NHS

Airedale, Wharfedale and Craven

Clinical Commissioning Group

Annual Review 2016/17

Contents

Clinical chair's welcome

Welcome to NHS Airedale, Wharfedale and Craven CCG's annual review

Welcome to this year's annual review, my first as clinical chair for NHS Airedale, Wharfedale and Craven CCG. I began in November 2016 following on from Dr Colin Renwick, who stepped down as clinical chair but has remained as a GP executive member.

I would like to thank Colin for his tremendous dedication and commitment to forging good working relationships with our partners in health and social care.

My thanks are also extended to Dr Phil Pue who returned to general practice following his resignation as accountable officer in October 2016.

This review gives you a snapshot of some of our progress and key achievements which would not have been possible without our hard working, committed staff. I would like to thank our staff, member practices and stakeholders across health, social care, the voluntary and community sector for their support in what has been a challenging year.

Successes this year include Bradford and Craven's mental wellbeing strategy. We have worked in partnership with voluntary and community services, mental health service users and carers to develop this ambitious five year strategy.

The self-care and prevention programme underpins the success of all our plans, as we encourage people to live healthy lives and prevent ill health. We ran a number of successful self-care events across the year which our staff worked hard to deliver.

Our work as a national Integrated Care Pioneer to deliver new models of care has continued. To support the pioneer programme's shared learning culture, we were happy to welcome international visitors from the Netherlands in December. As the Dutch health and social care experts begin to set up integrated care models in their own country, they were keen to learn about our successes and challenges.

The new complex care team is a fantastic example of partnerships transforming how care is delivered. Health and social care professionals from Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust, the voluntary and community sector, local authority and Yordales (a federation of local GPs), have provided additional physical, mental and social support to people with complex needs since April 2016.

Finally, I must say how pleased I am that so many patients and members of the public have taken time to share their views about local healthcare services. We will only continue to meet the needs of our communities if we know what people think about local services, what's working and what could be improved. This is vital so we can continue to make real changes and achieve the best health for all.

You can share your views and feedback by email at: engage@awcccg.nhs.uk or see the back of this document for other ways to get in touch.

Dr James Thomas
Clinical chair

Who we are and what we do

We design, buy (commission) and monitor the quality of healthcare services for people registered with our 16 member practices, as well as for those unregistered patients living within, or visiting, our area.

Clinical commissioning brings real benefits for patients, with most decisions about NHS spending being made in the community by health and care staff who understand the needs of local people.

Through clinical commissioning, doctors have the power and freedom to make decisions about the care and services they commission for their local communities.

The services we commission include:

- urgent and emergency care including accident and emergency (A&E), ambulance and an out-of-hours service
- community health services
- planned hospital care (e.g. hip operations)
- maternity services
- rehabilitation services
- healthcare services for:
  - children
  - people with mental health issues
  - people with learning disabilities
- continuing healthcare
- termination of pregnancy services
- infertility services
- wheelchair services
- home oxygen services
- treatment of infectious diseases.

There are some treatments, available on the NHS, which we do not commission. These include:

- cosmetic procedures
- various fertility treatments
- treatments not approved by the National Institute for Health and Care Excellence (NICE).

Our ambition is to transform the experiences of our patients; significantly improve their outcomes; and to use our member practices' creativity, talent, expertise and ability to innovate local services to help people live longer, healthier lives.

Our vision and principles

Our vision is to deliver proactive, co-ordinated, person centred-care with our health and care partners across our communities.

Our principles are that:

- no-one should be in hospital unless their care cannot be delivered safely in the community, 24 hours a day, seven days a week
- no-one should be discharged to long-term care without the opportunity to regain skills. This is also known as re-enablement
- our local population should have access to and delivery of co-ordinated care, 24 hours a day, seven days a week no matter their age, condition or location.

How we are governed

Our council of members (CoM) holds the governing body (GB) to account and is the voice of our member practices. It represents all of our practices including their interests and statutory responsibilities as members of the CCG. Members of the CoM are clinicians (usually a GP) and practice managers who meet no fewer than four times a year.

Our GB, which meets bi-monthly in public, provides assurance that the commissioning of health and care services for people in our area meets their needs. Everyone is welcome to attend and observe governing body meetings. We publish the agenda and papers on our website in advance of the meetings.

Peter Brunskill
secondary care consultant

Angie Clegg
registered nurse

Pam Essler
lay member

Neil Fell
lay member

Barbara Cox
registered nurse, (until Dec 2016)

Helen Hirst
accountable officer (from October 2016)

Karren Jolaoso
executive nurse (from Oct 2016)

Dr Brendan Kennedy
executive GP

Stephanie Lawrence
executive nurse (until May 2016)

Julie Lawreniuk
chief finance officer/ deputy chief officer (from September 2016)

Sue Pitkethly
chief operating officer

Dr Phil Pue
chief clinical officer, (until Sept 2016)

Dr Colin Renwick
clinical chair (until Oct 2016) executive GP (from Nov 2016)

Neil Smurthwaite
chief finance officer, (until Aug 2016)

Dr Graeme Summers
executive GP

Dr James Thomas
clinical chair (from November 2016)

Dr Gordon Wallace
executive GP, (until March 2017)

Dr Bruce Woodhouse
chair of the council of members

Who we work with

In October 2016, the three CCGs in Bradford district and Craven agreed to work more formally together through a shared accountable officer, chief finance officer and a shared management team. We meet formally each month to consider all those things that need a joint decision across the three CCGs.

We buy the majority of our services for patients from Airedale NHS Foundation Trust (ANHFT), Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) and Bradford District Care NHS Foundation Trust (BDCFT), which cares for people with community health, mental health and social care needs.

We also work with Bradford District Council, North Yorkshire County Council and Craven District Council. We work alongside the councils in their roles as both commissioners, and providers, of social care and public health.

We buy services from a number of voluntary and community organisations. They provide truly locally-focussed projects aimed at improving people's health and wellbeing, for example, by promoting health awareness and healthy living messages.

There are some services we jointly commission with other CCGs, for example:

- Yorkshire Ambulance Service
- NHS 111
- West Yorkshire GP out-of-hours service

In total we have 146 contracts and a register of contracts is available on our website.

Our partners

Health and wellbeing board (HWB): We are members of the two local health and wellbeing boards that cover our area: Bradford and Airedale Health and Wellbeing Board and North Yorkshire Health and Wellbeing Board. As sub-committees of the councils, the HWBs bring 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. The boards have some specific responsibilities, such as approval and performance monitoring of the Better Care Fund.

Integration and change board (ICB): The ICB's membership includes senior leaders across the health and social care system. It is responsible for overseeing a number of transformation programmes delivered in partnership. This includes developing the right workforce, digital solutions, using our buildings better and shared solutions to address the system-wide challenges we face.

This year, the ICB has supported the development of the accountable care systems in Airedale, Wharfedale, Craven and Bradford.

NHS England: NHS England commissions primary care – GPs, opticians, dentists, pharmacy services and some specialised services.

The North Yorkshire Commissioners forum: Accountable to the North Yorkshire HWB, the forum focuses on strengthening the support for the delivery of joint and local plans. As Craven is part of North Yorkshire, we work closely with the county council, as well as Craven District Council, in developing local plans to integrate health and social care. We have also contributed to other North Yorkshire-wide developments, including a strategy to improve the lives of carers and work to support 'living well with dementia in North Yorkshire – bring me sunshine'.

Healthwatch: Healthwatch organisations provide a voice for people in the delivery of their local healthcare services. In our area, Healthwatch Bradford and District engage with people from Airedale and Wharfedale and Healthwatch North Yorkshire engage with people living in Craven. This year, Bradford and District Healthwatch has reviewed our accident and emergency care departments and reported its findings to the A&E delivery board.

eMBED Health Consortium: eMBED replaced the Yorkshire and Humber Commissioning Support Unit in April 2016 and provides a range of services to support us to carry out our work. These include, for example, expertise in business intelligence and information technology.

North of England Commissioning Support Unit (NECS): provides us with data quality services.

West Yorkshire Commissioning Collaborative: Healthy Futures programme is the name given to the commissioning collaborative across the 11 CCGs in West Yorkshire and Harrogate. This was created to agree and lead health and care transformation across a larger area.

Our priorities and plans

Bradford district and Craven Health and Wellbeing Plan 2016 - 2021

In the last year, we have successfully worked with partners across Bradford district and Craven to turn our vision for sustainability and transformation into a delivery plan for the next five years. We have concentrated on understanding what our priorities must be to improve the health, wellbeing, care and quality of services for our communities and to meet our financial challenges.

One way of meeting this is to develop accountable care organisations which look at services across a whole community.

Two clear approaches to accountable care are emerging in Airedale, Wharfedale and Craven and also in Bradford. As functions and responsibilities for the accountable care organisations are set, they are expected to deliver transformation within the timescale of the wider West Yorkshire and Harrogate sustainability and transformation partnership (STP):

- diabetes
- out-of-hospital care
- planned care
- self-care
- complex care
- urgent care services.

West Yorkshire and Harrogate sustainability and transformation partnership (STP)

Together with colleagues across Calderdale, Kirklees, Leeds, Wakefield and Harrogate we serve a population of 2.6 million people. As a region, we are committed to working together at scale on common priorities. We believe this approach will bring more success in the outcomes we need.

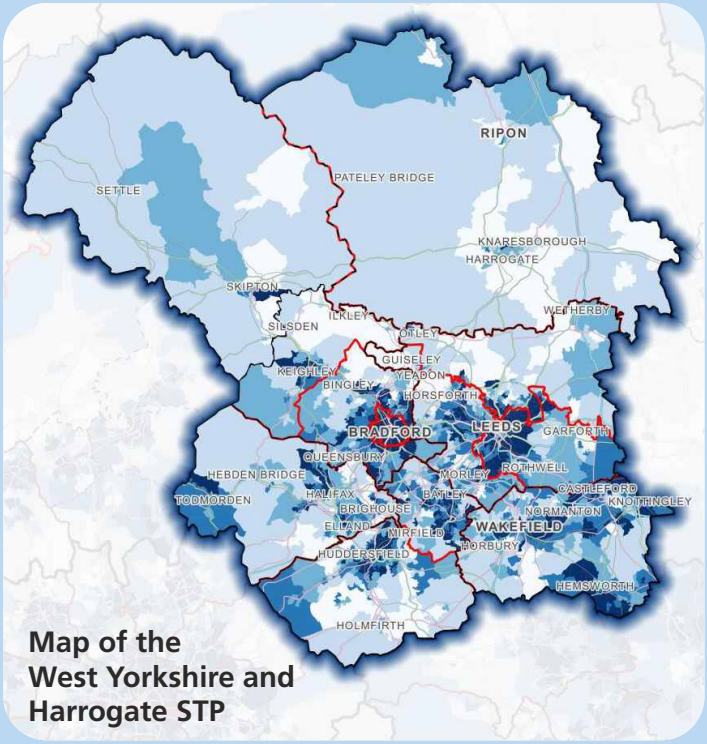
Within the West Yorkshire and Harrogate STP we are focussing on priorities in three significant gap areas:

- health and wellbeing
- care and quality
- finance and efficiency.

We are also collaborating on regional programmes to improve:

- primary and community services
- mental health services
- cancer services
- stroke services
- urgent and emergency care services
- acute care collaboration
- standardisation of commissioning policies
- specialised commissioning.

More information about the Bradford district and Craven Health and Wellbeing Plan and the West Yorkshire and Harrogate Sustainability and Transformation Partnership can be found on our website.



Map of the West Yorkshire and Harrogate STP

2016/17 Highlights and progress

Cancer services

We are part of the newly formed West Yorkshire Cancer Alliance and are actively involved in the shaping of cancer services. The alliance is aiming to work across West Yorkshire to implement the national cancer strategy.

During 2016/17, greater co-operation between hospital sites has improved the patient pathway including the transfer of patients, as well as access to more timely treatment.

Airedale NHS Foundation Trust has appointed a 'living with and beyond cancer' facilitator who links with the Cancer Alliance and other organisations to help people affected by cancer.

In addition, the Accelerate, Co-ordinate, Evaluate (ACE) programme has helped to establish new multi-disciplinary clinics for people who have symptoms that might be cancer. Patients can have several tests on the same day to help them receive quicker diagnosis and if cancer is detected, treatment will begin much sooner.

Dementia

Working to become Dementia Friendly

Many of our GP practices have become dementia friendly and one GP practice has also launched a dementia advice clinic. We also support other services we commission to become dementia friendly.

During the past 12 months we have:

- joined the national Dementia Action Alliance
- worked closely with North Yorkshire County Council in developing their Dementia Strategy 2017-2020, ensuring dementia services meet the needs of patients who live in the Craven district
- developed and implemented DiaDem in care homes - a protocol to support diagnosis of advanced dementia.

Serious Illness Conversation

We are one of only two national sites to pilot 'Serious Illness Conversation', in collaboration with NHS England and the Clatterbridge Cancer Centre NHS Foundation Trust, as part of the Serious Illness Care Programme UK.

The programme aims to transform the patient experience and enhance clinical care and support for people with serious illnesses.

It provides best practice training for GPs to have a meaningful conversation with patients when they are diagnosed with a serious illness. This helps patients to identify what matters most, along with their goals and priorities as they plan their treatment.

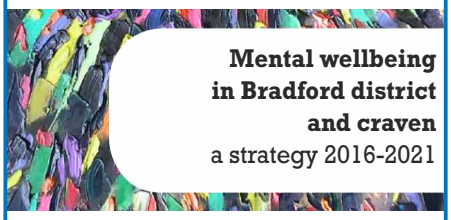
Releasing innovation across the district

Health and social care staff, along with staff from voluntary and community services, joined forces in a bid to release innovation across health and care services at the 'Learning and Innovation event' in October 2016.

Organised on behalf of the Integration and Change Board (ICB), the event aimed to create a platform for innovation to grow and transform the way services are delivered across the district, by encouraging people to share their ideas and experiences.

To help promote inspiration and stimulate further creativity, five established health and care projects showcased their approaches to delivering new models of care. We heard stories and experiences from the primary care wellbeing service, *Bradford Beating Diabetes*, the Gold Line service, *Bradford's Healthy Hearts* and the Sanctuary at Mind.

Mental wellbeing strategy



In January 2017, a new blueprint for improving the mental wellbeing of people in the Bradford district and Craven was launched.

Local health and social care organisations worked in partnership with mental health service users and carers to develop the new five-year mental wellbeing strategy which offers the best services to patients across Bradford district and Craven. The three CCGs worked closely with Bradford District Council to encourage people to share their experiences and say how they think things could be made better.

The strategy focuses on what can be done to retain and promote good mental health, prevent mental health problems and improve the health and wellbeing of those living with and recovering from mental illnesses.

As a result, the new strategy includes the views of people with experience of mental health issues. They have been involved in the plans to innovate and improve mental health services.

Self-care

Over 30 groups of staff and voluntary sector organisations have been involved with self-care engagement and training to help people be more active in maintaining their own health and wellbeing. More than 150 staff and volunteers have received training in motivational interviewing techniques.

We engaged with six local community groups to find out how people looked after themselves and what further support they needed to be more active. We were out and about with the Health Action Local Engagement (HALE) bus to take healthy living messages into places where people live and work.

Self-care week

Our staff played a key role in supporting national self-care week in November 2016 by holding public events at Craven College, Airedale Shopping Centre, Ilkley Clarke Foley Centre and Airedale Hospital. Staff shared self-care information and tips, meeting and talking to people living in our district.

The Bradford and Craven self-care and prevention programme has received national recognition by winning a National Self-Care Week Award and Dyneley House Surgery in Skipton was also highly commended.

Accessible information and patient flagging of records

A project group of GPs, CCG staff and patient groups have been looking at issues in accessing health services by patients who need information in more accessible formats. Examples of where things could be improved include appointment letters being sent to people with visual impairments, instances when language translators or British Sign Language interpreters are not available, or information not provided in a way that can be used. The group has identified a way of flagging patients' access needs in SystmOne, the patient record system used by all local GP practices.

We also worked with patients, carers and the voluntary sector to develop training for all primary care staff to raise the profile of meeting patient and carers' accessible information needs. This training has been adapted for staff at our hospitals.

New models of care

In 2014 we were identified as a national integrated care pioneer site and have benefited from support and help to develop our new models of care. The learning from these models has helped to ensure that people in our area receive individualised seamless care, and reduce the need for urgent and unplanned care by proactively managing patients' health and care needs.

The 4 areas being developed include:

1 Complex care

People with complex care needs are supported to take control of their own care and given support and specialist advice.

This year we have:

- funded a new service for people with complex care needs. The complex care team provides tailored care to reflect people's own needs, in or closer to their homes and reduces their need for emergency hospital care
- developed the role of personal support navigators (PSN) who offer a dedicated point of contact for people with complex care to help them maintain their independence and social needs.

2 Enhanced care

People with long-term conditions are provided with tailored support by their GP practice which helps them achieve their own personal goals.

This year we have:

- supported GP practices to develop different ways of delivering enhanced care based on their knowledge of their practice population and patient needs. Some practices have developed new roles to help provide more tailored care and support.

  Roles developed include:

  - care navigators
  - coordinators physiotherapists (Physio First)
  - pharmacists trained to support patients after discharge from hospital.

3 Wrap around care

An integrated community care response, which includes therapy support to help people stay independent for longer.

This year we have:

- extended the Integrated Care Community Nursing Service to include reablement and rehabilitation services
- enhanced discharge arrangements across health and social care
- provided a community dietetic service and a community stroke rehabilitation service.

4 Self-care

People are encouraged to set their own goals, look after themselves and seek professional support and advice when needed.

This year we:

- continued with our self-care programme and delivered motivational training to staff
- played a key role in supporting self-care week at a number of public events in November 2016
- supported the Craven Voluntary Sector Showcase event where health and social care staff took part in a 'speed dating' session as a way to learn more about organisations and activities in the Craven district
- continued to support the Pharmacy First scheme.

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.

Patient feedback is drawn from a range of sources, including the Friends and Family Test, Patient Opinion, NHS Choices, contract monitoring feedback and complaints.

Feedback is reported to the Clinical Quality and Governance Committee and then onto our Governing Body so that the views of local people feed into our decision making processes.

During 2016/17, we engaged on a number of different topics:

Maternity Services

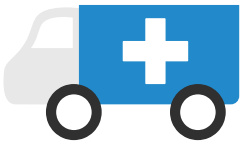
We held focus groups to hear about peoples' expectations of maternity services both before and after birth. We asked for opinions on the recommendations from the National Maternity Review and about birth plans.

Gluten free prescribing

Certified GF Gluten-Free

We conducted a 12 week consultation on the prescribing of gluten free foods. This finished on the 31 March 2017 and the feedback was presented to the Governing Body in July 2017.

Primary Care



We began the process of testing people's views on extended access over the weekend. We are piloting extended access with five GP practices in Keighley for registered patients. This will inform our future roll out of the service.

Mental wellbeing strategy

We talked to people with experience of services; children; young people and their families; schools, the local authority; GPs and clinical colleagues. We sought views on gaps and areas that needed to be strengthened.

Find out more

Reports and information about our engagement events, and consultations can be found on our website.

If you want to get involved in the work we do, please email: engage@awcccg.nhs.uk

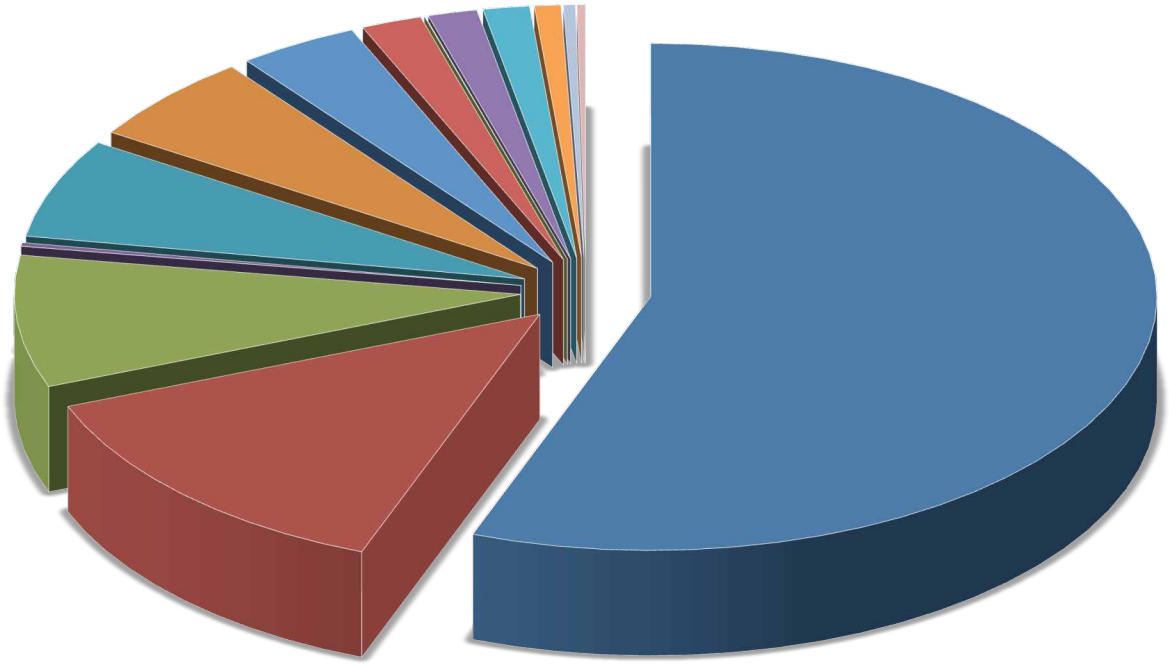
Our finances

We are using the principles of the NHS quality, innovation, productivity and prevention (QIPP) programme to help us meet the financial challenges facing the NHS. QIPP aims to maximise value for money across all services.

A detailed scheme for QIPP was developed by our senior management team in 2016/17 and has helped us identify areas where we can be more efficient, for example we have saved £0.6m through improvements to medication prescribing known as our GP prescribing incentive scheme.

We are planning a more ambitious QIPP programme for the coming year to continue with our financial recovery.

Our budget for 2016/17 was £208.4m and the chart below shows how we spent that money



Key

- Acute care, £116m, 56%
- Better Care Fund - locality schemes, £0.79m, 0.38%
- Better Care Fund - social care support, £4.04m, 1.94%
- CCG reserves, £0.04m, 0.02%
- Community, £13.19m, 6.3%
- Continuing health care, £11.71m,
- Enhanced services, £3.27, 2%
- General practice IT, £0.48m, 0.23%
- Medicines management, £27.84m, 13%
- Mental health, £17.50m, 8%
- Other, £1.75m, 0.84%
- Running costs, £3.08m, 1.48%
- Urgent care, £8m, 3.8%
- Voluntary sector, £0.56m, 0.27%

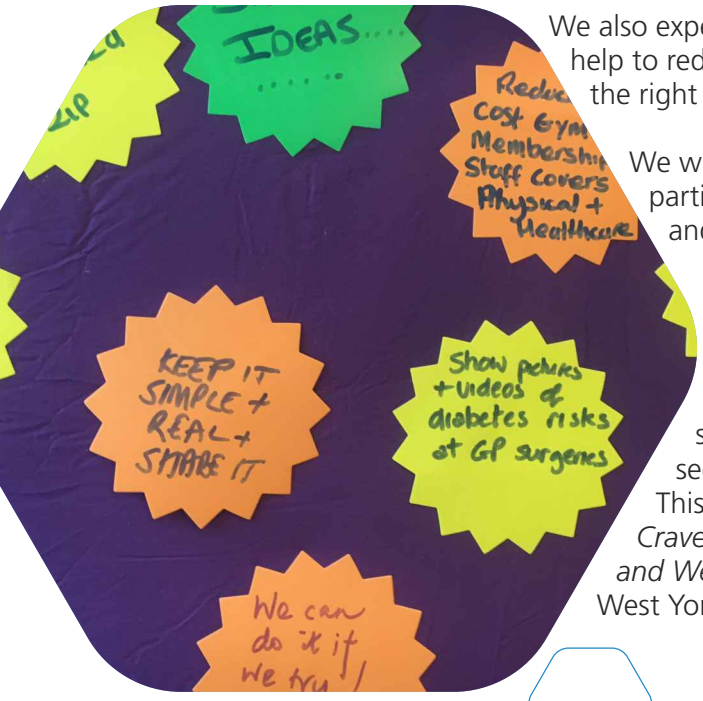
Looking forward

As we begin 2017/18, the journey to accountable care across Bradford district and Craven is well underway. This journey is expected to deliver transformation in many areas, including diabetes, self-care, out-of-hospital care, complex care, planned and urgent care services.

Nationally, the NHS is going through one of the most challenging periods in its history. In the past we have managed our financial position well but this is now a challenge. As well as achieving the best possible outcomes for our patients through commissioning high quality, clinically effective services, we must also ensure that the NHS lives within its financial means. The financial picture locally is the same, the CCG has an estimated £5m gap in 2017/18 between the cost and demand of services against the money we have available.

To help with our financial position, a more ambitious QIPP programme is required for the coming year. As part of this we are going to have to make some difficult decisions to ensure we have the right funding to change and improve services in the future.

Patient experience of access to GPs also continues to be challenging. As of April 2017, the CCG has taken on the commissioning of GP services from NHS England. This will enable us to build on existing relationships with GP practices and develop primary care services that meet the needs of their local communities. Over the next year the availability of GP appointments at more convenient times like evenings and weekends will be increased. Initially this will cover 30% of our population as work starts in Keighley with 8am until 8pm appointments.



We also expect the self-care programme and the community navigators will help to reduce the demand on GP services by supporting people to access the right care, in the right place at the right time.

We will continue to develop our new models of care which look at particularly supporting patients who regularly use A&E, primary care and other urgent care services.

We remain committed to engaging people about health services as well as our future plans. We will build and strengthen our plans with further engagement and consultation with the public and communities, patients and staff. We will look for solutions we can deliver together and seek support to make the right judgments on difficult decisions. This includes working together to deliver the *Bradford District and Craven Health and Wellbeing Plan 2016 - 2021* (our local delivery plan for the West Yorkshire and Harrogate STP).

On an average day Airedale, Wharfedale and Craven

3,938 People visit their general practice team

101 People attend a GP with special interest clinic

62 Patients admitted unexpectedly to hospital

109 Patients attend A&E

116 Radiology direct access tests completed

125 Patients discharged from hospital

34 calls to Mental Health First Response

6 Babies are born

538 Patients attend an Outpatient clinic

85 patients 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 bowel cancer

Diabetes

34 patients receiving an Hba1C 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

Contact us

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