City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Director of Director of Keeping Well at Home, Bradford Districts Clinical Commissioning Group, to the meeting of Bradford South Area Committee to be held on 27th February 2020

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Subject:

Update from NHS Bradford Districts Clinical Commissioning Group.

Summary statement:

This report provides an update on the priorities, recent initiatives and public engagement activities by NHS Bradford Districts Clinical Commissioning Group.

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Portfolio:

Health Wellbeing
Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

This report provides an update on the priorities, recent initiatives and public engagement activities by Bradford Districts Clinical Commissioning Group.

2. BACKGROUND

Bradford Districts Clinical Commissioning Group was established in April 2012 in shadow form and were fully authorised in April 2013. This report provides an overview of the CCG's recent activities in priority areas.

3. OTHER CONSIDERATIONS

See report attached at appendix 1.

4. FINANCIAL & RESOURCE APPRAISAL

Not applicable.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Not applicable.

6. LEGAL APPRAISAL

Not applicable.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

None.

7.2 SUSTAINABILITY IMPLICATIONS

Increased local decision-making has the potential to create more sustainable solutions to local issues.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

No specific issues.

7.4 COMMUNITY SAFETY IMPLICATIONS

There are no community safety implications arising from this report.

7.5 HUMAN RIGHTS ACT

There are no human rights issues arising from this report.

7.6 TRADE UNION

Not applicable.

7.7 WARD IMPLICATIONS

None identified.

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

Not applicable.

7.9 IMPLICATIONS FOR CORPORATE PARENTING

None.

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

None.

8. NOT FOR PUBLICATION DOCUMENTS

None.

9. OPTIONS

None.

10. RECOMMENDATIONS

Bradford South Area Committee is asked to note the contents of this report.

11. APPENDICES

Appendix 1: Report of the Director of Keeping Well at Home

12. BACKGROUND DOCUMENTS

None

Appendix 1

NHS
Bradford Districts
Clinical Commissioning Group

Report of the Director of Keeping Well at Home to Bradford South Area Committee

Bradford Districts Clinical Commissioning Group (CCG) is an NHS organisation that commissions (plans, buys and monitors) most of the hospital and community NHS services in the local areas for which it is responsible. Commissioning involves deciding what services are needed for diverse local populations, and ensuring that they are provided.

Services CCGs commission include:

- most planned hospital care
- rehabilitative care
- urgent and emergency care (including out-of-hours)
- most community health services
- mental health and learning disability services
- family doctor (GP) services

All three of our CCGs in Bradford District and Craven work closely together and have a shared management team. The CCGs applied to NHS England in 2019 to become one CCG from April 2020 and they are currently going through the due diligence process associated with this. Work will continue to take place locally through two partnership footprints following the proposed move to one CCG. Locally this will be through the Bradford Health and Care Partnership, which brings together local organisations involved in health and care with a view to making patient pathways more responsive to those who use them.

We also work as part of the wider West Yorkshire and Harrogate Health and Care Partnership on commissioning plans and decisions that would benefit from collective decisions about specific work programmes – for example, mental health, stroke and urgent care.

Prior to this meeting, the Area Committee requested information about young people's mental health, cancer and heart disease. The first part of this report focuses on this, whilst the second gives a broader overview of some of the other work of the CCG.

Part 1: Young people's mental health including self-harm admissions to hospital

In terms of self-harm admissions to hospital, we aim to address this through part of our New Care Models and Trailblazers in school work.

New Care Models: we have worked with NHSE using a care navigation role to reduce length of stay or avoid admissions to hospital stay and ensure better use of our safe spaces. This has released savings from using less inpatient beds which we have reinvested in our Intensive Home Support team who provide support to children in the home and communities. We have also increased capacity to the First Response service and to Guideline, which is our community based support line.
In addition to the above we have commissioned Kooth which is an online counselling platform providing support to young people.

We have been successful to be part of the national Mental Health Trailblazer programme. The Mental Health Trailblazer in schools will be tried in the City and Craven area initially. This work will provide specialist clinical and pastoral support in schools while also building links to peer and community based support. We have recently completed recruitment and training has commenced for the teams to be operational by January 2021. We are exploring the potential to expand the trailblazer work in South for January 2022. The Government intend to use the learning from the trailblazer sites to establish Mental Health Support teams in schools across the whole country by 2025.

In October 2019 the Mental Health Partnership Board (MWPB) agreed that a sub group to focus on children and young people's mental health would be formed to enable the system to focus on issues within children and young people's mental health, a proposal which was supported by the Health and Wellbeing Board. The group will build on the good work done with Future in Mind, but broaden out to be the governance for all things related to children's mental health, reporting into the MWBP.

Jenny Cryer, Assistant Director in Children's Service at the Council, Lisa Stead, Clinical Lead for Children and Adolescent Mental Health Services at Bradford District Care Foundation Trust and Sasha Bhat, Commissioner for Mental Health agreed to lead work with partners to scope the role of the new group and to work though urgent issues that have arisen within the delivery of mental health services for children and young people.

Work with the sub-group has focussed on four key areas – System changes, parental support, waiting list initiatives and information and communication. 13 priority actions were agreed, with an additional 2 made as work progressed. It was agreed to continue the sub group in its development phase until the end of March 2020 to own and move these actions forward.

One of the key actions has been the development of a coherent pathway that clarifies the support pathways available for children's mental health. This ranges from accessing children's mental health support to referral and to the right treatment interventions. The pathways will be integrated across community, primary and secondary care and work is ongoing to develop a trusted referral and assessment process to enable the smooth referral process for children to the right support.

A second key area of delivery has been the waiting list initiative. We have worked with Bradford District Care Trust to identify all children and young people waiting for assessment and waiting for treatment and offer support and guidance. This work will commence from 1st March 2020 and includes providing children who are waiting with additional support and counselling while they are waiting and prioritising children to get the right support.

Parental support session will be co-designed supported by the Roller-coaster parenting group and finally a large piece of work is taking place to ensure clear information and communications about the mental health offer is available to parents, children, services and communities.

Part 2: Cancer

Since summer 2019 there have been a number of changes to the infrastructure of cancer services across Bradford and Craven.

A Bradford and Craven Cancer Plan has been developed by Bradford and Craven Clinical Commissioning Groups (CCGs), together with key stakeholders, to ensure delivery of the cancer strategy for England 2015-2020 'Achieving World Class Cancer Outcomes' and the 'NHS Long Term Plan' 2019. This plan outlines how Bradford and Craven CCGs, in partnership with local health and care organisations, will implement the recommendations from the strategies, to transform services and improve care; treatment; support and outcomes for people affected by cancer in Bradford and Craven.

The Cancer journey requires a comprehensive and robust partnership approach to the delivery of a wide range of services. There are four key phases for patients;

- Prevention
- Diagnosis
- Treatment
- Supporting those living with and beyond cancer
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No one organisation is solely responsible for the commissioning and delivery of services for Bradford and Craven patients. Working together with patients, commissioners, providers, the local authority and being part of regional bodies, we will look at all aspects of provision for cancer, at every stage of the cancer journey, identifying areas where improvements and transformation can be made.

Bradford and Craven CCG Cancer Plan sets out an ambitious vision for improving services, care and outcomes for everyone with cancer; fewer people getting cancer, more people having a good experience of their treatment and care, whoever they are and wherever they live and more people being supported to live as well as possible after treatment has finished.

Local developments include:

- The CCG is working with public health to improve the general health of our population, meaning individuals are in a better position should they develop cancer. We can further improve our survival rates by catching cancer earlier and making treatment pathways as effective as possible. One area of work is how we can increase the uptake rates for the cancer screening programmes for bowel, cervical and breast cancer as historically this has been a local challenge. This includes education and awareness, promotion and accessibility and how we can work more closely with our communities.

- In order to increase uptake rates to the bowel screening service, the CCG is working closely with Yorkshire Cancer Research & Enable2 to implement a pilot

project using interpreters to phone non-responders on behalf of GPs across Bradford and encourage participation to the screening programme. The full roll out of the project was completed in December 2019 and we are currently in the evaluation phase, results of which are expected March 2020.

- Talk Cancer sessions have been run by Cancer Research UK and offered to partner organisations, practice staff and community groups across Bradford with the aim of raising awareness of cancer, lifestyle factors, signs of symptoms and improving communication skills to have possibly difficult conversations. 24 sessions (including a Train the Trainer session) were delivered over 12 months with very positive feedback.

- Contacting first time invitees to screening in order to give more information and encourage participation.

- Community engagement through Voluntary Community Support groups.

- Implementation of Faecal Immunochemical Test (FIT) from June 2019 to replace the Faecal Occult Blood (FOB) test for bowel screening, making the process much simpler and hopefully meaning that more people will participate. This will also allow GPs to make more appropriate referrals and ease pressures on our hospitals.

- A pilot initiative to target individuals at high risk of lung cancer and offer lung health checks, low dose CT scan as well as smoking cessation advice is within Bradford is currently being implemented and aims to diagnose cancers earlier when there is a better chance for effective treatment. The pilot programme is currently in the evaluation phase.

- There had been capacity issues within Dermatology services which had led to long waits. The CCG together with Bradford Hospital has increased the number of community dermatology clinics and developed new pathways which has reduced the backlog and developed a more streamlined service.

- Patient experience is important and helps shape the way services are delivered both in and out of hospital. There is a national annual patient experience survey where an action plan outlining areas for improvement is locally developed. We are currently implementing these recommendations.

- Work is ongoing to improve the quality of cancer related referrals using the urgent referral two week wait pathways. This includes strengthening criteria and using the Assist tool (an online pathway information and referral tool for general practice) to improve adherence to pathways and ensure all relevant information is captured in the referral in order that patients are seen within the most appropriate service in a timely manner.

- There are continued developments within the Rapid Diagnostic Clinics which is a single clinic for people displaying vague but concerning symptoms which could be cancer, where a patient can undergo several tests relevant to their symptoms on

the same day to prevent people from falling through gaps and get a quick diagnosis. Workforce is small and clinics vulnerable, we aim to strengthen this and long term plans include the introduction of community hubs.

- Cancer Equality and Quality Impact Assessments are currently being developed. These will shape and inform delivery of the cancer plan to ensure that initiatives and focus is in the right place where improvements are required.

- Living with and Beyond Cancer is a key aspect of the NHS Long Term Plan and we are working with voluntary and community sector partners to deliver the best range of support for our patients and to improve access to the four elements of the Recovery Package (a holistic needs assessment and care plan; a treatment summary; a cancer care review and access to health and wellbeing events).

- Implementation of the Personalised Support Coordination project in collaboration with Bradford Teaching Hospitals NHS Foundation Trust, Macmillan Cancer Support and Yorkshire and the West Yorkshire and Harrogate Cancer Alliance. This programme delivers a significant change to the way cancer services are delivered and experienced by patients. It is a means to make sure that every patient is offered a meaningful, person-centred conversation about their needs and linking people to support in their own communities. It aims to improve the experience of patients living with and beyond cancer and provide individually tailored support packages which may include counselling, financial advice or exercise programmes

Part 3: Heart disease

Successes from the Bradford's Healthy Hearts Programme are now being rolled out across the region as part of the West Yorkshire and Harrogate Integrated Care System. The work is following the same clinical areas, with a focus on Hypertension, Cholesterol and Atrial Fibrillation, with a further programme on diabetes planned in 2020. This work ensures that guidance is being implemented systematically resulting in improved care management and outcomes.

The region has seen an increase of nearly 8,000 patients with controlled BP (under 80s) from a January 19 baseline to now. This is in addition to the approximately 7,500 additional patients on hypertension register. This amounts to more than 15,000 clinical interventions.

These numbers, over the next 5 years, using conservative estimates, could have the potential to prevent:

- 65 deaths
- 122 strokes
- 82 hearts attacks

Our locally funded project by the British Heart Foundation has now reached an end in its current form, however HALE a local community voluntary provider, have agreed to continue testing as part of its healthy lifestyle programmes.

At the end of September 2019, 4,400 people have been tested for high blood pressure, and of these, over 240 people have been diagnosed and treated for high blood pressure, a great result.

Also, as part of this work, HALE agreed to do pulse checks (testing for Atrial Fibrillation (AF), an irregular heart beat) any irregularities in pulse were referred to their GP and advised to seek further advice, this resulted in 54 people being diagnosed and ultimately treated for AF.

We will continue to work towards reducing cardiac episodes by providing excellent care and management for people with cardiovascular disease, at the same time as aiming to reduce their risk of developing heart disease.

Part 4: other CCG health plans and initiatives

1 GP access

- The CCG's are working with NHS England to access national Estates and Technology Transformation Funding (ETTF), which will support a number of local GP practices to make improvements to their premises – including in some cases, conversion of admin space into additional clinical rooms, so that the practices can offer more or a different mix of services, and / or improve access to the premises through improved flooring, paving or parking.

- Local GP practices are promoting greater use of online services, to give more convenient access for patients – 100% of Bradford district and Craven CCG practices now offer online services and locally 32% (AWC), 32% (Bradford City) and 39% (Bradford Districts) of patients (compared with 29% of patients across England), are registered to book/ cancel appointments online and order their repeat prescriptions online (via a computer or smart phone), reducing the need to contact their practice.

- The new NHS App is also being promoted to patients, https://www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app/ which supports greater online access (via a computer or smart phone) to appointment booking, ordering repeat medicines, viewing your medical record, accessing self care advice, checking your symptoms, and even allows patients to register to be an organ donor.

- In addition to local GP practices adopting use of a system which gives patients access to an online consultation, (during 2019-20) plans are in development for a small pilot of a new video consultation software, which would allow a 'face to face' capability (via use of the internet), which could be most useful for more visual diagnoses, and supporting patients who find it hard to access the surgery, e.g. those who are frail or housebound.

- A collaboration between local GP practices and NHS 111, will soon launch allowing NHS 111 call handlers to book you an appointment with your practice, if being seen in primary care is the most suitable place to meet your needs. This may reduce some unnecessary A&E attendances, and further support patients with access to services out of hours.

2 Bradford Breathing Better

Working collaboratively with colleagues in both primary care and secondary care, we are concentrating on pathways of care and improved management specifically for people with Chronic Obstructive Pulmonary Disease (COPD) and Asthma. This will ensure that patients who exacerbate are seen in a timely manner and have the most appropriate treatment to support them and receive suitable follow up.

We realise that understanding your condition, your medication and how this works is paramount for people, and education is a key component to self-care. We want to make sure that our patients all have a care plan with details on what to do should they become unwell. Often people struggle with their condition before seeking help and then find that they are admitted to hospital as their condition has worsened.

Many patients who are admitted to hospital are in for a very short period of time often less than one day. For those people it may be that if we could provide support to them in the early stages of their condition worsening, we could prevent them going into hospital and allow them to be cared for in their usual place of residence. Supporting this we have commissioned BOC (a gas company) to work with primary care to identify people who are at a higher risk of being admitted (this is based on a number of clinical indicators).This is a joint initiative with our urgent care colleagues. These individuals will be invited to attend an appointment (or be visited at home if they are unable to get out) and their medication will be reviewed, they will receive information on how to keep well, exercises to do, how to take their medication (such as inhalers) and given a care plan. We have seen some very positive early indications of the success of this work and a full evaluation will be undertaken at the end of the project.

3 Winter pressures: urgent and emergency care

The Bradford system has been under a lot of pressure over the winter period. Attendances at Accident and Emergency (A&E) have been between 400 -500 every day with between 80-120 ambulance arrivals daily. Additional services have been put in to support this period including additional primary care before the festive period, on bank holidays and just after bank holidays.

A great deal of work has gone into place between organisations to ensure that A&E is utilised by the patients that have urgent and emergency needs. This has involved establishing pathways to ensure that ambulance convey people to services that best meet their needs. This includes pathways to First Response for people in mental health crisis.

Bradford Teaching Hospitals Trust has seen an improvement in its achievement of the A&E four hours standard in recent weeks and has been in the top 10% of hospitals in the country over the last week (Week start 3rd Feb). The additional services that have been commissioned over winter will continue until the end of Easter.

4 Integrated Care System (ICS)

Bradford District and Craven is one of six places of the West Yorkshire and Harrogate Health and Care Partnership. We are delivering services in ‘place’ through two local health and care partnerships, as referenced above.

We continue to build an integrated care system in conjunction with our health and care partners. This way of working is resulting in a change in the way that health and care commissioners and providers work together to take a population health management approach to the provision and commissioning of care. This has been supported by the development of a Strategic Partnering Agreement which all partners of the partnership have signed and commits to working together moving forward. It requires all organisations to be aligned, use the same words, same ethos, same vision and same measures of success. The ultimate aim of this way of working is to deliver our strategic vision of ‘Happy, healthy, at home’.

Ali Jan Haider
Director of Keeping Well at Home
Bradford Districts CCG

27 February 2020