Well Connected

The Worcestershire Integrated Care Programme

Pioneer Bid

Well Connected is a collaboration of all the main the health and social care organisations within Worcestershire to realise the vision of refocusing care from acute hospitals into the community by a process of improved integration. The initial driver to develop an Integrated Care Programme was the necessary review of acute services in Worcestershire. With the experience and corporate memories of the downgrading of Kidderminster Hospital in 2001, it was understood that to gain the consent of the public to any reconfiguration of hospital services, there had to be a new offer on the table. People would need to be persuaded that a transformational change in the way services were offered in the community would improve the quality of care and support they experienced across the health and care spectrum. A new 'contract' with residents would emphasise personal and community responsibilities in regard to their health and wellbeing and in return they would experience truly person centred, coordinated care without perceptible organisational boundaries.

The Joint Health and Wellbeing Strategy set out a vision with a greater emphasis on prevention and early help and on-going integration and improvement of the quality and value for money of health and social care services. The Integrated Care Programme, now renamed the *Well Connected* Programme, was therefore established under the auspices of a signed Memorandum of Agreement. Reporting to the Health and Well-being Board, *Well Connected* is governed by the Strategic Partnership Committee (SPC) formed by the Chief Executive Officers (CEOs) of Worcestershire Acute Hospitals NHS Trust, Worcestershire Health and Care NHS Trust, Worcestershire County Council and the Clinical Chairs and Chief Officers of the 3 Worcestershire Clinical Commissioning Groups (CCGs). There is also representation from the Voluntary and Community sector (VCS), Healthwatch and a lead County Councillor. The SPC and the programme steering group are chaired by the Director of Adult Services and Health – the Director of Public Health.

A jointly funded dedicated *Well Connected* team has been formed to provide day to day leadership and drive to the programme, improve communication, provide oversight to the current projects, identify gaps and new opportunities for integration, identify the best available evidence, analyse data to prioritise work programmes and ensure the key strategic outcomes are met.

1. Articulating a clear vision of its own innovative approaches to integrated care and support

Well Connected has a clear vision of what it wants the future care and support in Worcestershire to look like:

1. **Improve the experience of individuals, families and carers by joining up services across organisations and care settings.**
2. **Provide care and support that identifies and addresses individual needs in a whole-person approach, allowing them control and enabling them to achieve the outcomes important to them.**
3. **Investment in prediction, prevention and early intervention using the best available evidence and encouraging individuals and communities to take responsibility for their health and wellbeing.**
4. **Offer more care in community hospitals, the wider community and in people's homes, creating the capacity in the acute hospitals to maximise specialist skills for those who need it.**
5. **Improve the level of health in those communities and groups where health is poorest so that they live longer and have a better quality of life**.

The vision will cluster services around local communities and General Practices to facilitate the continuity of care and personal relationships that have traditionally been the strength of the General Practice model. Consultation with user and carer representatives has told us that they trust and know their practices and they want these to be the focus of communication and community services. In

recognition of the central role General Practices will have, the Director of NHS England Local Area Team has now joined the SPC to represent GP commissioning. All the CCGs are working to support GPs in the changing world of their provider function. The *Well Connected* team is engaging with grass roots GPs to help develop new models of General Practice that meet the changing needs of primary care and embrace the integration agenda and the *Well Connected* vision.

There is a strong vision that meeting the needs of the population in the future will require a sustained focus on individuals and communities taking responsibility for their health and wellbeing, promoting a positive two way 'contract' with the population rather than more traditional delivery of 'being done to'. The central role of the voluntary and community sector, investing in communities to develop social capital, working with individuals and communities in co-production and co-design of services and communicating through an honest, constructive dialogue with the public will all contribute to this vision.

The *Well Connected* vision has a collaborative cross sector approach based on clinical and service integration rather than organisational integration. The programme uses both large transformational innovations and approaches where front line staff are given the capacity and flexibility to innovate and test out ideas. Where these meet the desired outcomes, they will be implemented across the health economy to achieve the scale and pace that is required. The vision has the support of the clinical community across primary and secondary care and clinicians are actively involved in leading the projects for change. In addition the programme will support and develop clinicians as leaders in the local health and care system.

Use of narratives

The draft National Voices narrative was adopted by the SPC on the 7th May 2013 and the final wording is now adopted. Service user stories are used in a variety of ways. A brief narrative of 'Anne and John' has been used as a benchmark for our plans and a longer narrative to illustrate how improving integrated care can impact on the whole patient/user journey. Patient stories are used before each Trust Board meeting. Our service user consultation tells us that these stories help them understand what integrated care means and they will be used to communicate our vision to staff, users and the media.

Integrating around, and delivering better outcomes, including experiences for, individuals, families, carers and communities

The users of care and support, their families and carers are at the centre of the *Well Connected* vision. The aim is that their needs and goals are central within a shared care planning process, the boundaries between organisations delivering care are invisible to them, information is shared so that they only need to tell their story once and they know the single individual who is responsible for bringing together their care.

The *Well Connected* key strategic outcomes:

1. Improve the experience of the care and services that individuals receive.
2. Improve access to services that support people in looking after themselves and each other.
3. Provide timely access to all relevant patient/service user information for all those delivering services to an individual.
4. Reduce hospital admissions, hospital length of stay and the requirement for the use of long term residential care.
5. Improve swift and focussed access to acute hospital care when needed.
6. Provide better overall value for money

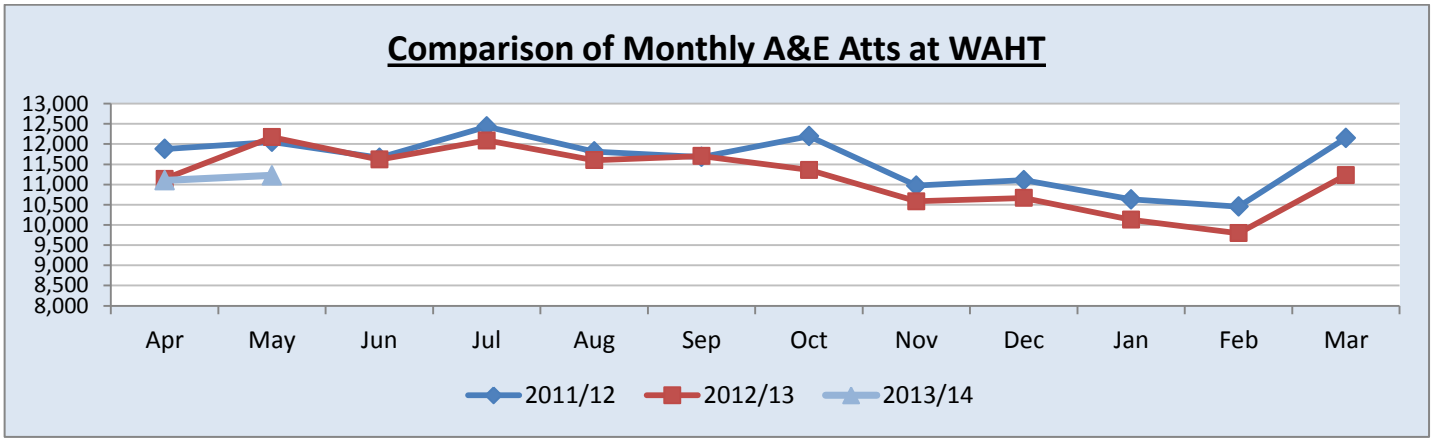
The service user experience is to be the central measure of service integration and we welcome the proposal to use the National Voices "I" statements as the basis for developing robust new service user experience outcome measures. Our commitment is illustrated by one of our CCGs having developed its own measures of integration in an attempt to measure its success in this area. We have used the learning from other areas to ensure all *Well Connected* outcomes are specific and measurable. These will be supported by individual project outcomes that align with the strategic aims.

The *Well Connected* outcomes are well aligned with the domains of the NHS Outcomes framework, the Public Health framework and the Adult Social Care Outcome Framework. The focus on health inequalities, individual and community responsibilities and community development, will ensure our outcomes are not only focussed on traditional 'health delivery' activity and outcomes.

Financial efficiencies.

The current financial climate and the requirement for each organisation within the collaboration to reduce costs and improve efficiency is a significant issue. *Well Connected* must add value to individual organisational efficiency programmes and is working with each organisation to help them achieve their targets while ensuring that investment in cost effective integrated care remains a priority.

Well Connected is currently taking the crucial step of understanding and mapping all the current funding flows within the county so all parties can better understand and maximise commissioning and funding flexibilities. A key outcome metric of the programme is to reduce the number of hospital admissions in the over 65's by 10% and length of stay for people aged over 65 by 25% and to reduce the number of long term residential placements. This will provide savings that can be reinvested into more cost effective community services. An example of success is the implementation of the Countywide Dementia Strategy which has seen a significant step change in relation to the availability of services to support patients and carers at home. This has reduced the number of admissions into specialist dementia care beds to such an extent that last year we were able to close a ward. .Attendances at A&E fell by more than 2% in Worcestershire during 2012/13, bucking the national trend, as a range of demand management schemes were successfully implemented



Savings will also be realised through more efficient use of staff and resources while meeting the aims of service users of reducing the number of individuals involved in their care, for example by using single assessments, merging health and social care roles and 'up-skilling' community staff. Improvements in Information sharing will avoid duplication and allow staff to work more efficiently

Well Connected is committed to using commissioning and financial incentives as a key programme enabler. There is an established principle of collaborative funding within Worcestershire. Since 2008, the Joint Commissioning Unit has been responsible for jointly commissioning substance misuse services, children's community paediatrics, sexual health, CAMHS and adult mental health, learning disability, carers support and older people's service on behalf of the Council, including Public Health, and the CCGs. These arrangements are governed by section 75 of the NHS Act 2006. The total value of the section 75 agreement is £173m. We are ambitious in the vision of using new ways of funding and await the outcome of pilot schemes such as the Year of Care payments. This is an area of support as a Pioneer that the programme feels will be particularly valuable.

Substantial modelling has been done on the efficiencies gained on the use of telecare and telehealth. Working with the Director of Innovation at the Department of Health, the Assistive Technology project has developed an innovative financial risk sharing model with providers with an ambitious service specification for the county. This project is currently at tender evaluation stage.

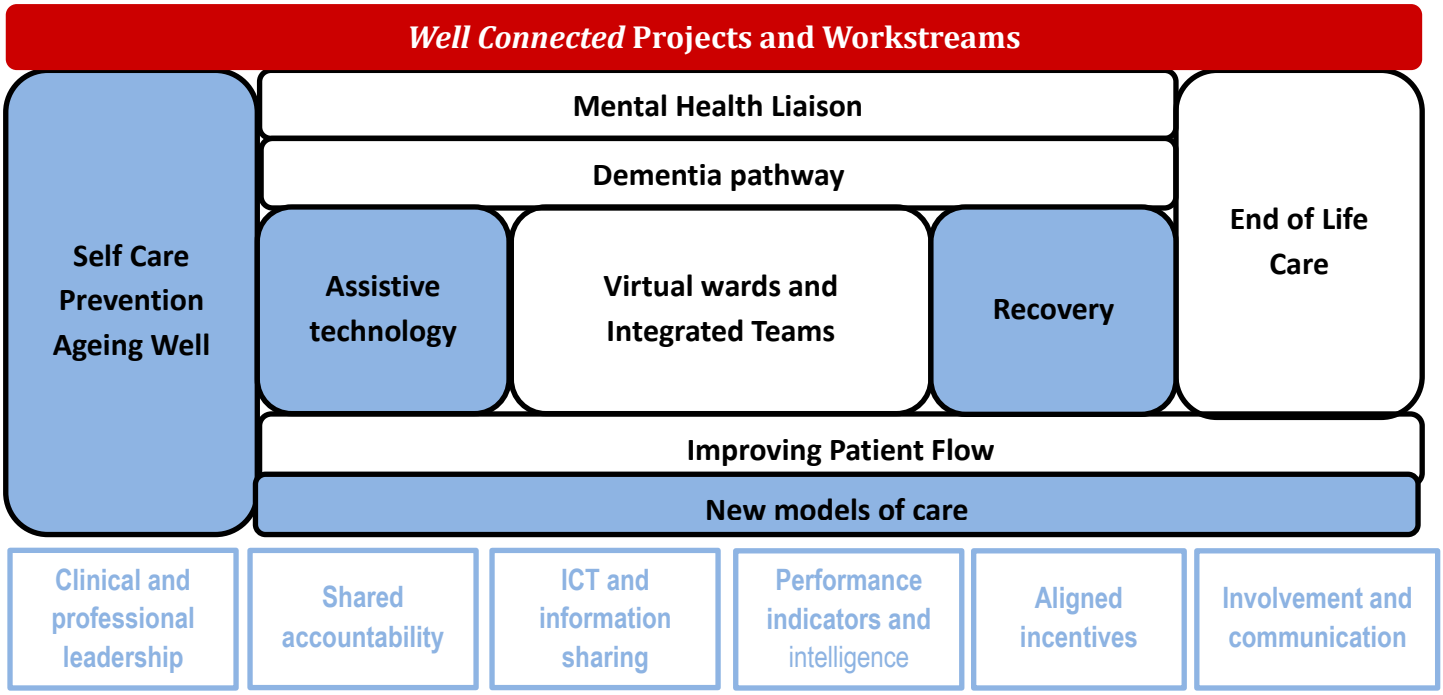
The programme is working with Social Finance to pilot the use of social impact bonds to improve health outcomes by reducing social isolation and improving care for patients with long term conditions. Current modelling suggests that significant benefits can be made in terms of individual well being, reduction in hospital admissions and GP consultations and reductions in residential care and welfare payments. The National Social Finance Advisory Board regards our proposals to reduce isolation and loneliness through the use of social capital supporting community and VCS initiatives as a vanguard initiative.

With the support provided as a Pioneer, we are ambitious to explore the use of different funding and contractual models to support changing models of general practice, for example through GP federations or 'super-partnerships', and maximise partnerships with private businesses, for example Care Homes, IT businesses and Out of Hours services.

2. Plan for *Whole System* Integration

Well Connected has an ambitious programme that encompasses projects for integration across the whole system. It includes physical and mental health, primary and secondary care and health and social care and spans preventative work through to end of life care. The wider role of the *Well Connected* team is to also be sighted on many other pieces of relevant work for which they do not have specific responsibility such work with community hospitals and GPs. The programme team will ensure that all the programme projects

and work-streams and those in other areas of work integrate with each other and avoid duplication. We are working particularly closely with the Urgent Care strategic and operational teams where there is significant overlap of work, with the plan to merge the governance arrangements after the 'task and finish' urgent care workstreams are completed.



Prevention

Prevention of ill health, self care and health promotion is a theme that runs through all projects but is a particular focus within the Future Lives Programme, which incorporates the **Ageing Well**, **Assistive Technology**, **Recovery** and **New Models of Care** projects shown in blue in the diagram above. The aim of Future Lives is to promote health and independence, allow greater choice and control, maximise quality and productivity and reduce the need for dependence on adult social care services.

A number of projects in the county are focussed on preventative work or increasing social capital. For example:

- The **'Areas of Highest Needs' programme** runs a wide variety of projects within six deprived areas of the county with projects that contribute to increasing social capital and a number directly related to Health and Wellbeing.
- The **Alcohol Liaison Nurse Service** is an innovative project in which individuals where alcohol is identified as a factor in their A&E attendance are seen by an Alcohol Liaison Nurse. It has resulted in year on year reductions in reattendances to A&E.
- **Age UK 'Well Checks'** provide an assessment and signposting service for the over 50's.
- **"Carewise"** has been developed as a result of a partnership between the County Council and leading voluntary and community organisations to provide a one stop online resource for information on social care and wellbeing at www. whub.co.uk/carewise
- **Worcestershire microenterprise project** is a partnership between the council and Community Catalyst UK which to date has supported 30 micro-businesses with people in receipt of direct payments. Many of these involve volunteers as well as paid staff.
- A wide range of voluntary and community services such as **MoodMaster** courses to promote mental wellbeing, **Dementia cafes** across the county and a range of peer support projects

Preventing deterioration in health

Many projects are aimed at preventing deterioration in health, particularly in those with long term conditions. The aim of the **virtual ward and integrated team** projects is to identify those most at risk and develop anticipatory care plans to prevent crises that trigger avoidable emergency admissions. The three CCGs are developing slightly different case management models, allowing teams the freedom to innovate in response to local needs and allow rapid evolution so, for example, specialist dementia nurses have been recently recruited to the enhanced care teams to great effect. It also allows evaluation and learning so that demonstrable benefits can be implemented at scale across the county. The **Assistive Technology** work-stream promotes personal independence and self care through self monitoring, reducing unplanned hospital admissions, preventing complications and improving quality of life. One element of the proposed **Social Impact Bond** also contributes to the management of long term conditions.

Timely access to health professionals is crucial in preventing deterioration in health. A variety of initiatives are being undertaken within the county to create capacity within general practice. Several practices have successfully piloted '**Doctor First'** telephone triage and 2

specific pilots are underway to run long term condition clinics with half hour appointments to undertake in depth anticipatory care planning. **The Improving Patient Flow** workstream aims to reduce length of hospital stay where appropriate and to avoid deterioration in health that result in readmissions through improved discharge planning. **The Mental Health Liaison Service** supports the acute hospitals in a range of complex health and social care needs including those related to alcohol and drugs, dementia, mental ill health and self harm.

The **Falls Response Service** is a collaboration between the CCGs and a consortium of local housing providers. The pilot avoided over 100 emergency admissions to hospital. Funded by 'winter pressures' funding, it is now being considered for full implementation.

Personalisation

Worcestershire County Council launched its programme for 'Making it Real' with Worcestershire Coalition of Independent Living in April 2013. The Council and its partners are committed to integrating these with the *Well Connected* aims and outcomes.

Worcestershire 'Making it Real' launch event identified a number of personalisation priorities:

- Having more direct control
- Being listened to in developing their support plans,
- Hearing the voices of those not always heard
- Greater transparency in processes

All Worcestershire social care clients have a personal budget and the county has reached its target of 25% of people receiving this through direct payment. The aim is to increase this proportion and in particular meet the challenge of increasing the number of older people who require personal assistants to receive direct payments. The council is working with the CCGs in developing personal health budgets for those with continuing healthcare needs and already has a few in place including an innovative national exemplar health and care package for a profoundly disabled individual with the budget administered by his parents.

Social work teams have re-prioritised the importance of carer assessments and generated innovative ideas to develop a 'barometer' to assess how carers are feeling and to provide more personalised care where carers are treated as individuals in their own right. Health teams have demonstrated the success of personalisation in the implementation of the Mental Health Recovery Model where a profound shift was required from traditional psychiatry based models to co-produced personalised care, bringing together multidisciplinary teams to care plan and align expertise along the service user's journey.

Personalised care plans are central in very many other areas. An innovative local example is the monthly multidisciplinary team meeting in the Wyre Forest where the patient or their carer sets the agenda. Telephone follow-up after the meeting assesses the patient's experience and provides learning for future formats. The End of Life workstream aims to meet the wishes of individuals, their families and carers as they near the end of life and several strands of this project increase personalisation, such as the roll out of advanced care planning across all providers.

We are working with our Integration Champions from the community (see below) to access those whose voice is not usually heard and *Well Connected* is committed to following the same 3 step process as 'Making it Real' to ensure there is greater transparency in process.

Those who will benefit most

The heaviest users of health and social care services are older people with multiple co-morbidities, often requiring services from many different partners and organisations. Risk stratification tools are used to select patients for the case management schemes, enhanced by the use of local knowledge of the patient and other social factors. GP practices will receive regular risk stratification data of their practice population and daily 'real time' data on hospital admissions to enable them to target care to individuals who will benefit most.

Residential and nursing homes have been identified as a source of many avoidable A&E attendances and admissions. CCGs are reviewing arrangements to enhance and improve care through providing dedicated GP input or providing advanced nurse practitioners responsible for clusters of care homes. Training and Development of care home staff has been identified as a significant area of need.

An overarching focus on health inequalities will ensure all schemes consider access to those groups and communities with the poorest health and have the most to gain. The proposed work with Social Impact bonds targeting social isolation is of particular relevance here. Patients with dementia feature disproportionately within the health setting. Significant success has already been demonstrated in the

Countywide Dementia Strategy resulting in earlier diagnosis, an increase in planned care and consequently a reduction in crisis response leading to admission.

Public Services integrating with unpaid contributions of families and communities.

The Voluntary and community sector are in the centre of *Well Connected* planning and represented on the SPC and Programme Steering Group. Specific patient and carers representatives will be part of the newly formatted *Well Connected* operational group. There is a very active network of volunteers in Worcestershire undertaking a very wide range of activities. The council has funded research to map volunteering in the county. Due to report soon, the recommendations will form the basis of the county response to support volunteering and what we need to do to attract and prepare volunteers for the future.

Worcestershire's approach to carers is a good example of innovative integrated working that has used a variety of funding streams to provide support across the whole system. The Carers Pathway has been identified within 'Making it Real for Carers' as an area of good practice. In this collaboration, any referral to the Council for a statutory carer's assessment triggers a referral to Worcestershire Association of Carers (WAC) who undertake a carer's 'wellcheck' by telephone as soon as the referral is received, providing immediate support and information. Information gathered is shared with consent with the social work team to avoid duplication.

With funding from the CCGs, WAC has set up an innovative scheme of carer support to GPs. 9 workers link with every GP practice in the county, allowing referral of carers they identify for both emotional and practical support. "Health Chat" training is provided to non clinical support workers to encourage carers to think about their own health, preventing deterioration in health in this group who characteristically ignore their own needs while caring for others. The dementia pathway funds carer support workers within the Acute Trust. This provides carers with early information, addressing their fears and anxieties and facilitating discharge planning. Transitions are smoothed by linking in with the GP carer support service. A survey of carers' experience on the wards is being undertaken by this service. Funding from the End of Life work stream provides specific support workers for carers of people reaching the end of life.

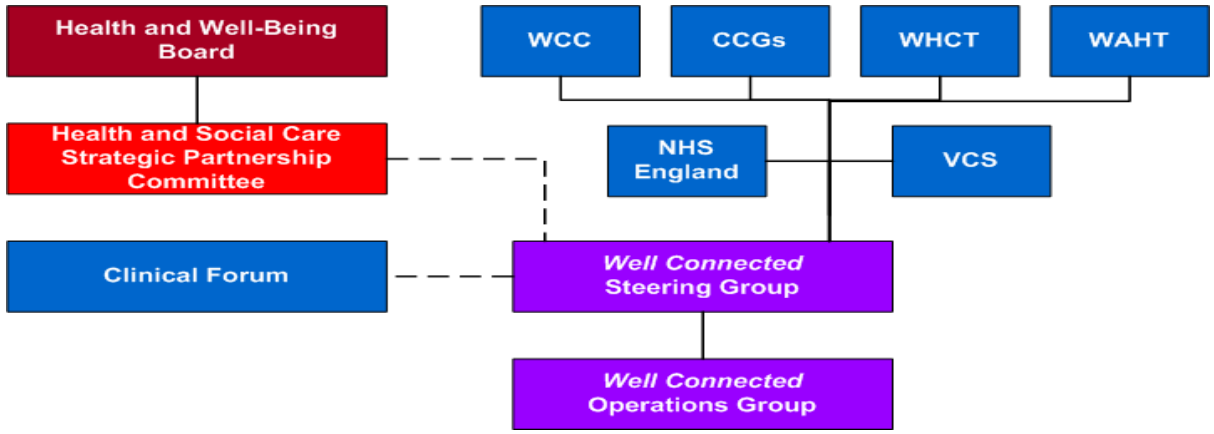
3. Demonstrate commitment to integrate and support across the breadth of relevant stakeholders and interested parties within the local area.

The genesis of the *Well Connected* programme came from the shadow Health and Wellbeing Board (HWB) and its aims are fully aligned with the HWB Joint Strategy. Health and Wellbeing is also one of the top four corporate priorities for the county council. The *Well Connected* programme (then still called the Integrated Care Programme) presented to the first formally constituted HWB meeting in April 2013 and the HWB fully support and welcome our application for Pioneer status.

Well Connected is collaboration between all the health and social care organisations in the county, including the Council, the CCGs our 2 NHS Trusts, the VCS, Healthwatch and NHS England. The Steering Group also has representation from West Midlands Ambulance service and it is proposed that representation from District councils is added. A newly formatted operational group will include the leads of all the projects and workstreams and representatives of patients, families and carers. Clinicians are strongly represented throughout and there is a dedicated *Well Connected* Clinical Lead.

The health economy has already demonstrated its ability to work together across boundaries in a wide variety of projects. For example, we have been shortlisted for a Health Service Journal Efficiency Award for our work in end of life care. This whole system clinically led programme is a collaboration of all providers across the health economy to improve the quality of end of life care.

***Well Connected* Governance Structure**.

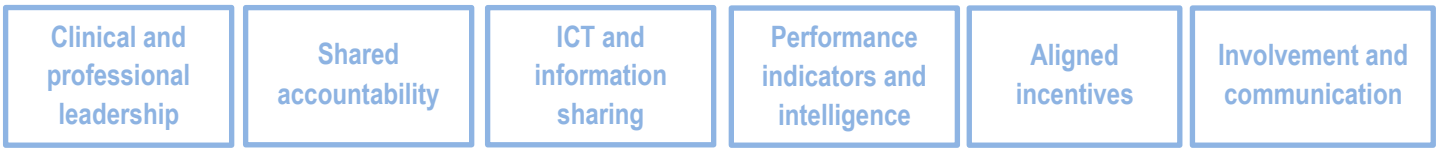


The Worcestershire Strategic Partnership brings together local government, public services such as health, learning providers, police and probation, voluntary and community organisations and local businesses. At the heart of the Partnership is the Shenstone Group, which builds trust and understanding between key leaders from public and private sectors and civic society, developing collaborative leadership and a shared vision for Worcestershire. "Thinking laboratories" explore issues in ways which are not possible in the formal forums and actions developed for participants to take back to their own organisations. For example, the group acts as a critical friend to the Areas of Highest Need project and leads on 'Worcestershire: Next Generation' where one of the three top priorities is 'living well'.

Timberdine Nursing and Rehabilitation unit is an innovative example of integration across stakeholders. Responding to the closure of a ward for the elderly at the Acute Trust, a focused team with a short deadline established Timberdine, providing short stay nursing step down beds, a dedicated stroke rehabilitation unit and a 6 week residential care rehabilitation unit. Timberdine is run by the County Council, employing social care staff, nurses and other health professionals. Health workers and social care managers work together to develop policies and protocols so that organisational boundaries are imperceptible from the point of view of the residents and carers.

Strong links with the West Midlands Ambulance Service resulted in the development of the innovative, 'GP with the Ambulance' project, which enables paramedics to contact a dedicated GP for advice or a visit where a transfer to A&E would otherwise be needed. An additional advantage has been the increased understanding and learning between primary care and the ambulance staff.

Enabling workstreams integrating support across stakeholders.



Six enabling workstreams operate across the whole system with all relevant stakeholders. **Clinical and Professional Leadership** and **Shared Accountability** workstreams are addressed though the implementation of the SPC and the recruitment of the jointly funded high level Director, Clinical Lead and Project Manager to the *Well Connected* programme. The **Performance and Intelligence** workstream provides an overarching role in performance monitoring and ensuring robust governance. The **Aligned Incentives** workstream is addressing the commissioning, contracting and financial flexibilities that can support integration across stakeholders.

Consultation with staff has indicated that their highest priority for integration is to improve information sharing. The **IT and Information Sharing** workstream is one of the most transformative of the Programme with the aim of providing timely access to all relevant information for all those who need it. In collaboration with EMIS, there is programme for every GP practice within Worcestershire to transfer onto the Clinical Information system EMIS Web, which has the capability of allowing primary, secondary and community practitioners to view and contribute to the healthcare record. A pilot is starting on 1st July with those practices already live on EMIS Web to allow access with patient consent on terminals in the A&Es, Medical Assessment units and the GP Out of Hours service with the aim of rolling this out to many other services such as Community Hospitals, community teams and the Worcestershire prisons. The vision is that where consent is given, this will extend to include social care and all other workers involved in the service user's care and support. Initially piloting 'Read Only' access, the vision is that appropriate entries in 'parallel' screens to the GP entries can be made by other teams and multidisciplinary care plans can be accessed and developed by all relevant staff. The technical solutions exist that enable EMIS Web to link in with other IT systems used within the county to provide an extremely exciting opportunity to meet the Information Sharing aims. Learning from other areas shows that Information Governance can be a significant delaying factor and barrier to information sharing innovations. Information Governance will be addressed and monitored through this workstream and is ultimately accountable to the SPC. We welcome the new Caldicott report and new recommendation on information sharing and the programme will particularly benefit from the support given to Pioneers in this area.

A communications manager provides specific support to the *Well Connected* programme through the **Communications and Engagement** workstream. A wide-ranging Communications Strategy has been developed and agreed by the SPC. The transformational shift from acute to community care will only be sustainable if users, families, carers and staff have been involved in co-production and co-designing services. Consultation with them tells us that people must feel confident that the shift in focus is safe, improves quality and experience and that the changes are not purely financially driven. A programme of engagement events through the summer and autumn 2013 will use the National Voices "I" statements as a framework. These will build on the significant work already being done with service users, carers and the VCS in helping shape and direct strategic vision and aspirations and influencing the county response to service reconfiguration and design. An initial workshop has provided us with links into the enormous number of user and carer groups and organisations in the county and we plan to develop a 'train the trainer' format where our identified 'champions' visit these groups to increase the ability to reach people that are normally harder to access.

The *Well Connected* team will continue to present to a range of groups and individuals to engage with all stakeholders and interested parties, for example commitments to present to the LMC, GP 'provider' forums, Trust Boards and Junior Doctor training programmes. The website wellconnected.co.uk went live in June 2013 with plans for it to provide an interactive forum for staff, users, carers and the general public. A staff questionnaire on integration is currently out to thousands of health and social care staff. Uses of social media are being explored as well as traditional media, being mindful of the needs of the elderly in particular. The 18,000 members identified as part of the Foundation Trust applications of the Health and Care Trust and Worcestershire Acute Trust provide an exciting opportunity to engage with interested residents. The media provides an important forum with links developed through regular press releases and, for example, a feature in the 'Worcester News' on the *Well Connected* Clinical Lead.

4. Demonstrate the capability and expertise to deliver successfully a public sector transformation project at scale and pace

The Worcestershire health economy has the capability and expertise to deliver public sector transformation at scale and pace, with a wealth of expertise and experience across the collaborating organisations. The governance structure provides a project management format to the programme with a mechanism of driving and monitoring the delivery plan and risk register. A very wide range of stakeholder views have been listened to and current structures, projects, local data and national evidence reviewed. A delivery plan is being developed with a realistic timetable for short, medium and long term goals, mindful of the need for scale and pace.

The SPC provides strong leadership from all the collaborating organisations. The Programme Director and Clinical Lead both have a strong track record in local leadership and change management. The SPC provides a robust forum to discuss and address local barriers with a membership with the authority for rapid decision making. Significant barriers that are not easily addressed are added to the risk register with action plans put into place to mitigate or overcome the barrier.

The programme has an overall risk register containing overarching strategic risks. Each project has responsibility for managing its own subordinate risk register. The main risk register is reviewed at each programme steering group meeting and significant risks presented to the SPC by exception. The major current risk mitigation strategies relate to risks that individual agendas and priorities from across the partners will conflict with the programme, the radical change in behaviour required of the public and by staff to achieve the transformational changes needed will not occur, perceived information governance requirements become a barrier to effective information sharing and financial flexibilities are not engaged/used to facilitate to the programme to a sufficient scale. These are being mitigated through a robust signed Memorandum of Understanding, a strong communications strategy, a dedicated Information Sharing workstream and a process of engaging with all the relevant finance directors.

Examples of Worcestershire's track record in successful transformational change at scale and pace:

- **Dementia Strategy** implementation, resulting in a re-focussing of care at home and reducing need for inpatient care.
- **Mental Health Recovery Model** implementation with a transformational change in behaviour and attitudes in staff and service users to a model of true person-centred goal orientated care.
- **Integrating Services for Mental Health and Learning Disability** through integrated management and delivery from health and social care resulting in step change in approach.
- **Enhanced Care Community Teams** developing multi-agency, multidisciplinary working clustering around GP practices.
- **Worcestershire Prisons Project**, transforming health delivery within the prisons up to NHS standards and beyond, working with many partners with different or even opposing agendas.
- **Winter pressures/urgent care strategy implementation** - a range of strategies across all partners and organisations that were rapidly implemented and robustly evaluated to provide learning of future years. A&E attendances in Worcestershire 'bucked the trend' of escalating A&E attendance numbers.

5. Commit to sharing lessons on integrated care and support across the system

Well Connected is fully committed to sharing lessons on integrated care across the system. We are already active participants in the Kings Fund Learning Network, having hosted and presented at the April network event. We have actively sought learning from other parts of the country to inform our own developments by attending conferences and visiting other projects such as North West London, Manchester and the Virtual Ward project in Dudley. We are committed to and look forward to working with ICASE. We are currently working with SCEI on an online learning resource on joint working using filming of several staff and the innovative Timberdine project.

Partnership and integrated working has led to many learning opportunities within the county. For example the Wyre Forest GP pairing project, where GPs and consultants work together on problems and pathways, disseminates learning through local and countywide meetings and is looking at other innovative methods such as the use of web-based forums. The CCG led Service Innovation Meeting in Redditch and Bromsgrove provides a local focus with participation from acute, community, social care, ambulance and GP out of hours staff to develop and improve services for the local population. The End of Life project provides training to primary care, the ambulance service and care homes across the county. The advantage of three CCGS within the county is exploited by allowing smaller groups to innovate with ideas and projects with the ability to cascade that learning countywide where appropriate. This will be formalised through the *Well Connected* operational groups but also happens through strong personal relationships and many other groups and forums.

The health and social care economy has very strong long standing links with Worcester University, which provides a large number of training and learning opportunities for staff. The University is committed to working as a partner in evaluating the effectiveness of our interventions and in future training and development and fully supports this bid. The University is already involved in working with the Assistive technology project in developing the outcome measures of this project. The county is fortunate in having the prestigious Association for Dementia Studies (ADS) at the University that aims to build the evidence-base for practical ways of working with people living with dementia. The ADS was involved in developing the training programme to support the implementation of our dementia strategy. Links are also being developed with other academic institutions, for example a senior consultant is developing links with Warwick Business School to evaluate one of the Virtual ward projects.

Providing skills development and training for staff will be essential for the success of efficient integration where more complex people are managed in the community and new cross-cutting roles help to minimise the number of staff involved with an individual. The Programme delivery plan will address workforce development, with the identification of training and skill development needs. We plan to work with the universities, local education and training boards and other training providers to develop a strategic training plan.

6. Demonstrate that its vision and approach are and will continue to be, based on a robust understanding of the evidence,

An overarching programme principle is to use evidence based working. One of the roles of the *Well Connected* team is to assess the available evidence and how this can be applied locally. The initial programme was developed from analysis of the local health and social care economy by McKinsey and Company. The evidence pulled together by the Nuffield Trust and Kings Fund to present to the Future Forum, 'Integrated care for patients and populations: Improving outcomes by working together' is the background to much of the *Well Connected* programme. The Kings Fund report 'Making Integrated Care Happen at Scale and Pace' usefully synthesises much of the evidence and the 16 recommended steps in that report have recently been reviewed and supported by the SPC.

Evidence is used wherever it is available to inform our programme. For example, evidence from a highly successful mental health liaison project in City Hospital, Birmingham, was used as the basis of our Mental Health Liaison project. However we are also aware that evidence is an evolving process, for example review of the evidence on case management approaches has been used for the development of the virtual ward and integrated team projects but recent evaluations of large scale case management based pilots have demonstrated improvement in quality of care but have not had the expected outcomes on reducing hospital admissions. Similarly national evidence has been used to develop the assistive technology workstream but recent further evidence on cost effectiveness has not been so positive. We strive to understand the detailed reasons for conflicting evidence to use this learning in our own projects.

As well as national evidence we also use local evidence and data to prioritise projects. For example, the positive evaluation of the 'GP with the ambulance' scheme developed through winter funding has resulted in the service becoming mainstream. Results from a demand and capacity review of health and social care facilities and a large scale point prevalence study reviewing utilisation of every 'bedded' facility in the county will be used to match new models of care to the assessment of need. As well as published evidence and local evaluation we have sought 'softer' evidence by contacting and visiting several other projects to utilise their experiences in developing the programme

Providers are represented on the SPC and many other multi-organisational meetings. This allows the potential impact on providers to be assessed. So for example, real time information for both acute trust and community bed availability is now available through the use of Electronic White Boards that are live within every hospital, improving patient experience and reducing length of stay. Our governance structures ensure close monitoring and real time evaluation allowing us to identify 'unintended consequences' for providers or on outcomes at an early stage, so that these can be understood and addressed. The Programme vision is that the user experience will be at the heart of our outcome measures. Although user outcomes are explored across the projects, this is not captured in a systematic way and we recognise this as a gap in our outcome measures. We fully welcome the opportunity to work with national

partners to co-produce, test and refine new measures of patient experience and view this as one of the major benefits to our programme of being a Pioneer.

We recognise and support the need for on-going robust evaluation, particularly in areas where there is conflicting evidence. We are committed to systematic evaluation of progress and impact over time and welcome the help and support in this area as a Pioneer.

Why Choose Worcestershire?

Worcestershire is very well placed to become a Pioneer as envisioned in *Integrated Care and Support: Our Shared Commitment*. Radical change is needed in the way that individuals and communities are enabled to look after themselves and in how care and support is provided. All the main parties in in the Worcestershire health and care economy are convinced that better integration of services is at the centre of what needs to change. *Well Connected* has the courage, vision, strong leadership and track record to be at the forefront of making the changes needed and is already implementing an ambitious system wide programme.

Well Connected provides the framework to be an effective Pioneer with commitment from senior leaders, the Health and Wellbeing Board, the VCS and Healthwatch. Members of the dedicated *Well Connected* team have worked in the Worcestershire health economy for many years with many relationships already in place and a track record in senior leadership and major change management. There is a strong track record of user and staff engagement to provide a platform for the use of the National Voices narrative and development of outcomes based on used and carer experience.

Well Connected will cover a large population providing robust evaluation evidence. Although the level of health of Worcestershire is generally slightly higher than the national average, there are significant pockets of rural and urban deprivation with demonstrable health inequalities. We have the challenge of integrating care and support over a large geographical area with a significant rural population and larger than average older population. The evidence we generate will be applicable across a wide range of settings.

Well Connected has many projects underway at varying levels of maturity and has many new innovative ideas. The support received as a Pioneer will assist our ambition to develop these to the scale that will make a fundamental difference to the people of Worcestershire. The senior leadership is prepared to take the calculated risks that are needed to achieve our vision. A better understanding of the financial flexibilities available and the legal position on contracting and tendering will maximise our ambition of working innovatively with all sectors to achieve the best outcomes possible. Early evaluation will help us ensure that we are achieving the outcomes that the people of Worcestershire tell us that they want, enabling us to alter direction when necessary. Our consultations tell us that users, carers and their families want change now and we are determined to bring about rapid change.

Well Connected is fully committed to sharing and learning as a Pioneer. We have used the learning from others substantially in the formation of our current projects. We are active participants in a Kings Fund facilitated 'learning network' and have a strong partnership with the local University. With all parts of the country sharing the integration journey we know that this will be done most efficiently and effectively if everyone is able to learn from each other and we greatly look forward to being part of that process.

Why Worcestershire?

- Courage, vision, strong leadership and a track record of change at scale and pace.
- A collaboration of all the main health and social care stakeholders in the county, the VCS and Healthwatch with clinical support across primary and secondary care.
- An ambitious system wide programme to improve the experiences of users, carers and families already in place, spanning preventative work and self care through to the end of life.
- A strong history of user and staff engagement, providing a platform for developing the National Voices narrative and outcomes based on user and carer experience.
- A Governance framework in place to be an effective Pioneer.
- A large population with areas of significant deprivation and a larger than average older population providing robust and varied evaluation data.
- A senior leadership that will take calculated risks to develop new ways of working and maximise the financial and contracting flexibilities available.
- Full commitment to sharing and learning as a Pioneer with a strong partnership with the local university.
- A programme where the support provided as a pioneer will develop our ideas to a scale that will make a fundamental difference to the health and care provided to the people of Worcestershire.