NHS
Bradford Districts
Clinical Commissioning Group

Report to Bradford South Area Committee

1 Sustainability and transformation plan

The Bradford District and Craven sustainability and transformation plan[1] (STP) – a partnership approach between the NHS and Bradford Council - has been published. It forms an integral part of the overarching West Yorkshire and Harrogate[2] plan.

The local plan includes the following developmental areas:

- Prevention and early intervention at the first point of contact, with a specific focus on children, obesity, type two diabetes, cardiovascular disease, cancer, respiratory illnesses and mental wellbeing;
- Creating sustainable, high impact primary care through our primary medical care commissioning strategy and commissioning social prescribing interventions;
- Supported self-care and prevention by maximising our community assets to support individuals and train our workforce to empower and facilitate 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.

In advance of formulating specific plans and proposals to support these aims, we are planning a series of conversations with the public to get a refreshed sense of their priorities and what's acceptable to them as we move forward. We intend that this programme of engagement will commence in March and will cover the whole of Bradford district and Craven.

The STP brings together our programmes of work, some of which include the following plans and priorities:

1.1 Quality, innovation, productivity and prevention (QIPP)

Nationally and locally the NHS is going through one of the most challenging periods in its history. As well as achieving the best possible patient outcomes through high quality, clinically effective services, we must also ensure value for money.

[1] Bradford District and Craven STP: http://www.bradforddistrictsccg.nhs.uk/be-informed/our-publications/sustainability-and-transformation-plan/
[2] West Yorkshire and Harrogate STP: http://www.southwestyorkshire.nhs.uk/quality-innovation/sustainability-transformation-plans-stps/west-yorkshire-harrogate-stp/

Like local government, the NHS is facing a massive financial challenge. Locally the gap between the funding that the Bradford CCGs receive from the government and local demand for existing services is around £13 million in 2016/17, and is projected to be around £16.9m in 2017/18 (of which £13.4m relates to Bradford Districts CCG). If we don't rein this back to a more manageable position, the outlook for future years is bleak.

In Bradford we've managed money well and our books have been in the black. But to keep it this way, and to have much-needed money to help transform services in the future, we must make some challenging decisions. This is not easy, or even sometimes palatable, but we are facing this challenge confidently to achieve the best solutions for Bradford people.

Through our QIPP plan – a national plan for the NHS to achieve quality, innovation, productivity and prevention – we are looking at how we can help to stop people becoming ill but, if they do, how we can do things even better, with creative solutions, and so prevent NHS resources from being used wastefully.

Despite needing to save money, we're continuing to focus on our plan that every patient experiences clinically effective high quality NHS services in Bradford and, where possible, is prevented from becoming ill. To help us make the decisions needed, we will involve and engage with local people, doctors, other clinicians and our stakeholders.

QIPP is here to stay; how we accomplish it to the greater good is very much a partnership with local people. Our five year QIPP plan will review all areas of CCG commissioning to ensure financial sustainability.

Early prescribing schemes that we have implemented in the areas covered by Bradford Districts and Bradford City CCGs include:

Gluten-free prescribing: One of the areas reviewed as part of the QIPP plan was the prescribing of gluten-free (GF) food for patients with coeliac disease – an issue which is being reviewed by many CCGs nationally.

We carried out a three-month public consultation and considered patients' views, clinical evidence, the maintenance of choice and financial information about the need for and cost of GF prescribing. The CCGs' joint clinical board decided to stop all GF prescribing, apart from patients with exceptional clinical circumstances, and have asked GPs to support them in ending this service. This has been a difficult decision for us but made against the backdrop of GF food being widely available and considerably cheaper than it was years ago, whereas the cost charged to the NHS to provide this food on prescription can be up to four times as much as the cost on the high street.

Airedale, Wharfedale and Craven CCG is also currently consulting local people and other stakeholders about this issue.

Ordering of repeat prescriptions: We have asked GPs to implement a new scheme which means that pharmacies no longer order repeat prescriptions on patients' behalf. Patients will continue to receive their repeat prescriptions as normal, but will order them directly from their GP instead of the pharmacy. Under the old system some patients built up a stock of unused medicines, resulting in considerable medicines waste. The new system is safer as the GP can monitor and discuss with patients what medicines they may, or may not, needed. Pharmacies continue to fulfil prescriptions and, where requested, make home deliveries. The initiative also helps us to save money by reducing waste. We are supporting this initiative through patient information and through a campaign to support patients to order their prescriptions, and make appointments, online via the SystmOnline mobile app.

Examples of other QIPP schemes include:

- working with patients and others to review the patients' journey through the NHS to ensure that it is as clinically effective and patient-friendly as possible;
- creating new ways of reducing unnecessary duplication of services and/or tests (for example, a central hub for medical test results to cut down the number of repeat tests ordered by GP practices and hospital consultants);
- where possible, expanding successful pilot schemes (such as the mental health wellbeing service);
- ensuring the most cost-effective drugs are prescribed, where appropriate;
- electronic systems and processes to assist general practices with the appropriate referral of patients;
- reviewing over-the-counter prescribing and Pharmacy First.

1.2 Mental wellbeing strategy

The Bradford District and Craven mental wellbeing strategy[3] 2016-21 was signed off by the Health and Wellbeing Board on 29 November. The next step is to create action plans to support the implementation of the strategy.

At some time in their lives, mental health issues will affect about 155,000 people in Bradford District and Craven, with about 6,200 people being in need of, and in contact with, specialist mental health services at any given time. The strategy takes an all-age, life-course approach with a strong focus on tackling the things that can cause mental health problems, and intervening early.

The launch of the strategy took place on Thursday 19 January and was attended by over 200 stakeholders, including partner organisations, young people, service users, VCS organisations and service providers.

1.3 Accountable care system: new model of care for diabetes

Bradford is developing a new way of working with health commissioners and providers to deliver new models of care which bring better outcomes for patients.

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[3] Bradford district and Craven Mental Wellbeing Strategy: http://www.bradforddistrictsccg.nhs.uk/be-informed/our-publications/our-strategies/

This is known as an accountable care system (ACS) which is a bedrock of NHS England's *Five Year Forward View* – which sets out plans to change the NHS to meet increasing patient needs amid a challenging financial environment.

In forming an ACS with our providers – Bradford Teaching Hospitals NHS Foundation Trust, Bradford District Care Trust NHS Foundation Trust, GP practices and the voluntary and community sector (VCS) – the Bradford CCGs are focusing on diabetes as the first new model of care to be developed.

From April, this will bring together all aspects of diabetes services, from primary prevention to managing long-term complications associated with diabetes, to create a standardised high level of care wherever patients receive care. This will dissolve traditional boundaries between primary care and hospital services, so that partnerships with patients are developed over the long-term, and in turn they receive excellent and effective care to reduce the impact of diabetes.

The CCGs will commission diabetes services, using the existing £17m annual budget, based on a clear set of outcomes which rely on the providers working in partnership to streamline care and really focus on prevention and keeping patients with diabetes well and in control of their condition.

In developing this, the first of many new models of care, the CCGs have worked intensely with patients and the VCS to find out where problems exist, where services can be improved and how this should work to improve patient care. There will be a new 10-year contract to provide a long-term opportunity for providers to establish new pathways and better outcomes.

1.4 Bradford's Healthy Hearts

Bradford's Healthy Hearts (BHH) was set up to tackle the mortality rate from cardiovascular disease, particularly in Bradford Districts CCG which has the seventh worst CVD mortality rate for people under 75 in England (28% of deaths). High blood pressure (hypertension) is a problem faced by 14.3% of the population, whilst over 21,000 people have high cholesterol levels.

By 2021, BHH aims to reduce cardiovascular events by 10% (150 fewer strokes and 340 fewer heart attacks). To date we have introduced measures to help combat high cholesterol levels by prescribing statins to people at risk, and by switching to a more effective statin to those already on them. More than 7000 patients took up the offer of a statin with an ensuing mean reduction of 0.38mmol/l in cholesterol levels. We have also worked to prevent strokes for people with an abnormal heart rhythm (atrial fibrillation), with almost 1000 people starting on blood-thinning therapy to reduce their risk of stroke. Most recently we have started a programme to improve blood pressure control for 38,000 patients with high blood pressure.

In the last year, BHH has potentially prevented or delayed over 100 illnesses that could damage the heart. Future plans include work around heart failure and chest pain.

1.5 Urgent and emergency care: winter pressures

Pressure on our local hospitals has increased over the winter months, often as a result of respiratory and Norovirus illnesses, but also because of the acuity of the patients being admitted.

Local NHS organisations and the local authority work closely together on a year-round basis so that services can cope with additional pressures on the system, and winter has been no exception to this. A range of initiatives has been rolled out over the winter months, as well as a public information campaign to reduce unnecessary visits to hospital and to encourage and prepare people for self-care, where appropriate.

The West Yorkshire Acceleration Zone (WYAZ) – the only one of its type in the country - has been set up to deliver rapid implementation of improvements in urgent and emergency care delivery across the West Yorkshire and Harrogate STP footprint, including in Bradford. From this, we expect to learn about the benefits of supporting one health and care system to go further, faster – and whether this approach should be rolled out in other areas of the country.

WYAZ has three programmes of work, looking at pre-hospital care, streaming and ambulatory care, and flow and discharge. Bradford Teaching Hospitals NHS Foundation Trust has been involved in the introduction of streaming, which focusses on increasing access to alternatives to A&E once patients have attended the emergency department. It has also rolled out an initiative to enhance patient flow through the system and the increase the opening hours of its ambulatory care unit. These are in addition to the existing virtual ward and telemedicine facilities, both of which help to reduce hospital admissions.

As a health system, a number of new services commenced in the lead up to Christmas and we have also commissioned other services to help absorb pressures. These include:

- increasing the capacity of out-of-hours GPs through Local Care Direct (LCD);
- additional GP sessions at Hillside Bridge walk-in centre which doubled capacity on Christmas Eve and Boxing Day;
- commissioning an ambitious primary care scheme covering the recent bank holidays and Christmas Eve, which was booked through NHS 111 and LCD. This enabled 700 additional GP appointments to be available across the period and is being evaluated to decide whether it should be re-run at other periods of pressure including Easter and other bank holidays.
- Leading up to Christmas, we re-focussed the urgent care practitioner scheme (which reduces unnecessary conveyance into hospital) to work with those care homes with the highest conveyance rates to hospital.

1.6 Access to GPs

Bradford Districts' practices are taking part in the standard access scheme only. The access scheme is aimed at encouraging practices to work collaboratively with their patient participation groups (PPGs) to improve patients' experience of accessing general practice.

The managing demand scheme is aimed at encouraging practices to look at new ways of managing demand within general practice, bringing the benefit of more meaningful community engagement and promoting health and wellbeing.

Examples of the kind of activity practices plan to implement include:

- newsletters to improve communication with patients
- reducing DNAs (did not attends), as this can waste appointments
- improvements to telephone systems to help patients get through more easily
- implementing a triage system so those patients needing an appointment can get one and others can be supported to self-care or access other support where required
- promotion of self-care to patients, via events, notice boards and printed material so they feel more confident to look after themselves for minor ailments, which may not require an appointment with a clinician
- coaching patients on how to register for online services, to make and cancel appointments
- encouraging more patients to provide feedback via the national survey, the Friends and Family Test, or via practices' own satisfaction surveys
- working with schools and community groups – working with young people to gain their views and get them more engaged with the practice, supporting them to lead healthier lives
- first aid training and peer support for new parents
- referring patients in to social prescribing initiatives which may provide other sources of support not always found at the practice, eg advice on benefits and financial matters, self-care, leading healthier lives, exercise, emotional support, support for carers, support groups for people with long-term conditions and reducing loneliness.

1.8 Engagement with local people

We have continued to strengthen and consolidate the mechanisms that we use to involve patients and the public in our commissioning decisions. Through the MyNHS website we are establishing a database that will map our patient engagement and enable us to tailor key messages and involvement and promote better communication. Areas that we have engaged the public about the development of health services include:

- the Mental Health and Wellbeing Strategy 2016 – 202.
- working with children's centres to understand the experiences of new mums and women planning pregnancy, feedback from which has been fed into our local hospitals to inform their service improvement, and to the Maternity Partnership.
- Community chest grant initiatives to support care navigation and self-care activity – seven events, working with 18 GP patient groups.
- So far, we have worked with five local schools (involving more than 230 children) to develop a campaign with young people to raise awareness of the Bradford Beating Diabetes programme and about having a member of the family with diabetes (aimed at young carers). We anticipate working with more schools over the coming months.

- Prescribing of gluten-free foods.

Our mechanisms for engagement include:

- **People's Board:** In its first year the People's Board has made a strong impact. To date they have been involved in the recent changes to gluten-free prescribing, helped to shape the mental wellbeing strategy and started an ongoing working relationship with the out-of-hospital team. The board has also helped influence commissioning decisions on self-care initiatives by conversing directly with commissioners and facilitating discussions with the Patient Networks.
- **Grass Roots insight:** a way of reporting patient feedback on health topics from a variety of sources, including the Patient Opinion website, patient complaints and concerns, feedback from our websites and information that is collected during general engagement with local people. This year we are expanding this to include Care Opinion which will provide experiences of people receiving care home support.
- **Patient network:** a network event, bringing together the patient groups from all our member practices, took place in June to share good practice. Patient groups delivered short presentations on their progress, challenges and achievements, whilst partner organisations – such as Healthwatch and the VCS forum – held stalls to promote patient involvement. The network is not a patient-led initiative.
- **Women's network:** supports better understanding of women's health issues For a report on the women's network activities see: http://www.bradforddistrictsccg.nhs.uk/get-involved/how-getting-involved-makes-a-difference/womens-health-network/
- **Engagement with GP practices:** a joint project with Healthwatch and Barnardo's to look at ways of improving participation of vulnerable groups of young people within GP practices: http://www.healthwatchbradford.co.uk/young-people
- **Community chest:** promoting partnership working with other practices and voluntary and community groups to ensure we are all working to achieve the CCG's strategic priorities. Practices with good ideas to make the district a healthier place have the opportunity to bid for funding of up to £1500 to get their ideas off the ground.
- **Maternity partnership:** works with providers and commissioners of maternity services to make sure that services meet the needs of local women, parents and families. Each year the partnership conducts a series of focussed discussion groups throughout the district to listen to the views and experiences of new mums and pregnant women on topics chosen by people who use the service (such as planning for pregnancy, perinatal mental health and safeguarding awareness).
- **Young people's event:** following a successful event in October 2015, we will celebrate another multi-partnership event this summer at which the CCGs will promote Bradford Beating Diabetes, Bradford's Healthy Hearts, supporting young people to seek employment opportunities in health and social care and work with patient groups.

- **Strategic planning group:** this brings together VCS provider organisations to work together with the CCGs to ensure we include the voluntary sector in our strategic planning and reflect the needs of local people in developing services.

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