Bradford District and Craven STP

In our place our focus is on :

- *Prevention and early intervention with a specific focus on Obesity, Type 2 Diabetes, CVD, Cancer, respiratory and Mental Wellbeing*
- *Creating sustainable, high impact primary care through our primary medical care commissioning strategies and commissioning social prescribing interventions*
- *Supported self-care and prevention through supporting individuals to get the skills they need and training our workforce to work in a way that empowers and facilitates independence .*
- *Provision of high quality specialist mental health services for all ages and early intervention mental wellbeing support services.*
- *Delivering population health outcomes and person centred care through new contracting, payment and incentives in line with accountable care models elsewhere.. This includes specific interventions that transform services to address the physical, psychological and social needs of our population, reducing inequalities and addressing the wider determinants of health.*
- *Developing a sustainable model for 24/7 urgent and emergency care services and planned care.*

Progress so far…

- *We have made significant progress in 2016/17 establishing provider alliances, including primary medical care at scale, and together with the commissioner alliance are making great strides towards population health outcomes and person centred care. The first population health outcomes type of contract for Bradford will be launched April 2017 focusing on primary prevention of diabetes, improved care and treatment of people with diabetes. Airedale , Wharfedale and Craven is moving to a shadow accountable care system as of April 2017*
- *We engaged with our population to develop our five year strategy and specifically around the design and delivery of our confirmed plans and these plans have been endorsed by our Health and Wellbeing Board*
- *We have aligned our three CCGs under a single accountable officer and chief finance officer and intend to move towards more shared arrangements over the next twelve months which will include formalised joint, placed based commissioning decision making arrangements*
- *We have ensured the significant shifts of secondary to primary care activity secured over the last ten years have been mainstreamed through the PMS review alongside improvements in primary care access and health inequalities reduction activity and in Airedale, Wharfedale and Craven have implemented an enhanced primary care programme.*
- *We are addressing the holistic needs of patients with multiple comorbidities through complex care models across the patch. Airedale, Wharfedale an Craven is a pioneer site and has seen a 2% reduction in non-elective admissions through their testing period*
- *We are a Vanguard site (Enhancing Health in Care Homes) and are evaluating video consultation in care homes*
- *Our crisis care concordat and first response services have received national recognition and we have had no mental health out of area placements in over a year*
- *We have a nationally recognised digital shared care record across health and social care*
- *We have an accelerator site for a new smaller acute hospital model*

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The Triple Aim

Health and wellbeing – by 2020/21 we will

- reduce childhood obesity by 5%
- reduce smoking by 5%
- have trained 10% of the health and social care workforce to support people to better self-care
- reduce cardio vascular events for around 600 people
- screen an additional 5500 women for breast cancer
- screen an additional 1500 people for bowel cancer
- screen an additional 500 women for cervical cancer

Care and quality - by 2020/21 we will

- save150 lives through reduction in variation of identified Right Care opportunities
- see commissioning and provision of improved population outcomes through the implementation of new contracting models
- reduce non-elective admissions by 4%
- roll out seven day services in hospital to 100% of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards)
- commission new models of primary medical care that ensures seven day access achieved for 100% population by 2021.
- ensure our local acute providers have all-age Mental Health Liaison teams in place and by 2020/21 will meet the “Core 24” standards.
- 90% of people who access Psychological Therapies will engage through direct self-referral.

Finance – by 2020/21 we will have

- delivered all organisational control totals in the local systems’ organisations in 2016/17
- closed the £221m gap by:
  - delivering efficiencies of £106.7m through provider and commissioner CIP/QIPP programmes including new models of care and transformation
  - developing and delivering further proposals of £46.1m in collaboration with WY colleagues including clinical thresholds procedures of limited clinical value, further right care opportunities
- mitigated the risk of social care cuts of £50m
- utilised £18.1m of STF funding in 20/21
- By 2018/19 we will have modelled additional schemes to shift transfer of resources equivalent to £1.8m to primary care

Key milestones & decisions 2016/18

Enablers - Accountable Care for Bradford & Craven by 2021

- Accountable care accelerator programme in AWC designing new contracting models by March 2017
- Shadow Accountable Care System(AWC) by April 2017
- Procurement of a new model of care for diabetes awarding one outcomes-based accountable care contract – April 2017
- Structured collaboration for Bradford out of hospital clinical and social care model commences in September 2016 with intention to create a new contracting model in 2017.

Health and Wellbeing/Care Quality Gaps

- Roll-out diabetes prevention and smoking cessation programme - 2017/18
- Implement Cancer taskforce recommendations
- WY Urgent Care Vanguard decisions
- Children and Young People’s Mental Health Transformation Plans implementation 2016/17 2017/18
- Workforce Strategy for H&C system by December 2016
- Estates Strategy for H&C system March 2017
- Digital Technology Strategy for H&C system June 2017

Financial Gap

- Analysis of plans to understand risk in plans within new models of care and QIPP/CIP in particular how social care funding gaps are managed
- Deliver worked up schemes for the opportunities within the £46.1m – October 2017
- Funding plan for long term self -care and prevention initiatives– March 2017