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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 8 February 2018 at 4.30pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT AND INDEPENDENT
Gibbons **Rickard**	**Greenwood** **A Ahmed** **Akhtar** **Johnson** **Shabbir**	**N Pollard**

Alternates:

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT AND INDEPENDENT
Barker **Poulsen**	**Berry** **I Hussain** **S Hussain** **Iqbal** **H Khan**	**Griffiths**

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer
Jenny Scott	Older People's Partnership

Notes:

- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
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- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From: **To:**

Parveen Akhtar
City Solicitor
Agenda Contact: Palbinder Sandhu
Phone: 01274 432269
E-Mail: palbinder.sandhu@bradford.gov.uk

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended –

That the minutes of the meeting held on 26 October and 7 December 2017 be signed as a correct record (previously circulated).

(Palbinder Sandhu – 01274 432269)

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS
(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Palbinder Sandhu - 01274 432269)

5. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

B. OVERVIEW AND SCRUTINY ACTIVITIES

6. BRADFORD STROKE SERVICE - UPDATE 1 - 6

NHS Bradford City CCG and NHS Bradford Districts CCG will submit **Document "AA"** which provides an overview of the current position regarding the Bradford Stroke Service, its relationship with the Airedale service and action plans to move a coordinated Bradford and Airedale Stroke Service forward.

Recommended –

(1) That the Clinical Commissioning Groups' commitment and actions taken to improve stroke services for the Bradford and Airedale patch be noted.

(2) That the actions being implemented to improve the stroke services in Bradford and Airedale be noted.

(3) That a further report be submitted to the Committee in 12 months on progress against the action plan.

(Kath Helliwell – 01274 237735)

7. PRIMARY MEDICAL CARE UPDATE - BRADFORD DISTRICT AND CRAVEN 7 - 16

NHS Airedale, Wharfedale and Craven CCG, NHS Bradford City CCG and NHS Bradford Districts CCG will submit **Document "AB"** which describes initiatives that CCGs and primary care providers are undertaking to improve the quality of services delivered, which includes access and how they are engaging patients in the process.

Recommended –

(1) That the Clinical Commissioning Groups' commitment and actions taken to improve access to appropriate primary medical care services be noted.

(2) That the initiatives being developed that will impact the primary medical service offer to residents be noted.

(Victoria Wallace – 01274 237524)

8. DIABETES SERVICES IN BRADFORD 17 - 24

NHS Bradford City CCG and NHS Bradford Districts CCG will submit **Document "AC"** which gives an overview of the development of the diabetes services in Bradford. This includes an update on the development of the new model of care, primary prevention services and national diabetes transformation funds.

Recommended –

(1) That the Clinical Commissioning Groups' commitment and actions taken to improve diabetes services and increase the focus on prevention of diabetes be noted.

(2) That the initiatives being developed that will impact the diabetes service offer to residents be noted.

(Kath Helliwell – 01274 237735)

9. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2017/18

A work planning discussion will take place on the Committee's work programme for the remainder of the 2017/18 municipal year.

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the NHS Bradford City and NHS Bradford Districts CCG to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 8th February 2018

AA

Subject: Bradford Stroke Service - Update

Summary statement:

This report will provide an overview of the current position regarding the Bradford Stroke Service, its relationship with the Airedale service and action plans to move a coordinated Bradford and Airedale Stroke Service forward.

Portfolio:

Health and Wellbeing

Report Contact: Kath Helliwell
Phone: (01274) 237735
E-mail: kath.helliwell@bradford.nhs.uk

1. Summary

1.1 A stroke is a serious life-threatening medical condition that occurs when the blood supply to part of the brain is cut off. Strokes are a medical emergency and urgent treatment is essential. The sooner a person receives treatment for a stroke, the less damage is likely to happen.

What is a stroke - A stroke is a brain attack. It happens when the blood supply to part of your brain is cut off. Blood carries essential nutrients and oxygen to your brain. Without blood your brain cells can be damaged or die. This damage can have different effects, depending on where it happens in your brain.

A stroke can affect the way your body works as well as how you think, feel and communicate.

As we age, our arteries become harder and narrower and more likely to become blocked. However, certain medical conditions and lifestyle factors can speed up this process and increase your risk of having a stroke.

Most strokes are caused by a blockage cutting off the blood supply to the brain. This is an ischaemic stroke.

However, strokes can also be caused by a bleeding in or around the brain. This is a haemorrhagic stroke.

2. Background

2.1 In August 2015, following a period of public consultation the 2 HASU (hyper acute stroke unit) beds at Airedale General Hospital (AGH) moved to Bradford Royal Infirmary to create a single HASU for people living in and around Bradford, Airedale, Wharfedale and Craven area.

The HASU provides the initial investigation, treatment and care immediately following a stroke. Patients will spend an average of 72 hours in the HASU before being transferred to their local stroke unit for ongoing multidisciplinary inpatient care.

It should be noted that for a HASU to provide the most effective care it is recommended they admit a minimum of 600 confirmed stroke patients each year and have six stroke consultants, trained in thrombolysis, available 24 hours, and seven days a week to treat 600 or more suspected strokes per year.

The HASU located at BRI is in line with this national guidance.

In the period leading up to this move Airedale General Hospital had experienced problems providing a HASU service due to a national shortage of stroke consultants. This national shortage remains a challenge.

Despite trying to recruit, AGH had not been able to secure a permanent consultant team therefore since March 2014, to ensure a full service was available, BRI had

been providing a HASU service to the population of Airedale, Wharfedale and Craven during evenings, weekends and at bank holidays.

2.2 Since the move the single HASU at BRI provides patients with: emergency stroke care 24 hours a day, seven days a week, 365 days a year (and it is the same care whatever the time of day or night); high quality, safe and resilient care; access to specialist stroke consultants at all times; and quicker scans and treatment for more patients. Acute stroke services and rehabilitation continues, unchanged at both AGH and BRI.

2.3 Activity

In 2016, 232 stroke patients from the Airedale, Wharfedale and Craven area were admitted to BRI. 4.3% (10 patients) did not access a stroke bed. 7 were repatriated to Airedale General Hospital directly from the admission wards, 2 passed away and 1 was discharged home.

222 stroke patients access the Acute Stroke Unit. The mean age being 73.0 and the range was 27-99 years, 100 years for females.

Of these, 210 patients (94.6%) were admitted directly from A&E. The remainder came from other medical settings:
Wards at BRI – 9 patients
ITU (intensive treatment unit) – 1 patient
GP – 1 patient
Leeds General Infirmary (LGI) – 1 patient

221 patients (99.5%) had a CT head scan within 12 hours.
18 patients (8.1%) were thrombolysed. 14 were subsequently repatriated to Airedale General Hospital, 2 returned directly home, 1 passed away and 1 was transferred to LGI for surgery.

3. **Report issues**

3.1 The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data across England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit, and post-acute organisational audit.

SSNAP aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence based standards. These standards are informed by the National Clinical Guideline for Stroke and are mandatory for organisations to complete. The findings are published so residents are able to understand how their local hospital stroke services compare to other areas.

The latest SSNAP data available for Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) from April to July 2017 is shown below. Further explanation will be provided verbally at the Health Overview and Scrutiny meeting.

Number of patients		Overall Performance[1]			
Admitted	Discharged	SSNAP Level	Case ascertainment	Audit compliance	Combined key indicator level
175	176	D	A	C↓	D

BTHFT received an alert in October 2017 regarding mortality outlier status based on its SSNAP data returns. However, investigation within the trust has revealed that data quality and input issues are likely to have been the cause of the alert, and have taken specific actions to address this concern (see actions section below). It is anticipated by the Stroke specialty team that these actions will help ensure data for the current financial year is not subject to the same quality issues. The Stroke specialty also continues to work on delivering a wider action plan aimed at developing areas of work to improve SSNAP performance which is overseen by the Trust Quality Committee. It is anticipated that as a result of the work outlined above the Trust will have a much more accurate reflection of care delivered by the speciality.

3.2 Progress to date:

3.2.1 An identified issue was the availability of specialist Stroke nurses to respond to the Stroke unit in a timely manner. Stroke responder nurses are now in place and this will facilitate treatment and appropriate transfer to the Stroke Unit in a timely manner.

3.2.2 Early Supported Discharge (ESD) is now operational and has been since 5th November 2017. With the implementation of this service patients are able to receive the same level of intervention such as physiotherapy and Speech and Language therapy in their own homes. Discharge is planned from admission and is based on health and social discussions.

3.3 The areas of challenge and actions including:

3.3.1 Below is a list of actions identified at a workshop between AGH and BRI Stroke teams. The expected timescales are also shown. Whilst it is not possible at this stage to comment on the extent to which patient outcomes will change as a result of these actions the Stroke teams are confident a marked difference is expected in mortality data where reaching a point of complete and accurate data is the primary focus.

a) Following receipt of a mortality alert in October 2017 BTHFT has identified a number of SSNAP data input issues. As an immediate action the Trust implemented a weekly SSNAP data group attended by anyone with input to SSNAP. The group reviews the status of SSNAP data, brings data queries to the group and undertakes an action focused discussion. This is already showing positive results with data for the second of four months having 100% of patient data. As of **January 2018** ANHSFT resource involved in SSNAP will also be attending this group so as to consider SSNAP data for the entire Bradford and Airedale service.

[1] The key indicators score is derived from the aggregate score across 10 "domains" or areas of patient care. Each domain is given a performance level (level A to E) and a key indicator score is calculated based on the average. The overall SSNAP level is the combined total key indicator score adjusted for case ascertainment and audit compliance performance.

b) Clear instructions for the collection and input of SSNAP data have been developed by BTHFT. These are available for ANHSFT and BTHFT resource.

c) Since the implementation of Electronic patient record (EPR) at BTHFT, staff involved in the collection of SSNAP data has reported a noteworthy improvement in the access and collection of data required. ANHSFT Stroke team has also confirmed a significant improvement in the completeness and timeliness of data when patients are transferred from BRI to AGH.

a) Stroke teams agreed to establish a joint business meeting across Bradford and Airedale teams. Initially this will be in addition to any local groups however the teams demonstrated commitment to working as one team. The Patient Services Manager for Stroke at ANHSFT will own this action and is aiming for the first of these monthly meetings in **February 2018**. This group will bring together clinical leads, nurses, therapists and managers/corporate resource who contribute to Stroke care. This team oversee future collaborative activities; publish a joint communication to AGH and BRI Stroke resource advising of the work underway in addition to attending to business as usual activities.

b) Attendees suggested coming together for a second workshop to review progress, spend time as a joint team and to plan further initiatives to improve outcomes. At the time of writing a date has not been confirmed and this will be for discussion at the first joint business meeting.

c) Attendees recognised a lack in understanding of the full Stroke pathway and acknowledged that all those involved in delivering Stroke care should be familiar with the whole pathway. Commitment was given to mapping the pathway of the Bradford and Airedale Stroke service. The Associate Director of Quality (BTHFT) is taking the lead on this activity with a target completion date of **May/June 2018**. It should be noted the Bradford and Airedale Stroke pathway is as per national recommendations. Significant changes are therefore not anticipated although minor adjustments may be required if this results in demonstrable improvements (outcomes, process, workforce etc.).

d) Demonstrating commitment to improving outcomes the Stroke team has expressed a wish to visit sites in the Yorkshire and Humber region where we can learn lessons. In particular Doncaster and Bassetlaw and Calderdale and Huddersfield. The Directorate Manager for BTHFT Stroke is taking ownership of this action with a target visit date of **March/April 2018**.

e) The existing quality governance group for the Bradford and Airedale Stroke service is considered to be of great importance and use to the Stroke teams. Due to timings, travel required, capacity and workforce pressures however it is challenging to create the time to attend. The Directorate Manager for Stroke (BTHFT) is exploring if and how this group could be connected by video conferencing to allow greater attendance and input. Initial findings due **February 2018.**

3.3.2 In addition to the actions above the Stroke team identified some longer term activities as detailed below. The progression of these will be discussed at the business meetings and brought to the second workshop.

- A workforce day to include celebrations, awards etc. for front line staff from the Stroke team.

- Communications, knowledge sharing events
- A shared SNAAP data set
- Map the workforce and consider the future, joint workforce along with new models for the provision of Stroke care.

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3.4 Patient engagement has proved difficult. We have met as a wider group with our local stroke groups however many of the members have (thankfully) no recent experience of the local stroke services and therefore are unable to contribute their views on how to improve the service. Finding the right balance is a challenge as newly diagnosed stroke patients are usually too unwell or unable to share their experiences with us.

We have started to work with Bradford Healthwatch around engaging with patients and carers to truly engage with our local healthcare users.

4. Options

Not applicable

5. Contribution to corporate priorities

To commission and ensure delivery of safe, high quality and effective services

6. Recommendations

The Health and Social Care Overview and Scrutiny Committee is asked to:

6.1 Receive and note the CCGs' commitment and actions taken to improve stroke services for the Bradford and Airedale patch.

6.2 Receive and note actions that are being implemented to improve the stroke services in Bradford and Airedale.

6.3 To report back to the Health and Social Care Overview and Scrutiny Committee in 12 months on progress against the action plan.

7. Background documents

None

8. Not for publication documents

None

9. Appendices

None

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the NHS Airedale, Wharfedale and Craven, NHS Bradford City and NHS Bradford Districts to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 8th February 2018

AB

Subject: Primary Medical Care Update – Bradford District and Craven

Summary statement: NHS Airedale, Wharfedale and Craven CCG, NHS Bradford City CCG and NHS Bradford Districts CCG continue to work with patients and stakeholders to improve the quality of all services they commission and to fulfil their statutory duty to improve the quality of primary medical care.

Portfolio: Primary Medical Care

Health and Wellbeing

Report Contact: Victoria Wallace
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E-mail: victoria.wallace@bradford.nhs.uk

1. Summary

1.1 This paper describes initiatives that CCGs and our primary care providers are undertaking to improve the quality of services delivered, which includes access and how they are engaging patients in the process.

1.2 Within this report if there is a difference in approach between the three CCGs then this is clearly highlighted. Therefore, if this is not stated then the information presented can be taken as a standard approach across the three organisations.

2. Background

2.1 The CCGs previously reported that they were undertaking a financial review of all primary medical service contracts. The review was completed and the CCGs implemented funding changes from April 2016. For some practices this has meant a reduction in funding and is being phased in over a period of 5 years (currently in year 4).

2.2 Recognising that the traditional model of general practice is unlikely to be sufficient to deliver its objectives, NHS England is supporting the development of new ways of providing and commissioning services. To set out our delivery of this the CCGs have developed 5 year primary medical care commissioning strategies, which were widely consulted on with partners and stakeholders. The Bradford CCGs published their strategy at the end of 2016 and Airedale, Wharfedale and Craven (AWC) CCG was published in January 2018.

2.3 A key priority within both strategies is to improve access to primary medical services, including the intention to commission extended hours provision. It also includes a requirement to improve the offer of digital access and improve access to technologies that promote self-care and prevention. The strategies also encourage delivery of primary care at scale and deliver high quality primary medical services.

2.4 The GP contract requires practices to provide essential services within core hours (8am to 6.30pm Monday to Friday). GP practices are required to deliver services within this period but there are no clearly defined standards. It is regarded that this should be something that the provider defines, ensuring that they meet the needs of the patients. In support of this the CCGs in Bradford have issued a “Position Statement on Opening Hours”, so that practices are aware of the requirements under the contract. This position statement is currently being refreshed to reflect recent local changes and updated national guidance. This will be done in conjunction with YORLMC (body who provides the professional voice for all NHS GPs and practice teams across North Yorkshire, the City of York, Bradford, Airedale, Wharfedale & Craven districts). Following sign off by the CCGs Primary Care Commissioning Committees this will be issued to all practices across the 3 CCGs.

2.5 GPs and practices continue to be under unprecedented pressure, with an increasing number of practices struggling to maintain existing services in the face of financial pressures, falling staff numbers and rising demand. It continues to be hard to retain GPs and increased numbers are retiring early, there is also an increase in GPs wanting to work part-time. Practices in Bradford especially are therefore reliant on a GP locum workforce.

Despite this all three CCGs are amongst the best performing CCGs in England for CQC ratings of Primary Medical services (CCG Improvement & Assessment Framework – 2017/18).

2.6 In measuring patient's satisfaction with GP opening the CCGs are required to use the GP National Survey. There are clear differences in the returns in the three CCG areas, with AWC CCG performing higher than the Bradford CCGs. Therefore there will be a clear focus from the Bradford CCGs on working with their practices and patients to understand the reasons behind this and to make improvements to patient outcomes.

3. Report issues

3.1 Improving Access

3.1.1 The most recent results of the national GP patient survey data (Jan to March 2017, published in July 2017) indicate that patients who gave a positive answer to the question: "Overall, how would you describe your experience of making an appointment?" responded as follows:

England average	73%
Airedale, Wharfedale and Craven average	74%
Calderdale (comparator CCG to AWC)	74%
Bradford City average	60%
Tower Hamlets (comparator CCG to City)	67%
Bradford Districts average	64%
North Kirklees (comparator CCG to Districts)	68%

This represents most recent published data as the survey is now only undertaken on an annual basis (previously bi-annual). It should be noted that when comparing the above results with the previous year there has been:

- an increase of 1% in satisfaction for AWC CCG
- an increase of 3% in satisfaction for Bradford City CCG
- an increase in 1% in satisfaction for Bradford Districts CCG

As reported last year within AWC CCG there is one practice that is an outlier in relation to the national patient survey. The experiences their patients report still 'skew' the overall CCG results due to the significant variation in experience being reported when compared with other practices although this is now improving. In April 2017 the CCG became delegated co-commissioners and we continue to work closely with the new long term provider of this practice to monitor progress against a range out outcomes that have been included as part of the practice contract linked to the GP survey results. Comparison of July 2017 GP survey results to 2016 for patients at this practice answering the following question, Overall, how would

you describe your experience of making an appointment?" positively show a 12% increase in satisfaction with their GP experience. The new provider has been in place since December 2016.

3.1.2 The funding review has meant that contracts are of more equal value and have resulted in a redistribution of existing funding across primary medical care.

Within the Bradford CCGs the review has enabled the CCGs to commission practices to undertake a more formal assessment of how they offer access to patients.

Practices were asked to actively use their Practice Participation Group (PPG) as a conduit to seek the views the people they serve and influence how services are delivered. These plans have now been in place for two years and examples of the kinds of activity practices included within their plans over this time were:

- improvements to telephone systems to help patients get through more easily
- implementing a triage system so those patients needing an appointment can get one and others can be supported to self-care or access other support where required
- active signposting training for front line staff
- promotion of self-care to patients, via events, notice boards and printed material so they feel more confident to look after themselves for minor ailments, which may not require an appointment with a clinician
- coaching patients on how to register for online services, to make and cancel appointments
- targeting patients that frequently use the accident and emergency department (A&E)
- MJOG – SMS messaging service reminders
- encouraging more patients to provide feedback via the national survey, the Friends and Family Test, or via practices' own satisfaction surveys
- working with schools and community groups – working with young people to gain their views and get them more engaged with the practice, supporting them to lead healthier lives
- first aid training and peer support for new parents
- working with the Voluntary Community Sector and Charities
- referring patients in to social prescribing initiatives which may provide other sources of support not always found at the practice – e.g. advice on benefits and financial matters, self-care, leading healthier lives, exercise, emotional support, support for carers, support groups for people with long term conditions, reducing loneliness.

The Bradford CCG's have recently assessed patient experience of primary care using the latest (July 2017) GP national survey results. The Primary Care Commissioning Committees have agreed that the access schemes that are commissioned need to be strengthened further to improve outcomes against these

surveys. This was following their reflection of the variation of results across practices. Some perform less well in comparable with their neighbouring practices.

A revised scheme is being developed and may include a requirement for each practice to comply with some key deliverables (number of appointments, including pre-bookable appointments, access to new technologies and clear information for patients on how and when to access services) this would ensure that practices are providing a standard access offer. Practices will be encouraged to work in groups to further understand how others are managing access, including using new technologies, working with the voluntary care sector, promoting self-care, sign-posting an care navigation initiatives.

3.1.3 In AWC the equitable funding review, which is known as PMS premium funding review, has been utilised to harmonise service provision across the patch following discrepancies in local enhanced services inherited from North Yorkshire and Bradford & Airedale PCTs prior to the creation of the CCG. This process has ensured there is equitable access to services for all patients across AWC. In addition the PMS premium funding has been used to facilitate regular engagement with practices which has supported the rapid mobilisation of the initiatives listed below.

In AWC there are a range of initiatives in place all of which continue to directly or indirectly support improved access to GPs or access to alternative support for individuals as appropriate, determined by their needs.

- Complex Care
- Enhanced Primary Care
- Pharmacy First
- Personal Support Navigators/ Care co-ordinators
- Increased self-management and prevention
- GP Streaming in A&E - additional primary care capacity is embedded within A&E 7 days a week
- Primary Care Quality Improvement initiatives and participation in NHSE improvement network
- Extended Practice Opening

3.1.4 All three CCGs commissioned extended access in 2017. This is nationally directed service, the detail of which was set out in the NHS Operational Planning and Contracting Guidance 2017-2019[1]. However, it should be noted that the three CCGs commissioned this a year earlier than other CCGs nationally (excepting those that had been part of the Prime Minister's Challenge Fund) as we were part of the West Yorkshire Urgent Care Acceleration Zone.

The Bradford CCGs commissioned Bradford Care Alliance CIC (BCA) to provide the service. Within Bradford there is currently one hub operational which serves

[1] https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

25% of the population. It operates out of Westbourne Green Health Centre and is open 6.30pm – 9.30pm Monday to Friday and 10am -1pm Saturday and Sunday. There are appointments with GPs, physios, welfare benefit and debt advice and mental wellbeing support. Plans are in place to deliver the service to 100% of the Bradford population by October 2018. The design of the service and location of the future hubs is being developed with the GP practices, PPGs and local populations. Once fully operational any patient in Bradford will be able to access any of the hub locations, if the appointment is convenient to them.

AWC CCG commissioned a group of practices working collaboratively to deliver a pilot for extended access from July 2017 as part of the WYAZ. There is currently one hub located at Farfield Practice in Keighley that provides extended access from 6.30-8pm Monday to Friday to 40% of the CCG population. A range of appointments with GP, Advanced Nurse Practitioner (ANP) and clinical Pharmacists are available to patients. Plans are in place to deliver the extended access service to 100% of AWC population by October 2018 in line with national requirements. The number of hubs and how the service will operate across our geographical area are still in development and we will work closely with practices, PPGs and our local population to determine the design of the service building on learning from the pilot and engagement work undertaken with the current users of the Worth Valley hub.

3.2 Working at scale

3.2.1 Our primary medical care commissioning strategies support practices working at scale and as a result we are therefore beginning to see practices working more closely, in order to share resources. In 2017 we have seen an increase in the number of practices working in networks, federated working and undertaking practice mergers.

3.2.2 As part of NHS England's General Practice Forward View[2] (GPFV) funding has been available as part of a GP Resilience Scheme. Both the CCGs and practices individually have been successful in applying against this fund to support practices to better work at scale. This funding has been utilised to support organisational development, legal advice, merging of clinical systems and development of new ways of working across sites.

3.3 New Models and Workforce

3.3.1 The three CCGs recognise that changes are required to the way that care is delivered to patients within primary medical care and the workforce required to deliver those changes as current methods of delivery will not be sustainable over the longer term.

3.3.2 Primary medical care services are a critical part of health service delivery and all three CCGs are ensuring that this is being built into new models of care that are being established. These are developing across two footprints locally; Airedale, Wharfedale and Craven and Bradford. These developments include all of the main

[2] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

providers of care locally, including acute, community, mental health and voluntary and community sector (VCS) as well as primary medical care.

As the 'left shift' in care occurs through, more proactive care, self-care and prevention work thereby helping to reduce the demand and cost of specialist acute services and partnership working, the role of primary medical care becomes all the more important, especially in regards to treating the patient holistically and a focus on prevention.

3.3.3 Across the Bradford CCGs the key method of engaging primary care within new models of care is through the development of Primary Care Home (PCH) communities and locality hubs. Each PCH community will be led by a leadership team which will include representation from GP practices, community nursing services, secondary care, community pharmacy, VCS and local authority. Each of these PCH communities will review their population profile data and undertake a range of activities to better understand the health, care and support needs of their population. The team will consider areas of duplication, gaps, blocks, and opportunities across current service delivery models. This will support in the identification of service improvement initiatives. The CCGs have identified some additional recurrent resource to allow for service development.

Within Bradford, 10 PCH communities have now been agreed and are currently establishing their leadership teams. To aid their development, the CCGs have identified some non-recurrent funding to support their organisational development needs. The system recognises the importance of the PCH communities as it has been agreed that they will be the foundations on which health and social care partnerships are built.

It will not be efficient for all service delivery to take place across a PCH community footprint and some services will be delivered at a locality hub level. There are 3 locality hubs within Bradford, aligned to the PCH communities. North locality (3 PCHs, approximately 130,000 population), Central locality (3 PCHs, approximately 160,000 population) and South locality (4 PCHs, approximately 180,000 population). Services delivered at a locality hub level will be the more specialised services, for example specialised nursing and reablement services.

3.3.4 In AWC primary care is the lynch pin of our new model of care as we are working to establish a single place based primary and community led 'system of care'. This will involve provider organisations coming together to manage the common pool of limited resources available and to collaborate as one system to improve the health and care for the whole population.

A key part of our journey towards ACA is to redesign the approach to healthcare and support for each of the 3 communities; Airedale; Wharfedale and Craven community and we have adopted the primary care home concept as a framework to build on.

Working with our practices we have aligned our 16 practices into the three communities. Alignment has been based on geography but has also taken into account where practice populations and community natural affinities lie. Each of the 3 communities (Airedale, Wharfedale & Craven) has its own local group consisting of a range of stakeholders and has identified clinical and managerial leads. Each

has commenced work to identify the priority areas that can make a difference to the 'here and now' as well as work towards the longer term transformation & sustainability and develop a new model of care for their community.

The model is being developed 'bottom up', informed by multi-agency clinician, local authority, social care representatives and VCS providers from each community. Each group is considering its approach to person and population engagement to ensure experience based co-design. The membership for each of the 3 communities groups continues to grow and develop as the work progresses. The community groups have been asked to focus initially on identifying priorities bespoke to their community but all share the following guidelines:

- to look at things differently
- focus on what's important to people, their family, carers rather than what's important for the system,
- focus on preventing people from being unwell
- take a pro-active approach to care
- address the broader factors that might affect their well-being such as housing, employment and isolation
- embed self-care to support culture change in both professionals and the public
- identify what's working well in their community and build on this

The community groups leading the care model redesign have cross agency membership and are jointly led.

3.3.5 The CCGs have utilised both local and national resources to support the development of new roles within our communities.

- Social Prescribing - We have a number of practices that have access to social prescribing and this is being rolled out to all practices from January 2018 in Bradford. This is a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'. The aim is that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector (VCS). In AWC there are currently 12 out of 16 practices have access to social prescribing and plans are in in place to roll this out to all practices in 2018/19.

- Practice Health Champions – We have a number of practices that are creating a 'community centred practice' through volunteering and patient involvement.

- Physio First – patients are seen by a physiotherapist before they see a GP, operational through the extended access scheme in Bradford and is available in 12 AWC practices.

- Clinical Pharmacists – these are pharmacists that work in practice and have a role in streamlining practice prescription processes, medicines optimisation, minor ailments and long term conditions management.

- Active signposting / care navigation – primary care reception staff are being trained to sign-post people to appropriate services (all three CCGs)

- Medical assistants – in 2018 primary care support staff (e.g. receptionists, HCAs) will be trained to handle some clinical paperwork to free up other clinicians (Bradford only). From November 2017 all practices in AWC have at least 2 primary care support staff trained as medical assistants and this role continues to be embedded in practice.

- Patient Engagement Leads – These roles are unique to Bradford City and have been shared by NHS England nationally as a good practice example. The roles have improved practice engagement with local communities and are improving practices ability to respond and engage with patients, building connections within local communities.

- Physicians Associates (PA) –In AWC one of our practices has successfully embedded this role as part of their practice team and we hope to expand this to other practices. PA's are graduates who have undertaken post-graduate training and are employed in general practice to support doctors in the diagnosis and management of patients. They perform a number of day to day tasks including; taking medical histories from patients; performing physical examinations; diagnosing illnesses; seeing patients with long-term chronic conditions; performing diagnostic and therapeutic procedures; analyzing test results; developing management plans and provide health promotion and disease prevention advice for patients (AWC only)

- Paramedic role in General practice – this role is currently piloted in one practice in AWC. The paramedic practitioner works as part of the primary care team seeing and treating patients and in particular as part of the practice visiting service seeing patients in their own home.

- Enhanced Primary Care (EPC) – this initiative in AWC has facilitated the development of a variety of new roles and tested out different ways of working in particular in regard to the care navigator and care co-coordinator roles

  All these initiatives are aimed at supporting access improvement throughout all practices by freeing GPs and clinicians up to see those that require their expertise.

3.3.6 In 2018 the three CCGs (in conjunction with the other CCGs in West Yorkshire) will be commissioning an online consultation system. The system will allow patients to connect with their general practice using a mobile app or online portal. Patients can tell the practice about their query or problem and receive a reply, prescription, call back or other kind of appointment. In some systems patients can also access

information about symptoms and treatment, supporting greater use of self-care. Further detail will be available following national roadshows.

4. Options

- Not applicable

5. Contribution to corporate priorities

5.1 Contributes to the CCGs priorities of:

- Improving patient experience
- Out of hospital care
- Use of assets

6. Recommendations

The Health and Social Care Overview and Scrutiny Committee is asked to:

6.1 Receive and note the CCGs' commitment and actions taken to improve access to appropriate primary medical care services.

6.2 Receive and note initiatives that are being developed that will impact the primary medical service offer to residents.

7. Background documents

- NHS Operational Planning and Contracting Guidance 2017-2019 https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf
- NHS England General Practice Forward View https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

8. Not for publication documents

- None

9. Appendices

- None

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the NHS Bradford City CCG and NHS Bradford Districts CCG to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 8th February 2018

AC

Subject: Diabetes services in Bradford

Summary statement: This report gives an overview of the development of the diabetes services in Bradford. This includes an update on the development of the new model of care, primary prevention services and national diabetes transformation funds.

Portfolio: Diabetes

Health and Wellbeing

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1. Summary

1.1 This report gives an overview of the development of the diabetes services in Bradford. This includes an update on the development of the new model of care, primary prevention services and national diabetes transformation funds.

2. Background

2.1 In 2016 the Bradford CCGs, as part of the wider health and social care system, agreed that the development of a new model of care for diabetes would be the first step Bradford would take on its journey towards the integration of health and social care.

On the back of this decision, the providers of health and social care came together to form Bradford Provider Alliance (BPA). BPA includes Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), Bradford District Care Foundation Trust (BDCFT), Bradford Care Alliance CIC (BCA) (representative organisation of GP providers), Bradford Metropolitan District Council (BMDC) and the Bradford Voluntary and Community Services Alliance (BVCSA). The formation of BPA would allow the providers to work together to deliver diabetes services to the population of Bradford.

2.2 There is a strong history of diabetes innovation within Bradford, and most recently this was seen through the development of Bradford Beating Diabetes (BBD). BBD was a programme of work that focussed on diabetes prevention. GP practices identified patients that were at high risk of developing diabetes (e.g. due to lifestyle or demographic information). These patients were invited into the practice to assess their risk levels and were either given advice or referred onto a lifestyle intervention programme. This work was included as part of a national pilot which has since developed into the national Diabetes Prevention Programme (DPP).

2.3 Although Bradford has been innovative in relation to diabetes, there are still issues with both diabetes prevalence and clinical outcomes. National data sets have highlighted high levels of spend but poor outcomes against key clinical indicators. Therefore, the choice of diabetes as the first step towards integration of care aims to reverse this trend.

2.4 Nationally there has also been a focus on diabetes. To support local areas to make improvements national transformation monies have been made available. In 2017 a bid was submitted to NHS England to improve access and increase capacity across four areas: Structured Education; improved management and achievement of the three NICE treatment targets (Blood Pressure, Hypertension and Cholesterol); Multi-disciplinary foot teams; and diabetes inpatient specialist nurses. Bradford City and Bradford Districts CCGs and Airedale, Wharfedale and Craven CCG submitted a joint bid totalling £1.5 million pounds.

Bradford City and Bradford Districts CCGs bid was for two of the four areas; Structured education and the three NICE Treatment targets. In Bradford we have a robust Multi-disciplinary foot team and diabetes inpatient specialist nurses and therefore we agreed that these areas should not be our focus. Airedale Wharfedale and Craven CCG bid for all four areas.

We wanted to focus on these two areas as according to the CCG Improvement and Assessment Framework (IAF) report Bradford CCGs performance in structured education needs improvement. National data suggests that only 3% of people within Bradford attends an education programme within 12 months of their diagnosis. The CCG is working with BTHFT, the education provider in order to improve this outcome. One of the issues is around recording and sharing the data within GP Systmone (GP clinical system) because if correct codes are not used it won't be shown in the national data searches. We are working with the CCG IAF team to identify correct read codes to be used across the system. We also recognise the challenges of demographics, ethnic and cultural variance and various languages used in Bradford and are working through the BPA to raise awareness of structured education. We have taster sessions for the practice clinical staff and for patients to attend and get a feel of the education programme. This helps practice staff to encourage people to attend the education programmes and also allows patients to better understand what will be gained by attending the full education sessions. We are also working towards providing more education sessions within GP surgeries and community centres, in different languages, women only sessions and different times including weekends so that people have more choice and can attend the programme closer to home and in a familiar environment.

The CCGs were successful in their bid and Bradford's share of the bid was £948,553. This was year one of a two year bid submitted. To date we still have no confirmation of year two funding.

Working collaboratively with our Bradford Provider Alliance we agreed a 12 month delivery plan. Implementation has proved challenging due to the lack of confirmation of year 2 funding and late release of the funds from NHS England. Much of the plan for improvement is based on additional recruitment and providers are understandably reluctant to go out at risk to recruit into posts.

As we approach the final few months of the funded period, we have not been able to fulfil the improvements that we had outlined in our plan. Therefore the CCGs in conjunction with BPA made the decision to seek approval from NHS England to revise our delivery plan, focusing on the last quarter of the financial year, reviewing activity and achievability. This revised plan was approved by NHS England and work is now underway to deliver this plan.

The structured education sessions will be developed locally in practices to increase capacity, working to deliver a sustainable model for the future.

Achievement of the NICE treatment targets will be undertaken by primary care. All practices have clinical reports showing which patients are not achieving all three of the targets. The focus will be on working with these individuals to improve management.

3. Report issues

3.1 Bradford CCGs have been proactive in regards to diabetes prevention. As BBD informed the development of the national DPP initiative, we were one of the first areas to roll out this work. As part of this national programme of work we have

commissioned a provider called Ingeus to provide a diabetes prevention programme to our population.

This programme rolled out in 2017 and is linked to the national Healthier You programme. It is a free service for people who are at high risk of developing Type 2 diabetes, delivered by Ingeus in partnership with Leicester Diabetes Centre. Participants attend a series of group sessions where they are supported to make lifestyle changes that are proven to significantly reduce their chances of developing diabetes.

To date there have been issues with the number of patients being referred into the programme, as they have been much lower than expected. The programme is being rolled out across the CCGs in a phased approach but despite regular engagement with practices numbers have been slow to pick up. However, following more intense engagement throughout December the referrals have improved and we hope to be back on track by the end of the financial year.

3.2 As detailed in section 3.1, the importance placed on diabetes prevention is high. However, there is also a key focus on supporting patients who have already been diagnosed with diabetes to better manage their condition. This has been at the centre of the national diabetes transformation fund and BPA were successful (as detailed in section 2.4) in being awarded funding to support this work.

There have been two key areas of focus locally for this national funding; structured education and the achievement of three clinical targets.

Access to structured education for patients diagnosed with diabetes is seen to be very important as people with diabetes spend around three hours a year with a healthcare professional and on average, the remaining 8,757 hours they manage their diabetes themselves. Diabetes is a complex and challenging condition. People need skills and confidence to manage the daily demands of self-management and avoid devastating complications.

Diabetes education is key to successful day-to-day diabetes management and can be life-changing for people with diabetes. Structured education courses are an opportunity to offer information and advice and give individuals these much needed skills to reduce their risk of developing complications. Locally, BPA have focussed on increasing the capacity of the service to allow for a greater number of patients to be seen and have discharged the responsibility of this indicator to BTHFT as well as the action detailed within section 2.4.

Great emphasis is also placed on the achievement of three clinical areas which have specific measures set against them: blood pressure; HbA1c; and cholesterol. The importance here is placed upon the fact that all three must be achieved to feel the greatest benefit medically. This was originally allocated to BTHFT to deliver against, but this responsibility has recently been moved to BCA to deliver within primary care.

3.3 In 2017 the CCGs in conjunction with BPA agreed a diabetes outcomes framework. The purpose of developing this framework was to move away from commissioning ‘parts’ of the system, to commissioning outcomes that providers would work

together and support each other to achieve. This is a key step towards integration and system working.

To encourage partnership working and to reduce risks to individual providers, the first two years of delivery will involve collecting baseline information and agreeing stretch targets over a further 8 years. This will encourage a 'left shift' in care and resources. (Currently, the majority of resources go into the acute end of the pathway but with increased provision around prevention and self care, the aim is to reduce complications relating to diabetes and 'shift' resources away from the acute services into primary care, community and preventative services).

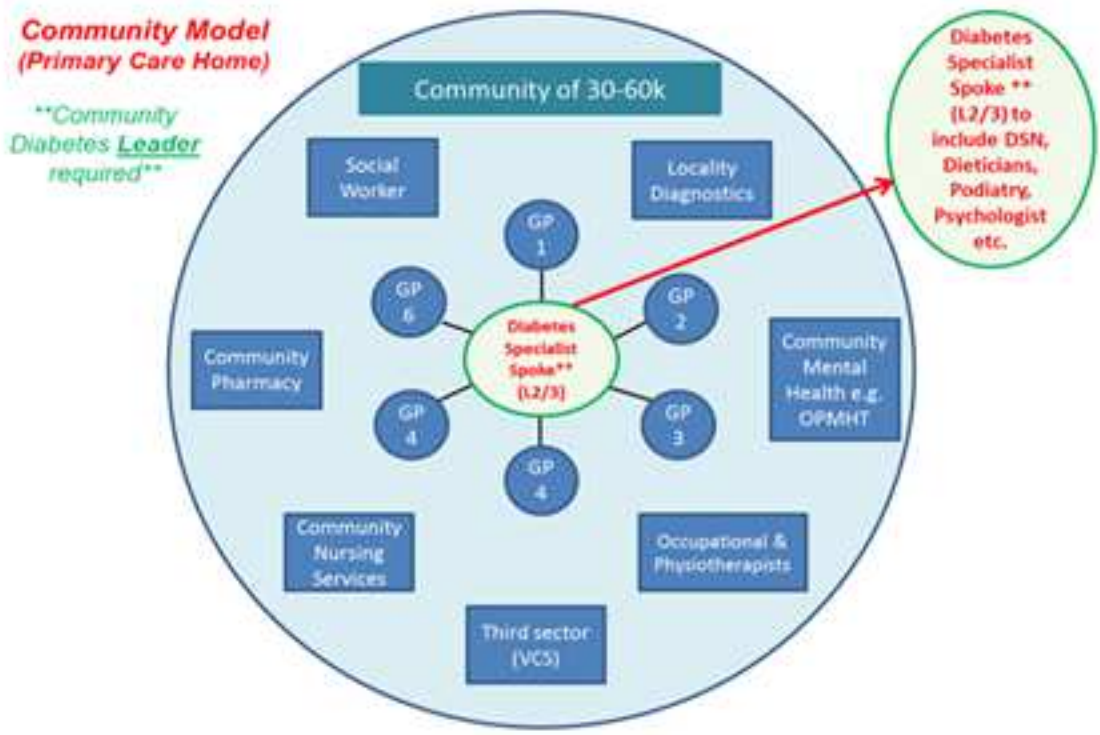
3.4 BPA in conjunction with the CCGs are leading the development of a new model of delivery for diabetes care which will deliver the outcomes set out within the framework over the next 10 years. There are two key elements to this work; primary prevention work which is being led by BVCSA and development of a community specialist diabetes service which is being led by BCA (both projects in conjunction with commissioners and other providers).

3.4.1 Our Primary prevention work will have a very specific focus on reducing the incidence of people developing Type 2 diabetes in the high risk population. Generally lifestyle, unhealthy diet and lack of exercise are the risk factors associated with the development of Type 2 diabetes. The primary prevention work will complement the national diabetes prevention programme and will be able to offer a range of interventions from local walking groups to exercise classes to suit all abilities and interests. This will be suited to people who do not wish to participate in group sessions delivered by Ingeus.

Nationally work is underway to evaluate an on-line option. This will allow for the development of a personal programme, will allow individuals to enter their achievements and will calculate improvements against their set goals. Again this recognises that different approaches suit different people.

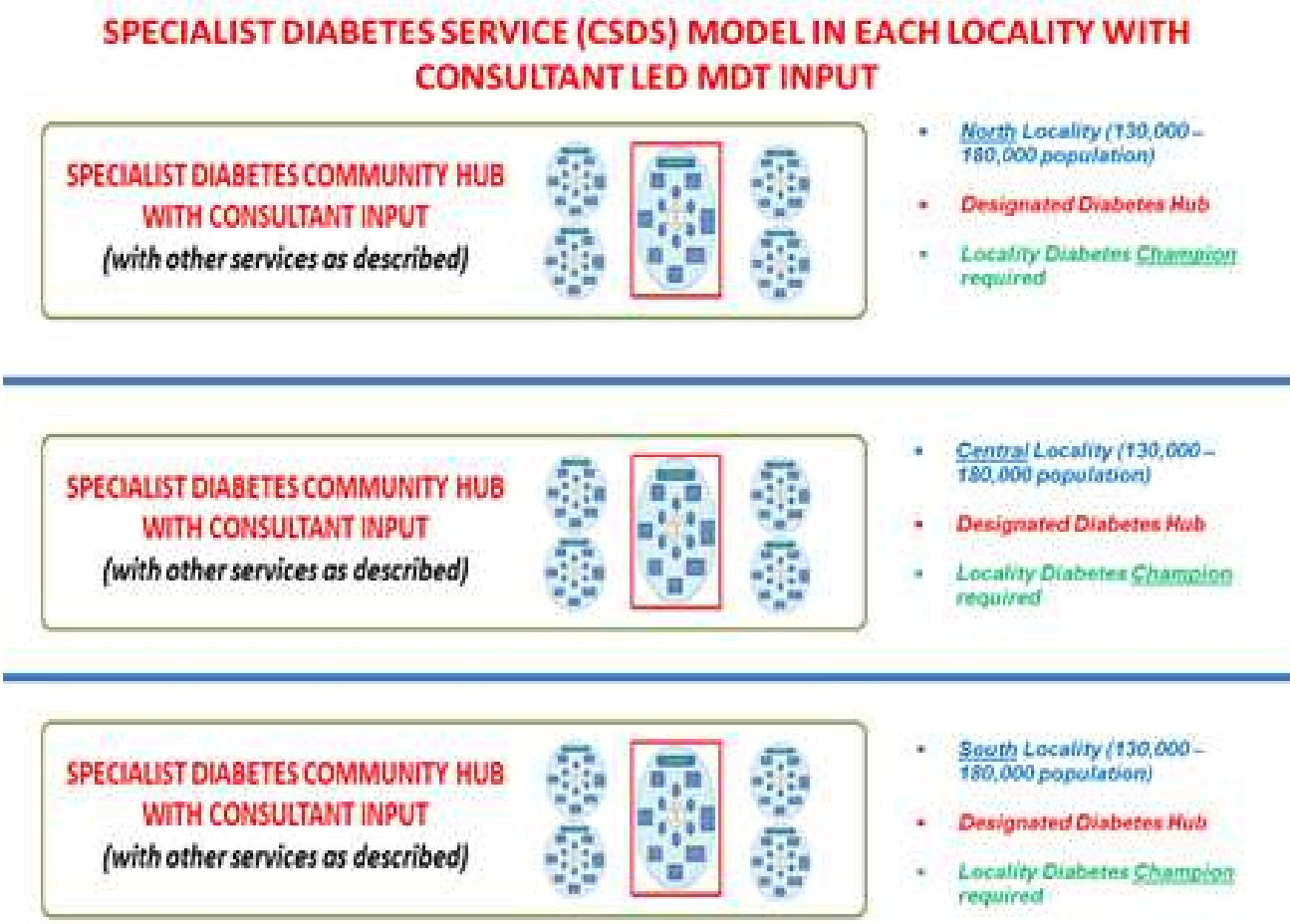
3.4.2 The development of a community specialist diabetes service (CSDS) retains the good practice that is already in place (e.g. multidisciplinary working) and builds upon the wider transformation work which is taking place locally. In regards to the latter point, the framework for the CSDS will be the primary care home (PCH) footprints. These are communities of between 30-60k population, which make geographic sense, that are structured around GP practice lists. The majority of clinical input will be delivered at this community level by multidisciplinary teams, as depicted in Diagram 1 below.

Diagram 1: Diabetes Community Primary Care Home



For patients who need additional specialist input that cannot be provided at individual community level they will receive their care via a locality hub. Within Bradford three localities are being developed; North, Central and South. Each of these localities will cover a population of 130-180k and each will cover either three or four PCHC's. This will include input from secondary care clinicians and practitioners with special interests for example. Diagram 2 below depicts this level of the new model of care.

Diagram 2: Diabetes Localities



Patients with highly specialised needs (e.g. gestational diabetes) will remain under the care of the secondary care consultants as part of the new model.

The main advantage for patients and providers is that under the new model the services will be delivering to patients at the same time as one service. The aim is to wrap care around the patient, with each PCHC taking responsibility for the quality of care delivered to their population. This way of working supports each provider to work towards the same outcomes and gives them the ability to hold the whole system to account on the quality of care delivered.

4. Options

➢ Not applicable

5. Contribution to corporate priorities

Contributes to the CCGs priorities of:

- Promoting self care
- Reducing variation in care
- Eight care processes for diabetes

6. Recommendations

The Health and Social Care Overview and Scrutiny Committee is asked to:

6.1 Receive and note the CCGs' commitment and actions taken to improve diabetes services and increase the focus on prevention of diabetes.

6.2 Receive and note initiatives that are being developed that will impact the diabetes service offer to residents.

7. Background documents

None

8. Not for publication documents

None

9. Appendices

None