Strategic Plan
Executive summary
October 2012
“Better health for the people of Bradford”
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Chapter one: introduction

Our ambition is to transform the experiences of our patients; significantly improve their outcomes; and to use the creativity, talent and ability to innovate that our member practices offer through the opportunity of clinical commissioning.

Our vision – better health for the people of Bradford – has been created through collaboration with our practices, strategic partners and patients.

Many of our patients will live longer and expect their lives to be healthier and happier than those of their predecessors. But there needs to be a step change if we are to make inroads into the health inequalities suffered by some of them and to address the future health needs of all our population.

Our main focuses, that underpin the majority of our strategic objectives, are transformation and integration. We will maximise our partnerships to ensure future sustainability of services as well as taking a strategic approach with partners like the Council to our investments in preventative services.

We believe that our strategy for greater integration is the key to delivery of a sustainable quality, innovation, productivity and prevention (QIPP) plan. More importantly though, it is what patient and carer feedback would suggest is the greatest area of concern. Patients and carers do not refer to it as integration but they do tell us about poor communication between teams, about struggling to navigate the system to ensure older people remain independent, about not wanting to go to hospital but not having a choice, about wanting to come out of hospital but not having the right support to keep them at home.

We inherit a sound financial position from NHS Bradford and Airedale. This enables us to reinvest some of our efficiencies to develop services fit for the future. It also enables us to plan for the next two years with confidence and use this period to put Bradford in a strong financial position by the time of the next comprehensive spending review.

Our organisation is genuinely clinically led and our members have been active in developing this overarching strategy. They continue to engage with each other through clinical commissioning fora to ensure these strategic objectives can be secured through our approach to commissioning. We will start to see the benefits of clinical leadership and ownership in the 2013 contracting round when we secure improvements to services as a direct result of practice and patient feedback.

We will work to reduce waste. For example, resources are wasted when patients feel they need to visit A&E when they could have been dealt with in primary care or community settings. To avoid this unnecessary waste we will focus on things like patient information, access to GP services, integration of services, and commissioning primary care skills and expertise in A&E to reduce, and better manage, demand.

Ultimately, our success will be judged on the difference we make for our patients. We expect that:

- 100 lives will be saved with fewer people dying from cancer and CVD;
- life expectancy for men will be improved by two to three years;
- 10,000 fewer people will use A&E instead of primary care;
- 6,000 people will live better lives with their long-term conditions;
- 235 fewer people will have a stroke;
- 70% of people with diabetes will receive the nine NICE recommended care processes;
- 1,000 people with ambulatory care sensitive conditions and dementia will avoid hospital and receive their care in the community.

Dr Andy Withers
Clinical chair

Helen Hirst
Chief officer designate
Chapter two: who we are

Forty-one GP practices, responsible for commissioning health services for 328,000 people in the Bradford area, make up Bradford Districts Clinical Commissioning Group (CCG):

Our practices come together in the council of representatives (CoR). To manage their ambitious clinical commissioning plans they have set up a clinical board, comprising mainly of elected GPs, and a governing body to oversee the delivery of objectives and ensure that appropriate governance arrangements are in place. Each practice is also a member of a clinical commissioning forum (CCF) which supports the clinical board in developing priorities for primary care improvement. There are two CCFs, one for the north based practices and one for the south.

The organisational structure comprises managerial and clinical leadership roles; the vast majority of the former are shared with Bradford City CCG, whilst some are also shared with Airedale, Wharfedale and Craven CCG.

Our population
The age profile of our population – totalling about 328,000, 19% of whom are South Asian – is similar to that of the Bradford district as a whole. Life expectancy for females is similar to the district, whilst it is shorter than our neighbouring CCGs for men (77.97 compared to 79.34 in Bradford City CCG). Forty-one per cent of our population live in the 20% most deprived areas in England; less than 10% live in the least deprived areas.
The growth of our population is expected to be faster than the national average, ensuring that pressure on services will not diminish:

**Life expectancy**

Life expectancy for males in Bradford Districts CCG is shorter than in neighbouring CCGs, and is increasingly less marked than in neighbouring CCGs. For females in Bradford Districts CCG life expectancy is similar to Bradford and district as a whole, and between 2008 and 2010 increased at approximately the same rate as the district average.
Major causes of death

Top 15 causes of death in Bradford Districts CCG, 2008-2010

<table>
<thead>
<tr>
<th>Cause</th>
<th>Average number of deaths per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischaemic heart diseases</td>
<td></td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td></td>
</tr>
<tr>
<td>Chronic lower respiratory diseases</td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasm of trachea, bronchus and lung</td>
<td></td>
</tr>
<tr>
<td>Dementia and Alzheimer’s disease</td>
<td></td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
<td></td>
</tr>
<tr>
<td>Symptoms, signs and ill-defined conditions</td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasm of colon, sigmoid, rectum and anus</td>
<td></td>
</tr>
<tr>
<td>Heart failure and complications and ill-defined heart disease</td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasms of lymphoid, haematopoietic and related tissue</td>
<td></td>
</tr>
<tr>
<td>Diseases of the urinary system</td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasms of breast</td>
<td></td>
</tr>
<tr>
<td>Cirrhosis and other diseases of liver</td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasm of prostate</td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasm of pancreas</td>
<td></td>
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</tbody>
</table>
Cardiovascular disease:
Cardiovascular disease (CVD) mortality rates for the CCG are consistently very similar to the rate for Bradford and district as a whole. Rates are higher amongst males than amongst females, and have remained consistent in both sexes on the last three years.

![Chart showing Cardiovascular disease rates over the years]

2008 2009 2010
Male 244.34 266.15 235.19
Female 154.57 138.87 142.90
Persons 194.69 193.18 184.68

Cancer
Cancer mortality rates are higher than in the other two CCGs serving Bradford and district, and therefore higher than the district average. Rates are higher amongst males, and over the last three years have been fairly steady amongst females and males.

![Chart showing Cancer rates over the years]

2008 2009 2010
Male 185.20 213.50 215.26
Female 147.23 165.30 140.71
Persons 160.70 184.31 173.11
Liver disease
Mortality due to liver disease appears to be falling, although it is consistently higher in Bradford Districts CCG than in the other two CCGs serving Bradford and district. Because there are relatively few deaths due to liver disease in the CCG the associated mortality rates fluctuate greatly.

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>16.61</td>
<td>20.37</td>
<td>12.38</td>
</tr>
<tr>
<td>Female</td>
<td>10.95</td>
<td>3.76</td>
<td>5.77</td>
</tr>
<tr>
<td>Persons</td>
<td>13.88</td>
<td>12.11</td>
<td>9.09</td>
</tr>
</tbody>
</table>

Respiratory disease
Mortality rates for respiratory disease have tended to be marginally higher than in neighbouring CCGs. The figures suggest that there may be a long-term downward trend in the number of deaths due to respiratory disease; however the reductions between 2008 and 2010 have been marginal.

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>108.15</td>
<td>108.55</td>
<td>104.05</td>
</tr>
<tr>
<td>Female</td>
<td>83.78</td>
<td>80.03</td>
<td>70.72</td>
</tr>
<tr>
<td>Persons</td>
<td>94.06</td>
<td>89.97</td>
<td>84.81</td>
</tr>
</tbody>
</table>
Conditions amenable to treatment
The rate of potentially avoidable death is consistent, and very similar to the district average. Rates appear to be consistently higher amongst males, and the 2010 figures suggest the difference in rates may be widening.

All age, all cause mortality
Death rates for the CCG are consistent, and very similar to the district average. Rates are consistently higher in men than in women.
Disease prevalence
The table below shows the prevalence (number and percentage) of diseases covered by the QOF for our practices in 2010/11. The chart shows the distribution of the practices’ prevalence in terms of ranks. Individual practices are shown as vertical bars with the height of the bar proportional to each practice’s population. The blue box shows the range of the middle 50% of practices in the CCG. The large diamond shows the average rank for the CCG and the dashed blue line shows the England average.

<table>
<thead>
<tr>
<th>QOF Disease Register</th>
<th>Number (%) and chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>12,141 (3.7%)</td>
</tr>
<tr>
<td>Stroke or transient ischaemic attacks (TIA)</td>
<td>6,079 (1.9%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>42,706 (13.0%)</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>7,170 (2.2%)</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>8,920 (2.7%)</td>
</tr>
<tr>
<td>Cancer</td>
<td>4,435 (1.4%)</td>
</tr>
<tr>
<td>Mental health</td>
<td>2,777 (0.8%)</td>
</tr>
<tr>
<td>Asthma</td>
<td>21,302 (6.5%)</td>
</tr>
<tr>
<td>Heart failure</td>
<td>2,496 (0.8%)</td>
</tr>
<tr>
<td>Heart failure due to LVD</td>
<td>1,345 (0.4%)</td>
</tr>
<tr>
<td>Palliative care</td>
<td>857 (0.3%)</td>
</tr>
<tr>
<td>Dementia</td>
<td>1,767 (0.5%)</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>4,202 (1.3%)</td>
</tr>
<tr>
<td>Cardiovascular disease primary prevention</td>
<td>3,263 (1.0%)</td>
</tr>
<tr>
<td>Diabetes mellitus (17+)</td>
<td>16,609 (6.6%)</td>
</tr>
<tr>
<td>Epilepsy (18+)</td>
<td>2,141 (0.9%)</td>
</tr>
<tr>
<td>Depression (18+)</td>
<td>29,402 (11.8%)</td>
</tr>
<tr>
<td>Chronic kidney disease (18+)</td>
<td>10,535 (4.2%)</td>
</tr>
<tr>
<td>Obesity (16+)</td>
<td>32,133 (12.5%)</td>
</tr>
<tr>
<td>Learning disability (18+)</td>
<td>1,431 (0.6%)</td>
</tr>
</tbody>
</table>
Our key issues
Our key health and wellbeing challenges are chronic conditions and their outcomes. In the main, these are a consequence of unhealthy lifestyles; it is also clear that social, economic and environmental factors either have a direct impact on health status or exacerbate existing ill-health. As a result, a powerful driver across all service provision, and in developing and implementing our policies, will be encouraging healthy choices to be made easily and as the default option.

Because of the high rates of childhood and adult obesity, diabetes, coronary heart disease, chronic obstructive pulmonary disease, mental ill-health and infant mortality found in our area, we are focussing on:

- **cardiovascular disease** (CVD) which is the leading cause of death and the second most significant cause of premature death. The prevention and management of CVD requires work in both primary care and population management. Whilst we are actively involved in this area we expect the outcomes will not be seen for some time.

- **respiratory disease**, where deaths have tended to be slightly higher than neighbouring CCGs, although figures may suggest a long-term downward trend. Rates for premature death from respiratory disease, whilst similar to the district as a whole, are higher among men than women and the gap may be widening.

- **cancer**, which is the leading cause of premature death and the second most significant cause of all deaths in our area. Death rates for the under 75s are consistently higher than our neighbouring CCGs.

- **people drinking hazardously and harmfully**, as we are seeing an increasing impact of this upon A&E attendances and hospital admission. Premature deaths from liver disease for the under 75s are consistently higher than our neighbours, as are all age mortality rates, although this is falling.

- **infant mortality**, which affects the whole of the local health economy. *The Bradford District Infant Mortality Commission report* (2006) highlighted two populations at risk of poor infant health and the diverse risk factors they experience: pre-term birth, younger teenage parents, smoking, alcohol and non-prescription drugs are greater risk factors for the white population. The risk of dying from congenital abnormalities is significantly higher in Pakistani heritage babies compared to white babies and the region or nationally.

- **mental health**, in particular early access to psychological therapies and dementia.
Chapter 3: our strategy

Our vision, mission and values

Our vision was chosen and developed by our member practices after reflecting on health inequalities, local health profiles and the JSNA:

“Better health for the people of Bradford”

Our mission

Bradford Districts CCG is passionate about making a positive difference. We will achieve our vision through genuine clinical drive and leadership in everything we do. Working in partnership with our members, our population and our stakeholders we will achieve a real integration and service transformation that makes a tangible difference to health and social care services in Bradford.

Our values

To achieve our vision and mission we will:

- drive innovation and clinical excellence;
- put the interests of patients and the community at the heart of everything we do;
- act with honesty and integrity.

Our key priorities

For each of our strategic objectives we expect the following key outcomes over the next three years:

1. To tackle health inequalities through prevention, integration and partnerships through:
   - improved early identification of intervention in life limiting conditions;
   - improved maternity and neonatal health outcomes;
   - a reduced impact of inappropriate lifestyles and behaviours on the health of the population, including hazardous and harmful drinking.

2. To improve patient safety and experience through:
   - increased patient and public engagement in the planning, commissioning and delivery of healthcare services;
   - improved experience of care for people at the end of their lives;
   - fewer healthcare acquired infections and other adverse consequences of treatment.
3 To improve primary care quality and ensure genuine engagement through:
- improved quality and patient experience of primary care services;
- services which are evidence-based, patient-centered, cost-effective and safe;
- primary care ownership of the CCG with maximum engagement of member practices.

4 To transform mental health and community services through:
- improved quality of, and access to, mental health services;
- timely assessment, diagnosis and treatment of dementia;
- appropriate and high quality health-commissioned learning disability services;
- integrated localities to deliver integrated care.

5 To improve outcomes for people with long-term conditions through:
- people feeling supported to manage their condition;
- fewer admissions to hospital for people with ambulatory care sensitive conditions;
- enhanced quality of life for carers;
- a reduction in the incidence of, and improved outcomes for, patients with stroke and transient ischemic attack;
- patients with diabetes receiving appropriate care to optimise the management of their condition.

6 To transform urgent care through:
- establishing a model of programme delivery for the transformation of urgent care;
- fewer admissions of children with respiratory diseases into hospital.

In designing our strategic objectives we used a wide range of information available to us, including the JSNA and the outline proposals for the health and wellbeing strategy, as well as presenting and discussing our priorities with the Health and Wellbeing Board.

Whilst responding to our local health needs, our strategic objectives also reflect the priorities set out in the *NHS Constitution, NHS Outcomes Framework*, the draft *Commissioning Outcomes Framework* and the draft *Mandate to the NHS Commissioning Board*.

We are working on establishing baselines specifically for the CCG (rather than the existing ones which are on a district-wide basis) and outcomes which are meaningful for our patients, communities and practices. In summary though, we will have been successful in our first two years if:
- 100 lives are saved with fewer people dying from cancer and CVD;
- life expectancy for men has improved by two to three years;
- 10,000 fewer people use A&E instead of primary care;
- 6,000 people live better lives with their long-term conditions;
- 235 fewer people have a stroke;
- 70% of people with diabetes receive the nine NICE recommended care processes;
- 1,000 people with ambulatory care sensitive conditions and dementia avoid hospital and receive their care in the community.
Chapter four: planning for financial sustainability

In a period of great uncertainty, the strategic plan sets out how we will allocate and manage our financial resources.

CCG budgetary allocations will be announced by the NHS Commissioning Board in the winter of 2012. All PCTs have completed a financial base-lining exercise which re-stated the 2011/12 outturn and the 2012/13 plan into the new commissioning architecture. As a result, our indicative budgetary allocation derived from this exercise is £413m which is equivalent to £1,290 per head of population and is slightly below the average for Yorkshire and the Humber. We have used this indicative budget as the start position.

We will take over the management of commissioning budgets from a financially sustainable PCT which has consistently met all its financial targets. The financial legacy we have inherited includes: consistent delivery of the financial control total target; delivery of capital and cash targets; delivery of QIPP targets; and a 2% recurrent surplus.

National financial context
Two years ago the government gave a commitment to provide ‘real terms growth’ to the NHS of just over 1% over the next four years and set out the following assumptions:

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<tbody>
<tr>
<td>Revenue</td>
<td>98.7</td>
<td>101.5</td>
<td>104</td>
<td>106.9</td>
<td>109.8</td>
</tr>
<tr>
<td>Increase</td>
<td>2.8</td>
<td>2.5</td>
<td>2.9</td>
<td>2.9</td>
<td>2.9</td>
</tr>
<tr>
<td>% Increase</td>
<td>2.8%</td>
<td>2.5%</td>
<td>2.8%</td>
<td>2.8%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

Financial assumptions
We have based our plan on the following three different financial planning scenarios – base case, downside and upside:

<table>
<thead>
<tr>
<th></th>
<th>Downside</th>
<th>Base case</th>
<th>Upside</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG allocation uplift</td>
<td>0.5%</td>
<td>1.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Pay &amp; prices</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>National efficiency</td>
<td>-4.0%</td>
<td>-4.0%</td>
<td>-4.0%</td>
</tr>
<tr>
<td>Net tariff</td>
<td>-1.5%</td>
<td>-1.5%</td>
<td>-1.5%</td>
</tr>
<tr>
<td>CQUIN increase</td>
<td>1.5%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Population growth</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
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</table>
In each of the scenarios we have assumed:

- the PCT £7.5m surplus is not carried forward to the CCG;
- our allocations will bring forward our existing recurrent budgetary surplus of 2% (£8.2m);
- we will invest 1% of our budget to meet our demographic pressures;
- we will invest between 0.5% (downside) and 1% (base case and upside) of our budget to meet national and local priorities;
- we will invest 1% of our budget non-recurrently to pump prime local initiatives and to support transformation;
- we will deliver an additional 0.5% recurrent headroom;
- we will deliver a surplus of 1% - which, combined with the 0.5% headroom, will provide an overall contingency/surplus of 1.5%.

**Productivity/efficiency requirements**

Based on the set of assumptions listed above, the following sets out our productivity requirements:

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<tbody>
<tr>
<td><strong>Opening allocation</strong></td>
<td>£412.92</td>
<td>£414.98</td>
<td>£412.92</td>
<td>£419.11</td>
<td>£412.92</td>
<td>£423.24</td>
</tr>
<tr>
<td><strong>CCG uplift</strong></td>
<td>£2.06</td>
<td>£2.07</td>
<td>£6.19</td>
<td>£6.29</td>
<td>£10.32</td>
<td>£10.58</td>
</tr>
<tr>
<td><strong>Inflation</strong></td>
<td>£-1.32</td>
<td>£-1.33</td>
<td>£0.42</td>
<td>£0.43</td>
<td>£0.42</td>
<td>£0.43</td>
</tr>
<tr>
<td><strong>Demographic growth 1%</strong></td>
<td>£-4.13</td>
<td>£-4.15</td>
<td>£-4.13</td>
<td>£-4.19</td>
<td>£-4.13</td>
<td>£-4.19</td>
</tr>
<tr>
<td><strong>Other investments</strong></td>
<td>£-2.06</td>
<td>£-2.07</td>
<td>£-4.13</td>
<td>£-4.19</td>
<td>£-4.13</td>
<td>£-4.19</td>
</tr>
<tr>
<td><strong>0.5% headroom</strong></td>
<td>£-2.06</td>
<td>£-2.07</td>
<td>£-2.06</td>
<td>£-2.10</td>
<td>£-2.06</td>
<td>£-2.12</td>
</tr>
<tr>
<td><strong>Savings required</strong></td>
<td>£-7.52</td>
<td>£-7.56</td>
<td>£-3.71</td>
<td>£-3.76</td>
<td>£0.42</td>
<td>£0.51</td>
</tr>
</tbody>
</table>

The base case scenario indicates that we would need to make productivity savings of £3.7m each year for the next two years, compared to a downside scenario which would require productivity savings of £7.5m per annum. The level of savings in the base case scenario are lower than current plans and is less than we have delivered over the last two and a half years.

Our QIPP plan for 2012/13 is £5.8m and is currently on track for delivery (see our Operational Plan for 2012/13). The downside scenario is very challenging with very low levels of CCG growth and low levels of investments. The downside scenario will require a different conversation with our patients, public and partners and is something we will plan for as part of our contingency arrangements.

We have a draft QIPP plan for 2013/14 – 2014/15 which was developed as part of our strategy for 2012/13 and has draft schemes which add up to £22.7m. The savings plan will be updated during November/December and will include a contingency for the downside.

Our top three schemes for next year are: assess to admit/ambulatory care - £840k; prescribing - £836k; integrated care - £313k.

By 2015/16 we must aim to take cost out of the system through innovation/integration and moving patients from acute to community settings (see planning for sustainability, below). The draft business case for integration sets out the current cost of long-term conditions, ambulatory care sensitive conditions and other conditions that could be treated in a primary/community setting without
the need for a hospital admission. The current cost/activity for these conditions is 6,787 admissions, 38,495 bed days, costing £14.2m and occupying 124 beds. If we saved 50% of these and the cost of re-provision equalled 50% of the cost saved, we would realise the following savings: £3.55m (25%) and save 62 beds, 3,393 admissions (65 per week).

Local health economy
The local NHS, in common with the national picture, is not expected to have its budget cut – but will have to cope with increased demand for its services with very little additional growth in its budget.

We will address the delivery of these challenges in a new and more inclusive way. We expect to utilise fully the unique nature of our new membership organisation and the close relationship that this brings with our patients and the public to enable real engagement in our future commissioning intentions.

Planning for financial sustainability
Given the scale of these savings targets and the efficiencies, it is clear that this economy-wide approach is necessary to ensure financial sustainability for the future. We have agreed to undertake a three-staged approach for the delivery of these targets:

- driving efficiencies in providers and commissioners to eliminate costs that do not contribute to the delivery of front line services;
- optimising spend and delivery quality including the prioritising of programmes, with a view to scaling back or eliminating those activities that are judged to be unaffordable or low priority;
- shifting care into more cost-effective settings and redesigning the way health services are delivered, including their interaction with social care services.

We will use existing data and intelligence to support the decision-making process including public health profiles/data packs, NHS Institute productivity indicators, evidence from our risk stratification work, Yorkshire & Humber QIPP resource packs, the NHS Atlas of Variation, evidence from an internal Deloitte's report; and local data from our business intelligence team.

Our longer term strategy will be informed by the outcomes of the integrated care pilots which will begin to be implemented across our CCG later this year. The business case is still in development but early indications would suggest that, through the better management of long-term conditions, reducing avoidable non-elective admissions and re-admissions and promoting more prevention, a significant amount of resource tied up in our acute bed base could be released to be deployed elsewhere.

Financial risk management
To help us manage our financial position, we will ensure that we retain some in-year flexibility by not committing all of our recurrent resources. In particular, we will:

- ensure our existing 2% headroom does not fall below 1.5%;
- explore the continuation of the current risk sharing of high cost low volume services with local CCGs;
- negotiate the continued 'ceiling and floor' arrangements with our providers.

Financial summary
Our strategic plan will focus, in the main, on a commissioning plan which supports that base case scenario but with mitigating strategies for both the downside and upside scenarios. Whilst the upside case shows that no further savings are required from 2013/14, we will continue with the delivery of the base case savings to both maximise the potential for future service investment and to increase our contingency reserves.
Chapter five: delivering our strategy

A number of enablers underpin the achievement of our vision and how our priorities are delivered. They are:

1 Improving quality
To a large degree, the public will judge our success on the quality of services that they use and we commission. We are committed to creating and sustaining the improvement of service quality; maintaining and strengthening safety; the rigorous monitoring of quality and safety measurements; and assertive action where quality falls short of expected standards.

Patient safety and safeguarding: Our services will put patients' safety first. We know that some patients, their carers and families are vulnerable and we are committed to ensuring that we meet our responsibilities for protecting the safety and wellbeing of children, young people and adults. This will also be reflected in our governance structure and in the role of our clinical leaders and senior management. We will share our safeguarding arrangements with Bradford City and Airedale, Wharfedale and Craven CCGs and together have established a senior role to lead this team.

2 Communications and engagement

Engagement with our patients, public and communities: because we want our patients to be at the heart of services, we will make sure that their views are heard and have influence.

Key areas of development for the next three years include:

- seeking people's views to help shape the services we commission;
- working with local groups to commission more joined up health and social care services at local level and so aid service transformation;
- helping practices to convert their insights about patients' needs and choices into plans for the CCG;
- accessing existing engagement structures to avoid duplication;
- helping patient participation groups to influence commissioning issues outside their own practices;
- gathering intelligence from other organisations by including feedback on patient experience in provider contracts;
- engaging with the Patient Panel around commissioning priorities;
- using a range of feedback tools and methods to ensure that our plans are accessible to everyone through a robust approach to equality and diversity;
- establishing an intelligence-led commissioning system.

Our communications and engagement strategy will help us to monitor progress as well as provide ongoing input from patients and other groups.

Engagement with our partners: to deliver our vision we must work in close partnership with the others to integrate and transform how services are commissioned. We are actively involved in developing the Health and Wellbeing Board and its strategy and the Joint Strategic Needs Assessment has supported this process.

We have also been involved in the transition of public health to the local authority and the development of a commissioning support unit so that we are confident that appropriate levels of support will be available to us in the future.
Organisational development

Our organisational development (OD) plan sets out the progress we have made in establishing a credible and viable organisation through the entire CCG team. The plan describes how we will make the most of the opportunity of the CCG model to improve outcomes for our patients:

Membership: As a membership organisation, the CCG is the sum of all of its parts rather than simply focussed on the clinical board, governing body and employed staff. Ensuring practice influence and ownership of commissioning intentions for 2013/14 are current pieces of work which set the tone for the future.

Working differently: As well as our own GPs, we are involving a broader set of clinicians in leading commissioning, particularly those from secondary care. We are also testing a new model (below) with our stakeholders and partners as a way of bringing about rapid change in a systematic and planned way.

Leadership: We are creating a distributed leadership across the CCG where individuals are able to contribute fully, are supported in taking risks, are open to challenge and take time to reflect, learn and improve. We will explore ways of working that are open and participative and ensure a genuine clinical drive behind commissioning decisions.

A culture of continuous learning and development will be reflected in how we work together. This will help us to assess capacity and capability across the CCG workforce, agree development plans and design appropriate learning programmes.

We are serious about succession planning; creating opportunities for new and aspiring leaders to contribute.

Structures: The organisational structure has been designed to ensure there is the right capacity and capability of clinical and managerial leadership and support; that there are clear roles that lead our collaboration (see page 17); and, that there is the right balance of in-house, shared and bought-in commissioning support. It also has the capability to accommodate additional areas of collaboration, such as with the Council, and there is flexibility to adapt the structure as we finalise our service level agreements with West Yorkshire Commissioning Support Unit.

Effective collaboration: Having three CCGs in the district, collaborative working in all possible areas is vitally important – for example, with Bradford City CCG with whom we share the majority of our staff, in respect of our contracts, quality assurance and service provision. We are a partner in the Bradford and Airedale Collaborative Commissioners’ Forum which shapes joint strategic
direction, provides a collective commissioner voice in service reconfigurations and, where appropriate, makes recommendations to the CCGs’ clinical boards. Public health partners are active contributors to our commissioning arrangements and the Memorandum of Understanding with the Council will secure this going forward.

We will collaborate and, where there is potential to do so, jointly commission with the Council for adult, children's and health improvement services and, beyond Bradford, we will work with the other CCGs and the NHS Commissioning Board in areas such as ambulance services, 111 and urgent care, and specialised services.

4 Transformation and innovation

So that local services best meet our patients' needs we are part of the creation of a radically new means of commissioning and providing local services through service transformation and integration. This programme takes a whole system view with organisations who deliver health, social care and third sector support being active in its development, alongside NHS commissioners and Bradford Council. Between us we have created a vision for the transformation and integration of health and social care for adults and children.

We have two-year trial programmes to address such issues as improving data sharing to eliminate repetitive questioning, improving choice of treatment options, involving carers in patients' care and reducing hospital admissions by providing community-based support closer to home, co-location of services through the best use of estates and financial changes such as delegating resources closer to the front line.

We are part of creating a culture that values innovation and are actively involved in the Bradford Transformational Change Board (TCB) and the Bradford City and Districts Transformation and Integration Group (TIG) – an arrangement endorsed by the shadow Health and Wellbeing Board. We firmly believe that improved outcomes for our patients will be easier to achieve and made sustainable if we work with partners to integrate and transform.

Primary medical care in the Bradford Districts CCG area is generally of a high quality. There has been much investment over the years in expanding services in primary care. We now need to develop new and innovative ways of further improving primary care, including how we manage demand better, how we continuously develop and improve and how we create greater consistency in outcomes and patient experience across the area.

Our information strategy is essential if we are to realise our ambitions and transform and innovate as well as supporting the CCG infrastructure. We have adopted the IM&T strategy of NHS Bradford and Airedale and will develop this whilst continuing to take the innovative and clinically driven approach that has been synonymous with Bradford’s IM&T. This will include our approach to e-consultations, electronic transfer of information, patient held records, telehealth and the continued drive towards connectivity across the health and social care economy.

5 Operational plans and commissioning intentions

We will set out how we are meeting the needs of patients and delivering our strategic objectives (as outlined in chapter two) through our operating plan. This also describes the governance and decision-making within the CCG and shows the financial plan in detail. It highlights the importance of transformational change and our QIPP programme for the next three years. For example, for cardiovascular disease (CVD) the major costs are seen in secondary care, prevention of disease, morbidity and mortality and continues to be an issue for primary and community care. Our practices have been actively involved in QIPP programmes in chronic kidney disease (CKD) and prevention of AF-related stroke with a marked change in practice. This is being extended into the management of left ventricular systolic dysfunction (heart failure) and the use of secondary preventive medication in people with established CVD in the next 12 months. Building on the experience of the QIPP process, we are developing mechanisms for the identification of CVD in anticipation of the national CVD outcomes framework.

Developing our commissioning intentions is the mechanism through which members, patients and the public are involved in the annual contracting process. Feedback from these and other sources sets the framework for our commissioning plan and the parameters for our contract negotiations.
Chapter six: risks to achieving our strategy

We have assessed our key risks as being:

- financial risks due to contract over-trade with core providers and non-delivery of QIPP projects;
- financial pressures in the local authority having an adverse impact on demand for health services;
- provider failure to deliver the quality, performance and information requirements within the contract;
- failure to actively engage practices, providers, public and patients in service design, delivery and improvements;
- failure to improve the patient experience;
- changes in demographics and failure to understand the needs of these patients;
- failure to put in place adequate governance systems and staff to deliver CCG requirements;
- inherent risks with the new commissioning landscape.

Our governing body assurance framework presents in detail the risks to achieving our strategic priorities. A risk register is also updated regularly.
In keeping with our belief that patient and public engagement sits at the heart of everything we do, we have already started to engage with patients, the public and other stakeholders about the direction of our strategic plans, but we have much further to go.

We will engage with our strategic partners through a variety of existing channels, including the Health and Wellbeing Board, Health and Wellbeing Hubs and Health Overview and Scrutiny Committee. Our existing relationships with these groups are strong, and we intend to build on them effectively in the future.

Our engagement with patients and the public will include the Local Involvement Network (LINk) and its successor, HealthWatch, the Bradford District Assembly, patient participation groups and a wide range of voluntary and community sector organisations. We will engage with existing community groups and organisations in the places where they meet, and in community languages, making our proposals as accessible as possible.

Along with Bradford City CCG, we are also planning a number of deliberative engagement events later in 2012 and early in 2013, where we intend to engage a range of participants to formulate our plans for the future.

Many of our plans are wide-ranging and will set a new pace and direction for health and health services in Bradford for the future. We intend to engage our stakeholders on these plans in manageable pieces, to maximise understanding and engagement and to gain the best possible relationship with our communities.

We understand, and will comply with, our statutory responsibilities in relation to consultation and engagement on changes to services, and will make our proposals easily accessible to people and organisations in Bradford. We will ensure that all of our stakeholders know the outcomes of discussions that we have with them, by feeding back how their views have influenced and helped to shape services.
Equality impact assessments (EqIAs) detail arrangements for assessing and consulting on the likely impact of our proposed policies. We are continuing to implement a programme to fully embed the use of EqIAs through all key functions. All of our new and reviewed policies, strategic proposals and significant pieces of work are now routinely subject to full equality impact assessment.

EqIAs check how an existing or new service, policy or procedure and the services being commissioned affect groups of people. They allow us to look at evidence or consult as to whether the service or policy is discriminating against particular groups of people. We can then make the necessary changes if there are adverse effects on some groups, or highlight it as good practice if it is having a beneficial effect.
Nine: suggested further reading

Single Integrated Plan, NHS Airedale, Bradford and Leeds

Bradford Alcohol Harm Reduction Strategy, Safer Bradford


NHS Constitution, Department of Health
http://www.dh.gov.uk/health/category/policy-areas/nhs/constitution

NHS Outcomes Framework, Department of Health

Commissioning Outcomes Framework (draft), NHS Commissioning Board

Mandate to the NHS Commissioning Board (draft), Department of Health
http://mandate.dh.gov.uk/2012/07/04/mandate-consultation/

Joint Strategic Needs Assessment, NHS Airedale Bradford and Leeds and Bradford Metropolitan District Council
http://www.bradfordobservatory.com/

Public Health Outcomes Framework
http://www.dh.gov.uk/health/2012/01/public-health-outcomes/

Adult Social Care Outcomes Framework
http://www.dh.gov.uk/health/2012/03/adult-social-care-outcomes-framework/