NHS Airedale Wharfedale and Craven Clinical Commissioning Group

Update to the Keighley Area Committee
1 March 2018

Our Vision

To deliver proactive, co-ordinated, person centred care with our health and care partners across our communities.

16 member practices

157,000 patients

Working in collaboration with both Bradford CCGs and three local authorities, Bradford, Craven and NYCC.

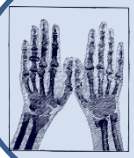
ON AN average day in AWC

6 Babies are born

62 Emergency admissions

109 A&E attendances

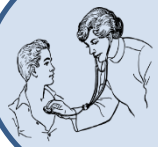
34 calls to Mental Health First Response



116 Radiology direct access tests completed

125 Patients discharged from hospital

3,938 People visit their general practice team



101 Attendances with a GP with special interest

538 Outpatient Attendances

85 People have an elective procedure

8,868 Prescription items dispensed

398 Community nursing contacts

Cancer

30 screened for breast cancer

25 screened for cervical cancer

28 screened for cervical cancer

Diabetes

34 Patients receiving a community diabetes check from their GP Practice

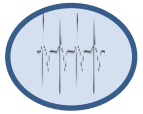
Children

96.11% of children under 12 months have been immunised for the 5 in 1 vaccine

Respiratory

40 Patients with COPD or asthma have their annual check-up in GP Practice

CVD



83 patients have their hypertension checked in GP Practice

CCG IMPROVEMENT & ASSESSMENT FRAMEWORK 2016/17

LOCAL CONTEXT

Baseline year	2016/17

This CCG spends an estimated £1,564 per head of population and is ranked as the 121st most deprived CCG (out of 209). The percentage population who are 65 years or over in this CCG is just 20.6%, higher than the England average 17.1%

★★★ Better ★★★ Similar ★★★ Worse

NHS
Airedale, Wharfedale and Craven
Clinical Commissioning Group

Quality of leadership ranked 31st place

Working relationships effective

Probity and corporate governance

Financial plan

RISK FACTORS

Smoking in pregnancy
★★★

Percentage of women smoking at the time of delivery is **9.9%**, which is similar to the England average of **10.6%**

Childhood obesity
★★★

Percentage of children aged 10/11 years who are overweight or obese is **30.2%**, lower than the England average of **33.4%.** The best achieving CCG result is **23%**

Inequalities
★★★

The difference in the rate of unplanned hospitalisation for deprived people with chronic ambulatory care sensitive conditions is **1,147** which is higher than the England average of **904** and ranked **161** / 209 CCGs

DIAGNOSIS AND SERVICES

Care quality ratings
★★★

Ratings for primary care, hospitals and community services are satisfactory and are similar to England, however adult social care is a concern ranked **174**/209

Experience of primary care
★★★

Experience of making an appointment at a GP practice in this CCG was **84.6%**, which is similar to the England average of **85.2%**

Dementia diagnosis
★★★

Diagnosis rate for those expected to have dementia is **73.7%**, which is higher than the England average of **67.6%** and ranked **58** / 209 CCGs

Cancer diagnosis
★★★

Early stage diagnosis is **50.2%**, which is similar to the England average of **52.4%** and ranked **147** out of 209 CCGs

Mental health
★★★

Early intervention psychosis within 2 weeks of referral is **61.8%,** which is lower than the England average of **74.4%,** however is above the national standard of **50%**

Feeling supported
★★★

People with long-term conditions who feel supported by health and social care services is **69.5%**, which is higher than the England average of **64.3%** and ranked **19** /209 CCGs

OUTCOMES

Cancer survival
★★★

One year cancer survival in this CCG is **71.7%**, which is higher than the England average of **70.4%** and ranked **32** / 209 CCGs

Mental health
★★★

Recovering following access to psychological therapies for is **56.5%** which is above the national standard of **50%** and ranked **20** / 209 CCGs

Emergency admissions
★★★

Emergency admissions for people with an chronic ambulatory care sensitive conditions is **902** which is similar to the England average of **895** and ranked **107** / 209 CCGs

Airedale NHS Foundation Trust

- The CQC inspected Airedale NHS Foundation Trust in March/April 2017.
- Overall the CQC rating is 'Requires Improvement'.

Bradford District Care NHS Foundation Trust (BDCFT)

- CQC inspected services in February 2018
- Overall the rating is 'Requires Improvement'

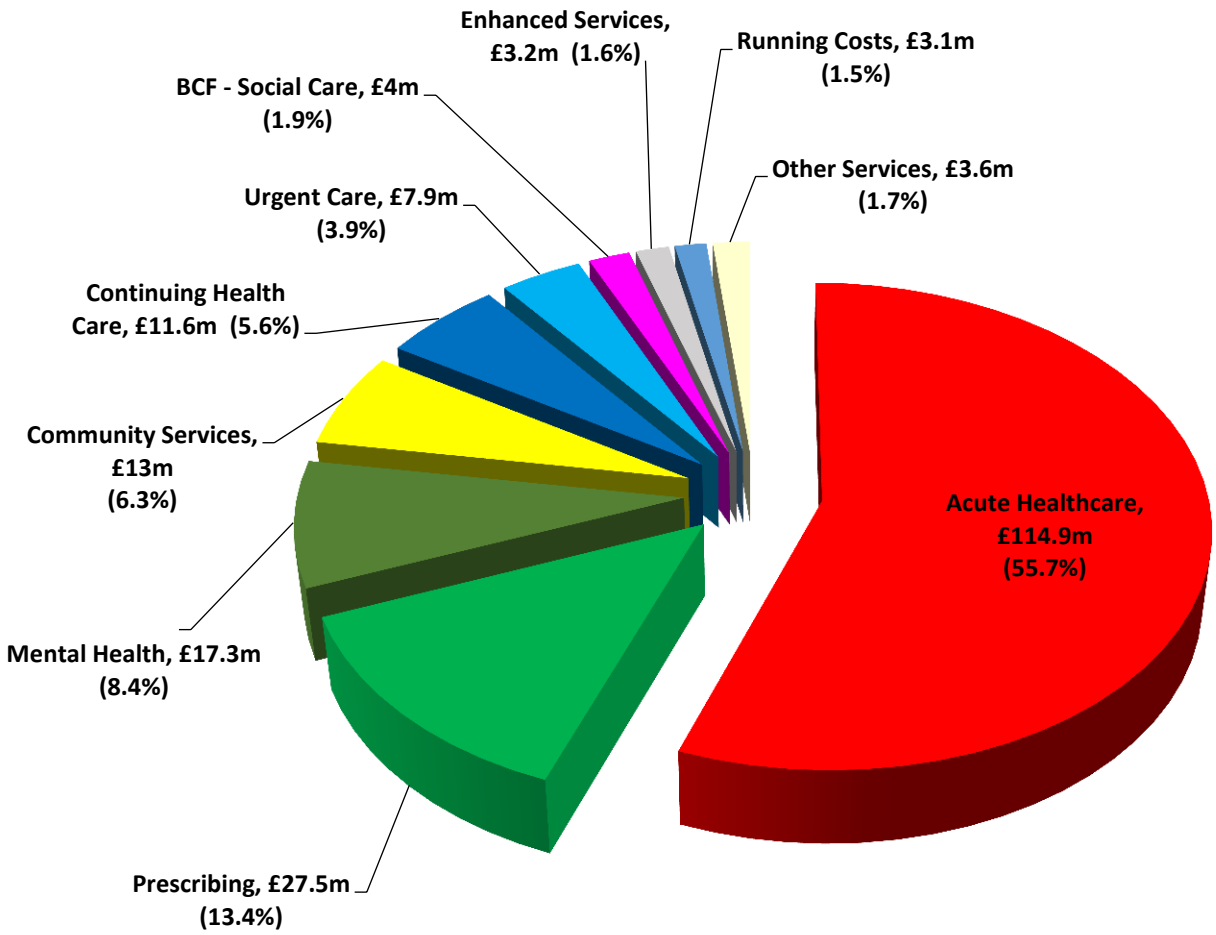
Bradford Teaching Hospitals NHS Foundation Trust

- CQC inspected services in June 2016
- Overall the rating is 'Requires Improvement'

Primary Care

- CQC - **15 GP practices** rated 'good', 1 practice rated 'outstanding'

How we spend our money



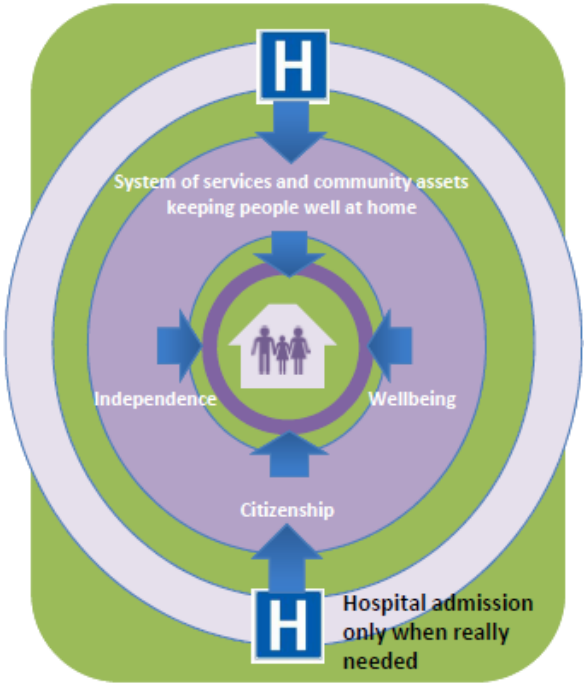
£206.1m

Efficiency savings and QIPP

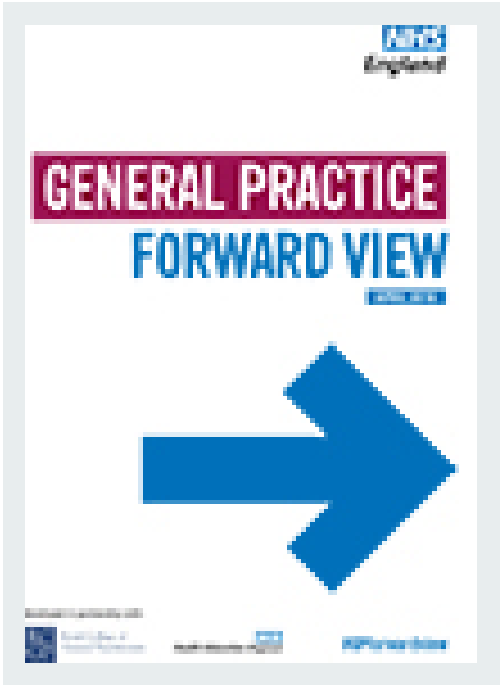
- Nationally, the NHS is facing immense financial pressure: it needs to save £22bn by 2020/21.
- In AWC we need to make efficiency savings of £7m in 2018/19 to close our gap.
- To do this we are reviewing certain areas as part of an NHS programme know as QIPP – quality, innovation, productivity and prevention.
- QIPP is all about making sure that every pound spent brings maximum benefit and quality of care to patients.
- Our plans are challenging and difficult decisions will need to be taken.
- We will be honest and open about the tough choices we face.

Our Future

West Yorkshire & Harrogate Partnership



Accountable Care System



New models in Primary Care

Primary care update

We published our 5 year Primary Medical Care Commissioning Strategy in January.

Airedale, Wharfedale and Craven (AWC) areas represent a wide range of communities, we need to update our services to meet the diverse needs of our population by using innovative new ways of working so that these services can be sustained into the future and work as effectively as possible.

There are four big challenges that GP practices in AWC are facing:

Rising demand on services, and more patients with multiple and complex conditions

Higher demands on the workforce and national shortages of staff making recruitment challenging

Delivering a seven day service and developing the workforce needed for this

Significant financial pressure alongside the need to change the way that services are delivered

Primary Care Commissioning Strategy

What the primary medical care commissioning strategy will do

The primary medical care commissioning strategy is based on the following vision:

"General Practice in partnership with Social Care, the Voluntary and Community Sector and Community service providers will lead the development and establishment of a sustainable system of accountable care, using a resilient workforce to deliver innovative and pro-active healthcare improving the wellbeing for all our population"

The 'accountable care system' is intended to improve the way that local services work together to improve people's health and improve their health and care experience, using the available funding as effectively as possible.

It is important that GP services continue to underpin health and social care in the 'accountable care system' and our commissioning strategy takes account of this.

We hope to deliver our vision by 2021, focussing on improving these key areas:

Improving Access - making sure that everyone has access to GP practice services

High Quality - making sure that all patients receive consistent, high quality and safe care

Building the Workforce – building a highly skilled team of health professionals who work closely with other professionals in integrated teams

Self-care and Prevention - empowering and supporting all patients to have more control over their own health and wellbeing

Collaboration and Partnerships – GP practices working more closely together. Patients and carers as key partners

Estates, Finance and Contracting – ensuring that the buildings and services we commission can deliver modern services well into the future

Accountable Care Simply Put…

For

lasting benefits…

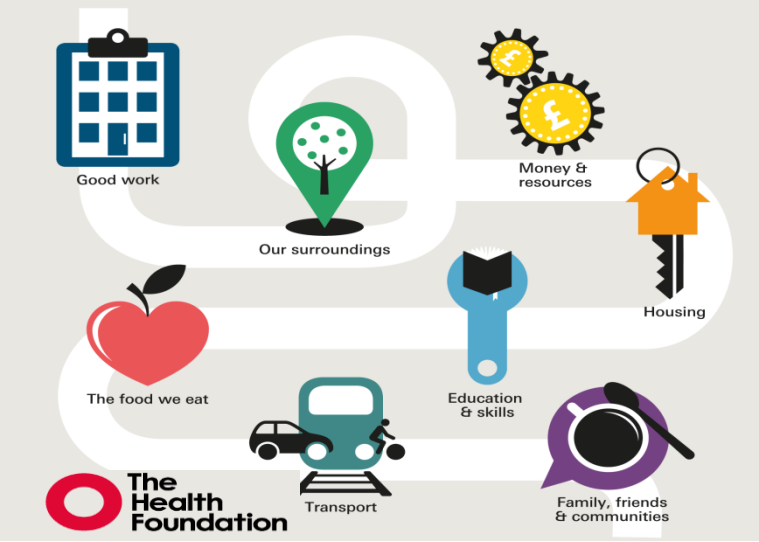
- Improved health and care outcomes for individuals and population
- Improved quality of care and support
- Enhanced staff and workforce experience and satisfaction
- Sustainable health and care system

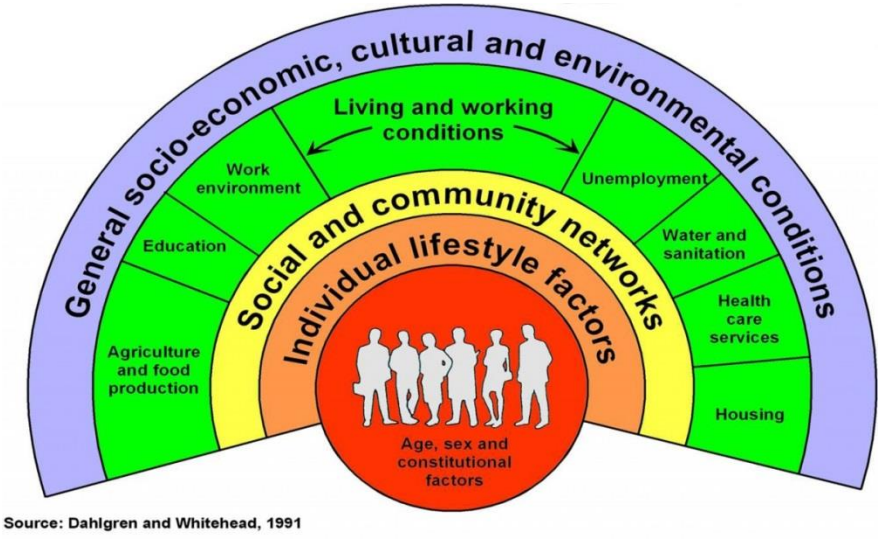
- ✓ It's about the person, people and care NOT organisations
- ✓ It's moving from current to a truly integrated form of care and support delivery
- ✓ It's groups of health care and support providers collaborating to achieve specific outcomes for defined populations
- ✓ It's keeping people as healthy as possible to decrease overall use of service
- ✓ It's minimising the use of high-cost hospital-based care by ensuring effective community -based care

The starting premise is much broader than just health

As little as **10%** of a population's health and wellbeing is linked to access to health care.

We need to look at the bigger picture !





Source: Dahlgren and Whitehead, 1991

…but the picture isn't the same for everyone

The healthy life expectancy gap between the most and least deprived areas in the UK is 19

The fundamental premise is that...

‘People Can’

Any model has to take account of broader determinants to improve health & wellbeing

Happy, Healthy, at Home

Housing
Employment
Finances
Family
Social Networks

Surroundings
Education/Skills
Food
Lifestyles
Transport
Technology

Asset based approach - people as active participants rather than passive recipients

‘What do you care enough about to act on?’

‘What skills, gifts, talents, passions can you contribute?’

‘Who else do you know that can get involved?’

3 communities, 1 system

- Our ‘3 Communities 1 System’ programme builds on the themes in the Five Year Forward View which set out plans for transforming the design and delivery of services.
- This will involve organisations coming together to manage the common pool of resources and collaborate as one system to improve the health and care of a population.
- We have adopted the ‘primary care home’ concept as a framework to build on.
- Working with our practices we have aligned our 16 GP practices into the three communities: Airedale, Wharfedale, and Craven.

The Delivery Model

Education & Employment

Urgent Care

Mental Health

Housing

Children & Young People

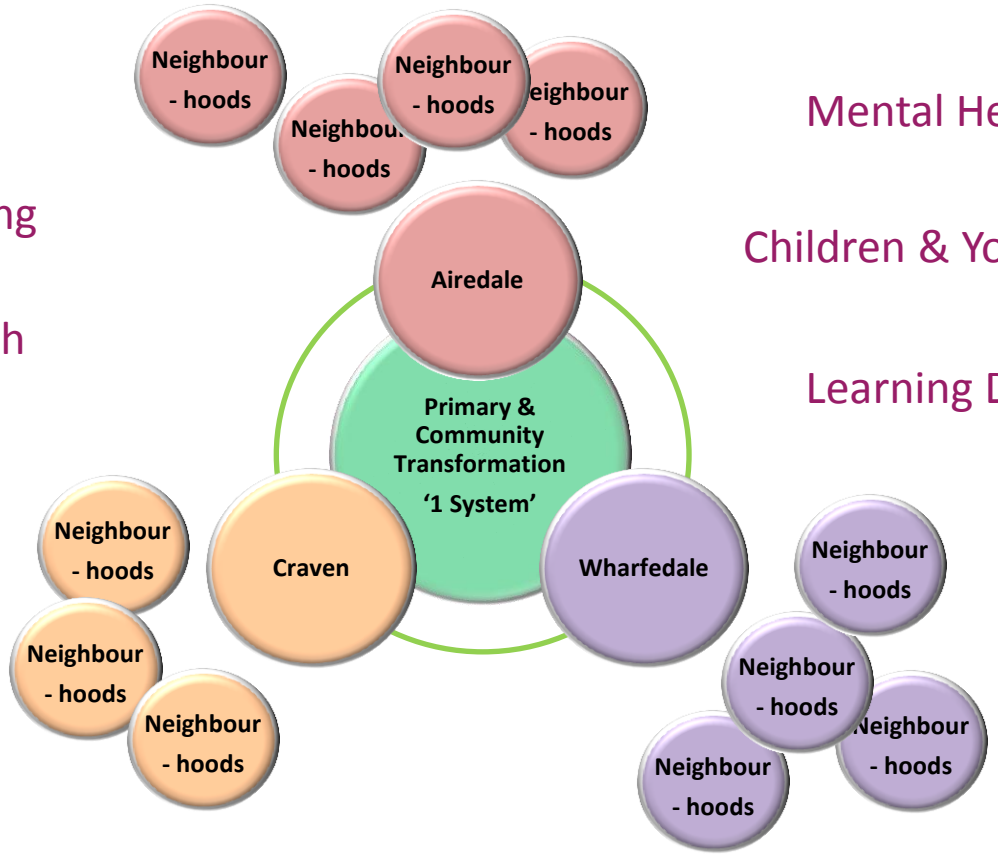
Mental Health

Learning Disabilities

Maternity

Etc etc etc …

Carer support



AWC shared system agreement to align everything we do to the 3 communities 1 system ('architecture')

Airedale Care – *Possible* High Level Operating Model 2018 - 2022

Starting with…

SHIFT RESOURCE – PREVENTION/WELLBEING/COMMUNITY

Whole Person: Early Help & Prevention
Address the needs of the next generation

‘People Can’

PEOPLE CAN
WORKING TOGETHER FOR BETTER LIVES

asset based community development

- Housing
- Employment
- Finances
- Family
- Social Networks
- Surroundings
- Education/Skills
- Food
- Lifestyles
- Transport
- Technology

People in the system working differently to deliver improved outcomes and the Triple (Quadruple) Aim

Happy, Healthy at Home
Wherever home is.. Either own home or care home.

Social; acute & expert (LTC) pro-active management through care visiting service

IUC

Clinical assessment of ED data to understand what could be done differently

Airedale Same Day Response

- Housing
- Employment
- Finances
- Family
- Social Networks
- Surroundings
- Education/Skills
- Food
- Lifestyles
- Transport
- Technology

One ‘Front Door’ for Same Day Need
Rapid Access Hub – All Ages
Prevention & Early Help
Integrated assessment and response
Holistic medical and social model
See/assess/diagnostics/treat/support or signpost/book apt/refer

Multi disciplinary; multi professional Pro-active Visiting Team

Acute Hospital Based Care

Real time remote connection for specialist advice / Diagnostic Interpretation
Consultant Outreach - Specialist Help and advice into the community
Referral if needs cannot be met

General Practice Specialist Hubs (up to 7)
Pro-active care
Holistic approach
Expert LTC MMT
Self Care & Prevention

Specialist Secondary Care

First Response

Secondary Mental Health

Community Based Intermediate Care

Step up/Step down

Engaging with local people

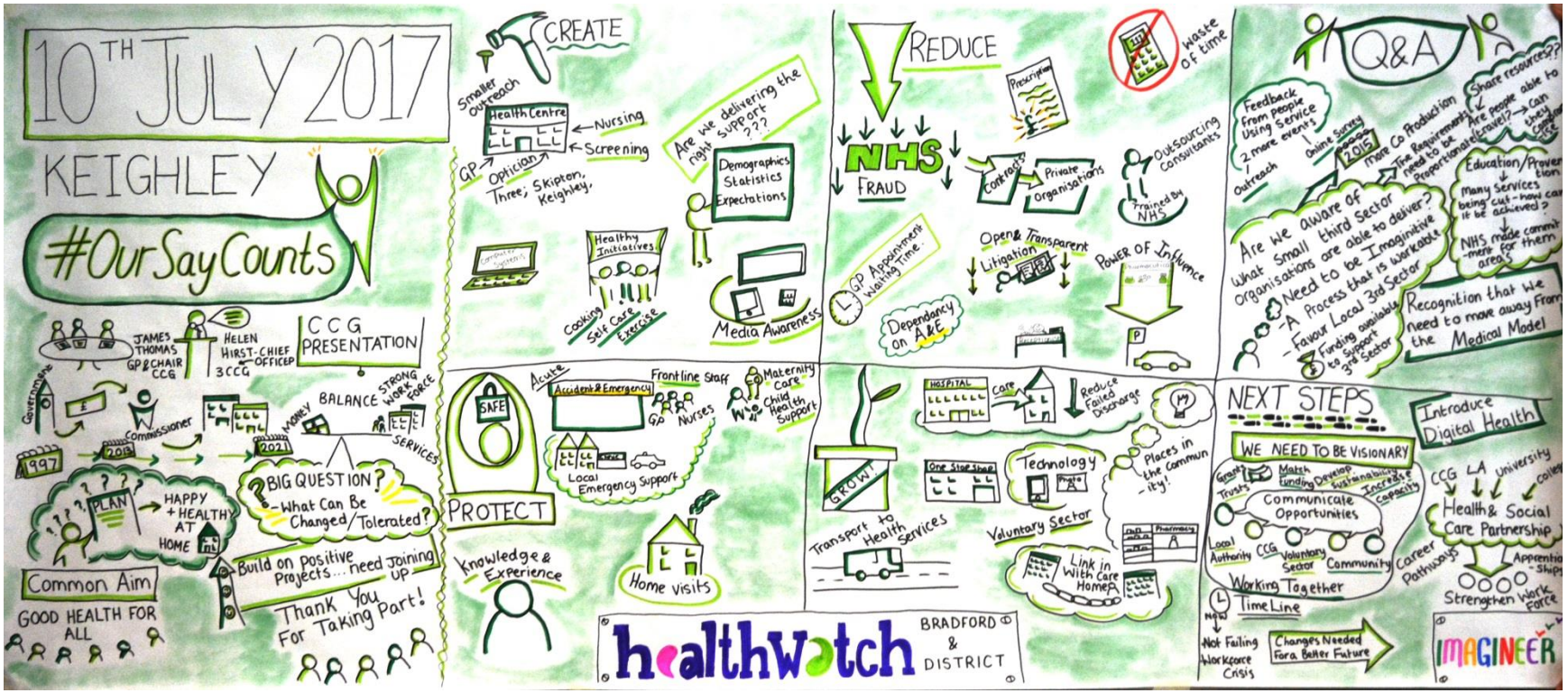
- We engage actively with patients, their families and carers, members of the public and our stakeholder organisations to help us understand what works well for people and where our services could be improved.

- We produce a quarterly patient experience report, Grassroots, which helps us keep up to date with patient views on the services they use.

- As we develop plans for transforming services in our '3 communities, 1 system' approach it's vital we engage with local people

- In 2017, the three CCGs across Bradford district and Craven worked with Healthwatch to create a conversation with local people about the future of health and social care.

The Big Conversation



The Big Conversation

- We wanted to find out what mattered most to people, where there might be willingness to compromise, and what people think could be done differently in the future.
- In total we had over 900 responses and contributions
- Full engagement report is now published on Healthwatch website http://www.healthwatchbradford.co.uk/oursaycounts
- This engagement gives us a good starting point as we develop plans for the 3 communities approach.