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 4th October 2018

M

Subject: Clinical Commissioning Groups' Annual Performance Report

Summary statement: This report presents performance against the NHS England Clinical Commissioning Group Improvement and Assessment Framework for 2017/18 for Bradford City (BCCCG), Bradford Districts (BDCCG) and Airedale, Wharfedale and Craven (AWCCCG) Clinical Commissioning Groups.

Michelle Turner Director of Quality
NHS Bradford City CCG and Bradford Districts CCG
Phone: (01274) 237796
E-mail: michelle.turner@bradford.nhs.uk

Julie Lawreniuk
Deputy Chief Officer and Chief Finance Officer, NHS Bradford City and Bradford Districts CCG
Phone : 01274 237642
Email: julie.lawreniuk@bradford.nhs.uk

Portfolio:

Healthy People and Places

1. Summary

This report presents performance against the NHS England Clinical Commissioning Group Improvement and Assessment Framework for 2017/18 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. The CCG Improvement and Assessment Framework (IAF) draws together the NHS Constitution, performance and finance metrics and transformational challenges and plays an important part in the delivery of the NHS 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 in a number of performance areas and this has resulted in an improved overall rating of 'OUTSTANDING' for Airedale, Wharfedale & Craven CCG (AWCCCG) and Bradford City CCG (BCCCG). Bradford Districts CCG (BDCCG) has maintained its overall rating of "GOOD".

These ratings compare to a national position as presented in the table below:

CCGs rating	**2017/18**		**2016/17**		**2015/16**	
	No.	%	No.	%	No.	%
Outstanding	20	9.7%	21	10.0%	10	4.8%
Good	100	48.3%	99	47.4%	82	39.2%
Requires improvement	69	33.3%	66	31.6%	91	43.5%
Inadequate	18	8.7%	23	11.0%	26	12.4%

Fifty percentage of the overall rating was based on performance against a range of indicators across the two domains of Better Health and Better Care, 25% is based upon financial performance and the remaining 25% is allocated to the quality of leadership assessment. Key points to note are:

- AWCCG - Particular areas that are performing well include, the levels of childhood obesity; antibiotic prescribing; CQC high quality care ratings for GP practices; and minimising admission rates for people at their end of life.

  The CCG has no indicators amongst the bottom 10 CCGs in England, although there are some areas where performance could be improved including: reducing health

inequalities; extended access to GPs; and patient and community engagement.

- BCCCG - Delivery of the Better Care and Better Health indicators remains more challenging. Whilst there has been improvement in 20 indicators including reducing injury from falls, antibiotic prescribing, early cancer diagnosis and maternity experience and choice, 14 indicators appear amongst the 22 worst performing CCGs in England.

  Areas in greatest need of improvement are: improving the quality of life for carers; one year cancer survival rates; reducing hospital admission rates for people at their end of life; hospital waiting times; access to psychological therapy services (IAPT) and associated recovery rates; the level of childhood obesity; health inequalities; and neonatal mortality and stillbirths.

  Patient experience of GP services has improved from 56.1% in 2016 up to 73.8% in 2017, although BCCCG is still below the England average. Our Enhanced Primary Care work stream is focussing on a number of key areas for 2018/19 including: Roll out of extended access to 100% of the population by October 2018; successful recruitment of international GPs; and the roll out of online consultation systems.

- BDCCG - Performance against both the Better Care and Better Health indicators is rated as AMBER. Over the year there have been improvements for 18 indicators with areas of good performance including antibiotic prescribing, one-year survival from all cancers, ensuring patients who require a mental health bed can remain local, reducing the reliance on specialist learning disability (LD) inpatient beds (allowing patients to remain in the community) and increasing the number of LD physical health checks conducted in primary care.

  Areas in need of improvement include, reducing childhood obesity levels; reducing health inequalities; improving quality of life for carers; IAPT access; experience of GP services; and extending access to GP services in the evenings and at weekend.

- The rate of unnecessary delays for discharge from hospital remains low. Funded via our Better Care Fund (BCF), we have multi-disciplinary teams in place to facilitate quick and effective discharges from hospital and minimise delays to patients and additional community beds have been commissioned during times of high pressure. As a result we continue to have one of the lowest rates of delayed transfers of care nationally and continue to minimise the use of hospital beds following emergency admission. We will continue to work with the local authority to fund and develop services which help people manage their own health and wellbeing, and live independently in their communities for as long as possible.

- However, inspection of the adult social care sector remains a cause for concern. As part of our 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 including training, support with CQC inspection processes, specialist equipment provision and use of technology.

- The number of referrals for hospital treatment, which were made electronically, remained below national averages in 2017/18 for all 3 CCGs. The national ambition is for all referrals to be made using the national e-referrals service from 1st of October 2018 as a key element in the move to a paperless NHS. Following Airedale Hospital Foundation Trust (AHFT's) & Bradford Teaching Hospitals Foundation Trust (BTHFT's) move to 'paperless' in March and June 2018 respectively, we are now

seeing a steady increase in the % of electronic referrals. Electronic referrals help patients to have more choice and control over their healthcare, the quality of referral information is improved and Trusts' benefit through reducing 'did not attend' (DNA) rates and improving administrative efficiencies.

- All three of our CCGs have been rated highly for Quality of Leadership with a GREEN STAR placing our 3 CCGs within the top 26 CCGs awarded this rating for 2017/18.

  The CCGs are part of the Bradford district and Craven (BdC) health and care system and collectively we have much to be proud of in pursuit of our shared ambition of keeping people Happy, Healthy at Home. The extent to which this vision is understood and owned across the system has been tested in the recent Care Quality Commission (CQC) review. The CQC remarked on the breadth and strength of partnership here and the commitment from all towards our common ambition of keeping people happy, healthy at home.

- All three CCGs delivered their statutory financial targets in 2017/18.

The ratings for five of the six national clinical priorities have also been published and CCG performance is shown in the table below:

	AWCCCG		BCCCG		BDCCG	
	Baseline rating	Latest Rating	Baseline rating	Rating 2017/18	Baseline rating	Rating 2017/18
Cancer[2]	Good	Good	Inadequate	Requires improvement	Good	Requires improvement
Mental Health[1]	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Good
Dementia[1]	Outstanding	Good	Outstanding	Outstanding	Outstanding	Good
Diabetes[2]	Requires improvement	Requires improvement	Inadequate	Inadequate	Requires improvement	Requires improvement
Maternity[2]	Requires improvement	Good	Requires improvement	Requires improvement	Inadequate	Requires improvement
Learning Disability	Requires improvement	Not yet published	Requires improvement	Not yet published	Requires improvement	Not yet published

[1] *Latest rating is 2016/17* [2] *Latest rating is 2017/18*

Key points to note are:

Cancer
Half of people are diagnosed at stage 1 or 2 in AWCCCG and BCCCG against a national ambition of 62% by 2010/21. This is less in BDCCG, but has improved from 38.3% to 48.8%. Whilst diagnosis at an early stage is also improving and all 3 CCGs have seen improvement in one-year survival rates, performance against the national cancer waiting times standards can sometimes be challenging and BCCCG and BDCCG rank poorly nationally in terms of patient experience.

It is recognised that cancer treatment pathways can be specialised and cross numerous providers. Work is ongoing to improve engagement with the national screening programmes for bowel, cervical and breast cancer and the CCG has partnered with several charitable organisations such as Cancer Research UK and Yorkshire Cancer Research to promote knowledge of cancer symptoms within our population as well as practical steps to reduce the risk of cancer. The West Yorkshire Cancer Alliance has provided additional money to develop and implement an education programme for Lung Cancer to raise awareness of early signs and symptoms to help detect cancers earlier;

Mental Health
There is strong evidence that tackling mental ill health early improves lives and around 1 in every 6 adults in England suffers from common mental health problems such as depression or anxiety disorder. The Mental Wellbeing in Bradford District and Craven: A Strategy 2016 – 2021, was launched in January 2017 to improve the wellbeing for the people of BdC. The strategy outlines three key strategic priorities:

- our wellbeing: building resilience, promoting mental wellbeing and delivering early intervention;
- our mental and physical health: developing and delivering care through the integration of mental and physical health and care; and,
- care when we need it: ensuring that when people experience mental ill health they can access high quality, evidence-based care.

However, our ratings suggest that there is still work to do to improve access to mental health service. Locally we have established the Bradford crisis care partnership and first response services which has received national recognition. We have had no out of area placements for people needing an acute mental health bed in over a year and we have established services in A&E and acute hospital wards to manage crisis care. Partners from the NHS, local authority, police and voluntary and community sector (VCS) organisations work together under the crisis care concordat to ensure that people who experience a mental health crisis receive the care they need from the service best placed to provide it, 24 hours a day, seven days a week. We also commission 'safe havens' (The Sanctuary, The Haven) and a safe space for children and young people from the VCS. These offer a warm and supportive place to stay for people experiencing a crisis but who do not need to be admitted to hospital, providing care in the least restrictive environment possible.

Our work across West Yorkshire and Harrogate Health and Care Partnership includes developing a local service framework for mental health and strong partnership working on child and adolescent mental health services, low, medium and secure forensic services, autism and suicide prevention.

Dementia
Dementia diagnosis and post diagnosis care for all 3 CCGs remains amongst the best in England. There are four key elements of post-diagnostic support: Access to a Dementia Adviser 2 weeks after referral; a Nurse review 3 months after diagnosis, of individuals physical and mental health and social care needs; a GP review every 12-15 months; and Dementia Friendly communities, businesses and services.

Working closely with local partners, including VCS organisations such as Carer's Resource and the Alzheimer's Society, our work across BdC has included:

- Improving access and waiting times to Memory Clinics;
- Caring and Sharing - relationship counselling for people with dementia and/or their partners;
- 23 Memory Cafes across Bradford for vulnerable people over 55, including 4 specifically for people with Dementia;
- Airedale Hospital has held a Living with Dementia Awareness Week and implemented dementia awareness training for all staff together with bespoke training to targeted areas and their Dignity Room provides provisions/clothes/toiletries etc. for patients and carers; and

- Diagnosis rates in Bradford District Care Foundation Trust's (BDCFT) Memory Assessment Clinics are now one of the highest in the region and their Daisy Hill Dementia Assessment Unit has received a Gold Award from Stirling University.

Stroke Services
The Sentinel Stroke National Audit Programme (SSNP) data has recently indicated there has been an overall deterioration in the quality of stroke services across the district. Work continues to establish the service as a single service across both acute hospital trusts, supported by the Head of Collaboration for Stroke. Some challenges persist in recruitment across all clinical teams and bed capacity, which the teams are actively working towards resolving. Pathway reviews are under way and the teams are also working towards a joint action plan to aid collaborative working.

As of 29th August 2018, BTHFT SSNAP data is showing an improvement which provides some assurance on all the focused work the trust is undertaking, and the team score (all patients whose full pathway is within the Trust service) increased to a level B (the highest score ever achieved for the Trust).

Diabetes
This national clinical priority is in place to incentivise CCGs to improve implementation of the NICE-recommended treatments (e.g. management of blood pressure, glucose (sugar) and cholesterol levels) and increase the number of patients attending structured education. Better management of diabetes can play an important role in the reduction of risk and complications of diabetes e.g. eye disease, kidney failure, stroke, heart disease, foot ulcers and amputation.

Across England 40% of people are within NICE recommended treatment levels, this is a low result and means that only 2 out of 5 people with diabetes are managed within recommended levels. For BdC, of the 35,545 people on GP practice registers, 13,650 were within all three NICE recommended treatment levels, the same result as England. While our focus via *Bradford Beating Diabetes* is on prevention and self-care, more work needs to be done on supporting those who have been diagnosed with the disease to make sure that people with the condition have the best outcomes.

Across England just 7.3% of diabetics completed structured education within the first twelve months of their diagnosis. This low result is thought to be in some part due to people not taking up the offer of education and in part due to methods of recording attendance. For BdC, of the 2,535 people who received a diagnosis during 2015, only 105 were recorded as completing 6 sessions of structured education within the first twelve months of their diagnosis, that's just 4%. We are working hard with our local hospitals, GPs and patients to make improvements in the way we provide structured education courses to encourage more people to take up the offer of life changing health and lifestyle advice, enabling people to attend them closer to home, in a suitable language and in a familiar environment, and we were awarded £702k to improve structured education in 2017/18.

We are planning to provide more education sessions within GP surgeries and community centres, in different languages, women only sessions and at different times including weekends so that people have more choice and can attend the structured education programme closer to home and in familiar environment.

Maternity
There has been an improvement in smoking rates during pregnancy for AWCCCG and BDCCG but an increase in BCCCG. Working in partnership with Public Health we will utilise the learning from the work undertaken by the Women's Health Network to

understand why women from some our communities don't access smoking cessation services to improve our local service offer. In addition, we will utilise the leaning from the Better Start Bradford case loading midwifery pilot to reduce our rates for smoking at time of delivery and at 6 weeks baby check appointment.

The neonatal mortality and still births rates have increased in AWCCCG and BCCCG, but reduced for BDCCG. We are working in partnership with colleagues across the health and care economy to reduce stillbirth, neonatal and infant mortality rates. This work recognises a number of factors including the impact of poverty, access to a range of services and the need to offer high quality maternity provision.

In general women's reported satisfaction with maternity services is good. We are continuing to develop our understanding of the needs of the local population through the development of BdC Maternity Voices Partnership and our work with the Women's Health Network. In addition, we will utilise the learning from the Better Start Bradford case loading midwifery pilot where 100% of women advised they would recommend the service they received. The CCGs commission the full range of maternity choices for local women and therefore future work will focus on how these choices are offered along the care pathway to ensure all women feel they have access to the full range of services available to them.

Our CCG wide Maternity, Children and Young People's Programme Board will oversee the implementation of the recommendations of the five year forward view for maternity services. Led by a senior clinician we have identified our local priorities, developed an action plan and will engage with senior management from across the local health and care system to achieve delivery. Locating maternity alongside the children and young people's developments allows us to maximise the opportunities for improving both maternal and child health outcomes.

Over 2016 and into 2017 the maternity services at BTHFT saw an increase in the level of serious incidents reported, alongside a range of other ongoing concerns. The CCG raised concerns and via our Joint Clinical Board (JCB) and Joint Quality Committee (JQC) a number of maternity themed discussions took place. Prevention of stillbirths has remained a major priority during 2017/18, and data for the trust indicates a significant reduction in stillbirths for this period. 2017/18 has therefore been a challenging year for the Maternity Services at BTHFT, as the unit has worked hard to complete and embed the Maternity Improvement Plan (MIP), which were the combined recommendations from the 2016 Maternity Quality Summit, the CQC and the Royal College of Obstetricians and Gynaecologist (RCOG) review, held in April 2017.

Learning Disability

The number of people with a learning disability and/or autism in specialist inpatient care has increased over time and nationally there is a drive to reduce reliance on inpatient care, and provide better community based care. Our system wide Transforming Care Partnership has plans in place to:

- Engage with and support providers who are new to Bradford but have experience of supporting people with very complex presentations;
- Develop community housing provision at 8 sites across Bradford and Keighley to offer people different housing options; and
- We are working with other CCG's in West Yorkshire to collaboratively commission an Assessment and Treatment service within the regional footprint.

Annual health checks are an important tool to help improve health and reduce premature death in people with a learning disability and the ambition is to improve access to health

checks for people with a learning disability over 14 years of age. To support this, BDCFT has recently re-launched easy read publicity, which has gone to GP surgeries and other public buildings, around the importance of having an annual health check.

However, the Royal College of General Practitioners (RCGP) suggest that nationally only around a third of the estimated numbers of people with a learning disability are on a GP register, meaning that appropriate adjustments to their healthcare cannot be delivered and a number of patients miss the benefits of targeted interventions such as annual health checks. We aim to increase the number of people with a learning disability on the register from the current level of 0.50% of the practice population through working with GP practices to promote the benefits of being on this register (some families and individuals are still reluctant to have their name on a register that indicates they have a learning disability). This will be supported by better sharing of information and data across health and social care.

The CCG have launched ThinkLD, a campaign which asks everyone involved in caring for people with a learning disability (across the health, social care and voluntary sector) to think about how they can make access to health services as easy and as positive as possible. The CCGs are also participating in the Learning Disabilities Mortality Review Programme, a review process for the deaths of people with a learning disability, with a view to take forward lessons learnt in the reviews to make improvements to service provision. Completion of reviews is a national challenge, and we aim to increase the number of Multiagency reviews completed. A Regional LeDeR Co-Ordinator has been recruited to facilitate this.

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)

The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). However, delivery of the target has been challenging as a result of increased demand and capacity issues across the local system.

Whilst AHFT delivered the RTT target overall in 2017/18 they did experience pressures at a specialty level (in particular General Surgery, Urology and Orthopaedics). However, there has been consistent poor performance at BTHFT.

Issues at BTHFT have been compounded by the introduction of a new Electronic Patient Record (EPR) system in August 2017. Capacity across the Trust was reduced for a number of months during implementation and data quality has been affected. The Trust has a full recovery plan agreed with NHS Improvement for delivery of the national target by March 2019, which is focusing on a number of areas:

- Patient safety & clinical harm: A process is in place to clinically review all patients waiting 52+ weeks. Currently no clinical harm has been identified;
- Operations & performance: Backlog clearance plans have been developed and specialty level trackers are being rolled out across the Trust in order to quantify specialty level delivery against recovery trajectories. Weekly reviews are taking place and there is a monthly stocktake of demand and capacity. There is also work ongoing to improve the management of the planned and diagnostic waiting lists, outpatient

referrals, reduce elective cancellations and improve communication to GPs;

- Data quality & validation: Whilst some of the increase in the waiting list will be a result of reduced capacity during EPR 'go live', there could be some impact from how patients are coded which may be resulting in duplicate entries; and
- Training: Additional training for staff on pathway management processes will be developed and standard operating procedures (SOPs) for managing waiting lists.

We are working in partnership with our local providers to develop a more sustainable planned care delivery model through our Planned Care Programme work. This work has identified a number of opportunities including reducing unnecessary follow up appointments, standardising GP referral criteria and limiting access to procedures which have been proved to have limited clinical effectiveness.

Diagnostic 6 week wait

Delivery of the 6 week diagnostic target was also a challenge in 2017/18. At AHFT, increased demand, coupled with staffing pressures in Ultrasound, were the main issues. BTHFT's diagnostic position was also affected by the EPR implementation, with technical issues resulting in incomplete performance data (figures still exclude Endoscopy and Neurophysiology), making it difficult to manage the capacity issues experienced for Endoscopy tests.

Cancer waits

Whilst in the main AHFT has delivered the national cancer standards in 2017/18, performance at BTHFT has continued to deteriorate. There has been increased demand and ongoing capacity issues in some specialties, particularly dermatology. Extra clinical sessions have been introduced and the CCGs are working with the Trust to review demand and the potential for lower risk patients to be treated in community services.

Cross organisational work between different hospital sites has also continued, in particular with Inter Provider Transfers, to ensure patient flow is streamlined and well timed to meet the national 62 day waiting time target.

Accident & Emergency (A&E) 4 hour wait

Ensuring we have a robust urgent care system also continues to be a challenge across the health and care system with performance against the 4 hour A&E access target remaining below the national 95% standard.

We have seen increased attendances, high patient acuity and high levels of bed occupancy. Locally, working with partners as part of the BdC Urgent Care Programme, we have introduced GP streaming of patients at the front door to A&E (ensuring only appropriate patients get A&E treatment), increased the numbers of NHS 111 calls transferred for clinical advice, increased extended access to GP appointments and implemented discharge to assess to trusted assessor models. As part of the West Yorkshire and Harrogate Health and Care Partnership, we have worked with other CCGs to increase clinical contact through NHS 111 calls and expand direct booking to GP practices from NHS 111.

We continue to rethink the way urgent and emergency care is provided to ensure more options are available away from hospital, ensuring our A&Es are supported by better primary and social care and improving the flow of patients in our accident and emergency departments.

Mental Health Access

We continue to deliver the national standard to ensure patients with a first episode of

psychosis commence treatment with a NICE approved care package within two weeks of referral, and to ensure this can be further improved, additional 2018/19 funding has been agreed. We also ensure that services are assessed, planned, co-ordinated and reviewed (CPA follow up) for people with mental health problems within 7 days of discharge from inpatient care.

The majority of patients are also able to access Psychological Therapies (IAPT) services within six weeks of referral. However, it is acknowledged nationally that IAPT recovery rates are lower for areas of higher deprivation and for BME communities. BDCFT has commenced innovative work within the City IAPT Team to consider and develop appropriate service responses to cultural issues. This work is supported by Hari Sewell, a national expert in the specialist field of equalities in mental health. They expect that this will support improvements in both access and recovery rates for BME populations across the district.

Quality of Care

VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein. This is most common in a leg vein but a blood clot can form in the lungs. Hospitals are required to ensure that medical, surgical or trauma patients have their risk of VTE and bleeding assessed using a national tool as soon as possible after admission to hospital. AHFT delivered above the 95% standard in 2017/18, but performance at BTHFT was on average around 90%. Whilst implementation of the new EPR system had some impact on effectively recording assessments, BTHFT has revised its approach to VTE, driven by a lead Consultant. A VTE assurance group has been re-established, reporting directly to the Patient Safety Committee and VTE incidents which have occurred have been reported and investigated via existing quality monitoring processes. As a result, the risk assessment position of the trust for VTE has improved in 2018/19. As part of an ongoing VTE action plan, further work is required to revise the VTE policy and Root Cause Analysis (RCA) tool, to reflect national guidance and support learning and governance associated with the outcome of the root cause analysis investigations

Health Care Acquired Infections (HCAIs) pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority and the CCGs continue to work with all providers across the system to minimise the number of HCAIs, through the use of Post Infection Review (PIR) panels to understand the root cause of infection, prevention and control actions and share learning. Cases of MRSA remain low, but against a challenging zero tolerance target, and CDiff infections continue to reduce in both an acute and community setting. In 2017/18 we also started to complete PIRs for E.Coli and MSSA infections. Going forward, through joint working between primary and secondary care, we hope to facilitate further reductions in the HCAIs.

The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. Breaches remain rare across our two hospital sites, although there were 2 breaches of the mixed sex accommodation standard at AHFT in 2017/18. Any breaches are reported within one working day to the CCGs, with an overview report of the circumstances. Following this a full investigation is undertaken by the provider and evaluated by the CCGs' Quality team.

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. 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.

For AWCCCG, BCCCG and BDCCG, the gap between our annual budgets and the increasing cost of providing healthcare to local people was £6m, £3.5m and £13.3m respectively during 2017/18. These gaps became our QIPP targets.

During the year there was an increased focus on delivery against the QIPP agenda, with a clear joined up approach to deliver our targets. Delivery for the year realised an over achievement of £0.3m for AWCCCG and a slight under performance of £0.1m for BCCCG. The challenge for Districts was much greater due to the high target, with a final achievement reported of £7.7m.

3.4 Looking Forward: QIPP 2018/19

The amount of QIPP that is needed to deliver the gap between anticipated incomes and planned spend for 2018/19, is shown below for all 3 CCGs:

- AWC CCG £6.67m
- Bradford City CCG £1.7m
- Bradford District CCG £5.3m

As part of the joint management structure the CCGs are working collaboratively with provider colleagues around QIPP to ensure that there is a joint approach to deliver these savings targets. There is now an alignment of programmes and schemes, where work is done once across the system that benefits our whole population. The table below outlines the QIPP plan for 18/19 for all 3 CCGs.

QIPP Plan Financial Year 2018/19

CCG	Airedale Wharfedale and Craven	Bradford City	Bradford Districts
Programme Areas	'£000		
Planned Care	1,864	463	1,904
Urgent Care	65	364	567
Primary and Community Development	328	32	95
Mental Health and LD	-	-	
Personalised Commissioning	100	100	315
Prescribing	1,565	561	1,877
Transactional	712	120	349
Unidentified	2,045	105	195
Total	6,679	1,745	5,302

Planned Care: The current growth in planned care activity is financially unsustainable. Our Planned Care Programme work has identified a number of opportunities where addressing patient flow will help to create a more sustainable health economy by addressing unwarranted variation and inefficiencies across care pathways, whilst also

improving waiting times for those patients who need hospital care.

Urgent Care: Work continues in the system Urgent Care Programme to develop schemes that assist in managing demand on A&E. Areas being reviewed include further development of GP streaming services within A&E to reduce inappropriate attendances, reviewing pathways of emergency care including developing services around ambulatory care and reviewing children and young people who visit A&E more frequently than average.

Prescribing: For all 3 CCGs, work continues on targeting inefficiency and waste within the area of medicine management spend. It is also an area that is leading in developing schemes that include working directly with external colleagues, and sharing benefits, be it resources or financial gains. Areas where the CCGs are focusing in 2018/19 are:

- Developing a new type of gain share model with our primary care colleagues to switch patients to more appropriate and cost effective medicines;
- Developing a risk share arrangement with our colleagues at BDCFT around wound care products, to develop a more financially sustainable service across our system;
- Continued work around oral nutritional supplements, vitamins and baby milk with our colleagues at BTHFT, where we have supported a continuation of a role that works across both organisations; and
- Working to support the national directive around cost effective medicine use.

New ways of working (Integrated Care Systems): 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. To support this, work has commenced with our local partners to develop new contracting models that will support this direction of travel and enable management of financial and system risk as a collective.

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:

- The transformation of community services to form a new model of care based around integrated and aligned health and social care 'Primary Care Home (PCH) communities which will understand and meet the needs of populations of 30,000 to 60,000.
- In-depth work on the role of community beds is being undertaken, in order to create an integrated, needs-led community bed resource for adults with complex health, care and support requirements.
- Development of a Community Access Network (CAN) to act as a front door to all community services in Bradford; and
- The implementation of the General Practice Forward View and the Bradford CCGs Primary Medical Care Commissioning Strategy is being overseen by the Enhanced Primary Care Implementation Group. The aim is to ensure high quality, safe and sustainable primary medical care services are in place in Bradford.

The AWC New Models of Care will ensure people in AWC receive individual and seamless care to reduce their need for unplanned and urgent care by pro-actively

managing their physical, psychological and social care needs. Specific work includes:

- The introduction of GP practice ‘at scale models’ which comprise of one super partnership and one large alliance. This approach will support delivery of improved population health within a sustainable CCG patch whilst retaining individual organisational statutory accountabilities;
- Looking at alternatives to hospital admission by streamlining pathways and reducing unnecessary/emergency hospital admissions;
- Primary and community led models of care are being developed and tested with self-care and prevention embedded and mental and physical health having equal importance; and
- Use of intermediate care as an alternative to hospital admission where appropriate continues to mature.

4. Options

Not Applicable

5. Contribution to corporate priorities

A number of metrics relate to joint working across the Bradford District and contribute to corporate priorities.

6. Recommendations

6.1 That the Health and Social Care Overview & Scrutiny Committee note the content of the report

7. Background documents

None

8. Not for publication documents

None

9. Appendices

1. CCG Improvement and Assessment Framework
2. CCG Scorecards