City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of 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 5 October 2017

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Subject: Clinical Commissioning Groups' Annual Performance Report

Summary statement:

This report provides an update on Clinical Commissioning Groups' performance for 2016/17

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Portfolio:

Health & Wellbeing

1. Summary

This report presents performance against the NHS England Clinical Commissioning Group Improvement and Assessment Framework for 2016/17 for Bradford City (BCCCG), Bradford Districts (BDCCG) and Airedale, Wharfedale and Craven (AWCCCG) Clinical Commissioning Groups.

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.

NHS England has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG. For 2016/17 NHS England introduced a new CCG Improvement and Assessment Framework (IAF) to replace both the existing CCG assurance framework and CCG performance dashboard. This new framework provides a greater focus on assisting improvement alongside the statutory assessment function.

The framework is intended as a focal point for joint work and support between NHS England and CCGs, and was developed with input from NHS Clinical Commissioners, CCGs, patient groups and charities. It draws together the NHS Constitution, performance and finance metrics and transformational challenges and will play an important part in the delivery of the Five Year Forward View.

3. Report issues

An overview of CCG IAF performance is presented in Appendix 1.

3.1 Overall IAF Performance

The CCGs have demonstrated improvement over 2016/17 in a number of areas and overall all three CCGs have been rated as “GOOD”. This is an improvement for AWCCCG from 2015/16 when it received a rating of ‘REQUIRES IMPROVEMENT’. These ratings compare to an overall national position as presented in the table below:

CCGs rating	2016/17		2015/16	
	Number	Percentage	Number	Percentage
Outstanding	21	10.0%	10	4.8%
Good	99	47.4%	82	39.2%
Requires improvement	66	31.6%	91	43.5%
Inadequate	23	11.0%	26	12.4%

NHS England commended us on our performance during 2016/17. In particular, BCCCG and Bradford Districts BDCCG share the Best in England position jointly for Quality of Leadership and AWCCCG are ranked among the best quartile in England. Ratings of 'OUTSTANDING' were achieved in some areas. The ratings for three of the six national clinical priorities were published for cancer, mental health and dementia (CCG performance is shown in the table below) with the ratings for maternity, diabetes and learning disabilities to follow later in the year.

	Cancer	**Mental health**	**Dementia**
AWCCCG	Outstanding	Requires improvement	Good
BCCCG	Requires improvement	Requires improvement	Outstanding
BDCCG	Good	Good	Good

Key points to note are:

- There were no extreme results for AWCCCG and the CCG saw improvements for maternity, learning disabilities and one year survival rate for cancer;
- Although overall AWCCCG experienced improved results for mental health services, implementation of the children and young people's transformation plan has seen slow progress;
- Across all three CCGs there are metrics associated with long term conditions, non-elective admissions for urgent care sensitive conditions and for chronic ambulatory conditions which require improvement. Our transformation programmes for urgent care and new models of community provision are addressing these issues;
- BCCCCG appears in the 10 worst CCGs for cancer survival and GP patient experience, although the latter has substantially improved;
- Other areas of BCCCG poor performance are quality of life for carers, cancer early diagnosis and cancer patient experience;
- BCCCG has delivered improvements in diabetes, although delivery of NICE recommended treatment targets for diabetes remains a challenge. The Bradford Beating Diabetes (BBD) programme has focused its attention on supporting people who are at high risk of developing type 2 diabetes and has identified about 38,000 people who are classed as being at risk. During 2016/17 we have continued to raise awareness and identify individuals who have been diagnosed at high risk and refer them to the intensive diabetes prevention programme. Going forward BBD will form part of an integrated

new model of care for diabetes;

- Improvements have also been seen for mental health and learning disabilities;
- There is still work to be done to improve provider staff engagement across Bradford providers. Evidence suggests that the more engaged a workforce is, the better the outcomes for patients. Work across the District to develop a system wide integrated workforce is being led by the Bradford Integrated Workforce programme. There is a focus on developing new skills and improving supply of key staff, improving integration through a common set of values and engaging, listening and involving staff across the system, whilst also promoting mental and physical wellbeing;
- Childhood obesity across the district is worsening and whilst Public Health commission a range of services, work is needed to create a joined up strategy and true partnership working across the district to tackle the wider issues of obesity e.g. poverty and the environment;
- Both Bradford CCGs performed poorly against the maternity metrics due to the rate of neonatal mortality and still births, and high levels of smoking in pregnancy for BDCCG. We have established a maternity programme board to support local implementation of Better Births five year forward view for maternity services and made a successful bid to the perinatal mental health services development fund to extend community psychiatric nurse provision across adult mental health services;
- Improvements in BDCCG have been seen in diabetes, mental health and learning disabilities;
- Poor performance against some of the constitutional targets had an impact on performance for all three CCGs;
- Across the board, CQC ratings for the main providers and for primary medical services (GP practices) have improved this year. However, inspection of the adult social care sector remains a cause for concern. As part of our Better Care Fund (BCF) work, in order to stabilise and improve the quality of care in the care homes sector, targeted support has been offered by the system. This has included training, support with CQC inspection processes, specialist equipment provision and use of technology. This has enabled improvements in setting with fewer homes being rated as inadequate and more homes being rated as good or outstanding; and
- Financial performance across all three CCGs has been challenging in 2016/17. Particularly as a result of the risks associated with achievement of our Quality, Innovation, Productivity and Prevention (QIPP) work and associated savings.

3.2 Constitutional Target Performance

The NHS Constitution sets out a number of standards which have been translated into a range of targets for waiting times and patient care. Performance against a number of these has impacted upon the CCGs IAF assessment. The latest CCG scorecard is presented as Appendix 2.

18 weeks Referral to Treatment (RTT): Airedale Hospital Foundation Trust (AHFT) delivered the RTT target overall in 2016/17 but did experience

pressures at a specialty level, in particular Urology (demand and urgent/cancer work impacted on delivery) and Orthopaedics (longer term capacity challenges in line with the position nationally). The Trust actively reviews speciality level issues closely through their weekly RTT meetings and is working with stakeholders to look at sourcing additional orthopaedic capacity.

Failure of the target at CCG level is primarily affected by the ongoing poor performance at Bradford Teaching Hospitals Foundation Trust (BTHFT). Improvements have been noted in a number of specialties but the positions for Urology, Vascular Surgery and Ear, Nose & Throat (ENT) remain a concern as a result of a combination of increases in demand and service capacity. The Trust is in the process of recruiting additional consultants and is in early discussions with AHFT regarding Vascular services, whilst also securing additional capacity from the independent sector.

All three CCGs are continuing to work on a number of initiatives to manage demand including reviewing the ratio of first to follow up appointments in a range of specialties where these are higher than national norms, reviewing referral pathways and variation amongst GP practices and investigating the potential to cease commissioning of a range of nationally identified Procedures of Limited Clinical Value. We have redesigned the pathway for the treatment of lower back pain so that patients are now reviewed by community-led musculo-skeletal services. As a result, outcomes for patients have improved and pressures on secondary care reduced.

Diagnostic 6 week wait: AHFT delivered the 6 week diagnostic target in 2016/17. Poor CCG performance is a result of ongoing demand pressure at BTHFT, in particular demand for Computer Tomography (CT) tests, with the Trust utilising its capacity to the full. Additional activity is being contracted by the Trust.

With our implementation of new NICE guidance for the identification and referral of patients with suspected cancer, the resulting lower threshold for referral has inevitably resulted in an increase in the number of patients being seen for diagnostic testing. However, more cancers will be found at an earlier stage and therefore treatment outcomes will be improved.

Cancer waits: In the main, the majority of the national cancer waiting times standards were achieved in 2016/17. Performance against the two month wait standard from urgent GP referral to start of 1st treatment remains the biggest concern, with ongoing under performance at BTHFT as a result primarily of increased demand. Specific pressures remain for Urology and Head and Neck and Lung specialities. Although backlogs are reducing slowly, issues continue with late inter provider referrals and patient compliance.

We continue to work at both a local and regional level on cancer pathways:

- At West Yorkshire Alliance level, the bid for early diagnosis funds has been approved and further monies may be available for transformational

work to support this;

- Locally, BTHFT held a workshop in July 2017 (attended by Trust staff from all levels and cancer sites as well as CCG representation) to look at where efficiencies could be made across the whole cancer pathway;
- To address patient compliance, a bid was submitted to Yorkshire Cancer Research (YCR) to fund a pilot scheme to use the Enable2 interpreter service to contact non-responders to the national bowel screening programme and encourage their engagement. The bid has passed the initial stage and is through to an "Excellence Test"; and
- During 2016/17, cross organisational work between different hospital sites has included a review of inter provider transfers to ensure that, where a patients care pathway requires a referral between different organisations, there is no additional delay in treatment and there is timely transfer of clinical and administrative information between providers; and
- A 'Living with and Beyond Cancer' project is also underway which includes a work programme to introduce the new national Risk Stratification mechanism by Tumour sites work. The concept is that by risk assessing people living with cancer, a more appropriate and personalised care package can be developed. As a result, patient experience and outcomes will improve, and hospital outpatient attendances and unplanned admissions will reduce. It is being piloted for patients that meet the criteria across a small number of tumour sites initially.

Accident & Emergency (A&E) 4 hour wait: Both Trusts failed the national target overall in 2016/17. Performance is viewed as part of a wider set of multiple system pressures regarding urgent care including a general increase in A&E attendances, increasing non-elective admissions and added complexity of patient needs and the impact of delayed transfers out of hospital for patients who are medically fit for discharge which impacts on available bed capacity in the hospitals on a day to day basis.

The district wide Urgent Care Programme, overseen by the A&E Delivery Board, continues to work on system wide solutions to these pressures and initiatives include:

- The West Yorkshire Accelerator Zone funding and support was continued into quarter 1 of 2017/18, with three schemes in Airedale being key to continued and sustained improvement: Streaming to primary care, Streaming to ambulatory care and Clinical support for out of hospital beds;
- Additional out of hospital physical bed capacity at Thompson Court and Homewood is continuing to be provided through local authority funding;
- A&E GP streaming is being implemented at both Trusts;
- There is ongoing work to look at ambulatory care pathways (those covering a set of health conditions e.g. diabetes and asthma, where care would be better managed in community settings) as an alternative way of managing patients presenting to hospital who would traditionally be admitted; and
- Winter planning has been reviewed at a system level with a test of our surge and escalation processes being planned for early October.

Work also continues across the CCGs on pathways and new models of care in the community setting, to see improved outcomes for patients and reduced non-elective demand on acute services.

In Airedale:

- The Phase 2 Wrap Around Care Programme provides alternatives to hospital admission by streamlining pathways and reducing unnecessary/emergency hospital admissions. Work on this model is currently being developed and implemented as a phased approach due to the complexity and scope of service provision;
- The use of intermediate care, as an alternative to hospital admission where appropriate, continues to mature with, in 2016/17, the Intermediate Care Hub receiving 3,908 calls (18.86% of these referrals were from GP's and 7.09% from the Ambulance Service); and
- The Telemedicine service received 2,136 calls in 2016/17 and, as a result, 1,842 patients remained in their place of residence and 162 refrained from calling an ambulance or attending A&E.

In Bradford:

- The Bradford Breathing Better programme was launched in 2016/17, focussing on chronic obstructive pulmonary disease and asthma which are the two respiratory conditions which result in the largest number of unplanned admissions to hospital;
- We have established a Bradford community complex care team to support people who are at risk of becoming unstable. Previously they could have been admitted to hospital but now they will be supported in their own homes;
- Bradford's Healthy Hearts programme has helped reduced non-elective admissions by 10% and prevented 74 strokes and 137 heart attacks; and
- The expanded home from hospital service supports patients in their own home following their discharge from hospital, making sure they have everything they need to stay well and independent and avoid any unnecessary return to hospital.

In addition, our Primary Medical Care Commissioning Strategy sets out how we will work with GP practices and commission services within primary medical care over the next five years. As a result, we are delivering plans for extended weekday opening and training and development of our workforce.

Ambulance response Times: Yorkshire Ambulance Service (YAS) have been participating in the national pilot looking at improving Ambulance Responses (ARP pilot), which has been developed by listening to feedback from ambulance staff, GP and healthcare professionals. The results have been impressive and demonstrated that, should these changes be adopted nationally:

- Early recognition of life-threatening conditions, particularly cardiac arrest, will increase. Based on figures from London Ambulance Service, it is

estimated that up to 250 additional lives could be saved in England every year;
- Up to 750,000 patients every year would receive an immediate ambulance response, rather than joining a queue; and
- The differences in response time between patients living in rural areas and those in cities would be significantly reduced;

All of this has been achieved with no patient safety or adverse incidents attributed to the ARP in those 14 million calls. The results of this pilot have informed the decision taken by the Health Secretary to change the current clinical standards and operating targets. As a result, Call Handlers will have more time to triage the calls as they come in to ensure the right response is sent to the scene of the incident rather than to just "stop the clock". If these recommendations are accepted then the intention is to fully implement these new standards by the beginning of winter 2017.

Mental Health: More than 50 percent of people experiencing a first episode of psychosis commence treatment with a NICE approved care package within two weeks of referral and performance continues to good in terms of identifying patients with dementia. Services are assessed, planned, co-ordinated and reviewed for people with mental health problems within 7 days of discharge from inpatient care and the end of year position demonstrated achievement against all the Improving Psychological Therapies (IAPT) access and waiting times' targets for 2016/17.

However, delivering the 50% recovery rate remains challenging for BCCCG. The national evidence is that it is harder to achieve recovery within black and minority ethnic communities and in areas of high deprivation. Bradford District Care Foundation Trusts (BDCFT) is undertaking a piece of work relating to cultural sensitivity, working with the Bradford City team as a pilot and the recovery rate has significantly improved over the last 12 months. Work they have been doing to further improve recovery rates includes:

- Repeating the Recovery Masterclass as an annual update (this covers effective use of clinical measures, analysis of data from measures, using data in clinical practice e.g. to determine session agenda);
- Introduced StressControl, a low-intensity group therapy course with improved recovery rates;
- Development of low-intensity psychoeducational workbooks for patients, with guidance/reviews from Psychological Wellbeing Practitioners;
- Roll-out of an online computerised cognitive behaviour therapy (cCBT) tool which has recovery rates of 60%; and
- Review of high intensity staff supervision arrangements, to ensure adherence to brief high intensity interventions.

At a system level, we have launched our local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy. Our Mental Wellbeing Partnership Board is driving forward our programme work to implement of our strategy for the

next five years. It focusses on three work streams: our wellbeing, our physical and mental health, and care when we need it.

Quality of Care: Risk assessment of adult hospital admissions (aged 18 and over) for Venous Thromboembolism (VTE) is recommended to allow for the administering of appropriate prophylaxis based on national guidance from the National Institute for Health and Clinical Excellence (NICE). Deterioration in reported performance at both Trusts has coincided with the introduction of the new electronic data capturing systems. As a result, there was renewed focus by clinical teams and a range of actions implemented, which has seen performance improve and AHFT are now achieving this target. Whilst improvements have been seen at BTHFT in the Daycases, Surgical Assessment and Elderly Assessment units, further work is required in the Acute Medical unit.

BTHFT is in the process of a whole systems approach to VTE driven by a lead Consultant (once in post). A VTE assurance group has been re-established (reporting directly to the Patient Safety Committee) and the VTE policy and Root Cause Analysis (RCA) tool will be revised to reflect national guidance and support learning and governance associated with the outcome of the root cause analysis investigations. A CCG deep dive quality review of VTE systems and management is planned for late Autumn 2017.

The CCGs continue to work with all providers across the system to minimise the number of healthcare acquired infections and CDifficile cases remain below CCG target levels. Cases of MRSA also remain low, but against a challenging zero tolerance target, and we continue to utilise Post Infection Review (PIR) panels to review cases and feedback their findings to providers, to enable further improvements. Further reviews of health care associated infections such as e-coli have commenced and we aim to achieve a 10% reduction in e-coli by the end of 2017/18.

Nationally, the number of breaches of the mixed sex accommodation standard has increased over the past two years. However, breaches remain rare across the three CCGs and all are subject to an internal review (both breaches at BTHFT, were based on the clinical need of the patient, who required treatment on a specialist ward). Data is reported nationally and CCG's and providers review all breaches collectively and internally via existing quality governance structures with contractual financial sanctions in place.

Delayed transfers of care (DTOC): Performance across the Bradford & Airedale system in general continues to be good, maintaining the national requirement of no more than 3.5% DTOCs/100,000 population. However, there are periods when increases in delays have impacted upon patient flow and performance, and therefore work continues to further improve processes, and trajectories have been agreed as part of the BCF planning process,
AHFT have hosted a Multi-Agency Discharge Event (MADE) to help facilitate the discharge of medically fit patients into the right care setting and in November held a Rapid Improvement Week focused on the SAFER bundle, a set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. Community Advanced Nurse Practitioners (ANPs) are working in the Trust's A&E department to support the

team and wherever feasible get people back home with support and AWCCCG is piloting a discharge to assess model in a local care home who are working in collaboration with the acute Trust.

By contacting a single number to arrange care, Bradford GPs can now help patients who need extra support to leave hospital or short-term support to stay at home. Support is provided in their own home, or a community intermediate care bed, by an integrated team of nurses, social workers and therapists – for example, by helping people regain their former levels of health and provide them with self-care skills. The service supports more than 120 people leaving hospital each month, and more than 50 people who would otherwise have been admitted to hospital. In addition, we have been working with providers to improve discharge processes from acute settings and the onward referrals to intermediate care and community services through the development of a multi-agency, integrated discharge team. The team creates a person-centred focus in discharge planning, using needs-based assessments to determine the level of support required to help a patient return to their own home following an admission to hospital.

3.3 The financial challenge and QIPP (Quality, Innovation, Productivity and Prevention)

Nationally, 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 that the NHS lives within its financial means.

In the past we've managed money well and our books have been in the black. However, for AWCCCG, BCCCG and BDCCG, the gap between our annual budgets and the increasing cost of providing healthcare to local people was £5m, £2.6m and £10.4m respectively in 2016/17. Whilst we have started to address this, realising savings of £2.4m in AWCCG, £0.9m in BCCCG and £3.5m for BDCCG, if we don't close this gap and get to a more manageable position, the outlook for future years remains challenging.

QIPP 2017/18: Our QIPP programme is all about making sure that each pound spent brings maximum benefit and quality of care to the public. Our approach to QIPP delivery is that the majority of schemes are delivered through our system change programmes which include representatives from across the system.

The amount of QIPP that we need to deliver is driven by the gap between anticipated income and planned spend. For 2017/18 the three CCGs have the following QIPP targets that they are aiming to deliver:

- AWC CCG £6.0m
- Bradford City CCG £3.5m
- Bradford District CCG £13.3m

As part of the new joint management structure the CCGs are working

collaboratively around QIPP schemes to ensure that there is a joint approach around saving schemes where appropriate. In 2016/17 the Bradford CCGs stopped the prescribing of gluten-free foods, following a public consultation, and changed the way repeat prescriptions are ordered. In 2017/18 AWC CCG have now started the journey to stop gluten free prescribing and changing the way repeat prescriptions are ordered to ensure there is a consistent approach over our communities.

To assist with delivering our plans to reduce waste we have launched a major communications campaign, "It's your NHS, don't waste it". The campaign is aimed at working together with the public to ensure we can meet increasing demand with local services meeting local needs. In addition there are examples of reducing waste and improving sustainability by increasing recycling where it is appropriate, for instance refurbishing equipment such as wheelchairs. The campaign looks at how to be more innovative, more productive while helping people use NHS resources better, ensuring services are still of the highest quality.

In addition, resources are wasted when patients feel the need to visit A&E when they could have been dealt with in primary or community settings or seek treatment when self-care would have been appropriate. To avoid this we are concentrating on areas, such as accessible patient information, access to GP services and having the right services in the right places.

The table below includes details for each CCG of the breakdown of savings required against the major programme areas.

QIPP Schemes Financial Year 2017/18

CCG	Airedale Wharfedale and Craven	Bradford District	Bradford City
	£000		
Planned Care	1,354	3,233	907
Urgent Care		546	214
Prescribing	987	3,974	1,468
New ways of working	654	685	364
Unidentified	1,535	4,259	233
Right Care Programmes	1,514	401	98
MH		33	17
Corporate		259	218
TOTAL	6,044	13,390	3,519

Planned Care: The overarching vision for planned care is to lead a system-wide approach that develops a model which is financially sustainable and that ensures maximum value at every clinical encounter. For this to work we have been working closely with our providers to ensure that any inefficiencies within the planned care system are removed. Areas that we have agreed to focus on include:

- Procedures of limited clinical value – this works looks to standardise

procedures across West Yorkshire, based on the right patient, right care, right time principle, whilst allowing for clinical exceptionality and improving consistency of care;
- Follow-up patient appointments - aims to reduce unnecessary follow-up appointments to comparator CCG levels and to offer alternatives to consultant-led appointments where it is clinical appropriate;
- Increasing patient responsibility (self-care programme) – this aims to highlight opportunities for patients to take more responsibility for their care throughout their journey of care and empowering them to do so; and
- Improving referral efficiency – looks at improving access to e-referrals and e-consultants and developing new easy-to-use tools to allow primary care clinicians to access pathways of care.

Urgent Care: Work continues in the system Urgent Care Programme to develop schemes that assist in managing demand on Accident and Emergency services (A&E). Areas being reviewed are:

- Implementing GP streaming services within A&E to ensure that patients are treated in the right place within the department and performance against the A&E target is maintained;
- Reviewing pathways of emergency care including developing services around ambulatory care;
- Reviewing patients who visit A&E more frequently than average; and
- A number of the schemes in other QIPP areas have a direct link with the reduction on urgent care spend, including both the Enhanced Primary Care and Complex Care schemes in Airedale and the Out of Hospital Programme within Bradford.

Prescribing: For all 3 CCGs work continues on targeting inefficiency and waste within the area of medicine management spend. As previously mentioned AWCCCG is starting on the journey of reducing costs around repeat prescribing and stopping gluten free prescribing. Other areas where the CCGs are focussing in 2017/18 are:

- Commissioning services that will provide medicine optimisation by providing pharmacist led medicine reviews for house bound patients, care homes and people on multiple medicines. A key factor to this work is providing education and information of medicine safety and how to manage medicine by preventing stock piles and wastage;
- Develop medicine management strategies across primary care, community and secondary care;
- All 3 CCGs have introduced a new software package within general practice to standardise prescribing across practices and improve medicine reviews;
- Reviewing prescribing of Oral Nutritional supplements and vitamins; and
- Working with providers of secondary care services to develop new formulas to ensure consistency in prescribing for all patients.

New ways of working (new models of care): All CCGs have a vision to

develop new types of services that will deliver care in a more integrated manner and that will reduce the complexities for patients having to circumnavigate the complex health and social care system.

Both Bradford CCGs are working closely with their main stakeholders including Acute, Mental Health and Community providers alongside primary care and the local authority to develop an out of hospital programme of care. This joint work will look at developing efficiencies within the system by doing things once and together, whilst reducing unnecessary admissions into the hospital. They are tackling this by:

- Developing an intermediate care hub and virtual ward that provides people over 65, with a team of nurses, social workers and therapists that will be provide an extra level of care to allow them to stay in their own home and preventing unnecessary hospital stays;
- Developing a complex care team (CCT) that has a range of community teams that can provide both reactive and proactive care and support when most needed;
- Expanding the home from hospital service; and
- Developing an extended primary care (EPC) function that provides evening clinics in Bradford. Services will include elements of support around self-care on both health and social issues.

Within AWCCCG they have been investing in a number of services to change the way services are delivered including:

- Complex Care – this works with the patients who have complex health and social needs that have led to a dependency on both health and social care services. Care is provided by a range of health and social care specialists; and
- Enhanced Primary Care – an addition to the historical primary care model that allows practices to develop a proactive and personalised care to patients that need a little bit more support who have a history or requiring a high level of support within both a primary and secondary settings.

The Right Care Programme: From a national perspective all CCGs have been involved in a programme that identifies areas when compared to other CCGs who have similar demographics, where we spend much more than they do and our outcomes are not as good. For all 3 CCGs the areas where we have been identified as outliers include: Diabetes; Coronary Vascular Disease; Musculoskeletal (MSK); Respiratory disease; and Gastroenterology. Work has started that will look at developing more appropriate pathways, removing waste and inefficient processes across all these areas.

Initiatives that have already started to improve these pathways are already in place across both our local systems. Bradford has implemented a number of services including Bradford Healthy Hearts and Bradford Breathing Better. Airedale has reviewed its MSK referral pathway and has developed an MSK pathway that keeps patients from being referred for unnecessary appointments within a hospital setting.

QIPP unidentified: For all 3 CCGs, when original QIPP plans were developed there was a shortfall in the QIPP schemes value against the total target required. Work is ongoing to close these gaps and all 3 CCGs are looking at areas were additional savings can be identified.