



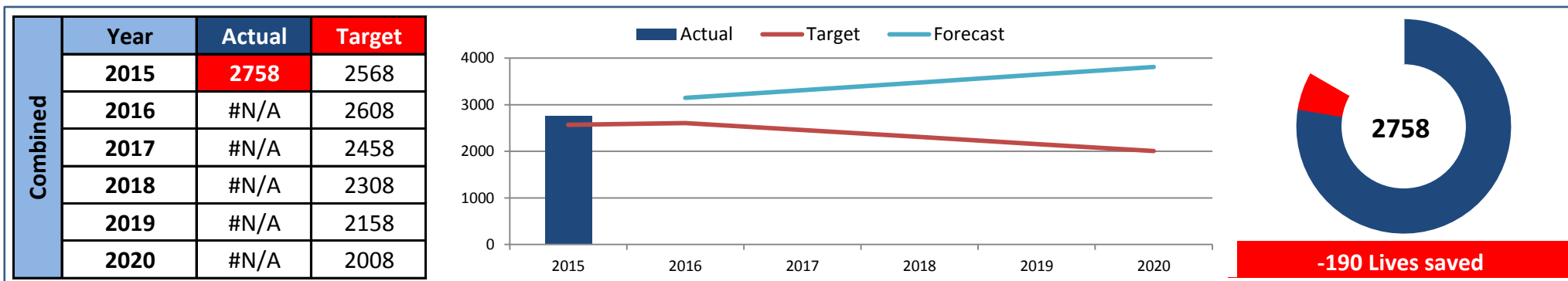
Care and Quality



2.1 Save 150 lives by reducing variation in care

Total Lives saved: -190

Total lives saved for Age-standardised rate of mortality considered preventable from : Cardio Vascular Diseases, Under 75 mortality: mental illness, Respiratory Disease, All Cancers.



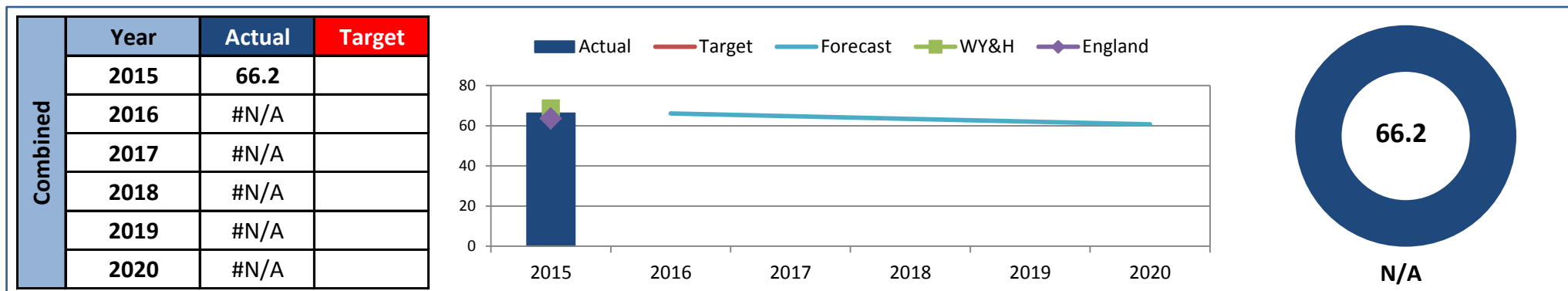
Narrative:

PLEASE NOTE: The Thresholds are provisional only - the projected number of lives to be saved is currently being calculated.

* Data Source: HSCIC/NHS Digital - Data at CCG level using registered population

2.1 Save 150 lives by reducing variation in care

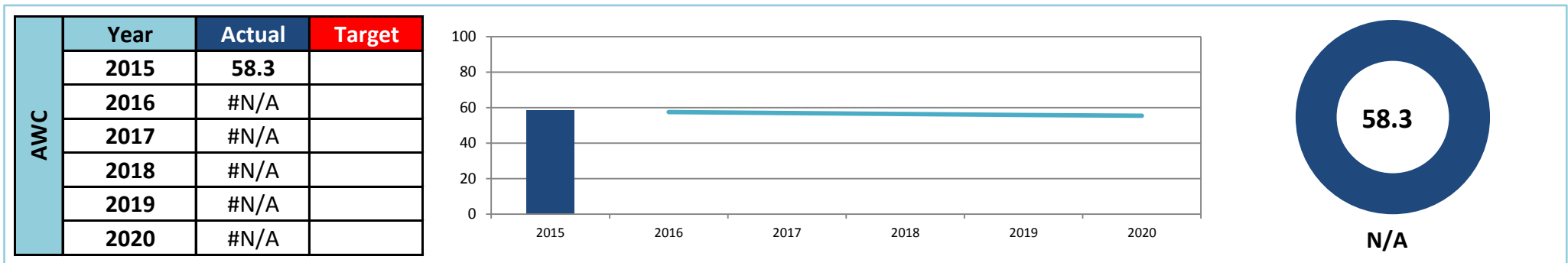
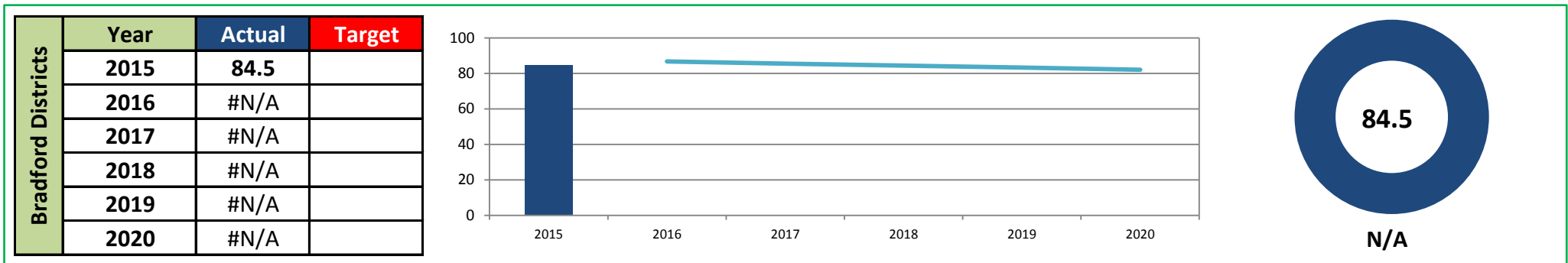
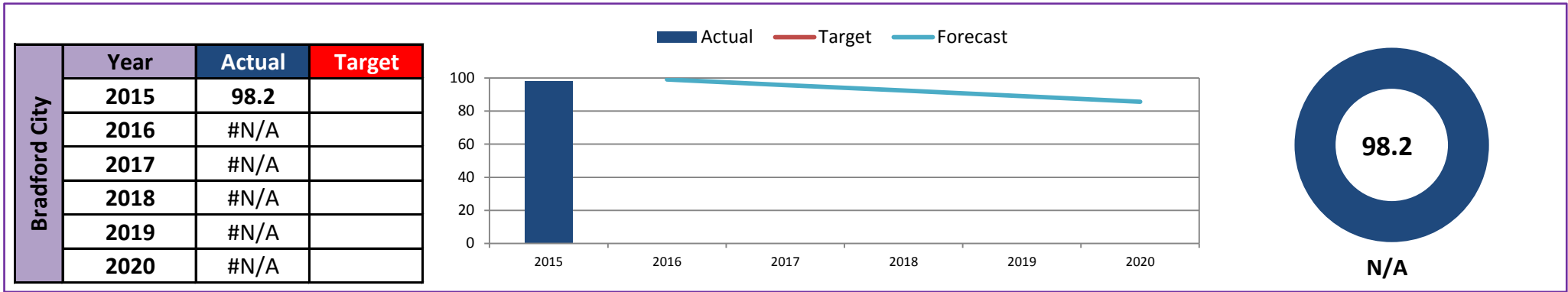
4.04ii - Age-standardised rate of mortality considered preventable from all cardiovascular diseases (incl. heart disease and stroke) in those aged <75 per 100,000 population



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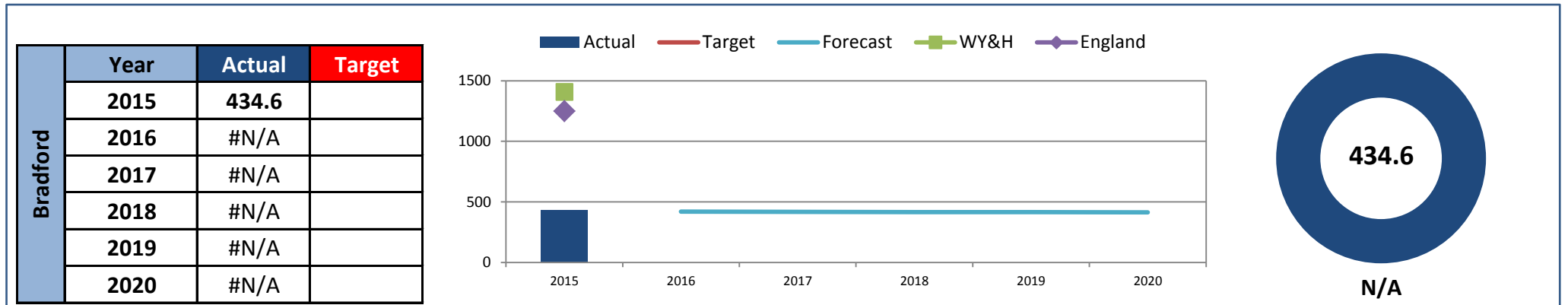
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2.1 Save 150 lives by reducing variation in care

1.5i Excess under 75 mortality rate in adults with serious mental illness – links to Mental wellbeing strategy



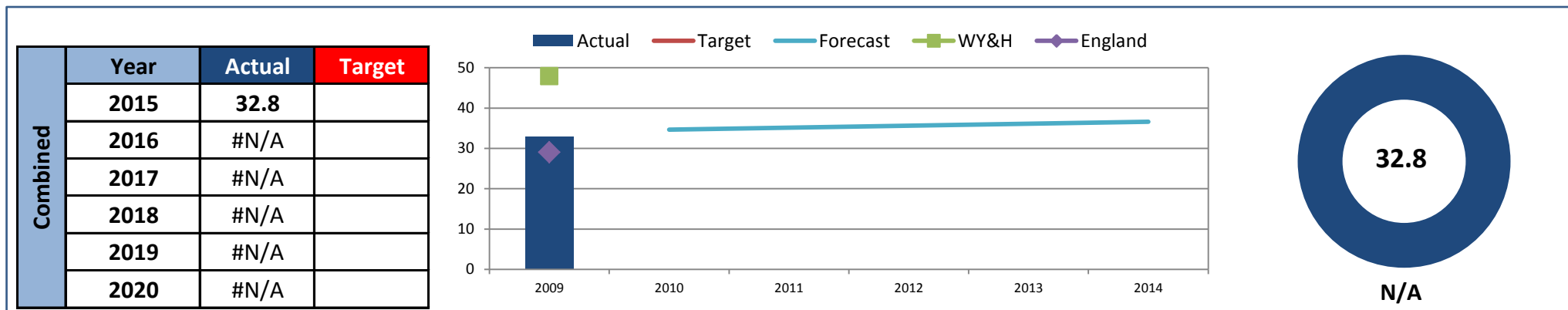
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2.1 Save 150 lives by reducing variation in care

4.07ii - Age-standardised rate of mortality considered preventable from respiratory disease in those aged <75 per 100,000 population



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The aim of the *Bradford Breathing Better (BBB)* programme is to improve the pathway of care from diagnosis, ensuring improved management of respiratory diseases with a view to reducing avoidable hospital admissions. This will result in improved patient experience.

BBB was launched in January 2017 at an event attended by around 60 GPs and nurses and other healthcare staff from across Bradford. Going forward, *BBB* will ensure that good practice is spread and improvement achieved by following a similar model to the Bradford Beating Diabetes and Bradford's Healthy Hearts programmes which have already achieved considerable success and recognition. A programme board is to be established and a lead is to be appointed. Each GP practice is to identify its own practice respiratory lead. Improvements will be made by concentrating on four areas: self-care, prescribing and formulary, clinical template development and pathways.

By working to improve the management of people with respiratory conditions we will improve patient experience, reduce health inequalities and reduce spend through reducing the number of preventable hospital admissions.

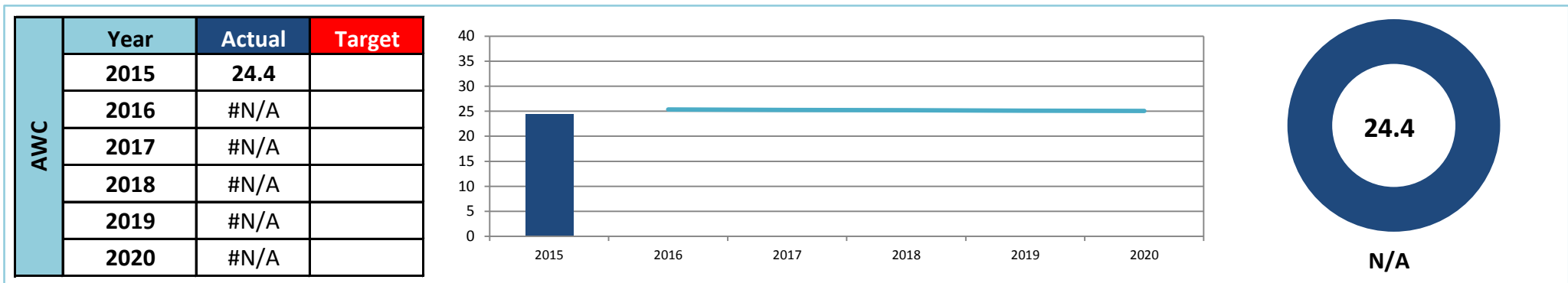
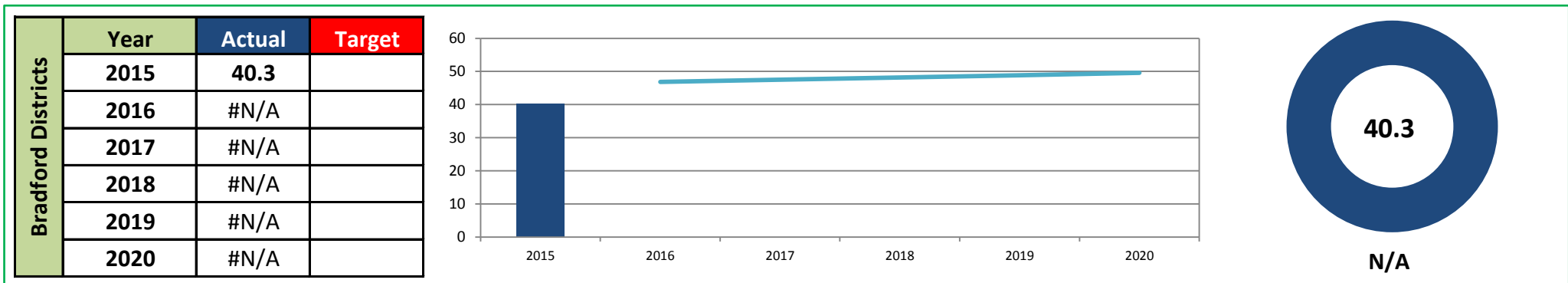
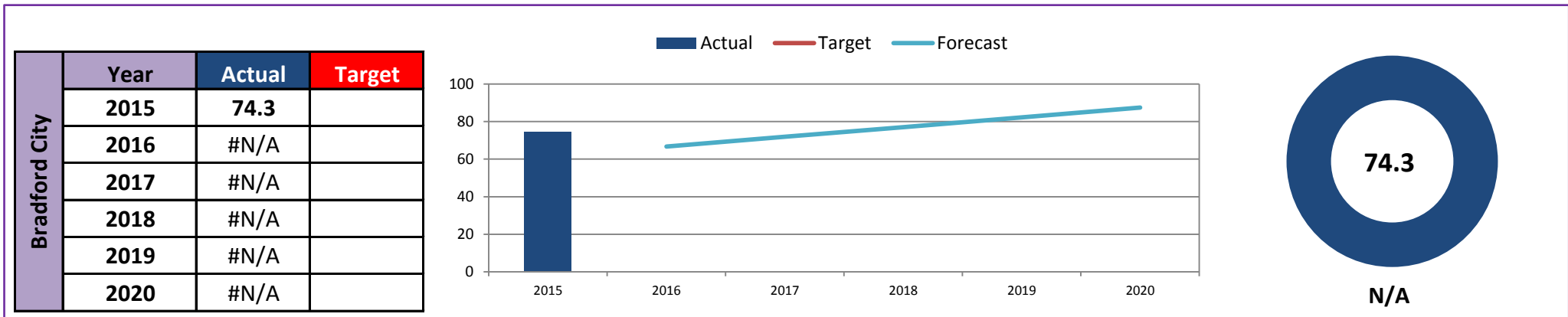
In Bradford the prevalence of asthma is above the national average and the prevalence of COPD is rising. We have higher emergency admissions, higher mortality and higher spend than other areas.

In 2015/16 there were 7,914 patients registered with asthma in City CCG and 21,955 patients registered in Districts CCG. Nationally, prevalence of asthma has fallen slightly from 6.0% in 2012/13 to 5.9% in 2015/16. This trend can be seen in Districts CCG where prevalence has fallen from 6.7% to 6.5%. Prevalence has however risen in City CCG from 6.3% in 2012/13 to 6.4% in 2015/16. Prevalence remains above the national average for both CCGs. It is suggested that some 12,000 people remain undiagnosed with asthma. (*Respiratory Health in Bradford and Airedale, March 2016, Bradford MDC*)

In 2015/16 there were 1,533 patients registered with COPD in City CCG and 8,177 patients registered in Districts CCG. Nationally, prevalence of COPD has risen slightly from 1.7% in 2012/13 to 1.9% in 2015/16 and this trend can be seen in both CCGs. Prevalence of COPD has risen in City CCG from 1.1% in 2012/13 to 1.2% in 2015/16.

In Districts CCG prevalence has risen from 2.3% to 2.4% over the same period of time. Prevalence remains above the national average for Districts CCGs. COPD is responsible for large numbers of non-elective hospital admissions – some of which are avoidable. It is suggested that for every 100 people on the COPD disease register

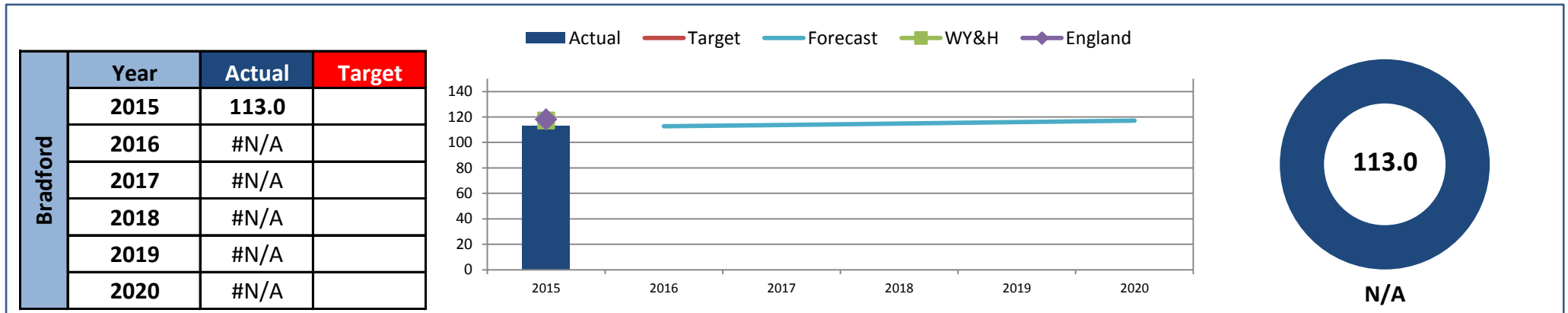
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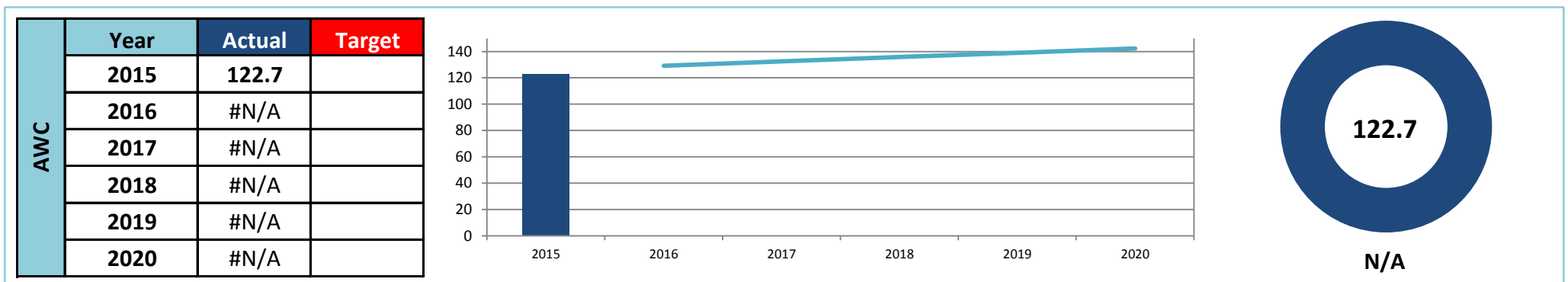
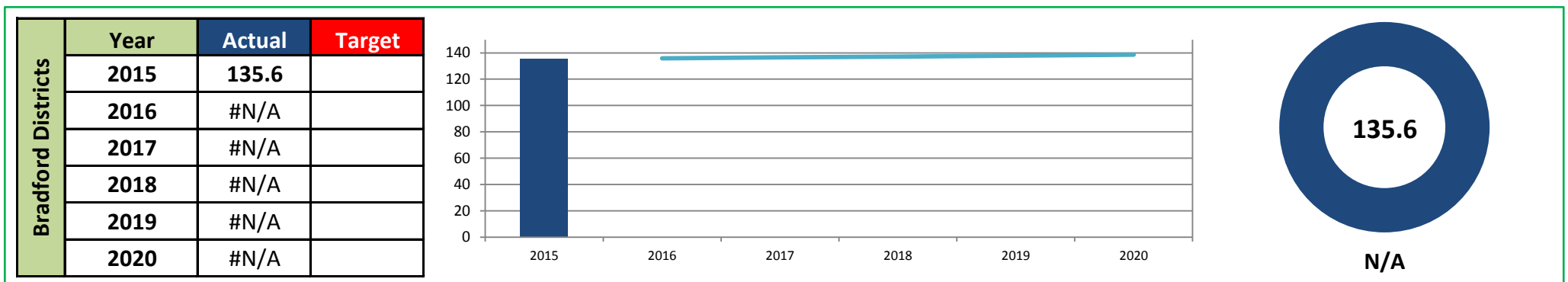
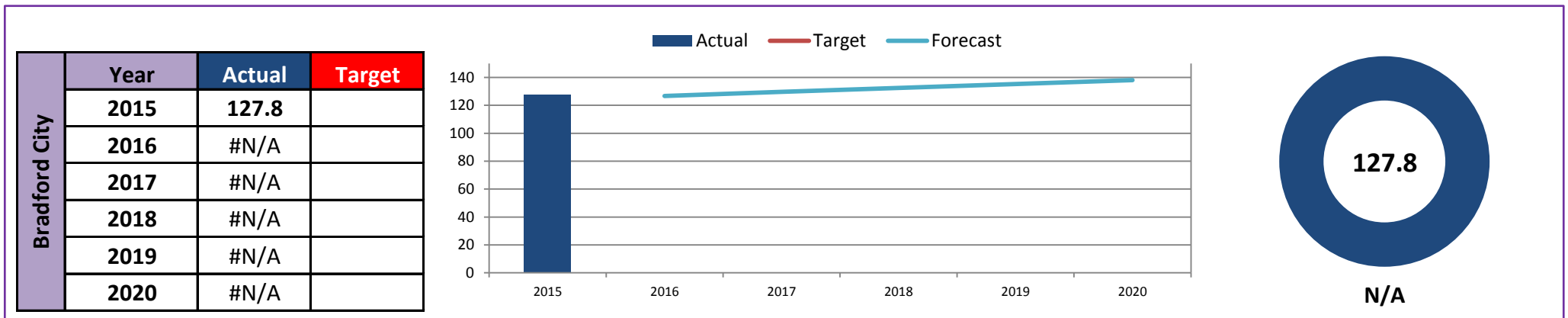
4.05ii - Age-standardised rate of mortality considered preventable from all cancers in those aged <75 per 100,000 population



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We have implemented the new NICE guidance for the identification and referral of patients with suspected cancer. The resulting lower threshold for referral will result in an increase in the number of patients being seen for diagnostic testing meaning more cancers will be found at an earlier stage and therefore treatment outcomes will be improved. In 2016/17, work was done to update the referral process for patients with suspected cancer in line with new NICE guidance. Streamlining this process allows patients to be seen quicker and enables providers to achieve the various waiting times standards as well as giving better treatment outcomes. We held an engagement event in conjunction with Cancer Research UK in June 2016 to understand the issues and barriers that affect uptake of cancer screening in Bradford. Following this, NHSE has set up a working group - including NHS commissioners and providers, the local authority, third sector organisations and patient groups - to spread the message about cancer screening throughout our population with the aim of diagnosing more cancers at early stages, thus improving patient outcomes and survival rates. BTHFT has continued its work to streamline care pathways in 2016/17, especially for patients with colorectal cancer. In 2017/18, this pathway will become operational and work will start to streamline pathways for breast and prostate cancer. This will include identifying the best location for treatment and the most appropriate ongoing treatment options depending on an individual's diagnosis, treatment plan and prognosis. Across provider organisations work is ongoing to improve utilisation of the recovery package, which gives patients greater control over and understanding of their treatment, thus improving their experience of care.

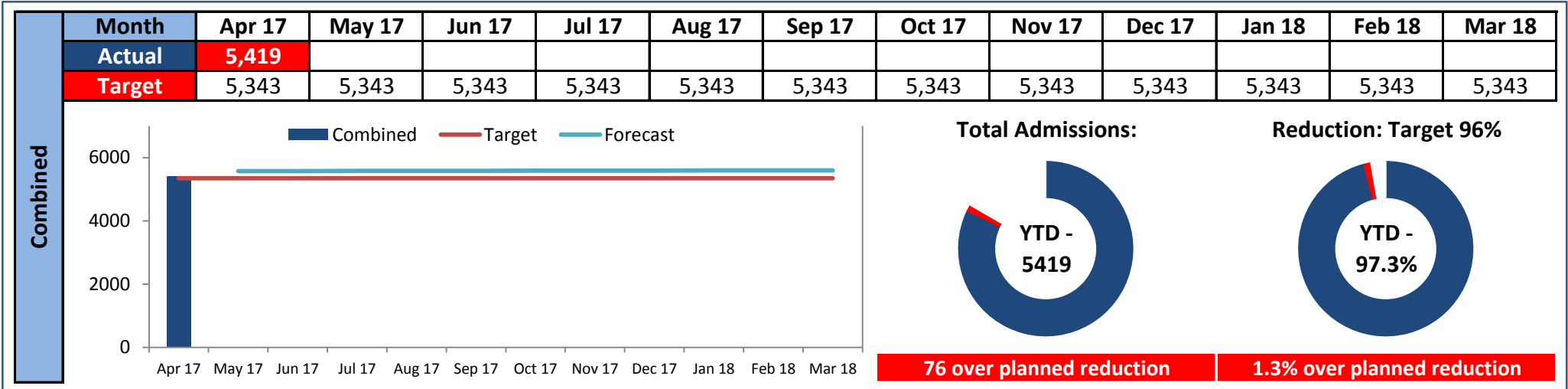
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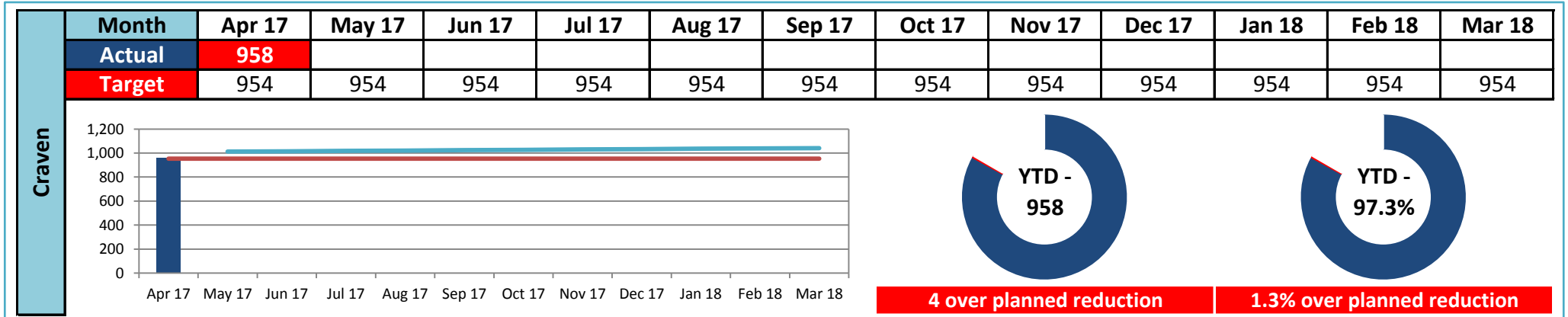
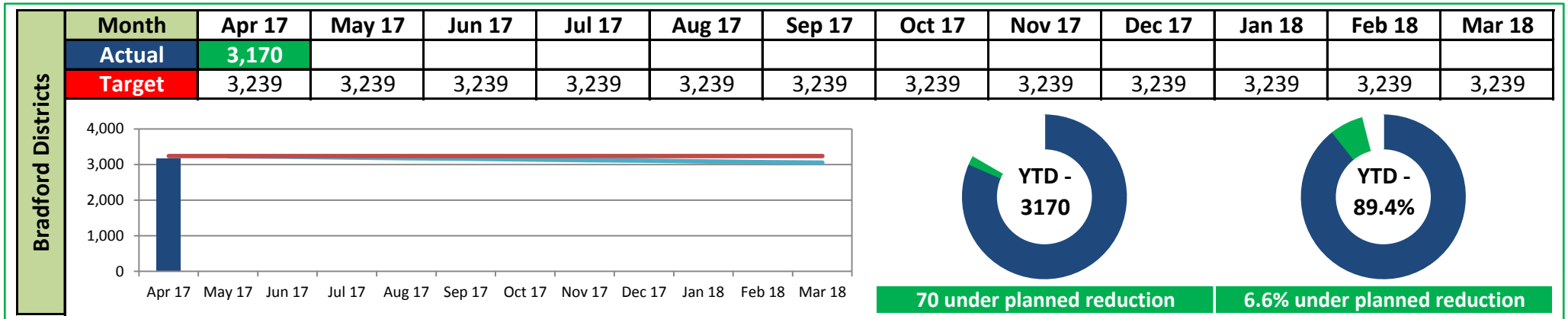
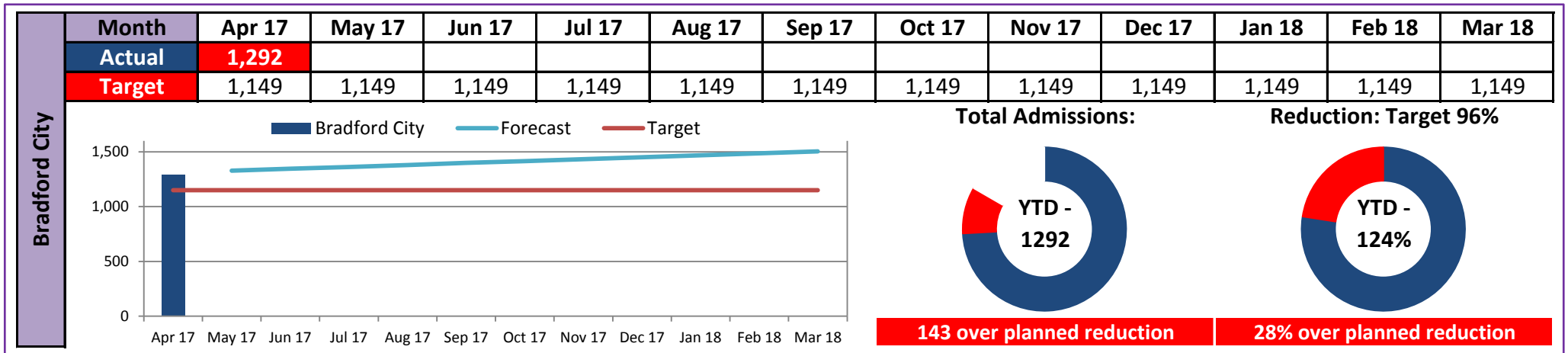
2.2 Reduce non-elective admissions by 4%

Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population



Narrative:

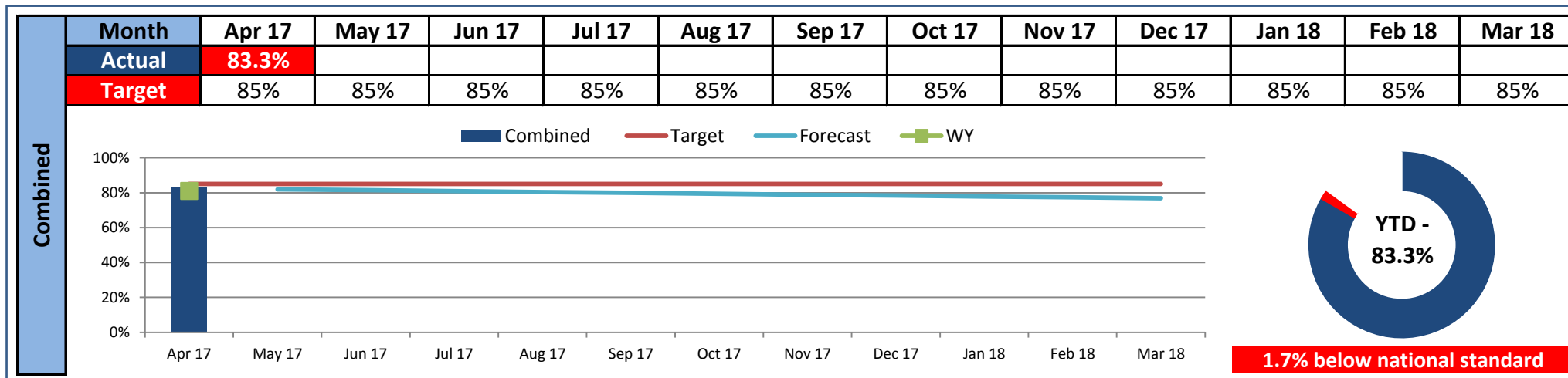
* Data Source: UNIFY2 - Data at CCG level using registered population



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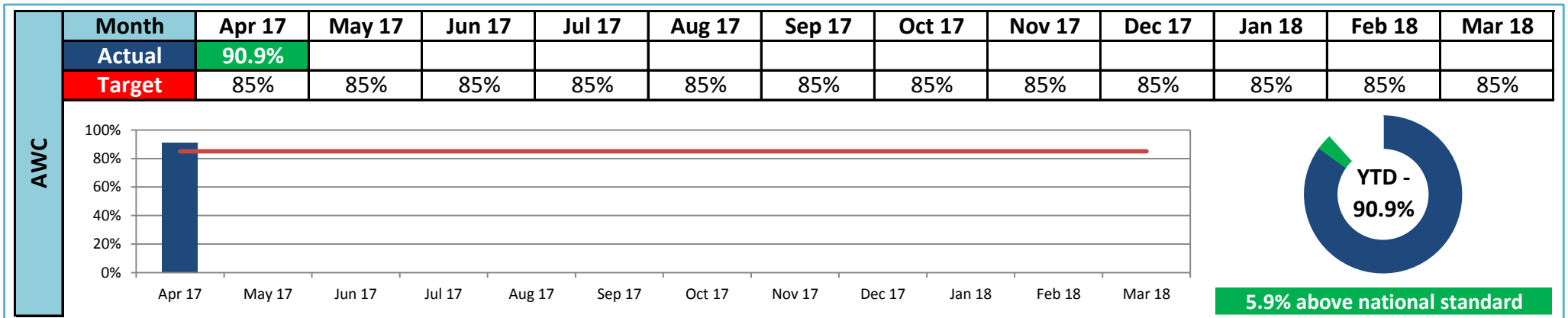
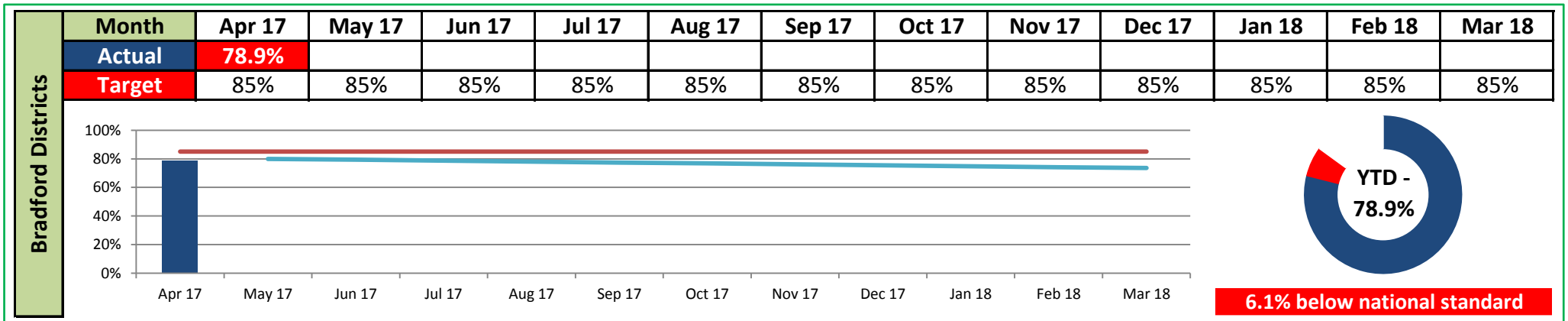
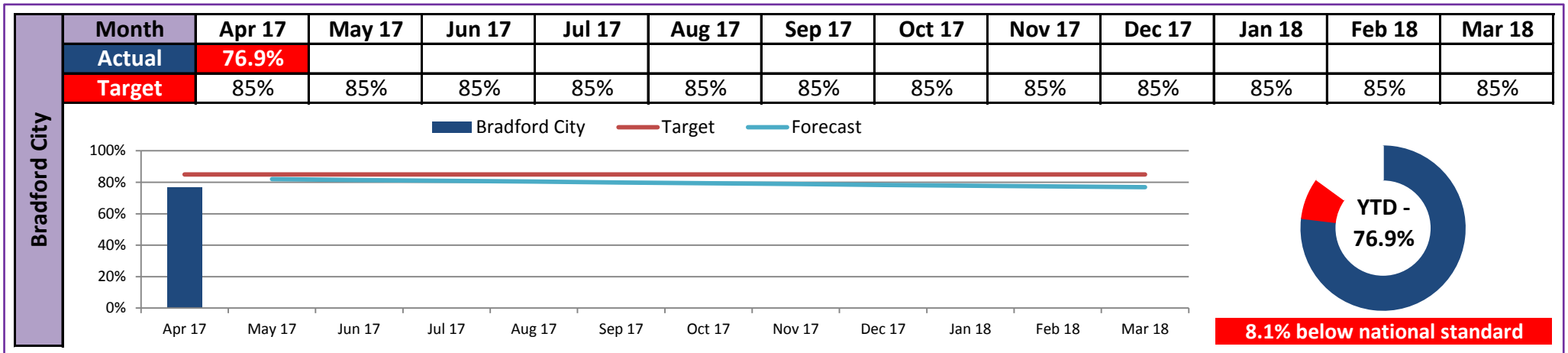
2.3b Develop a sustainable model of planned and emergency/urgent care that meets clinical and constitutional standards including seven day services in the 4 priority areas as a minimum (part B)

i. CCGIAF 122b People with urgent GP referral having first definitive treatment for cancer within 62 days of referral



Narrative:

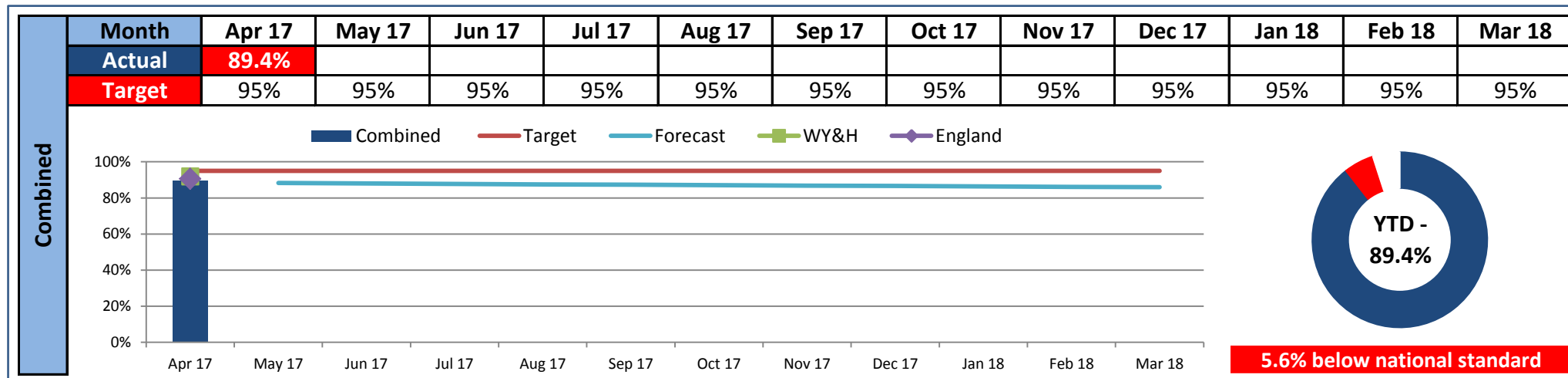
* Data Source: Open Exeter - Data at CCG level using registered population



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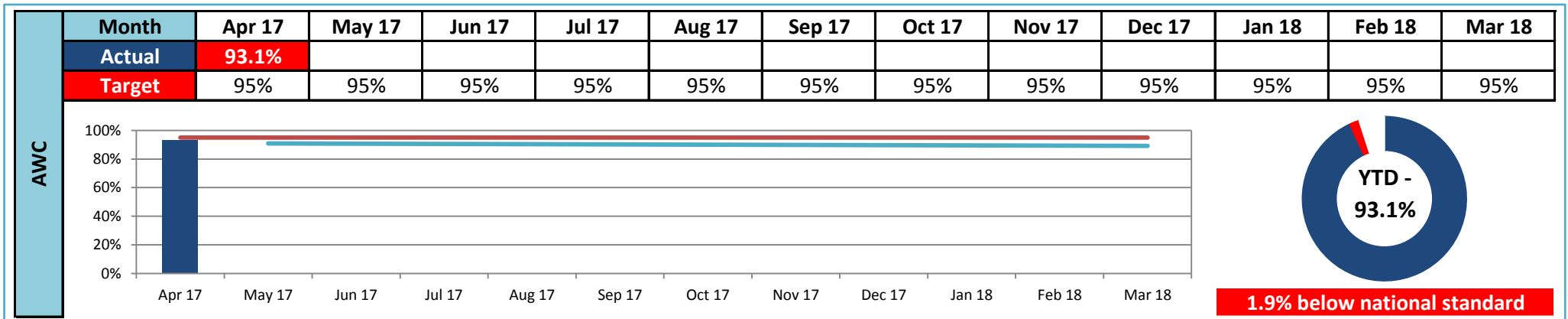
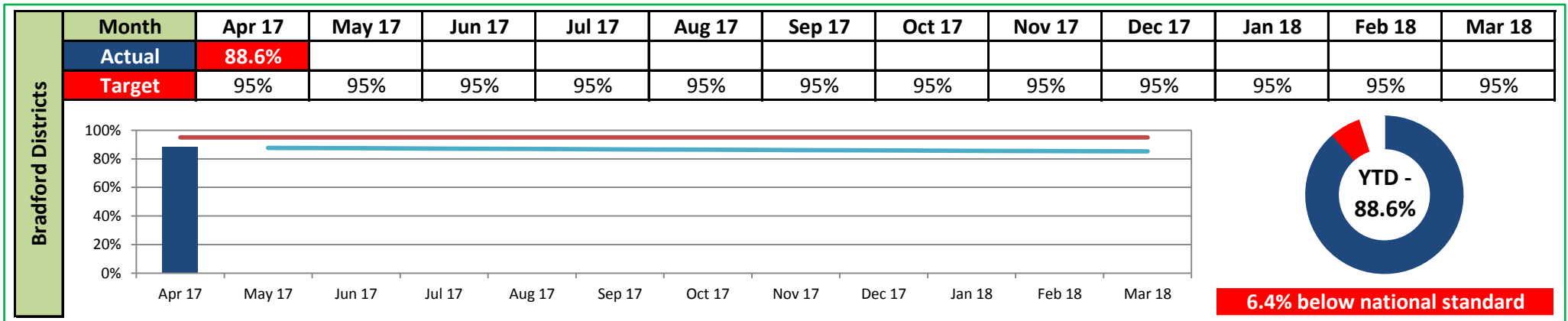
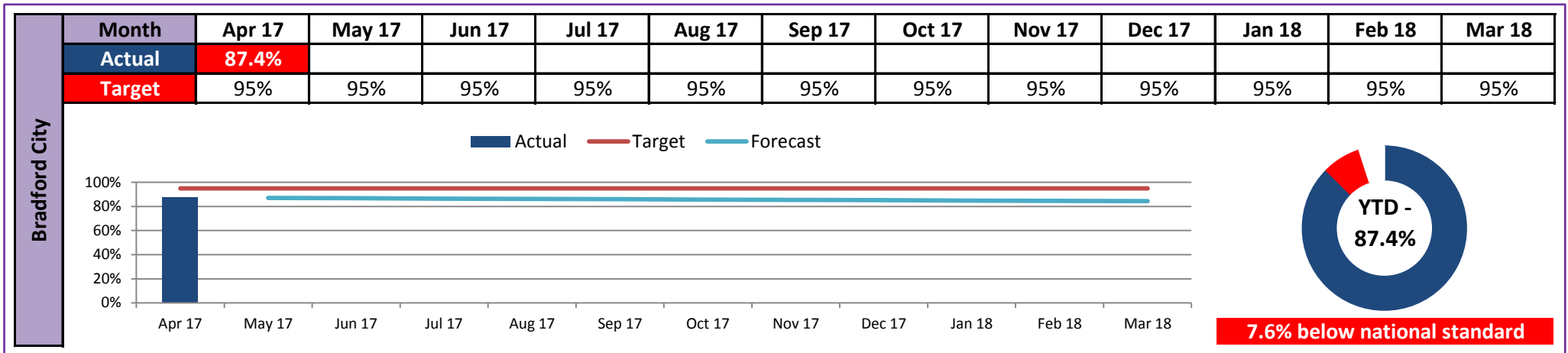
2.3b Develop a sustainable model of planned and emergency/urgent care that meets clinical and constitutional standards including seven day services in the 4 priority areas as a minimum (part B)

ii. CCGIAF 127c Percentage of patients admitted, transferred or discharged from A&E within 4 hours



Narrative:

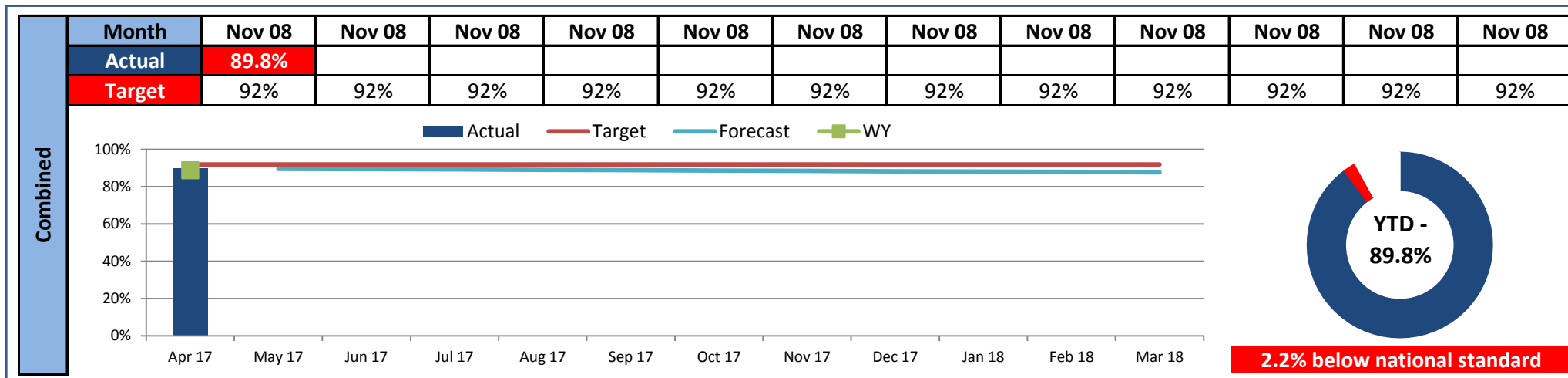
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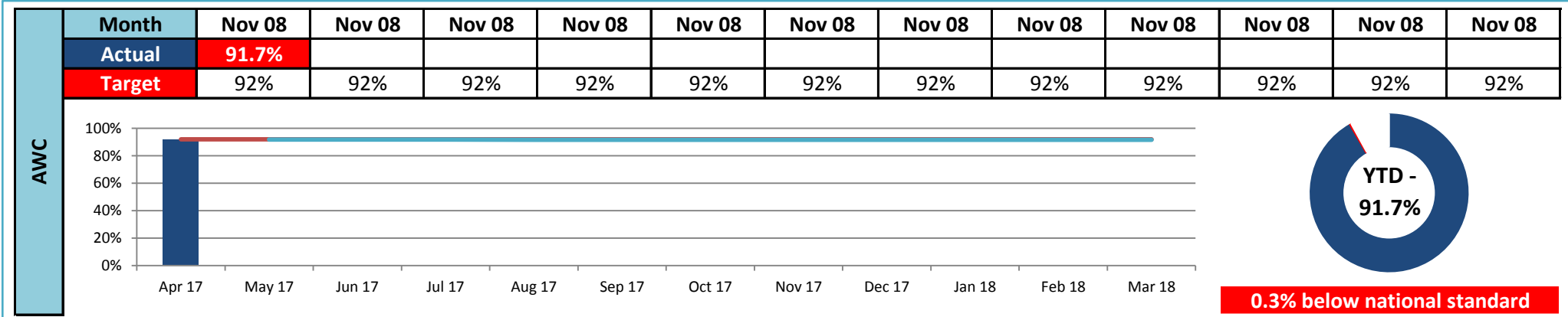
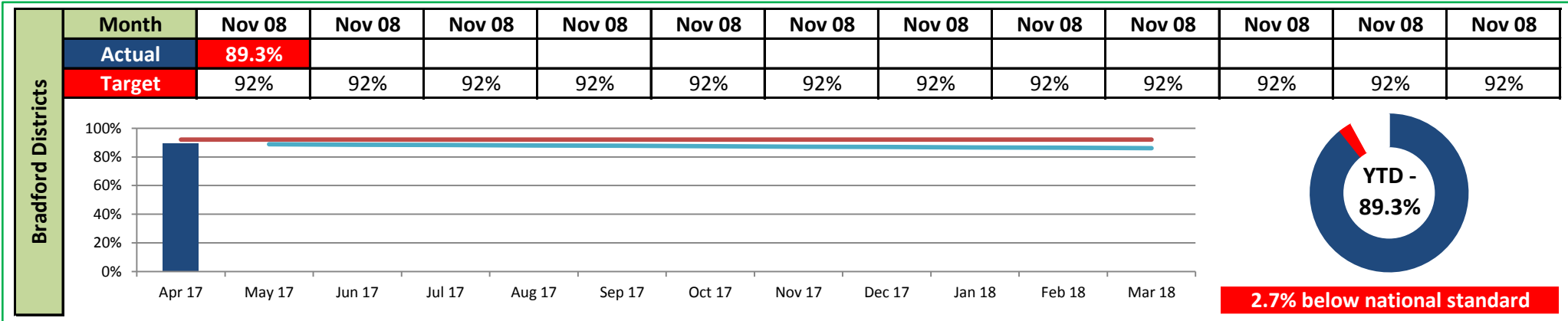
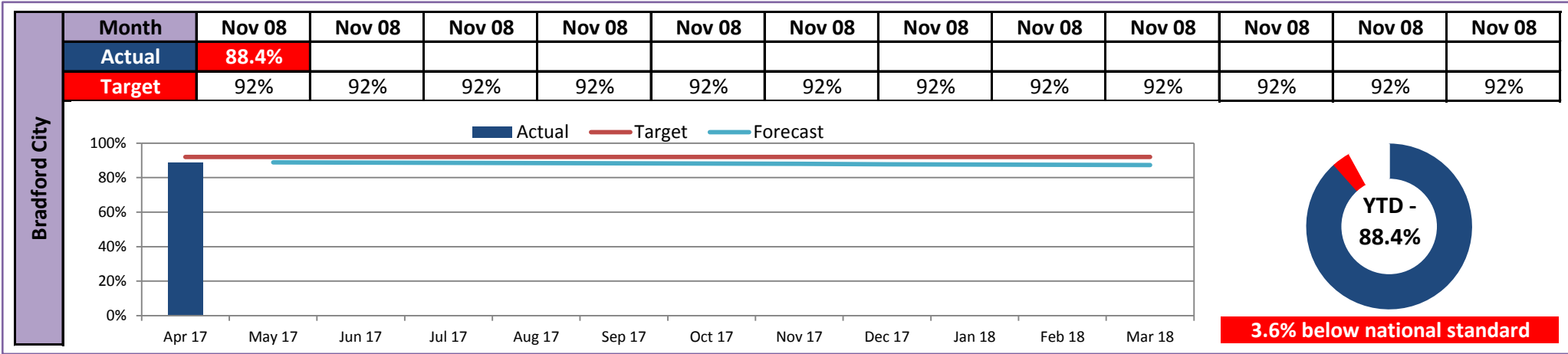
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iii. CCGIAF 129a Patients waiting 18 weeks or less from referral to hospital treatment



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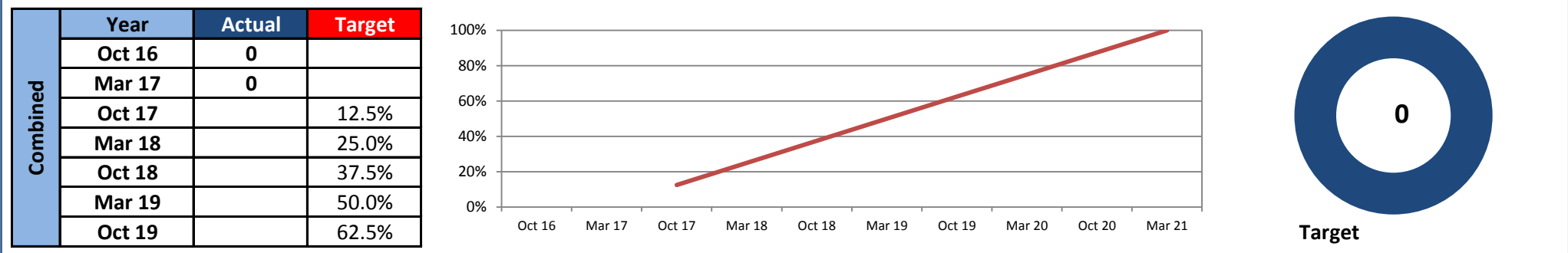
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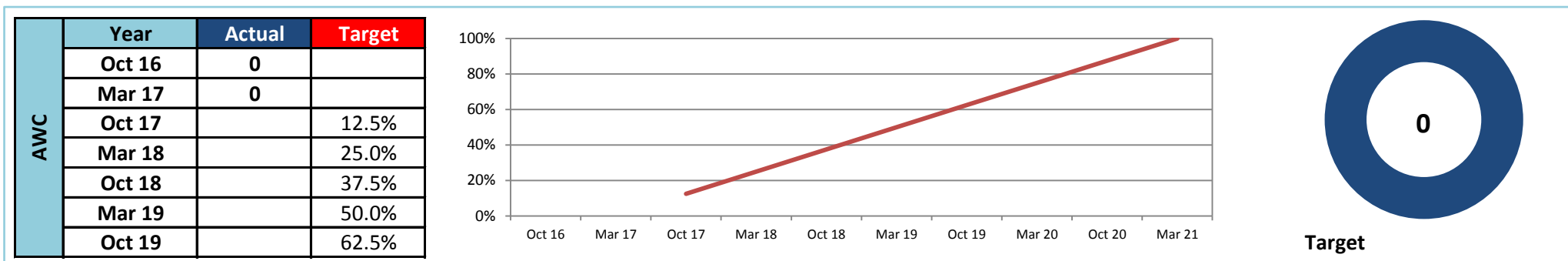
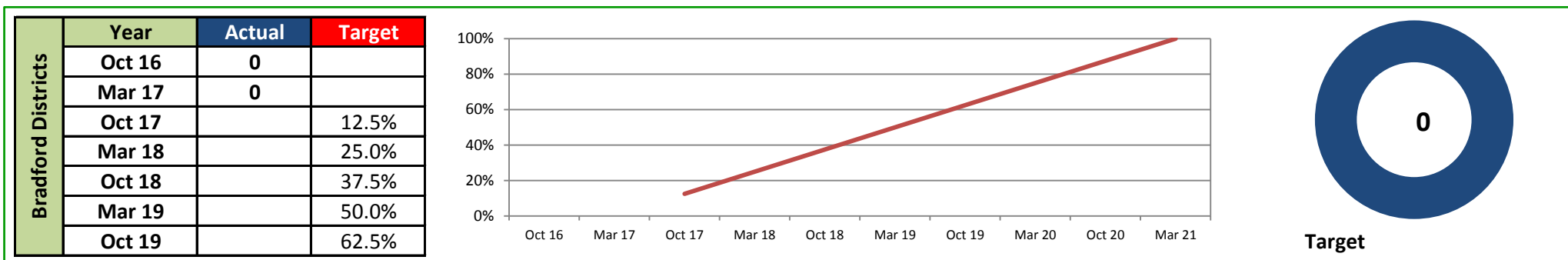
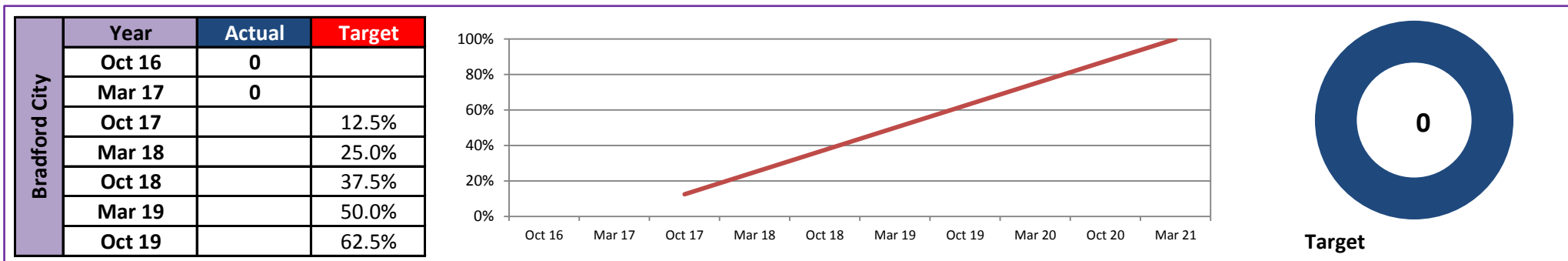
2.4 Commission new models of primary medical care that ensures seven day access achieved for 100% population by 2021.

CCGIAF 128c: Primary care access - extended access to GP services on a weekend and evening



Narrative:

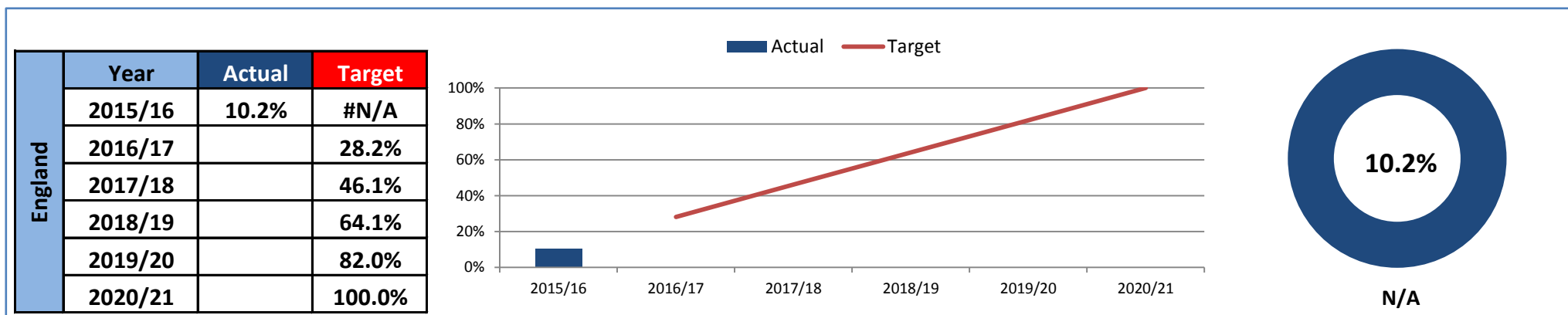
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2.5 i - Have all age MH liaison teams in place in all acute providers and meet the 'Core' 24 standards.

CCF IAF: 123d Mental Health: crisis care and liaison mental health services transformation. Staffed to deliver the 'Core 24 service' specification by 20/21



Mental wellbeing is much more than simply not being mentally ill. It is about having positive self-esteem, good coping mechanisms and feeling empowered and in control. In Bradford district and Craven we actively promote mental wellbeing through addressing social and environmental factors and offering support before problems lead to mental ill-health.

A new Mental Health Strategy was recently launched across Bradford – bringing together the health and care economy. The strategic priorities are given as:

Our wellbeing - We will build resilience, promote mental wellbeing and deliver early intervention to enable our population to increase control over their mental health and wellbeing and improve their quality of life and mental health outcomes.

Our mental and physical health - Mental health and wellbeing is of equal importance with physical health. We will develop and deliver care that meets these needs through the integration of mental and physical health and care.

Care when we need it - When people experience mental ill health the strategy will ensure they can access high quality, evidence based care that meets their needs in a timely manner, provides seamless transitions and care navigation.

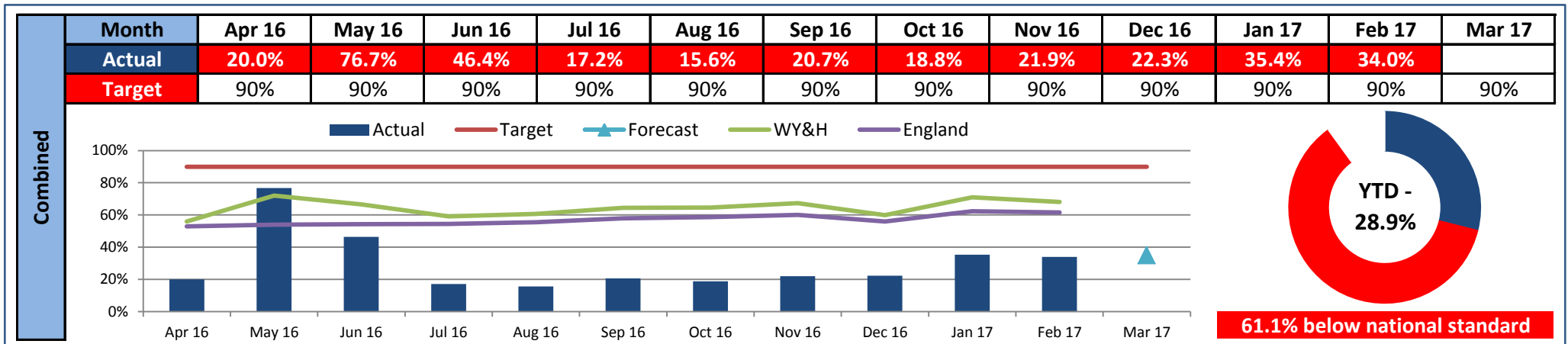
The strategy is comprehensive for Bradford district and Craven 2016-2020 and covers all ages. It provides an innovative focus on promoting mental wellbeing and tackling wider determinants of mental ill-health, and is aligned with national guidance. It was developed through close engagement with local people, carers, VCS, NHS providers and local authorities in Bradford area and Craven

Work is now underway to implement the strategy with the close involvement of a wide range of partners in strategy development and implementation.

* Data Source: NHS England Mental Health Five Year Forward View Dashboard - National Data only.

2.5 ii - 90% of people who access Psychological Therapies will engage through direct self-referral.

Self-referral: where a person chooses to access the service directly - usually by telephone, referral pack (with information about the service which may



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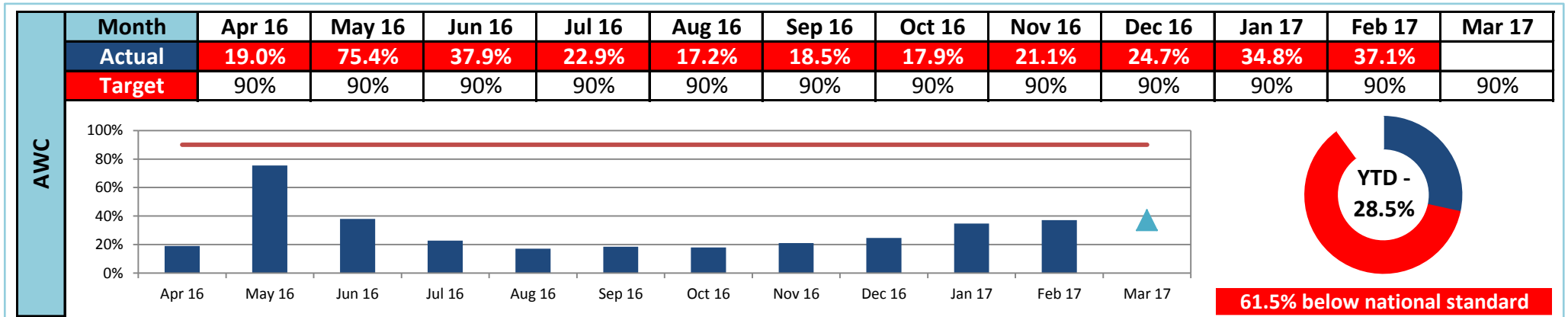
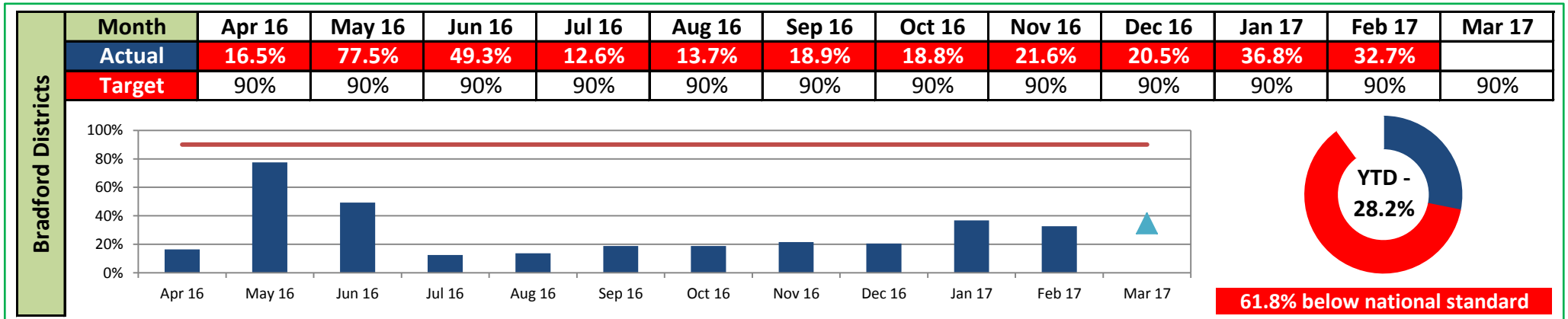
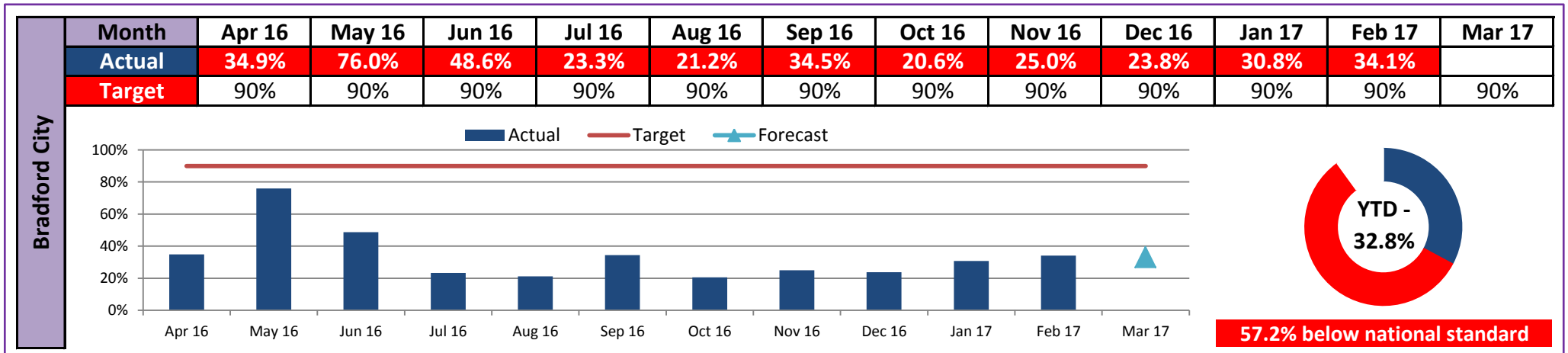
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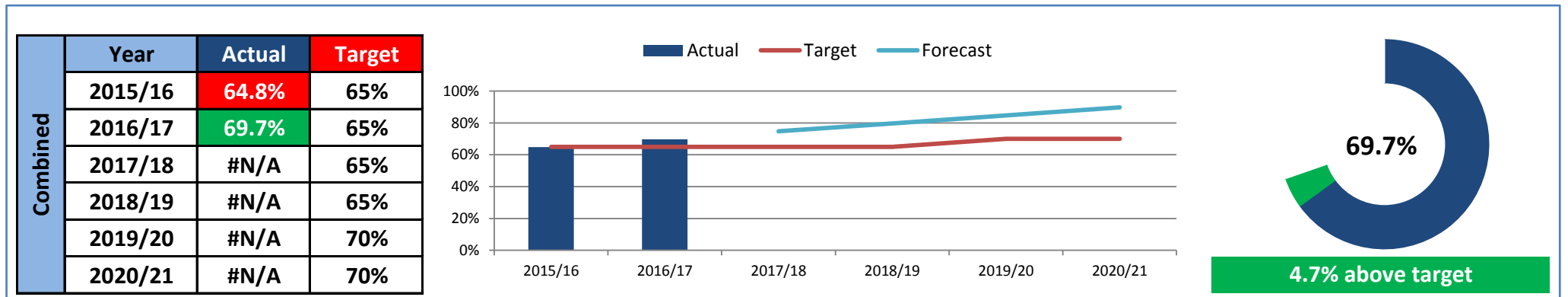
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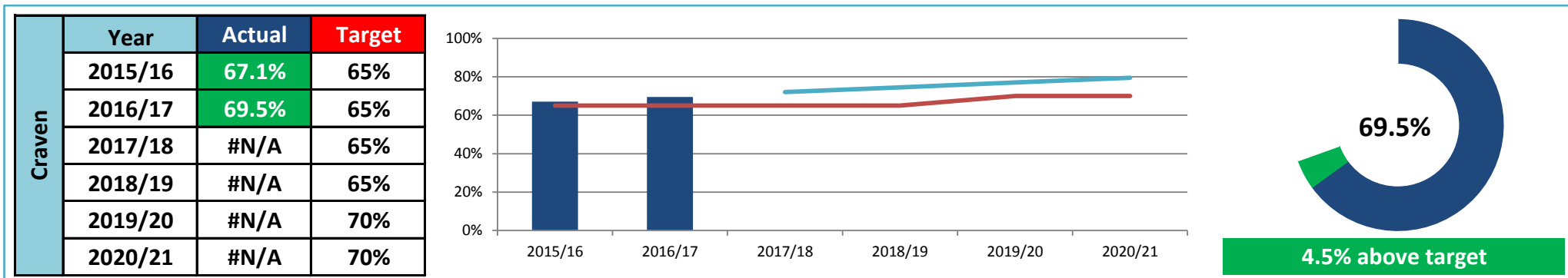
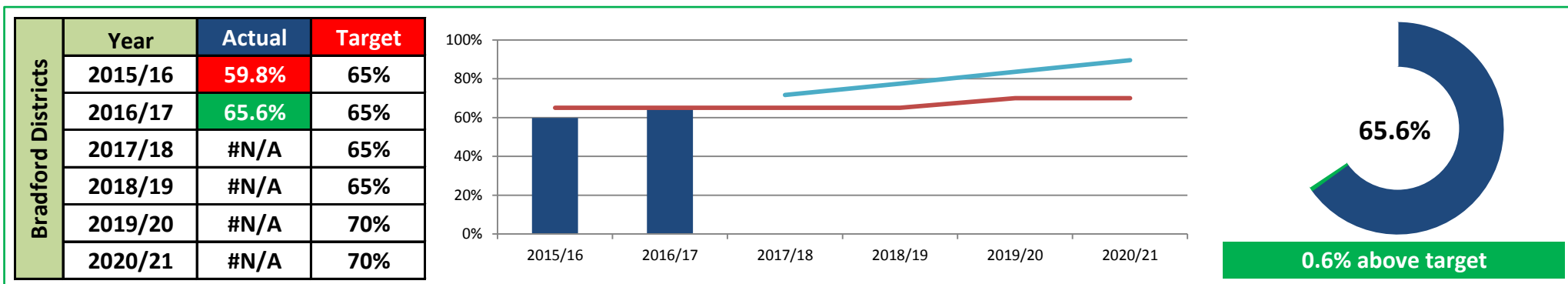
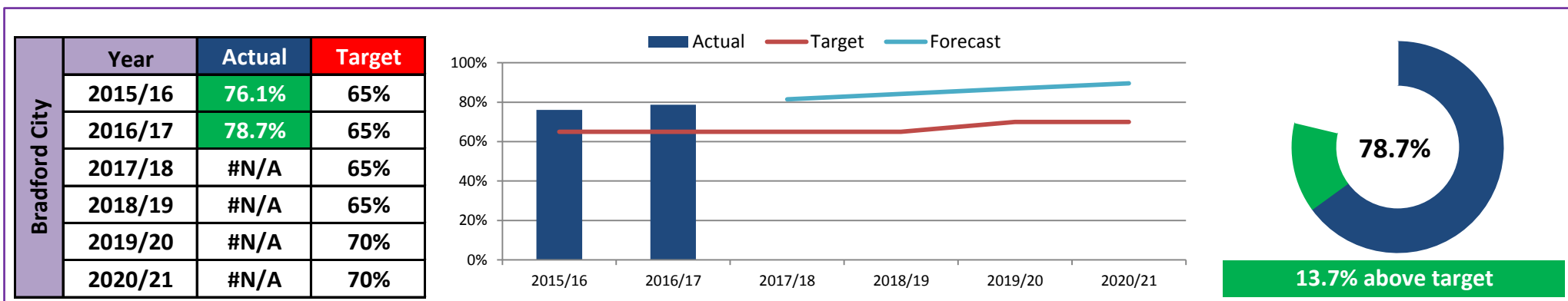
2.6 Ensure 70% of people with diabetes experience the 8 care processes

Diabetes - 8 care processes



Narrative:

* Data at CCG level using registered population



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