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Report of the Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6 October 2016

Subject: Clinical Commissioning Groups' annual update

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Summary statement:

This report provides an update on Clinical Commissioning Group achievements and challenges for 2015/16.

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Portfolio:

Health and Wellbeing

1. **Summary**

This report provides an update on Clinical Commissioning Group achievements and challenges for 2015/16.

2. **Background**

Clinical commissioning groups (CCGs) are clinically-led statutory NHS bodies responsible for planning, buying (commissioning) and monitoring health care services in their local area.

Commissioning is about getting the best possible health outcomes for the local population, by assessing local health needs, deciding priorities and strategies, and then buying services on behalf of the population from a range of organisations including hospitals, clinics and community health bodies. CCGs are responsible for the health of their entire population and their performance is measured by how much they improve outcomes.

CCGs are:

- membership bodies, whose members are constituent local GP practices;
- led by an elected governing body made up of GPs, a nurse and a hospital consultant, and lay members;
- responsible for about 60% of the NHS budget;
- responsible for healthcare commissioning, including mental health services, urgent and emergency care, planned hospital care, and community care;
- independent and accountable to the Secretary of State for Health through NHS England.

NHS England directly commissions highly specialised services (such as bariatric surgery) and primary care (services provided by family doctors, pharmacists, opticians and opticians). CCGs work with NHS England's local area teams to ensure joined-up care. Some CCGs – including Bradford City and Bradford Districts CCGs - also jointly commission services from local GP practices.

Through health and wellbeing boards, CCGs work closely with local authority public health teams to achieve the best possible health outcomes for the local community. Together they develop a joint needs assessment and strategy for improving the health of local people.

3. **Report issues**

UPDATE ON HOW WE ARE PERFORMING

Working with local people

We want to deliver high quality and safe services for the people of Bradford, Airedale, Wharfedale and Craven. Engaging local people in a meaningful way is central to the way we work and to understanding the needs and experiences of people who use the health services we commission.

Our vision for engagement is to involve the people and communities in all of our work so they can help shape our decision-making and priority setting. Effective engagement will help us to improve patient experience, improve health outcomes, as well as make the best use of public resources.

There are a number of ways in which we do this across the three CCGs by working with local patient groups, the voluntary and community sector, and organising or attending engagement events and activities.

Grass Roots insight report and quality walk rounds

Grass Roots insight is the monthly insight to patient experience which captures intelligence from a variety of sources (including, for example, Patient Opinion, NHS Choices, Healthwatch, complaints, MP and public feedback, communities and voluntary sector services). Through collaboration, *Grass Roots* continues to increase its reach.

In the Bradford CCGs there is a proactive approach to insight which includes the joint quality committee regularly undertaking in-depth reviews into key areas of our commissioning and ensuring that patient, carer and community perspectives are shaping them. In the past year, deep dives, service engagement and surveys that have informed *Grass Roots* have included the urgent care strategy, access to psychological therapy services, children's experience of hospital services, and maternity services.

In Airedale Wharfedale and Craven (AWC) CCG, alongside *Grass Roots*, members of the governing body do regular walk rounds of services to listen first hand to patient's recent and ongoing experiences of their care. These visits allow the CCG to work with the providers in developing actions plans for improvement.

People's Board

The *People's Board* champions patient and public participation across the two Bradford CCGs, providing assurance, support and advice on the delivery of programmes of work. It ensures that patients and the public have a voice and - through challenge, support and co-production - are able to work with, and influence how, the CCGs delivers their vision. The idea grew from the CCGs' involvement with patients, carers and the public, via our patient networks and community engagement, right from the creation of the CCGs in 2013, and became operational in January 2016.

The *People's Board* works with the CCGs on policy and service design. Key areas of work include:

- influencing (creating two-way dialogue to inform the CCGs' decisions);
- greater transparency (holding to account and improving feedback);
- involvement and reach (ensuring we hear and involve all Bradford communities);
- effective activity (building trust to have effective discussions and actions).

Through the *People's Board* we hope to 'hard wire' the patient and public voice into our key decision-making processes. However our patients experience of primary medical care remains an area requiring improvement, particularly in relation to

access, and we are trying to find new and innovative ways of meeting the rising demand for services with limited resources.

Key Issues

Improving access to psychological therapies (IAPT) – Bradford District Care NHS Foundation Trust

Traditionally, medicines have been the only type of treatment available for people suffering from depression and anxiety disorders. The IAPT service – which involves a programme of talking therapy treatments - was created to offer them a realistic and routine first-line of treatment combined, where appropriate, with medicines. First targeted at people of working age, IAPT was opened to adults of all ages in 2010. For monitoring purposes, national targets for IAPT are based on an estimated number of patients who would benefit from access to the service and an expectation that 15% of this group will be seen each year. The Bradford CCGs fell slightly below the 15% target by 31 March 2016, with Bradford City CCG treating 1420 (14.8%) and Bradford Districts CCG treating 6135 (14.8%). AWC CCG achieved the target at 15.9%. There is a further expectation that, after using this service, at least one in every two people (50%) who receive therapy are expected to recover. Again, for patients who have received psychological therapies, those who moved to recovery fell short in Bradford CCGs with just one in three patients moving to recovery, and AWC performing below the target at 47.2%.

With the move to the lead provider model from 1 April 2016 both the implementation of the new **patient case management information system** (PCMIS) data system and the development of a full training plan will provide assurance that recovery rates will improve through 2016/17.

Constitutional measures

The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of the Constitution in their decisions and actions. The CCGs measure the performance for the services they commission against the standards in the NHS Constitution; performance for 2015/16 is shown in the table below:

	Target	AWC	City	Districts
Methicillin-resistant Staphylococcus Aureus (MRSA) (a type of bacteria resistant to a number of widely used antibiotics)	0	2	1	2
Clostridium difficile (C-Diff) (a bacterium that can be found in people's intestines)		45	14	116
Cancer two week wait (time taken to see a specialist after urgent referral for suspected cancer)	93%	96.3 %	94.6 %	95.3%
Cancer 31-day (time taken from receiving diagnosis to first definitive treatment)	96%	98.5 %	98.3 %	98.3%
Cancer 62-day (beginning first definitive treatment following urgent GP referral)	85%	89.8 %	86%	87.4%
Mixed sex accommodation (CCGs are required to eliminate unjustified mixing in relation to sleeping accommodation)	0	0	0	3
Referral to treatment (RTT) incomplete pathways (Patients yet to start treatment who have waited no more than 18 weeks from their referral)	92%	93.1 %	93.3 %	93.8%
A&E four hour wait (how long it is expected you wait at an A&E department to be treated and discharged)	95%	95.68 %	93.49 %	93.49 %
Diagnostic test waiting times (patients waiting over 6 weeks for a diagnostic test)	99%	99.7 %	98.7 %	98.4%
999 calls – Red Category A in 8 minutes (for the most serious cases, ambulances are required to arrive in 8 minutes)	75%	56.1 %	79.1 %	69.4%
999 calls – **Red Category A in 19 minutes**	95%	88.5 %	97.5 %	97.2%
A&E Handovers from crew to hospital staff	95%	82.1 %	85.1 %	85.1%

There were 133,590 attendances at Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) accident and emergency (A&E) during 2015/16 with 124,867 (93.5%) achieving the emergency care standard. At Airedale NHS Foundation Trust's A&E there were 54,744 attendances in the same period, of which 52,390 attendances met the 95.7% target. Nationally only 46 out of 165 trusts achieved the emergency care standard during October to December 2015.

While we have not seen an overall increase in attendance at BTHFT A&E through the winter period, there have been times of peak attendances, which have proved challenging. We have seen a decline in assessments through the ambulatory care unit with half as many patients going via ambulatory care. This is in spite of an increased focus by BTHFT. This implies that we have seen a greater number of people attending A&E rather than being admitted to a hospital bed (an increase of over 10% when compared to quarter 4 of the previous year), leading to an increase

in bed occupancy for patients with urgent care needs. This has resulted in high levels of high dependency unit resuscitation bed occupancy and some paediatric patients being admitted to beds outside of Bradford. In summary, the acuity of patients has proved the main challenge throughout the winter.

Although for AWC the emergency four hour standard was achieved for 2015/16, continued pressures for urgent care within the health system mean that this standard continues to be a challenge to deliver.

Attendances at Airedale Hospital's A&E department have increased over the past year. Patients who are ready to be discharged to another care provider - such as a nursing or residential home, or with a home care package - are experiencing delays for a number of reasons such as the capacity in these areas or due to a patient choosing a specific home that does not have availability.

During times of pressure through 2015/16 regular operational update meetings are held with providers and oversight is provided by our system resilience group. The emergency care intensive support team (ECIST) has been working with BTHFT to agree a phased physical redesign of A&E. The intermediate care hub and expansion of our virtual ward are key to reducing acute admissions.

Non-achievement of the A&E standard both locally and nationally is being reviewed by NHS Improvement.

The CCGs are working with partners across the health and care system to reduce unnecessary hospital admissions, transform care for people with learning disabilities, create sustainable urgent and emergency care services and to create a better environment to promote self-care and prevention.

In recent months, partners from our system resilience group (SRG) have participated in a patient flow review to look at areas of improvement across BTHFT and Airedale NHS Foundation Trust (AFT) facilitated by the Academic Health Science Network. We have also participated in a national pilot of urgent and emergency care by the Care Quality Commission (CQC) and we await feedback from the CQC on the findings of this review.

The intention of the Better Care Fund (BCF) is for health and social care to work together to ensure that a range of outcomes are met for the local population. This is explored later in the report. It should be noted that a requirement of this fund is to develop an action plan to address delayed transfers of care. This will support the providers in the delivery of the A&E standard and will enable more beds to be made available.

Ambulance response times (AWC CCG, Bradford City and Districts CCGs) – Yorkshire Ambulance Service

The ambulance waiting times standards continue not to be met by the Yorkshire Ambulance Service at the provider level overall. They are also not being achieved for Bradford Districts CCG or AWC CCG populations. The standards are being met for the population Bradford City CCG.

NHS England is piloting giving ambulance call handlers extra assessment time to improve clinical outcomes. At present, ambulance services are allowed 60 seconds before the clock starts to decide what the right course of action before dispatching an ambulance or initiating another response. Two pilots have been announced where call handlers will be allowed up to a maximum of an additional 120 seconds for assessment, before the clock starts, for all 999 calls except immediately life threatening calls (Red 1). Yorkshire Ambulance Service joined the national pilot in mid-April 2016. We expect the outcome of this pilot will change the construct of the national standard.

To support improvement of ambulance response times in areas where it is a challenge to meet them, AWC CCG has invested in a number of defibrillators to provide 24-hour access for the communities in which they are sited. These have been placed where there is high footfall from local residents, in rural areas and in other places that can be hard to reach during rush hour. If this improves response times and outcomes for patients, it can be considered across other areas in the Bradford district.

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Whilst also encouraging providers to improve, its role is to ensure that health and social care services provide people with safe, effective, compassionate and high-quality care.

Airedale NHS Foundation Trust

At the time of writing this report, Airedale NHS Foundation Trust had only just received their CQC report which had given them an overall rating of “requires improvement”. The CQC carried out its inspection from 15 -18 March 2016 and undertook two further unannounced inspections on 31 March 2016 and 11 May 2016. The report was published on 10 August 2016 and the Quality Summit was scheduled for a week later (17 August 2016). The CQC reported that services were caring, effective and responsive but needed improvement to be safe and well led. An action plan is required by 19 September 2016.

Bradford District Care Foundation Trust

In June 2014 Bradford District Care Foundation Trust (BDCFT) received an overall rating of “requires improvement” following a CQC inspection which focused on patient safety and the trust was required to implement actions to improve. The trust was subsequently re-inspected on 11-13 January 2016 as part of the new inspection regime and has subsequently received a rating of ‘good’. The CQC found that the actions to address the improvements required had all been achieved. The health-based places of safety (HBPoS) environments have been refurbished and now meet the Royal College of Psychiatrists’ guidance. The trust has also made improvements relating to the availability of medical staff to review patients on the acute wards.

Bradford Teaching Hospitals NHS Foundation Trust

In October 2014 Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) received an overall rating of "requires improvement" following a CQC inspection. The trust was required to improve in the domains of effective, responsive and well-led, was rated as inadequate for safety and 'good' for the domain of caring. The improvement focused on a number of clinical areas and governance structures including addressing a backlog of referral to treatment waiting list, infection control and cleanliness, availability and suitability of equipment and premises and involvement of staff and service users and governance systems. A total of 36 areas of improvement were required. BTHFT developed a detailed improvement programme to action the required improvements. On 11- 13 January 2016 and 26 January 2016 the CQC again undertook a focused inspection of the trust, reviewing areas that required improvement from the 2014 inspection. The inspection report was published on the 24 June 2016 and the trust has received an overall rating of 'requires improvement' with the domains of safe, responsiveness and well-led rated as 'requires improvement' and effectiveness and caring rated as 'good'. The good progress made by BTHFT was noted by the CQC. The CQC also noted several areas of outstanding practice, including collaboration with neighbouring trusts to recruit and retain a workforce that reflects the black, Asian, minority ethnic population of Bradford; leadership in the 'well-North' programme aimed at improving the health of the poorest communities and achievements in hip fracture and palliative care services.

Key messages from the 2014 inspection and noted improvements in the 2016 inspection include:

- A high volume of patients were waiting for a review of their outpatient care pathway after previously having been seen by a consultant at the 2014 inspection. The CQC in the 2016 inspection noted some real improvements in some of the core services and noted that the trust is "making significant improvements" overall in this area. The total number of patients waiting for an outpatient appointment has reduced from 205,000 to 11,790 by December 2015. In July 2016 this figure was less than 3,000.
- The stabilisation of children - the skills and experience of some staff in the stabilisation room - required improvement in 2014 and has now been fully addressed by the trust. Changes have also been made to the workforce model. The trust commissioned an external review of the service and a children and young people's board has been established.
- Improvements to non-invasive ventilation - level two high dependency unit (HDU) standards which were not being met in 2014 have now been fully addressed.
- Staffing issues, including a shortage of suitably skilled, qualified and experienced staff in line with best practice and lack of a system to triangulate staffing levels against other information remains an ongoing issue since the 2014 inspection. The CQC acknowledged the Trust's actions to address workforce issues through its approval of £2.5m of additional staffing in December 2015.
- Improvements were noted in governance and decision-making but more work is needed to ensure that this is properly embedded at ward level.

The trust has developed an 'accountability and responsibility' framework and has revised its governance structure to address ongoing improvements.

GP practice ratings

The CQC also inspects GP practices. By August 2016, 21 Bradford City CCG GP practices had been inspected, one of which was rated as "outstanding" whilst 19 were rated as "good" and one was rated as "requires improvement". Thirty-three practices in Bradford Districts CCG have been inspected - 31 were rated as "good" and two as "outstanding". Ten practices in AWC CCG have been inspected – one was rated as "outstanding", eight were rated as "good" and one as "requires improvement". GP practices rated as "outstanding" are among the top 3% of all GP practices in the country.

Bevan Healthcare CIC, a practice which provides health and social care to homeless people, asylum seekers and refugees, was one of the practices rated as "outstanding" by the CQC for the standard of care it provides to its patients, who are some of the most disadvantaged in Bradford. Professor Steve Field, Chief Inspector of General Practice, made the following statement following their recent CQC inspection; *"This is one of the best practices CQC has inspected. Bevan House was outstanding in each of the categories we inspect against and outstanding in every one of the six population groups – a remarkable achievement. The work that this practice was doing in the wider community is exemplary and deserves recognition. It is very clear that the practice is providing outstanding, personalised, patient-centred care very often connecting with traditionally difficult-to-reach patient groups."*

Where GP practices have required improvement a practice action plan has been submitted to the CQC. Progress against these plans is monitored by the CCGs.

Care home ratings

The CQC has inspected 94 out of 124 care homes across Bradford and Airedale CCGs under the new CQC inspection regime of which currently 14 (11.3%) homes are rated as inadequate, 33 (26.6%) homes require improvement and 47 (37.9%) good, leaving 30 (24.2%) still to be inspected by the CQC.

CCG KEY ACHIEVEMENTS

Mental health

Working closely with BDCFT as our main provider of services, as well as other services and organisations across Bradford, Airedale, Wharfedale and Craven, we have developed a joint action plan for improving the care for people in a mental health crisis, the crisis care concordat. As a result of the concordat, we implemented a 24-hour, seven-day, joint health and social care First Response service. The service has open access and responds to calls from anyone experiencing or encountering someone in mental health crisis. It also works closely with the police to provide 'street triage' for anyone they come into contact with who may require mental health intervention or require a place of safety. First Response has access to both the Safe Haven during the day (opened from August 2016) and The Sanctuary in the evening to avoid people having to attend A&E when they are experiencing a crisis. Both these services are provided in partnership with the voluntary sector.

This year BDCFT has worked closely with GP services to provide physical checks for over 5,000 people who have serious mental illness, and this has been highlighted as a model of best practice by the King's Fund. We have also developed the primary care wellbeing service, so we can evaluate the clinical and cost effectiveness of using a liaison psychiatry approach to treating people with medically unexplained symptoms in a non-stigmatising way in primary care. Early evaluation shows a strong case for further development and the importance of this approach has also been recognised by the King's Fund.

Our children and young people's mental health transformation plan 2015-2020, *Future in Mind*, aims to promote resilience, prevention and early intervention; improve access to effective support; provide care for the most vulnerable; develop the workforce; and be accountable and transparent. This has resulted in a clear action plan to take forward with our partners.

We are currently reviewing mental health in Bradford District and Craven to develop a vision and strategy for the mental health and wellbeing of the district to underpin a five-year transformation plan.

Self-care and prevention

Self-care is a key component of work being undertaken by the CCGs and public health which requires a mind-set change for both staff and members of the public. The 2015 theme for the Bradford district self-care week was 'self-care for life' which raised awareness about to safely treat minor ailments such as colds or fever. It also highlighted how people can live healthily and prevent avoidable, but serious, long-term conditions such as type 2 diabetes or heart disease.

A number of events took place over the week which offered tips on living healthily and well – ranging from a conga in Bradford's City Park, to wellbeing café events and more. There was also advice on hand throughout the week at community venues, GP surgeries, schools and libraries.

The Self-Care Forum announced the self-care and prevention programme as joint winners of the first National Self Care Week award. Alongside Bracknell and Ascot, Bradford and Airedale were praised for their activities during 2015.

Workforce

The integrated workforce programme (IWP) is an overarching and enabling programme that aims to work collaboratively to identify, and work towards, a system-wide integrated health and social care workforce that is fit for the future.

A successful workforce event was held in November 2015 where challenges, key priorities, good practice and potential workforce solutions were identified and brought together from a wide range of health and care, voluntary and education partners. The vision, created and developed from the event was:
"*The best people, providing seamless care, the Bradford District and Craven way*".

A number of 'big ideas' were also identified, including developing a system-wide integrated workforce strategy. The strategy was given priority during the remainder

of 2015 and was co-designed, co-created, shaped, tested and refined by partners within and across the health and care system. Work also commenced during 2015 on the shaping of the other 'big ideas' that would support delivery of the strategy and also in identifying system wide leaders to take them forward.

The strategy's success will be measured on its ability to promote health and care as the sector of choice to work for; to attract and recruit people to the Bradford District and Craven and to engage, develop and retain people within the wider health and care system in order to maximise workforce resilience and sustainability in the longer term. The underlying principles are, as far as possible, to grow and develop our own both across the system and the district as well as influencing the wider determinants of health by supporting routes into work and healthy living.

In 2016 the way people and organisations will need to work together seamlessly, in an integrated and system-wide way, will be clearly defined, communicated, measured and jointly owned through a series of milestones. There will be an expected cultural and mind-set shift to working for and with 'the system' with a shared commitment to the development and ownership of a common set of values, behaviours and core competences. The underpinning philosophy will be one of promoting prevention, self-care/self-management through the empowerment of others and, delivering direct care in a seamless and integrated way through the implementation of new models of care, to those that have more complex care needs.

The common identified priorities include:

- Co-creating and co-designing a district/system wide workforce strategy for health and social care;
- Inspiring and attracting young people to work in health and social care (11-18 years old);
- Promoting and encouraging new entrants and re-entrants to work in health and social care and in the Bradford District and Craven;
- Working with education partners to develop shared apprenticeship schemes;
- Developing a wide range volunteering opportunities;
- Developing system-wide joint leadership programmes;
- Creating and providing the conditions to attract and retain staff across a system, for example, by engaging, listening and involving; providing benefits and rewards; promoting mental and physical health, work and well-being and supporting employees to live healthier lifestyles;
- Promoting and ensuring diversity and inclusion is a common thread throughout.

Continuing healthcare (CHC)

The package of ongoing care that is arranged and funded solely by the NHS for people who are not in hospital, and have been assessed as having a 'primary health need', is an extremely busy area for us. In the last year we dealt with over 3,000 requests for assessments for CHC or funded nursing care in the Bradford

district, as well as reviewing many historic cases for funding eligibility. The CCGs' approach has been commended by NHS England.

Flagging patient records

In the first pilot of its kind in the country, five local GP practices have trialed a new way of flagging patients' access needs. This includes, for example, visually impaired people getting GP and hospital letters in alternative formats - such as large print, audio or via a phone call - so that receptionists and healthcare staff are aware of any individual requirements people may have.

Bradford CCGs

***Bradford Beating Diabetes* (Bradford City CCG and Bradford Districts CCG)**

The aim of the *Bradford Beating Diabetes (BBD)* programme is to reduce the risk, by postponing or delaying the onset of developing type 2 diabetes and to provide sufficient information and advice so patients can understand what being at risk means and about the complications associated with diabetes. The programme is supported by NHS England, Public Health England and Diabetes UK. Bradford has been chosen as one of seven national demonstrator sites for the national diabetes prevention programme.

The programme has two phases: firstly, to identify patients who, from a previous blood test, are known to be at risk; and, secondly, to identify all other eligible adults (for example, people over 40 years old, from high risk black and minority ethnic groups, and adults with conditions that increase the risk of type 2 diabetes).

Finding patients who are at risk

In Bradford City, where phase one has now finished, over 17,000 people (out of around 42,000 people invited) have taken up the invitation to have a repeat blood test. Just over 1,900 people have declined to take part. The test identifies people who are at high, moderate or low risk of developing diabetes. Those who are at high risk have received a referral into a programme to support them make small, achievable changes in their life. Phase two of the campaign is now the priority.

In Bradford Districts CCG phase one delivery began in October 2015 and almost 3,000 people (out of around 9,000 people invited) have taken up the invitation to have a repeat blood test. Just over 200 people have declined to take part. Those who are at high risk have received a referral into a programme to support them make small, achievable changes in their life.

Bradford's diabetes prevention programme

In Bradford City CCG more than 1,200 people have accepted a referral to a structured education programme - known as *Bradford's* Diabetes Prevention Programme - with over 50% starting and more than 40% attending five or more sessions. Around 2,100 people who were offered a referral declined it. People who have attended have seen changes in weight, their blood pressure and other clinical measures, all of which have reduced their risk of developing type 2 diabetes.

Leeds Beckett University has evaluated the structured education and results have shown improvements in blood sugar readings (HbA1c), weight and waist circumference. It has also shown an improvement in the individual's knowledge of diabetes and has been a "wake-up call" to the seriousness of the condition. The report also shows an improvement in the consumption of fruit and vegetables, as well as increased levels of activity.

New cases of type 2 diabetes found

In Bradford City CCG our data shows that, across the CCG's area - for the duration of the project (November 2013 to March 2016) - 1,545 patients have been added to the diabetic register. This shows that *BBD* not only raises awareness, but also identifies people with diabetes at an early stage, thus reducing the risk of associated complications.

In Bradford Districts CCG our data similarly shows that 442 patients have been added to the diabetic register since 1 October 2015.

Bradford's Healthy Hearts **(Bradford Districts CCG)**

Bradford has one of the worst death rates from heart disease in England. That's why one of our main priorities – through *Bradford's Healthy Hearts (BHH)* – is to reduce the risk of heart attack and stroke.

Through our workstreams, clinicians working with the *BHH* programme, have:

- used the QRISK2 assessment (a calculator to work out the risk of heart attack and stroke) to identify people with more than a 10% risk of having a stroke and to start them on statin medication. This has resulted in more than 6,000 patients starting to take a statin to reduce their cholesterol levels.
- worked to prevent strokes for people with atrial fibrillation (an abnormal heart rhythm that increases the risk of stroke). This programme has assisted almost 1,000 people to start oral anticoagulation (blood thinning) therapy to reduce the risk of stroke.
- developed a workstream which aims to improve blood pressure control for 38,000 patients who have high blood pressure, around 13,000 of whom are currently above target.

Based on assumptions from clinical trials, *BHH* has potentially prevented or postponed over 100 cardiovascular events. This has been done in a variety of ways, using innovative ways to encourage patients to understand how to reduce their blood pressure and cholesterol levels along with commencing therapies to help them do this. A website has been also been developed and our patients have reported positively about how they have been able to take responsibility for their condition and the medication they take.

We have started a series of monthly patient education events to help people learn more about cardiovascular disease (CVD), how to reduce their risk, and how to look after their health when they have the disease. Again the sessions have proved a huge success with 100% reporting that their knowledge of CVD had improved following the session.

During the year the *BHH* team was honoured to win a number of national awards, including:

- General Practice Awards 2015 – clinical team of the year (winner)
- General Practice Awards 2015 - general practice team of the year (winner)
- Association of Healthcare Communications and Marketing – best website (runner-up)
- BMJ Awards 2016 – clinical leadership team of the year (winner)

and was shortlisted for the HSJ Valuing Healthcare Awards 2016 – use of IT to drive value in clinical services.

A summary of some of our other successes:

- Our new integrated intermediate care hub, based at St Luke's Hospital, is now up and running and helping to provide health and social care closer to home for elderly patients. It provides a single point of access for GPs, staff in the community and other health and social care professionals to refer patients into all intermediate care.

- One particular highlight has been the creation of our *People's Board* (see page 3).

Delegated function – Co-commissioning primary care

From 1 April 2015 Bradford City CCG and Bradford Districts CCGs also became responsible for the co-commissioning of local GP services. We were one of only 64 CCGs in the country that had been given this responsibility, delegated by NHS England. The ability to commission these services means that local people will have a greater say in deciding how services are developed. Part of the reason for our success in gaining full delegation is that we are committed to improving the quality of services in general practice in Bradford and that we are able to make decisions that are sensitive to local needs. We are already working with our GP practice members to improve standards and we will extend this work further.

During 2016 we finalised our primary care commissioning strategy with our members enabling our commissioning decisions not to be taken in isolation.

We are responsible for helping our GP practices improve the quality of services provided for patients. We have reviewed a number of key themes including patients' perceptions of GP access, unwanted variation between practices, for example prescribing patterns and customer care training for GP practice staff.

Airedale, Wharfedale and Craven CCG

Integrated care pioneer programme

In 2013, a nationwide programme was launched and national bodies asked local areas (NHS and local government) to express an interest in working together to develop ambitious and innovative approaches to efficiently deliver integrated health and social care. The aim is that individuals have an improved experience, there is less waste and people's lives improve. In becoming 'national pioneers' there is a requirement to act as exemplar sites, and to share with others the use of unique approaches to efficiently deliver integrated care. AWC CCG was successful in its application and the subsequent selection process and is one of 25 sites in the

country who receive national support to progress integration programmes of change. The programme is known as new models of care (NMoC). Support is in the form of programme funding, shared learning and shared best practice from other national sites that will help inform our models of care and increase the pace of change and rapid delivery of our new models of care programme. The programme within AWC is made up of four areas on which the CCG is currently working with partners. Examples of two of the areas of progress in preventing hospital attendances, hospital admissions and in ensuring people receive the care most appropriate for their needs are:

Complex care

AWC CCG, together with health and social care partners and patient representatives, developed a new service for people with complex care needs as part of our NMoC work. A new complex care team – funded by the CCG – started work in April 2016 to provide dedicated and co-ordinated support to people with complex needs. It has a strong focus on proactive, rather than reactive, care and the team from Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Yordales (a federation of local GPs), are working to understand people's needs fully and, where there is a risk of increased use of health and care services, to act before this happens. They work closely with individuals and provide support and treatment wrapped around patients' needs in, or closer to, their homes to reduce their need for emergency hospital care. A unique addition to this team is the personal support navigator (PSN). This new and unique role is delivered in partnership with the local authorities and voluntary and community services (Age UK and Carers Resource). The PSN is a dedicated point of contact for these people and an integral part of the team supporting individuals to help them make more informed decisions and live more independently. Some early case studies demonstrate the impact this new approach to care is having on people's lives, in particular the PSN role is helping individuals and their carers to achieve their own goals, reduce isolation, improve self-care and self-management. The roles allow for flexibility in approach and one to one contact and support for individuals, backed up with clinical experts and social care services.

Enhanced care

Enhanced care is focused on looking at the issues faced by patients who see their GP on a regular basis or who frequently end up in hospital. The enhanced primary care schemes commenced in 2015 and have provided more proactive care and support to address patients' needs. The support varies and is tailored to an individual by addressing their overall needs (physical, mental health and broader needs which may not be health-related). GP practices across the area have been trialling different ways of delivering enhanced care based on their knowledge of their practice population. Some practices have employed advanced nurse practitioners or care co-ordinators (who may not be clinical) to find suitable patients and co-ordinate their care, offering one-to-one support. Others are contacting patients after an unplanned admission to hospital to review their needs and the reason for admission. They ensure support is in place upon discharge to help rehabilitation and help prevent re-admission. Another example is employing people with different skills such as physiotherapists and pharmacists to work in practices to better respond to people's needs. The schemes have nurtured innovation and creativity among practice staff but most of all have made real improvements to

people's health and wellbeing. The results and stories shared by those receiving this new approach to care have been far-reaching with patients becoming more confident to manage their own health and care needs reducing use of services, have more knowledge, and the ability to access services in the community making better use of other professionals' skills instead of reliance on their own GP.

A summary of some of our other successes:

Falls pathway

This pathway has been established in 2015/16 with partners to help identify people who are at risk of falling and reduce fall-related injuries. The pathway will be introduced in 2016/17 to identify people at risk of falling earlier so that preventative measures can be taken. Staff from health, social care, fire and voluntary and community services will work in partnership to offer people more support to maintain their independence

Care home quality improvement scheme

This scheme runs across a number of care homes in the AWC locality providing proactive care for elderly and vulnerable patients. Care plans are developed with GPs, and the patient and their families to ensure the patient's wishes and needs are taken into account, staff in the home receive education and support from the GPs on an ongoing basis, and the homes have a named GP or nurse providing continuity of care. GPs and nurses attend the homes on a regular basis and review people to prevent issues rather than wait until someone becomes ill. This has improved quality and people's experience. The service has resulted in a reduction in 999 and A&E activity, and in emergency admissions to hospital.

Diabetes

Towards the end of 2015/16 the CCG commenced procurement of an innovative service which will provide enhanced care to people with diabetes and also meet people's specialist podiatry needs. The CCG has worked with clinical experts and patients to determine what outcomes the service would need to deliver to ensure the optimum diabetes care. This will improve the lives of individuals and reduce the risks of complications. On award of the contract the contract provider will be held to account for delivering these improved outcomes which include better disease control, reduced complications, reduced kidney disease and amputations, people knowing more about the disease and being more in control of their care through self-care and self-management, with an improved approach to prevention so less people get diabetes.

CCG Assurance 2015/16

NHS England's overall assessment on the performance of AWC CCG for 2015-16 is 'good'; they reported their full assurance on all aspects of governance, finance, quality and performance:

One of the five components in the 2015/16 CCG Assurance Framework is "planning"; importantly this looks at the wider set of plans that the CCG is responsible for developing and implementing across the short and long-term. There

was recognition that the CCG had experienced some financial challenges in 2015/16, and although the CCG had developed a financial recovery plan and subsequently met its financial targets for 2015/16. NHS England felt the CCG did not currently have a financial plan that met their planning rules in 2016/17 and therefore decided to record “limited assurance” in the planning component.

This resulted in the CCG receiving an overall rating of “requires improvement”.

NHS England’s assessment of Bradford City CCG and Bradford Districts CCG rated as “good” across all domains with an overall rating of “good” for 2015/16.

PROGRESS TOWARDS INTEGRATION OF HEALTH AND SOCIAL CARE

The Bradford and Airedale health and wellbeing board brings together key people from the health and care system to provide a single place to work together to shape and improve the health and wellbeing of the local population.

During the year the health and wellbeing board has overseen work on jointly managed (between the local authority and CCGs) aftercare arrangements under Section 117 of the Mental Health Act 1983. Linked to approval of the *Better Care Fund*, the board has considered progress towards integration of health and social care. This focussed on enhancing health and wellbeing and accelerating an improvement in outcomes for the local population through integrated commissioning. It includes building on the *Better Care Fund*, expanding joint commissioning particularly for mental health and learning disabilities services and delivering new models of care. All this work moves us closer to delivering our vision for 2020 of a sustainable health and care system.

Pooled budget – the Better Care fund

The *Better Care Fund* (BCF) is a Government initiative to drive more integrated working and at a faster pace. The Bradford CCGs and AWC CCG, along with Bradford Council, have aligned agreed budget lines. BCF monies will be deployed to help services work closer together more effectively to improve integrated working and health and care of our local population.

Together, the CCGs want to improve the outcomes and experiences of people, families and carers by doing things differently: getting organisations, people and communities working together and thinking creatively so that health and social care are fit for now and for future generations. The BCF will support us to achieve greater integration and to deliver our vision of integrated health and social care and support. An important point to note is that the BCF is made up from existing CCG and council money – it is not new or additional. Across the Bradford district and Craven the fund is being used to to focus on:

- capital funding including disabled facilities grants;
- carers’ break funding;
- expansion of intermediate care services, including the Bradford virtual ward, early supported discharge schemes, community equipment, Airedale Collaborative Care Team (ACCT), intermediate care beds, intermediate care support in the community, mental health and palliative care – community support, reablement services in social care and NHS;

- Care Bill implementation;
- protecting social services.

Non-elective admissions

During 2015/16 a total 15,047 patients had a non-elective admission to hospital. A rate of 2,780 non-elective admissions per 100,000 (in Quarter 4), this was below the health and wellbeing board target of 2,843 admissions per 100,000 populations. Work plans to support the Integrated Care Programme include:

- Testing of new models of pro-active care
- Intermediate care service
- Community step-up and step-down service
- Intermediate care in the patient's own home (via the virtual ward and collaborative care teams)
- Use of intelligence to identify those at risk of admission, predictive risk stratification, frailty index, clinical judgement
- Integrated health and social care communities

Throughout 2015/16 BCF partners reported a risk regarding non-elective activity. A reduction in such admissions is linked to the expanded virtual ward. Recruitment challenges for the virtual ward resulted in a delay in the opening of this facility. This subsequently led to an overtrade position in non-elective admissions. As such BCF partners agreed the performance fund would fund this increase in activity.

Delayed transfers of care - achieved

Our excellent performance on delayed transfers of care, both overall health and social care, has been maintained. This has been highlighted as best practice in regional sector-led improvement and in December 2015 we delivered a 'Masterclass' session at a joint local authority and NHS regional event chaired by Sandy Keene (National ADASS.). We are not complacent and will continue to work in 2016/17 on maintaining this position.

Admissions to residential and care homes - achieved

We are on track to meet the agreed target of no more than 750 admissions to residential and care homes. Current year end out-turn value is expected to be around 735 which is based on approximately 415 permanent admissions to residential or nursing care during the year. This figure has yet to be validated by the Health and Social Care Information Centre (HSCIC).

Effectiveness of reablement - full target not achieved

There is good evidence that reablement improves service outcomes (that is, it prolongs people's ability to live at home, and removes or reduces the need for standard home care). Measured by its capacity to enhance the chances of staying at home, reablement also contributes to user independence and wellbeing. There is moderately good evidence that reablement improves outcomes for users, in terms of restoring the ability to perform activities of daily living (ADL) or improving morale. Reablement comprises 'services for people with poor physical or mental health to

help them accommodate their illness by learning or re-learning the skills necessary for daily living'. The focus is on helping people to do things for themselves rather than the traditional home care approach of doing things for people that they cannot do for themselves. Reablement is usually a 6–12 week intervention, focused on dressing, using the stairs, washing and preparing meals, although there is growing recognition of the need for reablement also to address social and psychological needs. Although reablement overlaps with intermediate care, its focus on assisting people to regain their abilities is distinctive.

We are not on track to meet the agreed target with a current year end estimate of around 88%. We are exploring care pathway data on short-term reablement type support to supplement this metric, which will inform and influence more effective local monitoring of integrated short-term support services such as the Bradford and Airedale integrated intermediate care services at the districts' hospitals. The hubs are contributing to improving reablement particularly in ensuring individuals receive the appropriate care within their home or a step up facility, all of which supports admission avoidance, early supported discharge and delayed transfers of care. The original target of 95% was recognised by the health and wellbeing board and Bradford Health Care Commissioners as unrealistic given the enablement model and the England average of 82%. Admissions to residential and care homes saw a significant increase in April 2015 but have been declining since then, this could be attributed to changes realised via the better care fund. Locally there is a view that no-one should be admitted to long-term care without all opportunity for reablement being exhausted first.

Local indicator – dementia case finding

The local indicator selected for Bradford BCF relates to the proportion of people diagnosed with dementia compared to the estimated prevalence rate. The local target is set at 75% of those expected to have dementia to have a diagnosis recorded. The national target is set at lower at 67% of those expected to have dementia to have a diagnosis recorded. In 2015/16 the England average for finding all cases of dementia is 67.6% with the best five achieving CCGs averaging 86.5% of patients who are expected to have dementia, having a diagnosis. Across Bradford and Airedale in the last quarter of 2015/16 we achieved 81.6% of our population who were expected to have dementia, with a diagnosis. (note: this result is based on the footprint of the three CCGs – we are currently unable to split out Craven GP practices' population)

FINANCIAL PERFORMANCE

Airedale, Wharfedale and Craven CCG

In 2015/16, revenue resources of £202.7m were available to the CCG, compromising £199.2m for the commissioning of healthcare services (programme allocation) and £3.5m for administration costs (running cost allocation). The programme resource allocation included a national growth uplift of 1.4% on the 2014/15 resource baseline, whilst the running cost allocation was 10% lower than last year (in line with the national policy on reducing administration costs).

2015/16 was financially challenging but we are pleased to report that the CCG successfully achieved its statutory financial duties and reported a surplus position

of £2.019m. As part of its financial planning process, AWC CCG recognised a number of risks in achieving its financial plan and to achieve its targets it would need to generate cash-releasing savings of approximately £4m. In September 2015, as a result of the risk of increasing healthcare activity and costs, and lower than expected savings, AWC CCG was formally placed into financial recovery with NHS England. A comprehensive financial recovery plan has been developed to ensure targets were met by the end of the financial year, and that AWC continues to achieve financial stability in future years.

Bradford City CCG

In 2015/16, revenue resources of £146.1m were available to the CCG, comprising £143.5m for the commissioning of healthcare services (programme allocation) and £2.6m for administration costs (running cost allocation). The programme resource allocation included a national growth uplift of £4.4m (3.78%) on the 2014/15 resource baseline, whilst the running cost allocation was 10% lower than last year (in line with the national policy on reducing administration costs).

New areas of expenditure incurred by the CCG related to primary medical services (£17.5m) following the delegation of commissioning responsibility from NHS England, and also the *Better Care Fund* (£2.6m of additional investment) which is a national policy initiative designed to promote integrated working between health and social care.

Overall, the CCG continued to manage its resources effectively and met its statutory financial duties to keep revenue expenditure within available revenue resources, and to keep administration costs within the CCG's running cost allocation. Also, cumulative surplus funds carried forward to 2016/17 decreased by £0.2m to £3.5m as a result of using some funding to progress the *Bradford's Healthy Hearts* initiative.

Bradford Districts CCG

In 2015/16, revenue resources of £484.3m were available to the CCG, comprising £477.2m for the commissioning of healthcare services (programme allocation) and £7.1m for administration costs (running cost allocation). The programme resource allocation included a national growth uplift of £13.6m (3.42%) on the 2014/15 resource baseline, whilst the running cost allocation was 10% lower than last year (in line with the national policy on reducing administration costs).

New areas of expenditure incurred by the CCG related to primary medical services (£48.4m) following the delegation of commissioning responsibility from NHS England, and also the Better Care Fund (£10.5m of additional investment) which is a national policy initiative designed to promote integrated working between health and social care.

Overall, the CCG continued to manage its resources effectively and met its statutory financial duties to keep revenue expenditure within available revenue resources, and to keep administration costs within the CCG's running cost allocation. Also, cumulative surplus funds carried forward to 2016/17 increased by £0.9m to £7.3m as a result of non-recurrent transformation spend being less than planned.

Using the *NHS Right Care* approach to inform CCG priorities

The *Right Care* commissioning for value work programme originated during 2013/14 in response to requests from CCGs that they would like support to help them identify the opportunities for change with most impact. It is a partnership between NHS England, Public Health England and *NHS Right Care* and the initial work was an integral part of the planning approach for CCGs.

Right Care is about identifying priority programmes that offer the best opportunities to improve healthcare for populations; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system. By providing the commissioning system with data, evidence, tools and practical support around spend, outcomes and quality, the programme can help clinicians and commissioners transform the way care is delivered for their patients and populations and reduce variation in health inequalities.

Commissioning for value is not intended to be a prescriptive approach for commissioners, but rather a source of insight which supports local discussions about prioritisation and utilisation of resources. It is a starting point for CCGs and partners, providing suggestions on where to look to help them deliver improvement and the best value to their populations. It also supports CCGs to meet their legal duties to have regard to reduce health inequalities.

Many of the themes from the *Five Year Forward View* (FYFV) are reflected in the principles of the *Right Care* programme. The focus on value, health outcomes, empowering the patient, transforming through systems and networks of care, and the need to drive down variation in quality and health outcomes are all key themes of both *Right Care* and the FYFV.

The *NHS Right Care* programme has one key objective and three key phases. Its key objective is to maximise value at population and individual level. The key phases are ‘where to look’, ‘what to change’ and ‘how to change’.

‘Where to look’ helps health economies to identify where they need to prioritise their transformation and health care improvement effort, based on where they can most improve. Each CCG has been compared to its ten most similar CCGS based on deprivation, population size and density, highlighting where any variation occurs. This data allows CCG to focus their efforts on areas where they can improve patient outcomes and reduce costs.

The second phase, ‘what to change’, helps CCGs to work out what is optimal and what changes are needed to move from where they are to where they want to be. The third phase ‘how to change’ comes when evidence has been gathered, and a case has been made

AWC CCG is part of wave one which commenced in 2015, and the Bradford CCGs are part of wave two which will commence in September 2016. The three priority areas which are being focused on in AWC CCG are respiratory, cardiovascular disease and cancer. Work has started with clinicians to improve pathways and outcomes for specific patient groups. This focus on outcomes has highlighted a variation in the effectiveness of certain medical procedures and those identified

with limited clinical effectiveness may be removed or replaced. The Bradford CCGs have used the *Right Care* approach when developing *Bradford Beating Diabetes* and *Bradford's Healthy Hearts* and will continue this as part of their *Right Care* programme in 2016.

NATIONAL PROGRAMMES

Care home vanguard

This new care model, which aims to enhance health for residents in care homes, brings together more than a dozen organisations – including the CCGs - from health and social care services, care home providers, technology specialists and academics working across Airedale, Bradford, Craven, East Lancashire and Wharfedale.

Chosen from 269 applications from across the country, the local partnership has been named as one of the first 29 vanguard areas that have won a share of a £200m transformation fund.

Vanguard sites pilot plans to significantly improve patients' experiences of local healthcare by bringing home care, mental health, community nursing, GP services and hospitals together for the first time since 1948.

The local scheme will use technology, such as telemedicine, to integrate services and provide immediate access to expert opinion and diagnosis, where appropriate, as well as supporting individual independence and improving the quality of life of residents by focusing on proactive rather than responsive care and delivering more specialist services into the care home.

- Across the three CCGs there are 131 homes signed up for telemedicine, these include 49 homes across NHS Airedale, Wharfedale & Craven CCG and 82 homes across in NHS Bradford City CCG and NHS Bradford Districts CCG.

Urgent and emergency care vanguard

Established in 2014, the West Yorkshire urgent and emergency care network vanguard covers Leeds, Bradford, Calderdale, Kirklees, Wakefield and Harrogate. It serves a population of around three million people.

The vanguard works with partners, including five local system resilience groups, to build on progress already made in transforming primary, community and acute care services. Work on the vanguard includes:

- Yorkshire Ambulance Service developing a stronger focus on becoming a mobile treatment service delivering care at patients' homes with conveyance to hospital for those who really need to go
- three mental health service providers working with West Yorkshire Police to deliver major service change which will see rapid crisis response through emergency response control centres and 'street triage'
- creating an integrated West Yorkshire care record and a system-wide information dashboard which reports in 'real-time'.

4. Options

Not Applicable

5. Contribution to corporate priorities

A number of metrics relate to joint working across the Bradford District and contribute to corporate priorities.

6. Recommendations

6.1 That the Health and Social Care Overview & Scrutiny Committee note the content of the report

7. Background documents

None

8. Not for publication documents

Not Applicable

9. Appendices

None