City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 22nd November 2018

X

Subject:

Respiratory Health in Bradford District

Summary statement:

Respiratory disease is an important cause of ill health and early death in Bradford District. The District performs relatively poorly compared to other areas in England. Recognising this, partners across the District, including the local authority and NHS, have prioritised respiratory health with the aim of improving health outcomes and reducing inequalities.

This paper provides an overview of respiratory health in Bradford District and outlines what partners across the NHS and local authority are doing to improve outcomes for people in the District. There is a specific focus on prevention and on asthma and chronic obstructive pulmonary disease (COPD), as these conditions account for a significant amount of the ill health and subsequent costs associated with respiratory disease in the District.

Bev Maybury
Strategic Director of Health and Wellbeing

Report Contact: Toni Williams,
Consultant in Public Health
Phone: (01274) 434071
E-mail: toni.williams@bradford.gov.uk

Portfolio:

Healthy People and Places

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

Respiratory disease is an important cause of ill health and early death in Bradford District. The District performs relatively poorly compared to other areas in England. Recognising this, partners across the District, including the local authority and NHS have prioritised respiratory health, with the aim of improving health outcomes, including reducing associated ill health and early death, for people in the District. In Bradford this work is being driven by the Bradford Breathing Better Programme, and in Airedale, Wharfedale and Craven (AWC) through the AWC Respiratory Action Plan Group.

2. BACKGROUND

Respiratory diseases are diseases that affect the air passages, including the nasal passages, the bronchi and the lungs. They include acute conditions such as pneumonia, and long term conditions such as asthma and COPD. They are influenced by lifestyle factors such as smoking, as well as environmental factors such as air quality.

Some of the greatest ill health locally is associated with asthma and COPD. COPD is also an important cause of early death. It is for these reasons why asthma and COPD are local priorities, particularly for the NHS, in terms of respiratory health.

COPD is a disease of the lungs that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, sputum production and wheezing. It is caused by long term exposure to irritating gases or particulate matter, most often cigarette smoke. Although not curable, COPD is treatable. With good management, most people with COPD can achieve good symptom control and quality of life, as well as reduced risk of other associated conditions.

Asthma is a condition characterised by the narrowing of the airways which makes breathing difficult. This can trigger coughing, wheezing and shortness of breath. For some people asthma is a manageable condition, however, for others it can be a major problem that interferes with daily activities and may lead to a life threatening asthma attack. Whilst asthma can't be cured, its symptoms can be controlled.

3. OTHER CONSIDERATIONS

3.1.1 Overview of respiratory health

Respiratory disease is a leading cause of dying early in Bradford District. Rates of early death (before the age of 75) from respiratory disease in the District are amongst the highest in England and the second highest in Yorkshire and Humber. Each year more than 500 people die from respiratory disease in the District; an estimated 25% of these deaths are preventable. The main causes of death from respiratory disease include COPD and pneumonia.

It is not only early death that is an issue, but the associated impacts on people's day to day lives. Respiratory diseases such as COPD and asthma have a significant impact

on the quality of life of those who are affected. Exacerbations can result in attendance at A&E or admission to hospital. Around 30% of people with COPD attend A&E on at least one occasion each year, whilst one in five people are admitted to hospital each year.

3.1.2 COPD

13,154 people across the three CCGs in Bradford District have been diagnosed with COPD. Disease rates are lowest in City CCG, however, this is, in part, a reflection of the younger age structure of the City population.

One of the main challenges in managing COPD is that many people are unaware that they have the condition. Late diagnosis has a substantial impact on symptom control, quality of life, outcomes, and cost. Often people aren't diagnosed until the disease is at an advanced stage; this is because people sometimes do not recognise the symptoms of COPD because they develop gradually; many people think that the symptoms they are experiencing are normal or associated with age; and when people present to their GP the symptoms may be treated rather than the cause of the symptoms investigated.

Whilst 13,154 people in the District have been diagnosed with COPD, it is estimated that the actual number of people with COPD is closer to 19,300; an estimated 6,150 people remain undiagnosed. The proportion of people with COPD who remain undiagnosed varies between CCGs and also between GP practices. Whilst some degree of variation is expected, the variation described suggests that some GP practices are better than others at detecting COPD, and that there is capacity for improvement.

Most of the care for people with COPD is provided in primary care. Effective management can lead to improvements in symptom control and quality of life, and also a reduction in exacerbations and associated hospital admissions. NICE guidance and the GP Quality and Outcomes Framework (QOF) sets out a number of standards for the way in which people with COPD should be managed. For example, people with COPD should have an assessment of breathlessness (one of the main symptoms of COPD) on a regular basis. There is variation between CCGs (and also between GP practices) which suggests that there is scope to improve this element of the management of COPD.

A significant challenge in effectively managing COPD is multimorbidity. Multimorbidity is the presence of more than one long term condition; in the District multimorbidity for people with COPD appears to be the norm. More than three quarters of people with COPD have at least one other long term condition, such as high blood pressure or diabetes. This is a challenge because of the way in which health care services are traditionally delivered. The use of many services to manage individual conditions can be inefficient and frustrating for people. Individuals with more than one long term condition are much more likely to experience problems with the coordination and integration of their care, and are more likely to have an unplanned hospital admission.

Figure 1: Variation in the management of COPD in primary care, City, Districts and AWC CCGs, 2016/17

	% of people with COPD who have had a review, incl. an assessment of breathlessness using the MRC dyspnoea score in the preceding 12 months	% of people with COPD with a record of FEV_{1*} in the previous 15 months
AWC	78.1%	69.7%
City	81.5%	75.6%
Districts	81.3%	71.7%
GP practice range	58% - 100%	42.4% - 100%

FEV_1 (forced expiratory volume) refers to the amount of air that a person can forcefully exhale in 1 second. This provides an indication of the severity of COPD Source: Quality and Outcomes Framework

3.1.3 Asthma

41,858 people across the three CCGs in Bradford District have been diagnosed with asthma. Disease rates are similar across all three CCGs, but higher than the England average. This number is likely to be an underestimate of the actual number as, as is the case for COPD, some people with asthma will not have been formally diagnosed. Getting a diagnosis and starting appropriate treatment early can lead to better long term outcomes, improved quality of life, symptom control, and fewer exacerbations. Modelled estimates of the number of people with asthma do exist, however, they are now out of date and, therefore, there are some concerns over their accuracy. Whilst it is not possible to estimate the number of people who have asthma but who have not been diagnosed, it is important to recognise the importance of having an accurate and timely diagnosis.

Most of the care for people with asthma is provided in primary care. Effective management can lead to improvements in symptom control and quality of life, and also a reduction in exacerbations and associated hospital admissions and mortality. NICE guidance and the GP Quality and Outcomes Framework (QOF) sets out a number of standards for the way in which people with asthma should be managed.

Figure 2: Variation in the management of asthma in primary care, City, Districts and AWC CCGs, 2016/17

	% of people who have had an asthma review in the last 12 months	% of people with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 12 months.
AWC	72.9%	83.9%
City	77.0%	93.2%
Districts	71.3%	86.3%
GP practice range	54.4% - 95.6%	63.6% - 100%

Source: Quality and Outcomes Framework

For example, people with asthma should be reviewed on a regular basis and young people with asthma should have a record of their smoking status because smoking can exacerbate the condition. There is variation between CCGs (and also between GP practices) which needs to be addressed to ensure that wherever you live in the District your asthma is well managed.

3.1.4 Smoking

Smoking has long been recognised as one of the main causes of preventable illness and early death. It is particularly important in the context of asthma and COPD because it is one of the main causes of COPD, and is also an exacerbating factor for asthma.

- The number of people in Bradford District smoking has remained stubbornly high for a number of years, however, there are signs of improvement. The smoking prevalence fell from 22.2% in 2016 to 18.9% in 2017 (the lowest level recorded in the District).

- The proportion of the population of Bradford District smoking is higher than the national average; furthermore, smoking remains more common in people in routine and manual jobs, where the proportion smoking is 31.8%

- Smoking in pregnancy rates in Bradford District are steadily declining, however the number of woman smoking at the time of delivery remains higher than the national average – 13.8% compared to 10.7% in England as a whole.

3.1.5 Air quality

Air pollution is also associated with poor respiratory health; it has been established to be causative for asthma, and associated with exacerbations of both asthma and COPD. In Bradford an estimated 5.0% of early deaths are attributable to particulate air pollution.

3.2 Improving respiratory health in Bradford District

Improving respiratory health and reducing health inequalities remains a priority for the Department of Health and Wellbeing, wider local authority and NHS partners. Action to improve outcomes focuses on two main areas:

- ***Prevention*** involves addressing the risk factors for respiratory conditions to reduce the number of people developing them in the first instance. The main preventable risk factor for COPD is smoking.
- ***Early intervention and good quality primary care*** involves action to improve the management and care of people with respiratory conditions such as COPD to slow down progression of the disease, and to reduce the frequency of exacerbations and complications.

3.2.1 Tobacco control

The Department of Health and Wellbeing commissions services to support people to stop smoking, and also activities to prevent people, particularly children and young people, from taking up smoking in the first instance.

Stop smoking support in the District is provided by a team of specialists within a central service, and also via a network of providers in primary care and pharmacies. The specialist stop smoking team within the Department of Health and Wellbeing provides

stop smoking support at a range of venues including GP practices, libraries, supermarkets, and children's centres, to ensure that support is accessible in those communities with the highest smoking prevalence. As smoking is more common in routine and manual working groups, support to quit in the workplace is provided by the specialist team, and is targeted at organisations with a high proportion of routine and manual workers. Within the secondary care setting, for people referred to the service on admission to hospital, support to quit smoking is provided by a specialist team on the ward.

Smoking in pregnancy has been a priority for a number of years. Recognising the importance of stopping smoking during pregnancy, the Department of Health and Wellbeing commissioned a specialist midwife to, over a three year period, train staff and establish policies and procedures. This includes ensuring that a systematic and evidence based approach to tackle maternal smoking is embedded throughout the antenatal care pathway.

In addition, the Department of Health and Wellbeing, Bradford City and Districts CCGs and Public Health England have funded babyClear; this is an evidence based midwifery programme to ensure consistency of advice and interventions for pregnant smokers from the first booking appointment with a midwife. This is complemented by further interventions including smoking cessation and smoke free homes champions in the health visiting service and children's centres.

NHS England have provided additional funding to tackle the high number of women continuing to smoke in pregnancy in Bradford Districts CCG. This has enabled the introduction of carbon monoxide (CO) screening at 36 weeks pregnant to improve the accuracy of reporting, and provides a further opportunity to promote the uptake of smoking cessation services. In addition, midwives assessing women in the maternity assessment centre and day unit have received additional training and resources to implement an intervention with women who continue to smoke in pregnancy and attend hospital with a pregnancy concern.

Breathe 2025 is the vision for Yorkshire and Humber promoted locally - to see the next generation of children born and raised in a place free from tobacco, where smoking is unusual. A multipronged approach to reduce the number of young people taking up smoking has been adopted. Priorities include:

- Continuing to de-normalise smoking and discourage young people from being influenced by adult smoking.
- Promoting the implementation of smoke free areas for organisations involved in the care or education of young people and children.
- Making every contact count – ensuring that all opportunities in health and social care (including primary and secondary care) are maximised to support people to stop smoking. This includes identifying smokers, signposting, and referral to services where appropriate.
- Ensuring that all national and regional campaigns are well publicised and resources made available to primary and secondary health and social care professionals.
- Tackling the trade in illegal tobacco. 'Keep it Out' is a programme jointly funded by local authorities across West Yorkshire to combat the damage illegal tobacco does to our communities. Available from a range of sources within some local communities, the sale of illegal tobacco seriously undermines the impact of other

tobacco control measures, makes it easier for children to start smoking, enabling them to become addicted at a young age.

West Yorkshire and Harrogate Cancer Alliance have identified tobacco control as a key element of its work to prevent cancer and cancer-related deaths. The tobacco control workstream aims to strengthen existing tobacco controls and smoking cessation services across West Yorkshire and Harrogate, in line with reducing smoking prevalence to below 13% nationally by 2020. Outcomes are focused on:

- Reducing smoking related admissions and demand on services;
- Increasing referrals to specialist stop smoking services;
- Systematic implementation of NICE guidelines in acute hospital and mental health services.

Lung Cancer is the most common cancer in West Yorkshire. Variation has been identified in route to diagnosis, stage at diagnosis and one year survival across the region. West Yorkshire and Harrogate Cancer Alliance are funding a programme in Bradford and Wakefield to tackle lung cancer across the district through four specific programmes of work:

- ***Support people to stop smoking*** including those already receiving treatment in the NHS for smoking-related illnesses, by using every patient contact to offer help to quit.
- ***Raise awareness of early signs and symptoms*** so people seek information and advice earlier than is often the case, making more cancers curable.
- ***Develop a pilot 'lung health check' scheme*** to invite for screening those identified in the community or through their GP as most at risk of cancer, using low dose CT scanning in community venues, such as supermarket or community centre car parks.
- ***Improve the experience for those affected by lung cancer*** by ensuring care and treatment pathways are as speedy and efficient as possible.

This work creates the opportunity to establish a local health and care partnership between the local council, providers of NHS services (hospitals, mental health, GPs and community services) and commissioning organisations in order to drive the four-pronged programme.

3.2.3 Bradford City and Districts: Bradford Breathing Better

Bradford City and Districts CCGs are working collaboratively to deliver a programme of work (known as Bradford Breathing Better, "BBB") to improve respiratory health outcomes for children, young people and adults in Bradford with COPD or asthma.

The primary aim of Bradford Breathing Better is to promote early and appropriate diagnosis, and through effective and proactive care, support people to manage their conditions, reducing exacerbations and unplanned hospital admissions.

With the support of the programme we will provide people with respiratory disease the tools and techniques to feel confident in managing their condition. We will also provide, as clinically appropriate, rescue packs of medication to prevent people, where it is clinically safe to do so, from going to hospital when their condition worsens.

The planning and implementation of Bradford Breathing Better is underway, and will continue to be rolled out in 2018/19. Our Bradford Breathing Better Steering Group is a partnership involving primary care, secondary care, Public Health, the voluntary and community sector, and organisations such as The British Lung Foundation and Asthma UK. We have engagement from all of our local GP practices, as well as IT to support the collaborative and data driven approach to our programme.

A recent extremely successful work shop was held with colleagues from across primary and secondary care with a view to help carve out our plans in more detail and secure support from partners in delivery.

We are starting with the education of our workforce. All practice staff treating people with respiratory conditions have access to an online respiratory education programme. This also has a quality improvement platform where projects, specific to Bradford, can be uploaded and undertaken by practices.

Data is currently being extracted from practices by Optimim Patient Care who will provide us with not only CCG and practice data but also on an individual basis. This data will guide us to where we need to focus our efforts.

Improving management (including self-care) of COPD and asthma, will have a great impact on people being able to look after and care for their own lung health and our patient events that have been held during the year have helped inform plans on what our local respiratory patients' needs are. Two practices have started doing group consultations for COPD rather than 1:1 annual reviews, with a view to rolling this project out across GP practices. The idea being that clinicians are able to not only educate people but also empower them to manage their condition better and ultimately reduce their chances of ending up in hospital.

We are working with our local Breatheasy Group, to try to develop more practice based respiratory groups for local people to attend to help them to benefit from the support each other can provide.

Working with Public Health colleagues, we are supporting smoking cessation, to increase the number of people stopping smoking, and during September and October we have funded the Health Bus to deliver these messages across Bradford. As part of the GP Quality Improvement Scheme practices are being incentivised to ensure that all staff who come into contact with smokers undertake online training in Very Brief Advice. Also key to respiratory self-care is the flu vaccine. Again in partnership with our colleagues in Public Health, we will work with primary care to support the flu campaign for our patients, particularly those who are at most risk.

Self care

As mentioned, one of the priorities locally is to support individuals to manage their condition, be it COPD or asthma, and to understand any triggers for exacerbations, so that exacerbations can be managed in a timely, safe and supportive way. People have told us that they feel vulnerable when they have a flare up of their condition, and often they have no alternative available, particularly out of hours, but to call emergency services. This often leads to an A&E attendance or an unplanned hospital admission.

We aim to provide each person with a detailed, personalised care plan which outlines how to manage their condition and what to do if they start to feel unwell.

Prescribing and formulary

A significant amount of CCG spend on COPD and asthma is on prescribing, therefore, it is important to look at the outcomes that we are achieving for this spend. In order to ensure that people receive the right medication at the right time, a prescribing formulary that covers primary and secondary care is being developed, with any changes considered at an individual's annual review. Furthermore, there is a growing body of evidence to show that prescribed medication is rarely used effectively; meaning that a person's respiratory condition might not be as well controlled as it could be. Accordingly, approaches to improving inhaler technique will also be considered.

Clinical template

Primary care teams currently have a number of templates open for them to follow to support the management of people with COPD and asthma in primary care settings. This can be cumbersome and confusing. Therefore, as part of Bradford Breathing Better we will look to simplify the process by creating one overarching template. This will support appropriate prescribing, proactive care planning, and facilitate referral to other services such as smoking cessation services, and pulmonary rehabilitation.

Pathways

People with COPD and asthma are primarily managed in primary care settings, however, some will require care in acute hospital settings. It is important that a consistent approach to managing COPD and asthma is taken across primary and secondary care, and, therefore care pathways will be reviewed. Pathways will be evidence based and compliant with best practice contained within the NICE Quality Standards for both COPD and asthma. Training and education will also be delivered to staff to ensure that pathways are implemented and embedded across primary and secondary care.

Each of our GP practices has a dedicated nurse lead that will support the development and implementation of the Bradford Breathing Better Programme.

3.2.4 Airedale, Wharfedale and Craven (AWC) Respiratory Action Plan

AWC have adopted the principles of the NHS Right Care Programme to improve respiratory health outcomes in Airedale, Wharfedale and Craven. The Right Care Programme is based on the principle of unwarranted variation. Some variation between CCGs in terms of health outcomes, hospital activity, prescribing, and what CCGs spend on health care is expected; this is because CCG populations are different. However, some variation is unexplained, and by using data and evidence to identify such variation, areas and programmes which offer the best chances of improving outcomes for people in the District, as well as making the best use of resources, can be identified.

Much of the respiratory work programme in AWC focuses on improving respiratory health outcomes for people with asthma and COPD. The focus is primarily on primary care because this is where most people with these conditions are routinely managed, but also includes some pathway development work between primary and secondary

care, to ensure that when people do require management in acute settings, that their care is as joined up as possible.

The respiratory work programme is delivered by the Respiratory Action Plan Group.

The Group is focusing on:

- Promoting early and appropriate diagnosis.
- Improving care and management of people who are diagnosed with a respiratory condition through care planning and patient education.
- Encouraging people to attend their annual reviews, where their medication can be reviewed and people are supported and educated to administer their medication correctly. Their care plan can be discussed and rescue packs can be provided where suitable.
- Encouraging self-care, starting with ensuring that people are using their inhalers correctly.
- A consistent approach between primary and secondary care, including the development of a paediatric pathway.
- We have also recently applied for and been granted 660 myCOPD licences. myCOPD is currently the only NHS approved app. It is being delivered to patients who are newly diagnosed with COPD, patients being discharged from hospital and patients at their annual review. It is also being offered to people who find it difficult or unable to attend class-based pulmonary rehabilitation, and in areas where there are long waiting lists for class-based pulmonary rehabilitation.
- There has been an increased focus on pulmonary rehab, with services available across the patch. PR has many benefits for people with COPD. It can improve the ability to function and quality of life.
- An Asthma Hot Clinic has been set up in Craven for patients discharged from Airedale Hospital. The clinic's aim is to provide education about asthma and the importance of concordance with treatment, step up appropriately and triage those people that should be referred into secondary care.
- A pilot has been set up at Townhead surgery for people to use the Gold-Line so they can call and talk to someone if they are feeling anxious or they have a flare up of their condition. In some cases this means that exacerbations can be managed in a timely, safe and supportive way with the person feeling supported. This would negate the need to call emergency services, which can lead to an A&E attendance or an unplanned hospital admission.
- The establishment of an AWC Respiratory Network, with practice nurse leads in every GP practice will improve the care and management of people.
- Creating a single template for COPD and asthma care to be used across the AWC practices. This aims to improve the delivery of patient focussed annual reviews, targeting of rescue packs for COPD exacerbations to the right individuals, increase referrals to pulmonary rehabilitation and improve information sharing with secondary care with patient consent in case of requiring step up or step down care.

3.2.5 Living Well: winter respiratory campaigns

The Self Care and Prevention Programme has commissioned the Voluntary and Community Sector Alliance to deliver engagement sessions to people of all ages living across Bradford District and Craven to promote winter wellness/respiratory health campaigns from September 2018.

The focus of the engagement is to deliver targeted health messaging to communities over the winter months using the 'Choose Well' and 'Is my Child Unwell' campaign resources, as well as promoting 'keep warm, keep well', flu vaccinations, management of respiratory conditions, and supporting parents/guardians of 2-to-3 year olds.

The Self Care and Prevention Programme is also working in partnership with the School of Pharmacy and Medical Sciences at Bradford University; pharmacy students will be engaging with the public during Self Care Week in November to promote 'Staying Well in Winter' campaign resources, provide information on respiratory health, and signpost members of the public to appropriate support services.

3.2.6 Bradford District Flu Vaccination Plan

The Flu season occurs every winter and is a key driver of NHS winter pressures and ill health in winter. It impacts on those who become ill, the services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. The flu vaccine is one of the evidence based modifiable risk factors helping people to stay well over the winter. Accordingly, it is important that those eligible for the vaccine receive it. Vaccine uptake varies between at risk groups and across the District. In order to address this we have a comprehensive flu vaccination plan, developed in partnership between the local authority, NHS England, Clinical Commissioning Groups and Community Pharmacy West Yorkshire. The Flu vaccination plan aims to reduce the impact of flu in the Bradford and District population through a series of complementary measures.

4. FINANCIAL & RESOURCE APPRAISAL

Tackling public health issues requires long term commitment and investment. Much of this already exists and is directed towards activity which will positively influence the indicators in the Public Health Outcomes Framework. The Public Health service is grant funded by the Department of Health, the total funding for 2018-19 is £41.826m and it is anticipated that the service will balance the budget. There are no financial issues arising from this report on respiratory health in Bradford.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

None

6. LEGAL APPRAISAL

The provision of respiratory health services falls within the Council's responsibilities for health and wellbeing under the provisions of the Health and Social Care Act 2012. This act requires the Council to consult and follow any guidance issued by the Secretary of State for Health and Social Care. There appears to be no relevant statutory guidance issued at this time save for NICE treatment guidelines, which the report indicates are in scope for current service provision.

The fact that the principal providers of first line treatment for respiratory disorders are GP's providing Primary Healthcare services suggests that this is an area where significant gains may be made through the integration of health and social care services provided by the Council and the local NHS providers and contracted primary care services.

This report does not appear to raise any other specific legal issues.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

None

7.2 SUSTAINABILITY IMPLICATIONS

None

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

None

7.4 COMMUNITY SAFETY IMPLICATIONS

None

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

- The impact of respiratory disease varies across the District. This highlights the need for targeted work, for example, with primary care to address variations and reduce inequalities.

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

None

7.9 IMPLICATIONS FOR CORPORATE PARENTING

None

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

None

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

Not applicable.

10. RECOMMENDATIONS

That the Committee note the information provided in the report and support on-going work seeking to address the main challenges going forward.

11. APPENDICES

None

12. BACKGROUND DOCUMENTS

None