features Airedales Right Care programme and our work on telemedicine and one patient, one record. It is also intended to assist commissioners, providers and their local partners, as they develop their ambitious 5 year plans. This report outlines just the sort of potentially transformative options that local health economies may wish to consider.
NHS England

i) Surgical Never Events Task Force recommendations
The Surgical Never Events Taskforce have published their recommendations on how never events can be eradicated from surgical care. The recommendations are set out in three themes covering education consistency, standardisation of operating department practice and harmonisation of never event reporting, publication and dissemination of learning. NHS England has now started work to consider how the recommendations can be put into practice

ii) NHS Annual Staff Survey Results
The results of the NHS staff survey have been published, showing the opinions of 203,000 NHS employees. They show how the NHS is achieving against the four pledges of what staff should expect from their employers in the NHS Constitution. 79 per cent of staff were satisfied with the support they received from colleagues, but only 41 per cent were satisfied with how their organisation values their work. Only 30 per cent of staff felt that their managers involve staff in important decisions. However two-thirds of respondents felt that care of patients was their organisation’s top priority, an improvement on the previous year. A report on Airedale’s results is included in the Board papers.

National Audit Office Report on Social Care
In a new report, the National Audit Office found that around three-quarters of the reduction in spending by local authorities has come from cuts to the amount of care provided, whilst a quarter has come through cutting costs. It warned that cuts were increasing pressure on other parts of the system, such as the NHS and accident and emergency, however the government was unclear on how these pressures would be absorbed. Spending on adult social care fell by 8 per cent in real terms over the three years, with “older adults aged 65 and over (having) experienced the greater reduction, 12 per cent in real terms”, the report stated. The NAO concluded that while spending on social care was failing, the demand for care was rising.

NHS Confederation Ripping off the sticking plaster
The NHS Confederation’s Urgent and Emergency Care Forum has called for an end to ‘sticking plaster solutions’ to urgent and emergency care, and put forward a package of practical recommendations to reduce pressures on services. Ripping off the sticking plaster – a response to Sir Bruce Keogh’s review of urgent and emergency care – argues that redesigning services around patients in the community and having staff who can make crucial clinical decisions to keep people at home are vital measures to be explored. Airedale’s collaborative care team and ambulatory care model feature as a case study in the report.

The report welcomes Sir Bruce Keogh’s review and makes recommendations on its implementation that broadly fall into three areas:

- **Access to urgent and emergency care**: The NHS should not simply label patients’ decisions about where they access services as wrong. Instead, more needs to be done across the whole NHS to enable better access to care. This means a move towards a clear single point of access for urgent and emergency care, with a consistent triage to ensure people with physical and mental health
needs are supported into the best part of the system to meet their needs. For example, this could be realised by more widespread use of co-located urgent and emergency care services on a single site, particularly in urban areas, as well as community alternatives to A&E, and improved online access to NHS 111.

- **Getting the best from staff:** Having staff with the right skills is crucial to providing care in the right parts of the system. Staff should be empowered to decide whether a patient should be treated in an emergency department or elsewhere. The NHS must also improve training and investment in its staff to ensure services are fit for the future. For example, the report encourages the development of more community-based ambulance services, through enhancing paramedic practitioner roles. The report also recommends greater clinical engagement and interaction with NHS 111 in the next phase of its development.

- **Emergency care networks:** While the report welcomes Sir Bruce Keogh's proposals on the development of emergency care networks, it says NHS England should avoid being prescriptive and must allow local areas the freedom to establish networks suitable for their population needs.

**Royal College of Nursing *Frontline First***
The Royal College of Nursing (RCN) has published a report, *Frontline First*, which raises concerns about falling numbers of senior nurses. Ministers say hospitals have hired thousands of nurses over the past year in response to the public inquiry into Mid Staffordshire, but the RCN says new recruits have been mainly junior staff. The number of senior posts last September was almost 4,000 lower than in April 2010.

### 1.3 Consultations

**Department of Health on new criminal offence if wilful neglect**
The Department of Health is consulting on proposals for a new criminal offence of wilful neglect to be extended across all formal health care settings. In the proposals individuals could face up to five years imprisonment and/or £5,000 in fines for neglect or ill-treatment of patients. The organisations that employ them could face far stiffer financial penalties. It estimates that up to 240 prosecutions a year could occur.

The recommendation came from an advisory group chaired by Don Berwick, an international expert on patient safety, after Robert Francis’s verdict on Mid Staffs. But ministers believe it should apply far more widely, including in private hospitals, nursing homes – whether they be under NHS, local authority or private management – and in the voluntary sector.

**Monitor and NHS England on new NHS payment system**

Having published the national tariff for 2014/15, Monitor and NHS England have turned to potential improvements to the payment system in 2015/16 and beyond. In particular, they are considering what changes to the national tariff will support new patterns of care and, at the same time, help the NHS to meet the expected financial challenge of 2015/16 and make best use of the Better Care Fund.

Their proposed aim for the 2015/16 national tariff is that it should contain national prices, payment rules and incentives that promote changes to patterns of care in all
local health economies. Their starting point is to consider how to allocate financial risk optimally across the sector. They believe that risk should reside with those organisations best placed to manage it, so they plan to develop proposals for sharing risk differently both between providers and commissioners and among providers. They have developed an initial set of hypotheses that they will be testing with evidence and feedback from the sector.

1.4 In the news

Final words from outgoing NHS Chief Executive, Sir David Nicholson
Throughout this month the national and professional media have featured interviews with Sir David Nicholson who retires at the end of the month.

- Speaking to the Sunday Times, Mr Nicholson outlined a six-point action plan to prevent the decline of the NHS which includes enhanced primary care and more GPs, integrating health and social care and closing accident and emergencies to create specialist trauma centres. He also believes that an NHS which is free at the point of need is still sustainable provided that the changes are made.

- In an interview with the Guardian Mr Nicholson warned that billions of extra funding will be needed for the NHS to help push through “painful and unprecedented” changes during the next parliament, arguing that it could not survive if it had to remain facing austerity-era flat budgets after 2015. He said the NHS needed to be allowed to ditch its outmoded reliance on hospital-based treatment and switch to a new model of community-based care. He warned that hospital services would also have to be centralised on a huge scale, while GP surgeries needed to give up their role as the NHS’s equivalent of “corner shops”. Nicholson added that in future there needed to be no more than 40-70 major centres of A&E care while the number of organisations providing specialist services such as cardiac care and transplantation had to shrink from 300 to 15-30.

- Speaking at the Health and Care Innovation Expo in Manchester Mr Nicholson said he regretted not intervening properly when concerns about Stafford hospital emerged and was wrong not to meet relatives of patients who received poor care there. Addressing the NHS’s future sustainability in the face of rising demand for care but tight budgets, Nicholson called for hospital funding to be slashed and instead used to provide medical care closer to patients’ homes. He urged politicians to stop adopting short-term approaches to the NHS and be prepared to defend the greater centralisation of hospital services.

CQC Chair on failing Trusts
By the time the CQC finishes inspecting the acute sector under its new regime up to 30 hospitals trusts could have been placed into special measures, according to CQC chair David Prior. In an interview in the HSJ Mr Prior also endorsed drafting in successful operators of foreign (EU and American) hospital chains to turn around failing NHS organisations through long-term management contracts with hospital assets staying within the NHS and providers operating within the same rules as the rest of the NHS. He cited Circle’s 10 year franchise to operate Hitchinbrook as a potential model and asking successful NHS providers to take on poorly performing hospitals. This follows last months announcement by Jeremy Hunt that he had appointed David Dalton to lead a review of feasibility of hospital Chains in NHS.
Hunt orders NHS to cut night bed moves
The Times reports that Sir Bruce Keogh, medical director of NHS England, is to instruct hospital trusts to stop patient transfers that are not carried out to improve care, after Health Secretary Jeremy Hunt pledged to reduce the number of patients moved around hospitals at night. Mr Hunt maintained that patients “should only be moved between wards at night for clinical reasons”.

NHS England on Care.data
National media interest in the Care.data controversy continues following the pause of the national launch last month. Tim Kelsey from NHS England has indicated he is now considering looking at moving to a system where patients opt in rather than opt out following feedback from patient groups. There is also widespread coverage of an announcement by health secretary Jeremy Hunt that patient information collected under the care.data programme will not be allowed to be sold for commercial insurance purposes, or in circumstances without a clear health or care benefit.

NHS England Executive Team Changes
There has been extensive media interest in changes in the Executive structure at NHS England following the announcement that Joanne Wass, Director of HR and OD and Bill McCarthy, Director of Policy are to leave to pursue careers in the University sector. Simon Stevens, the incoming Chief Executive has announced he is restructuring and has made his first appointment, Karen Wheeler from the Department of Health, who joins as Director of Transformation and Change and will pick up the majority of Jo and Bill’s portfolios.

Ehealth Insider on Digital Maturity Review
eHI have just published the results of their recent digital maturity review across all NHS Trusts. Airedale currently ranked 27th out of 160 which is very encouraging.
SL/jp

28 February 2014

Councillor David Green
Chair - Health and Wellbeing Board
City of Bradford Metropolitan District Council
City Hall
Centenary Square
BRADFORD
BD1 1HY

Dear David

NHS Provider Contribution to future working of the Health and Wellbeing Board

Twelve months into the operation of the Health and Wellbeing Board, we welcome the opportunity to review the terms of reference and, therefore, the working arrangements and future direction of the Board. We are pleased to be given the chance to contribute to that review from the perspective of NHS providers. From a wider point of view, it is clear that there is general agreement about the value and potential of the Board as a means of bringing together the major local partners that are responsible for addressing the health and wellbeing needs of the local population. However, the national evidence would suggest that Boards need to be clear about what they want to achieve, and there are tensions between their role of overseeing commissioning and in promoting integration across public health, local government, the local NHS and the Third Sector.

The King's Fund review one year on indicates that there is little sign yet that Boards have begun to grapple with the immediate and urgent strategic challenges facing their local health and care system. Health and Wellbeing Boards have been borne out of substantial changes in the way the NHS operates and within a climate of substantial economic challenge for public services generally. For us, it is clear that the primary purpose of our local Health and Wellbeing Board is not to directly manage the commissioning activities of health and social care; rather it is to establish a strategic framework in which resources from across all organisational boundaries are applied to the outcomes identified in the Health and Wellbeing Strategy. We believe that this will be best achieved through using skills in influencing and relationship-building rather than formal managerial control and accountabilities.

The review of the terms of reference provides the opportunity to deliver strong, credible and shared leadership across all local organisational boundaries. It is within this context that we believe the exclusion of NHS providers has the potential to undermine integrated working. Systems leadership in the 'new world' is a much more complex process where there is a requirement for NHS providers to collaborate and demonstrate new partnerships and approaches to best use of their resources. All NHS providers are crucial to promoting integration across the local health and social care economy. We believe that it is essential that all three local NHS providers are involved in the establishment of a renewed principle of the Health and Wellbeing Board to influence and lead across organisational and professional boundaries. From this perspective, we see it will be difficult to suggest that a single NHS provider can represent all three providers. We do not believe the opportunity to re-focus the Health and Wellbeing Board is about hearing a representative NHS provider voice: it is about actively building a framework for systems leadership that equally involves all three significant providers and employers within the local economy.

Chair: Michael Smith
Chief Executive: Simon Large

You and Your Care
The Health and Wellbeing Board tends to focus on integrated services as they relate to the council rather than the whole system, and the challenges therein. Of course, integration as a concept and practical application is equally about changes across health acute and specialist provision, both in physical and mental health and also the consideration of primary, secondary and tertiary infrastructures.

Nationally, of the 158 Health and Wellbeing Boards, 25% have achieved a working arrangement whereby the local NHS providers are core members and, for many of the remaining, there is a forward programme of regular provider summits and stakeholder events. It is possible to incorporate NHS providers into the direct workings of the Health and Wellbeing Board.

As a health and social care system, we are just beginning to understand the challenge we face locally. A review of the Health and Wellbeing Board’s terms of reference is an opportunity to fundamentally review the working arrangements and not just to ‘tinker at the edges’. The roles and responsibilities of different national and local organisations have become more complex as a result of the Government’s reforms and the need for local mechanisms for full partnership and coordination has never been greater. We hope that the Health and Wellbeing Board sees the opportunity for a systems leadership framework which involves all the key partners.

Yours sincerely

Simon Large  
Chief Executive  
Bradford District Care Trust

Bryan Millar  
Chief Executive  
Bradford Teaching Hospitals NHS FT

Bridget Fletcher  
Chief Executive  
Airedale NHS FT

cc Tony Reeves Chair – Integration and Change Board
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

This agreement sets out the specific system changes that need to be implemented across the health and care economy over the next 2 years. Integrated care provides a significant contribution to the transformation of the whole system in Bradford and the reduction of demand and associated costs to the health and care economy.

Author: Cath Doman on behalf of the Integration and Change Board
3/11/2014
Final Board version
Members of the Integration and Change Board support and will work towards achieving the ambitions and pace set out in this agreement

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Chief Officer</th>
<th>Signature</th>
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<tbody>
<tr>
<td>Airedale NHS Foundation Trust</td>
<td>Bridget Fletcher, Chief Executive</td>
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<tr>
<td>Bradford District Care Trust</td>
<td>Simon Large, Chief Executive</td>
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<tr>
<td>Bradford Health and Wellbeing Board</td>
<td>Cllr Green, Leader of the Council</td>
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<tr>
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<td>Bryan Millar, Chief Executive</td>
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<tr>
<td>City of Bradford Metropolitan District Council</td>
<td>Tony Reeves, Chief Executive and Chair of the Integration and Change Board</td>
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<td></td>
<td>Janice Simpson, Strategic Director - Adult &amp; Community Services</td>
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<td>Michael Jameson, Strategic Director of Children’s Services</td>
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<td>Anita Parkin, Director of Public Health</td>
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<tr>
<td>NHS Airedale, Wharfedale and Craven City Clinical Commissioning Group</td>
<td>Dr Phil Pue, Clinical Chief Officer</td>
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<td>NHS Bradford City Clinical Commissioning Group</td>
<td>Helen Hirst, Chief Officer</td>
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<td>NHS Bradford Districts Clinical Commissioning Group</td>
<td>Richard Flinton, Chief Executive Officer</td>
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<tr>
<td>North Yorkshire County Council</td>
<td>Richard Webb, Corporate Director Health and Adult Services</td>
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<td></td>
<td>Pete Dwyer　Corporate director - Children and Young People’s Services</td>
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Better for Bradford, Airedale, Wharfedale and Craven: right care, right place, first time.

1. Introduction

Health and care services across Bradford, Airedale, Wharfedale and Craven are engaged in a well-established programme of working collaboratively as partners in care to integrate care services as the primary mechanism for reducing avoidable demand on the system through increasing planned and self-care in the community. Care closer to home will be the default service offer across the health and social care economy.

We already have agreement on the vision for the future model of service delivery in the Programme Definition Document (PDD) agreed by the Integration and Change Board’s predecessor, the Transformation and Change Board, in May 2012. This document therefore does not repeat the content of the PDD, but uses it as the foundation to establish an agreement between commissioners and providers within the local health and care economy as to the specific changes that now need to be implemented.

This is the agreement across the health and care economy which provides clarity about the specific changes required and therefore gives permission to all managers and staff to proceed in implementing change.

2. What this document is for

This is an agreement of an approach that sets out how the Integration and Change Board’s vision for the health and care economy in Bradford, Airedale, Wharfedale and Craven will be delivered. This needs to take place within the next five years, with the majority of delivery taking place within 2014/15 and 2015/16 in line with organisations’ 2 year plans.

Collectively, the Integration and Change Board has the responsibility to deliver change within the local health and care system and has the power to achieve the required changes.

The changes described are what ICB understand to be the right approach at this point in time. As we implement integrated care and understand more fully the financial challenge and its solutions, targets and deliverables will be refined and become clearer. This document gives us a starting point and clarity over direction of travel that we can all work together to move towards.

This agreement is intended to signal a next step in our commitment to patient centred integration with aspirational targets for change.

The Integration and Change Board agree to work together to deliver the ambitions described which will contribute to achieving better health outcomes for Bradford citizens.

The ICB have agreed a set of principles under which they will operate and work together:

- Working better together is first and foremost about what is best to add value for the people we care for
- We will improve the quality of care and support available
- We will look for improvement through the eyes of the people we care for and the staff providing the care
There will be no blame or scape-goating of or by individual organisations – we’re in this together, working as a whole system

We will continue to create a culture of trust, openess and transparency, including demonstrating a collective stewardship of resources

We will put the interests of the people we serve ahead those of our individual organisations

We will share our learning from working together with one another, and others as well as learning from elsewhere and will share our learning more widely

We will build on existing work that has established strong foundations for integration e.g. Airedale and Craven Collaborative Care Teams, Bradford Virtual Ward, Integrated Care test-sites

We will collectively agree our future priorities as a whole system

We will adopt a positive mind-set – ‘we can, we will’

Our clinicians, social care professionals, managers and others will work together to make change happen

We commit to working at pace, to achieve rapid progress, make decisions and see them through

3. Preceding contextual documents

This agreement is the final of a suite of three, the preceding documents being:

1. The Journey to Integration (2011) sets out a health and care economy commitment to integrate services and was agreed by the Transformation and Change Board

2. The Integrated Care for Adults Programme Definition Document (May 2012) sets out the detailed model for integrating care and increasing the capacity and capability of community services to support more people with more complex conditions at home.

The PDD was supported by a case for change for each of Airedale, Wharfedale and Craven and for Bradford.

- The case for change (Airedale, Wharfedale and Craven) January 2013
- The case for change (Bradford) January 2013

These documents use health economy and demographic data to quantify the potential to avoid unplanned admissions to secondary care in three key areas:

i. People with long-term conditions
ii. Ambulatory sensitive care conditions
iii. Cases that could be treated in primary care

This document builds on its predecessors; so much of the detailed narrative is now omitted. The aim of this document is to make explicit the specific transformational changes that partners responsible for the delivery of health and care services in Bradford, Airedale, Wharfedale and Craven have agreed to implement.

The other important document to recognise is the multi-agency bid to become health and social care integration Pioneers. Although the application was unsuccessful, ICB’s commitment to deliver the model of integrated care described in the bid, at scale and pace, remains undimmed.
4. The financial challenge to the local health and care economy

The estimated funding deficit in the health and care economy in Bradford is c. £243m by 2018/19. This is based on a combination of commissioner and provider cash-releasing efficiencies of at least 4% per annum for the next 5 years.

There is an increasing recognition that health and social care organisations will need to work together if savings of this magnitude are to be delivered in a sustainable way, given that many of the easier cost savings have been achieved. This presents an unprecedented challenge to the health and care economy and necessitates a radical approach to transforming service delivery in the very near future.

N.B: The programmes of integrating and transforming care described in this document cannot release the totality of the savings above alone. They will make a contribution to it however the extent of that contribution is yet to be defined and is subject to detailed and rigorous financial analysis and economic modelling led by the Directors of Finance.

5. The quality challenge to the local health and care economy

Recent publications around quality of care - including The Public Inquiry into the failings at Mid Staffordshire NHS Foundation Trust (Robert Francis, 2013), the review into the quality of care and treatment provided by 14 hospital trusts in England: overview report (Sir Bruce Keogh, 2013) and ‘A promise to learn – a commitment to act’ (Professor Don Berwick, 2013) emphasise the importance of high quality care for all and that poor care must not be tolerated. It is therefore imperative that the quality of care is a primary driver of the Integrated Care for Adults programme.

Integrated care and care closer to home will enable patients to have more choice about where they receive treatment and allow them to remain as independent as possible in their own homes for as long as possible. Integrated care is essential to meet the needs of the ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives.

The programme will enhance the quality of care people receive and improve overall quality of life as well. Integrated care must reduce duplication for people receiving care and provide increased continuity which leading to an improved patient experience which is an important aspect of high quality care. For patients with highly complex needs it is imperative that they have a named case manager (Lead Practitioner) responsible for co-ordinating care and that there is a shared and agreed plan of care. This will ensure care is coordinated, joined up and seamless for the patient and should help improve patient experience.

High quality care is also about ensuring care is safe and effective. Integrated care will deliver this by involving the person and carers/relatives in all that is done. The person will be central to their plan of care and will be assessed and treated in a holistic manner. This will ensure the patient is treated in the most effective way by the relevant health and social care professionals and this care will be frequently re-assessed by the multi disciplinary team.
6. Transforming care
There are two primary objectives to the Integrated Care programme, both delivered in the context of the financial challenge and need to maintain the quality and safely of care:

1. Improving the quality of care and experience of care by joining up health and care services around the needs of the person

   This will drive efficiency by having joint roles, working in an integrated system supported by an infrastructure that reduces duplication:
   - hybrid workers
   - coordination of care across health and social care
   - IT that enables joined up care
   - Integrated assessment of people’s needs, triage and referral/dispatch of the right service first time

2. Delivering as much care as is safe and feasible as close to home as possible. This will mean building both the capacity and capability of community services so that community-based services become a genuine and viable alternative to unplanned hospital admission or long-term care.

   The benefits are fiscal savings to be achieved through:
   - reducing non elective hospital admissions
   - reducing placements to nursing and residential care homes
   - reducing the number of A&E attendances
   - reducing the number of days people stay in hospital

We will work together to deliver these objectives, by putting the following in place:

<table>
<thead>
<tr>
<th>Ambitions set out in the Programme Definition Document</th>
<th>How we will deliver this</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Commissioning, procurement and payment models that enable integrated care to be delivered</td>
<td>1.1 Joint commissioning of voluntary and community sector services led by CBMDC as a core part of the regeneration strategy.</td>
<td>CCGs and LA</td>
<td>15/16</td>
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<td></td>
<td>1.2 Develop the business case for 7 day services to understand the benefits and return on investment</td>
<td>CCGs and LA</td>
<td>14/15</td>
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<td></td>
<td>1.3 Deploy new approaches to whole system commissioning e.g. prime contractor models that facilitate both horizontal and vertical integrated care delivery</td>
<td>CCGs and LA</td>
<td>14/15</td>
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<td></td>
<td>1.4 Develop community services strategies which identify and specify opportunities to support the shift of appropriate hospital-based services to delivery in the community</td>
<td>CCGs</td>
<td>14/15</td>
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<td></td>
<td>1.5 Develop payment models that enable and incentivise integrated care delivery and which operate across sectors following the needs of the patient, e.g. payment for an episode that includes acute, intermediate, community and social care</td>
<td>CCGs</td>
<td>14/15</td>
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<td></td>
<td>1.6 Shift funding around system from hospital to community-based services as patterns of demand change to create community-based capacity and capability to deliver more care at home and create savings from avoided high cost services</td>
<td>CCGs</td>
<td>15/16</td>
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<td></td>
<td>1.7 Establish the evidence base for integrated care locally and receive assurance regarding its impact by commissioning an external evaluation</td>
<td>TIG /CCGs/LA</td>
<td>14/15 – 15/16</td>
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<tr>
<td>Ambitions set out in the Programme Definition Document</td>
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<td>1.8 Understand how to delegate combined NHS and care budgets as close to local communities as possible. Establish indicative health and care budgets delegated to each Integrated Community Team providing the manager/local leadership team with the autonomy to deliver services in ways that achieve the right health and care outcomes for the community.</td>
<td></td>
<td>CCGs/LA</td>
<td>15/16</td>
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<tr>
<td>1.9 As part of the development of CCG-specific community services strategies, review of the services transferred to BTHFT under Transforming Community Services to consider whether the services fit in with the overall strategy for integration of health and social care.</td>
<td></td>
<td>DOFs</td>
<td>14/15</td>
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<tr>
<td>1.10 Establishment of Community Services/Integrated care Service Development Groups across all providers to deliver community strategies.</td>
<td></td>
<td>CCGs</td>
<td>By April ’14</td>
</tr>
<tr>
<td>1.11 Re-procurement against new community services specifications to enable integrated and community-based care in the context of the financial challenge.</td>
<td></td>
<td>CCGs</td>
<td>Anticipated from Spring ’15</td>
</tr>
<tr>
<td>1.12 Work collaboratively to overcome the challenges of payment mechanisms and competition between providers</td>
<td></td>
<td>DOFs</td>
<td>14/15 - 15/16</td>
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<tr>
<td>1.13 Detailed economic modelling to be undertaken to scope the scale of the changes required, and to fully understand the system and financial changes that are required to respond to the economic challenge, including the costs and investments required to achieve long-term sustainability.</td>
<td></td>
<td>DOFs/external consultancy</td>
<td>December ’14</td>
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<td>1.14 Development of Better Care Fund proposals that align with and support the delivery of the Integration and Change agenda</td>
<td></td>
<td>CCGs/LA</td>
<td>April ’14</td>
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<td>1.15 Understand other influences that will have a bearing on the aspirations for integration and change shared by partners, e.g. specialised commissioning and urgent care strategies</td>
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<td>CCGs</td>
<td>14/15</td>
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<td>2 Know the population well and respond proactively</td>
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<td>2.1 Develop community profiles to provide a clear understanding of the total resources and community assets within each of the 21 communities to enable integrated services to be tailored to meet local need</td>
<td></td>
<td>CBMDC Public Health</td>
<td>14/15</td>
</tr>
<tr>
<td>2.2 Predictive Risk stratification embedded in all general practices and used to proactively identify people before their need becomes urgent</td>
<td></td>
<td>All</td>
<td>14/15 - 15/16</td>
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<tr>
<td>2.3 Develop predictive risk stratifications to provide real-time information and to include all-age and social care data to create a richer resource better able to predict and proactively manage need</td>
<td></td>
<td>CCGs via CSU, LA</td>
<td>14/15</td>
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<tr>
<td>2.4 Sharing practitioner intelligence and local knowledge by working together, shared records and co-location</td>
<td></td>
<td>Providers NHSPS</td>
<td>14/15 – 15/16</td>
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<td>2.5 Focus our attention on vulnerable families and communities in an integrated way and how best to support them</td>
<td></td>
<td>All</td>
<td>14/15 – 15/16</td>
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<td>3 Co-production with service users and communication in general</td>
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<tr>
<td>3.1 Establish deep involvement of the public and service users in changes to the way we deliver services locally</td>
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<td>All</td>
<td>14/15</td>
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<tr>
<td>3.2 Communications are proactively managed and coordinated across agencies to provide a consistent and managed message to all stakeholders</td>
<td></td>
<td>All</td>
<td>14/15 – 15/16</td>
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<tr>
<td>3.3 Work well with the media and manage the relationship successfully</td>
<td></td>
<td>All</td>
<td>14/15 – 15/16</td>
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<tr>
<td>Ambitions set out in the Programme Definition Document</td>
<td>How we will deliver this</td>
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</table>
| 4 Work together as a single, coordinated service       | 4.1 Integrated Community Teams:  
• The delivery of health and care services for each of the 21 communities will be through Integrated Community Teams  
• Organisational boundaries are non-existent with pathways of care offered seamlessly  
• The ICTs will work together to maximise their impact for the local population.  
• ICTs will ultimately cover all ages, but commencing with adults  
• ICTs will have a skill mix appropriate to the needs of the local population with providers working together to deliver this. The skill mix may vary from community to community  
• The ICTs’ workforce will be configured to deliver person-centred support  
• Generic support workers/new types of worker will be developed to drive up the efficiently and quality of care. Varying terms and conditions will need to be addressed and value for money assured  
• Opportunities for role blurring and skill sharing will be optimised across professional boundaries, whilst preserving the relevant unique skills offers by different professional groups  
• As services move closer to people’s homes, some staff traditionally based in hospitals will move to community settings  
• Increase social care capacity in social work, occupational therapy and support staff, strengthening their impact in integrated community teams  
• Strengthen the impact of the Third Sector including improving the efficacy of engagement mechanisms  
• Establish the new function of Lead Practitioner to provide care coordination/case management for complex cases  
• As services operate together as a single service, there will be parity in the ability of organisations’ to access each other’s services to establish care packages | All | 14/15-15/16 |
| 4.2 Management and leadership of Integrated Community Teams:  
• Each ICT will be led by a manager/leadership team appointed by the system, with delegated authority from each of the contributing provider organisations to operationally manage their staff and resources as a single resource  
• The manager/leadership team will be responsible for the delivery of health and care services for the local population  
• The manager/leadership team will hold and manage the local integrated health and care pooled budget  
• Governance arrangements will be established to ensure that the requirements and duties of the partner organisations are upheld | All | 14/15-15/16 |
<p>| 4.3 GPs and practice nursing are central to Integrated Community Teams and will work as integral parts of the ICTs | CCGs | 14/15 |</p>
<table>
<thead>
<tr>
<th>Ambitions set out in the Programme Definition Document</th>
<th>How we will deliver this</th>
<th>Who</th>
<th>When</th>
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</thead>
</table>
| 4.4 Workforce planning will be undertaken across whole system, so that changes can be planned strategically, e.g.:  
• Development of new types of worker  
• Capacity management  
• Succession planning  
• Influencing Higher Education Institutes | All | 14/15 – 15/16 |
| 5 Deliver care as close to home as is feasible and safe | 5.1 Commissioners and hospital trusts identify secondary care services capable of being delivered in the community that have a significant role in avoiding planned or unplanned admissions. Develop the business case and economic model, understanding the investment/double running costs to achieve the long-term ambitions. | CCGs, BTHFT & ANHSFT | 14/15- 15/16 |
| | 5.2 Increased access to community-based step-up services to prevent non-elective admissions | BTHFT & ANHSFT | 14/15- 15/16 |
| | 5.3 Establish new ways of working in secondary care (in partnership with community and primary care services) that optimise care outside of hospital, e.g. virtual ward approaches in medicine, surgery, paediatrics, diagnostics | BTHFT & ANHSFT Community services | 14/15- 15/16 |
| | 5.4 Adjust bed base as services move to community/home-based settings | CCGs, BTHFT & ANHSFT | 14/15 – 15/16 |
| | 5.5 Develop models of care that reduce the gap between primary and secondary care | CCGs, primary care, ANHSFT, BTHFT | 14/15 – 15-16 |
| 6 Intermediate care and rehabilitation services: optimise people’s independence, health and wellbeing through person-centred services and self-care | 6.1 Ensure access to intermediate care services for people with mental health problems, learning disability, younger people with physical impairments | All | 14/15-15/16 |
| | 6.2 Establish an expanded intermediate care virtual ward in Bradford and expand ACCT/CCT in AWC:  
  a) Short-term: non-recurrent funding to March ’15  
  b) Long-term: reinvestment of savings from avoided admissions, long-term care placements and reduced demand on secondary care | CCGs/BTHFT/LA | March 2013 |
<p>| | 6.3 Significant growth in the availability of step-up care to strengthen its impact on preventing avoidable admissions. Step-up care will be a major function of intermediate care services. | CCGs, BTHFT, ANHSFT, LA | March 2015 |
| | 6.4 Day assessment and rehabilitation: review to understand the value that this adds to community-based rehabilitation. Development of a coordinated approach to outpatients/day assessment for frail older people working with ICTs to provide rapid assessment and care planning facilitating care at home and avoiding admissions wherever safe. Learn from Child Development Centre model | CCGs, LA, BTHFT, ANHSFT | 14/15 – 15/16 |
| | 6.5 Complete the analysis to understand the total number of secondary care and intermediate care (NHS and LA) beds required for the new model of service delivery, taking into account new ways of working and demographic shifts | CBMDC PH | Mar ’14 |</p>
<table>
<thead>
<tr>
<th>Ambitions set out in the Programme Definition Document</th>
<th>How we will deliver this</th>
<th>Who</th>
<th>When</th>
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<tbody>
<tr>
<td>6.6 Commission joint health and social care intermediate care beds with integrated functions and an explicit focus on rehabilitation and reablement as part of the local solution to keeping people in their own community and avoiding unnecessary admission to care or hospital, incorporating day rehabilitation where needed</td>
<td>CCGs/LA</td>
<td>14/15 – 15/16</td>
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<tr>
<td>6.7 Self-care: Patients and service users are in charge of their care and are empowered to make good decisions and engage in self care. Expectations are clear for everyone about what is possible to support independence and wellbeing - Core to regeneration and capacity building in Bradford - CBMDC to lead development of self-care strategy new approaches to enabling self-care in primary care -patient-held records as default -Develop the role of the Third Sector in a co-produced system -Challenge all service models for their ability to support self-care</td>
<td>CBMDC, CCGs, LMC</td>
<td>14/15</td>
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<tr>
<td>7 Be safe, responsive and reliable</td>
<td>7.1 A 24/7 integrated care system operating across primary, secondary, community health, social care and the third sector capable of responding in a timely way</td>
<td>All</td>
<td>By end 15/16</td>
</tr>
<tr>
<td></td>
<td>7.2 Rapid access to community-based diagnostics and geriatrician assessment, speeding up access to clinical assessment using virtual ward approaches to avoid admit to assess approaches (see 6.4)</td>
<td>CCGs/BTHFT/ANHSFT</td>
<td>By end 14/15</td>
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<tr>
<td></td>
<td>7.3 7 day working for appropriate community and secondary care services to ensure: a) safe community-based services that are a viable alternative to secondary or long-term care b) Rehabilitation, assessment and discharge planning continue over the weekend</td>
<td>All</td>
<td>By end 15/16</td>
</tr>
<tr>
<td></td>
<td>7.4 Align YAS, 111 and GP out of hours services including digital record systems</td>
<td>CCGs, YAS, LAT</td>
<td>By end 15/16</td>
</tr>
<tr>
<td></td>
<td>7.1 Establish an integrated system of regulation and governance for integrated care services to ensure that organisations are supported to work together safely, including clear medical responsibility</td>
<td>All</td>
<td>By end 14/15</td>
</tr>
<tr>
<td>8 Systems and infrastructure that enable integrated care and the move to a digital health economy</td>
<td>8.1 Embed assistive technology as part of the solution (telehealth, telecare, community equipment services etc)</td>
<td>All</td>
<td>By end 15/16</td>
</tr>
<tr>
<td></td>
<td>8.2 Proactive use of information and data to pre-empt need and have the right infrastructure to share information easily and safely across key stakeholders</td>
<td>All</td>
<td>By end 15/16</td>
</tr>
<tr>
<td></td>
<td>8.3 Establish a single, coordinated assessment process</td>
<td>All</td>
<td>By end 14/15</td>
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<td></td>
<td>8.4 Implement a single, coordinated and case-managed care plan for people requiring support from two or more services</td>
<td>All</td>
<td>By end 14/15</td>
</tr>
<tr>
<td></td>
<td>8.5 Establishment of an Integrated Digital Care Record across social care and NHS services including ambulance and out of hours services</td>
<td>ICDR Programme Board</td>
<td>April ’15</td>
</tr>
<tr>
<td>Ambitions set out in the Programme Definition Document</td>
<td>How we will deliver this</td>
<td>Who</td>
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<tr>
<td>8.6 The NHS number will be used as unique patient identifier across</td>
<td>ICDR Programme Board</td>
<td>April ’15</td>
<td></td>
</tr>
<tr>
<td>8.7 Estate to be managed and deployed as a collective resource to optimize efficient use, enabling co-location of services and enabling the establishment of Integrated Community Teams in the 21 communities</td>
<td>All + NHSPS</td>
<td>14/15 – 15/16</td>
<td></td>
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<tr>
<td>8.8 Establish the minimum amount of access routes into integrated services with providers working together to achieve this</td>
<td>LA lead. BTHFT, ANHSFT, BDCT,</td>
<td>14/15</td>
<td></td>
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<tr>
<td>9</td>
<td>Expand integrated care to include children’s services</td>
<td>9.1 Apply this framework for integration across the whole spectrum of children’s services, building on work already in development in response to the Children and Families Bill.</td>
<td>LA lead. CCGs BTHFT, ANHSFT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9.2 The ambition is to incorporate the wide array of children’s health and care services into this model or Integrated Community teams, including Education Services, Early Years service, Youth Services etc. to achieve integrated all-age services for each community. Timescales are likely to be longer and the detail of the model applies to children’s health and care services needs to be worked up and agreed. There are likely to be earlier opportunities for the Children with Special Educational Needs and disabilities to integrate into the Integrated Community Teams model.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Expand integrated care to include universal services e.g. police</td>
<td>10.1 Harness the intelligence gathered by the police, fire service and other agencies that have high volume of visits to the homes of vulnerable people and families. They have a significant potential to identify risk in those people that possibly not yet known to health or social care services and work in a more integrated way with health and care services.</td>
<td>LA lead. Police NHS services</td>
</tr>
</tbody>
</table>
7 ICB recognise, accept and will manage the following consequences of integrating care services

Potential consequences for the existing system:
- Changes to the provider landscape
- Fewer community hospital/local authority intermediate care beds
- Staff working in multi-professional and multi-agency teams
- Reduction in the need for growth in hospital beds as services as capacity grows in the community
- Staff working to managers not within their own organisations
- Staff working alongside colleagues from a range of organisations
- Staff working across services (e.g. geriatricians)
- Changes to policy, systems and processes
- Increased skill sharing across professional groups

People using health and care services in Bradford, Airedale, Wharfedale and Craven can expect:
- Nothing about me, without me
- Person-centred care
- A rapid and timely response
- Proportionate, coordinated assessments
- Coordinated care designed to meet their goals
- Care provided at home or closer to home
- Reduced exacerbations of long-term conditions
- Reduced avoidable hospital admissions
- Regaining and retaining health, wellbeing and independence for longer
- A reduction in premature admission to long-term care
- Reduced dependence on NHS and social care services
- They do not experience being passed between services or being excluded from locality-based service delivery because of arbitrary and exclusive criteria
- Support to self-care
- The right care in the right place at the right time
8. Aspirational deliverables

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<th>Deliverable</th>
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| 1 | A reduction in avoidable non-elective admissions  
(Avoidable emergency admissions (composite measure – BCF metric))                                                                 |
| 2 | A reduction in avoidable re-admissions                                                                                                      |
| 3 | A reduction in permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population (BCF metric) |
| 4 | A reduction in continuing healthcare packages as more people are enabled to be less dependent                                                    |
| 5 | A reduction in long-term social care packages as more people are enabled to be less dependent (relative size and overall numbers)               |
| 6 | A reduction in ambulance call outs, for example for falls or other conditions that can successfully be managed at home                           |
| 7 | An increase in the availability of step-up care as a proportion of all intermediate care                                                     |
| 8 | An increase in the availability of care at home                                                                                                |
| 9 | An increase in the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (BCF metric) |
|10 | An increase in the availability of services to support therapy, rehabilitation and reablement                                                  |
|11 | A reduction in delayed transfers of care from hospital per 100,000 population (average per month) (BCF metric)                                  |
|12 | An improvement in patient/service user experience (BCF metric)                                                                               |
|13 | A reduction in the total cost of estate                                                                                                       |

A critical part of refining and agreeing the programme deliverables is to understand the current baseline, establish jointly-owned targets and understand their fiscal consequences. This will enable ICB to recognise the contribution to the total financial challenge that the integration and change agenda will make.
Appendix 1: Describing the operational delivery model (taken from the Programme Definition Document)

Local service delivery

Integrated care services for adults will be delivered on a locality-based system, with all services operating to common boundaries. The size of the locality in terms of population served and geography is to be determined.

GP practices will be assigned to localities, based on their geographical coverage, so that close linkages can be made between general practice and integrated locality services.

**Outcome:** geographical boundaries of localities will be set to enable patients and service users to access community services as close to home as possible

Integrated community teams:

Each community will provide access to the functions described in section 2 of this document (PDD) delivered in an integrated way by a team of staff drawn from a wide range of specialities and providers.

Each community will have a shared caseload based on proactive identification of people at risk through the use of the agreed risk stratification tool and those referred in as they are identified.

The functions provided by the teams will closely inter-relate and patients/service users may at different times, need different types of support. For example, if a person with a long-term condition has an exacerbation of his condition, needing more intensive support to bring it under control; he may need temporary support from the intermediate care function.

Services should flow around the needs of the patient, with the patient experiencing coordinated care and not in any sense feel that he is being ‘moved’ to a different team. Services should escalate and withdraw according to need. The case management function should remain a constant in any changes in the type of support received.

**Outcome:** patients and service users experience an integrated and coordinated service orientated around their whole range of needs. They will not experience being transferred from service to service.

Specialist support

There is a range of specialist support services, which by their very nature cannot be included within each locality, e.g. tissue viability, continence, adult protection. These services will continue to provide district-wide services, or for larger specialist services, they may be able to cover two or more localities.

Each locality must be clear about the pathways into specialist services.

The involvement of specialist support should also be part of the case managed support services, drawn in as necessary, with clear outcome-based objectives.

**Outcome:** Specialist practitioners, providing district wide services, will be spread amongst localities to ensure patients and service users have equitable access to specialist community services, coordinated alongside mainstream locality-based services.
Case management
All patients/service users will be case managed. There will be one person nominated for each case who takes
a lead in the coordination of the person’s care, bringing in other members of the team or specialist services as
necessary.

The appointment of the case manager [Lead Practitioner] will depend on the prevailing needs of the person
and which team member can offer the best match in terms of skills. The case management function could
therefore be undertaken by the social worker, a nurse, therapist or other member of the team.

Outcome: A case management approach will enable patient/service user experiences to have a main point
of contact and a coordinated approach to their care across mainstream and more specialist services. They
do not experience being passed from service to service.

Assessment and care planning
All patients/service users experience an integrated assessment process, with team members and external
specialists contributing to it as appropriate. This will include rapid access to clinical investigations where
indicated.

People do not experience having to repeat their story again and again.

There is a single patient/service user record and a single, common care plan oriented around achieving the
person’s goals. The plan is held and owned by the person in receipt of the service.

Outcome: All patients and service users will experience an integrated assessment process oriented around
achieving their individual health and social objectives

Coordination of the network of services
Each community will have management arrangements in place to ensure contributing services are coordinated
and delivered in an integrated way for people in the locality. These arrangements will be responsible for:
- Integrated service delivery
- service management, performance and quality
- staff performance, management, deployment, recruitment
- estate
- managing risk
- governance and regulation
- ensuring professional leadership
- financial management

These arrangements will be responsible for service delivery in the locality and will work collaboratively with
managers of staff in the originating organisations to ensure a safe and coherent approach to governance,
policy and regulatory processes.

Outcome: All contributing services from partner organisations are coordinated, organised and managed to
derive integrated services for the locality

Risk stratification/predictive tools
Through the use of risk stratification tools, each locality will have a clear assessment of need for their patch.
The team will know which patients/service users and carers are most at risk and care can therefore be planned
proactively to help minimise escalation of need.

The teams will work in partnership with practices within the locality with GPs providing clinical leadership for
patients in their care.

Outcome: Predictive risk stratification tools and techniques will provide clear information on need in each
locality to enable local integrated services to provide a proactive approach
**In-patient care**

Each community will have access to community-based in-patient intermediate care for people who need additional medical and nursing support to prevent an avoidable admission to hospital/admission to long-term care.

In-patient intermediate care will provide an amalgam of services currently provided by community hospitals and local authority intermediate care beds in recognition of the similarity of their offer and to prevent people being moved unnecessarily across the system.

The focus will be on rehabilitation and reablement, with appropriate levels of medical, therapy and nursing care.

There will be a need for sub-acute capacity. Depending on agreed levels of need, this may be able to be provided in one or two units to provide rapid access to medical assessment where this can’t be managed at home. The focus should be on step-up support, preventing avoidable, non-elective admissions.

Patients will continue to access acute care (planned or non-elective) as required and will only be supported in the community where the clinical assessment indicates that it is safe to do so.

**Outcome:** there is adequate access to community-facing bed provision enabling the system to avoid unnecessary dependence on hospital care. Community beds provide a range of services meeting the patient or service users whole range of needs.

**Links with secondary/acute care**

There will be agreed share care pathways for ambulatory care and long term conditions which indicate the appropriate level of care following patient assessment. This will mean that only patients who cannot be managed in primary or intermediate care will be admitted to hospital. Secondary care assessment and advice will be available to patients and community teams via telemedicine, phone or specialist outreach.

For patients admitted to hospital care (generally Bradford Teaching Hospitals or Airedale General Hospital, but also including patients to be repatriated from out of district hospitals), the community will work proactively with the hospital team to make arrangements for a timely and successful transfer of care back to community services.

For patients known to the Integrated Community Team, this responsibility will reside with the Lead Practitioner.

All patients discharged from hospital will have a holistic plan to reduce the risk of re-admission and optimise independence once recovered. This plan may include specialist support from the hospital, especially on relapse, in order to manage more patients at home.

For patients not known to the Integrated Community Team, the integrated, community-based delivery of community services will enable hospital services to identify and work with their community counterparts much more easily.

**Outcome:** Case managers and other staff will co-ordinate with acute services to achieve a ‘pull’ through the whole system will be evident enabling a coordinated flow of patients from acute care to home.

**General Practice**

General practice will be a central part of the Integrated Community Team. Each practice will be assigned to a community and will be able to build close relationships with the locality team. There will be absolute clarity for the referring GP where community-based support can be accessed and this will be done through a single point of access.
Medical responsibility for the care of community-based patients is as defined by the GMS, PMS and APMS contracts.

**Outcome:** general practice services are part and parcel of integrated care within the locality and there is strong clinical leadership in place to support care as close to home as possible.

### 24/7 whole system integrated care

A 24/7 Integrated care system across primary, secondary, community health and social care will be developed to ensure a comprehensive response to prevent avoidable admissions is available at throughout the day and night. This will include primary care out of hours services being more fully connected into mainstream in-hours services.

**Outcome:** The system is responsive to need whenever it occurs.

### Day care/rehabilitation

Existing day care including social care day care and day hospital will need to be reviewed as part of this programme and the added value it brings to community-based rehabilitation assessed and understood. Any future day care/day hospital services will be commissioned to deliver an integrated model across health and social care.

**Outcome:** the model of day rehabilitation and day care provides added value to integrated community services having a direct impact on the ability to support patients and service users at home.

### Staff

Each locality will have a staff skill mix made up of health, social care and the third sector staff. Staff will work together as part of a single, integrated team, regardless of the organisation they are employed by. The contract of employment remains with the original employing organisation at this stage.

Support staff will be trained to be competent in delivering generic support services across a number of functions including supporting delivery of therapy, nursing and home care tasks, reducing the number of different staff contacts for the patient/service user.

Over time, teams will be able to capitalize on skill sharing and role blurring, in recognition of shared core skills across a number of professions. This will enable staff to provide a more coordinated approach to person’s care, rather than depending on a number of different professionals being involved. An example of this is the case management function which is within the competence of most professionally trained health or social care staff.

Unique skills and competences will not be shared and staff will not be expected to undertake tasks for which they are not competent.

Opportunities for rotation of staff will be supported to enable staff to experience practice in a range of settings. This is particularly valuable for newly qualified staff, but should also be considered for more experienced staff.

Teams will be supported by appropriate levels of administration and other support functions e.g. finance, performance, IT.

**Outcome:** Integrated teams will have the appropriate skill mix to deliver community services in their locality, enabling patients and service users to regain and maintain their optimal levels of health, wellbeing and independence. Staff work together to meet the health and social care needs of the local population.
**Regulation and Governance**

Arrangements for regulation, governance and medical responsibility must be clearly established from the outset to ensure that the transition to community-based service delivery and integrated teams are safe for patients/service users and provide partner organisations with adequate protection and confidence in the new arrangements.

**Outcome:** Appropriate Regulation and Governance will provide a safe system for the delivery of integrated community services.

**Electronic Assistive technology and community equipment**

Emerging technologies such as electronic assistive technology (telecare, telehealth, telemedicine) will be part of mainstream care delivery. Core infrastructure services such as community equipment services, which provide essential elements of supporting people at home, will be able to respond to need seven days a week to prevent avoidable admissions or unnecessary dependence on care services.

**Outcome:** People are less dependent on direct interventions and are supported to take control of their own care.

**Rapid assessment and diagnosis**

There is rapid access to a range of diagnostic and assessment resources and expert opinion (personnel and equipment) to enable GPs and other practitioners to make an informed and timely decision on how and where the patient’s care needs can best be met.

**Outcome:** Unnecessary admissions to acute care are avoided and people can be supported as close to home as possible.
5 March 2014

Ms Bridget Fletcher,
Chief Executive
Airedale NHS Trust
Airedale General Hospital
Skipton Road
Steeton
Keighley
West Yorkshire
BD20 6TD

Dear Bridget

Q3 2013/14 monitoring of NHS foundation trusts

Our analysis of Q3 is now complete. Based on this work, the Trust’s current ratings are:

- Continuity of services risk rating - 4
- Governance risk rating - Green

I have attached a one page executive summary (Appendix 1) of your Trust’s Q3 results for your information and a report on the aggregate performance of the NHS foundation trust sector will shortly be available on our website (in the News, events and publications section) which I hope you will find of interest.

For your information, we issued a press release on 21 February 2014 setting out a summary of the key findings across the NHS foundation trust sector from the Q3 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 0203 747 0169 or by email (Jenna.Knight@Monitor.gov.uk).

Yours sincerely

Jenna Knight
Senior Regional Manager

cc: Mr Colin Millar, Chair
    Mr Andrew Copley, Director of Finance
### Summary Income & Cash Flow vs Plan

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Q3</th>
<th>2013/14 YTD</th>
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<td>35.9</td>
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<td>(23.4)</td>
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<tr>
<td>PFI Op. expense</td>
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<tr>
<td>All other Op. costs</td>
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<td>Net cash flow</td>
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<td>Borrowing (excluding PFI)</td>
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### Continuity of Service Risk Rating

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<td>YTD Actual:</td>
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<td>Declared Risks in Year:</td>
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<td>Breaches for Current Period:</td>
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### Summary

- The Trust has previously identified compliance with the A&E and C-Difficile performance indicators to be at risk in 2013/14. However in Q3 it met all of its performance indicators, which has led to the Trust reporting a Green GRR.

### Key risks

- Work has now commenced on the £6m A&E capital development. This is expected to take up to 12 months to complete and will, amongst other things, enable the Trust to treat more patients in a timely manner and to redesign its pathways and staffing models to fundamentally change its provision of emergency care.

### Action taken / committed

- Operational actions that the Trust has taken to mitigate the risk of failing the target include developing an A&E action plan, putting in place winter-specific actions (for example a ‘winter ward’ with an additional 30 beds), continuing the roll-out of telemedicine in care homes and strengthening its Collaborative Care Team.

### Gaps and residual concerns

- Clinical Directors from the Trust have met with local GPs to consider alternative ways of caring for patients.

### Compliance with A&E target

- At APR the Trust declared a risk to compliance with the 95% A&E target.

### Delivery of CIPs

- At Q3 the Trust delivered £3.2m (71%) of the planned £4.5m YTD CIPs target. The main area of slippage is recurrent pay costs due to operational pressures and difficulties in recruiting substantive staff.

### Sustainability

- The Trust has developed a ‘Right Care’ strategy that it believes will deliver a financially and clinically sustainable model. The transformational aspect of the strategy is to reduce to the gap between primary and secondary care, and integrate the pathway between the hospital, GP, social care and the voluntary sector. The strategy also requires greater partnership working and moving more acute care into community settings.

### Next steps

- Continue quarterly monitoring